PUBLIC MEETING

Via GoToWebinar

Thursday, October 28, 2021
10:30 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

Session 1: Panel Discussion: Data issues in monitoring access to care for Medicaid beneficiaries

Introduction:

Ashley Semanskee, Analyst..............................4

Panelists:

Genevieve Kenney, Ph.D., Urban Institute...............7

Joseph Caldwell, Ph.D., Brandeis University............9

Barry Cambron, Alabama Medicaid.......................11

Further Discussion by the Commission.....................52

Public Comment...68

Session 2: Mandated study on Money Follows the Person qualified residence criteria: results from analytic work

Kristal Vardaman, Policy Director.....................73

Tamara Huson, Analyst.................................77

Session 3: Vaccines for adults enrolled in Medicaid:

interview findings

Amy Zettle, Senior Analyst..........................107

Chris Park, Principal Analyst and Data Analytics Advisor

Public Comment..146

Session 4: Required annual analysis of disproportionate share hospital allotments to states

Aaron Pervin, Senior Analyst........................149

Jerry Mi, Research Assistant........................151

Public Comment..163

Adjourn Day 1...165

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

2 [10:30 a.m.]

3 CHAIR BELLA: Good morning. Welcome, everyone,
4 to the October MACPAC meeting. We appreciate you all
5 joining us. Good morning to all the Commissioners.
6 We're going to start off this morning with a
7 panel discussion on data issues in monitoring access. This
8 is a continuation of our work in this area, and we are
9 thrilled to have three external folks joining us.
10 Ashley, good morning. You are going to kick us
11 off, I know, and do some moderated Q&A. I think we're
12 waiting for the panel to join. Is that right?
13 MS. SEMANSKEE: Actually, I think we're just
14 waiting for everyone to come up.
15 CHAIR BELLA: Okay, great.

16 **### PANEL DISCUSSION: DATA ISSUES IN MONITORING**
17 **ACCESS TO CARE FOR MEDICAID BENEFICIARIES**

18 * MS. SEMANSKEE: Here they come. Great.
19 Well, good morning, everyone, and thank you,
20 Melanie, for introducing the session. As you know, in this
21 cycle we're focusing on how to improve systems of
22 monitoring access to care for Medicaid beneficiaries. In

1 September, staff presented background on the current access
2 monitoring systems in Medicaid, and today we'll focus on
3 data available to monitor access and suggestions for
4 improvement based on findings from a literature review and
5 stakeholder interviews with states, CMS, plans, providers,
6 beneficiary advocates, and experts. We'll also hear from a
7 panel of experts who will provide additional insight.
8 Now I will briefly introduce our panelists, and
9 their full bios are in your materials.
10 We have Dr. Genevieve Kenney, who is co-director
11 and senior fellow at the Health Policy Center at the Urban
12 Institute and an expert on quality and access in Medicaid.
13 We also have Joseph Caldwell, who is director of
14 the Community Living Policy Center at Brandeis University
15 and an expert in long-term services and supports and
16 Medicaid home and community-based services.
17 We also have Barry Cambron, deputy commissioner
18 of Health Systems at Alabama Medicaid agency. He leads the
19 Managed Care Operations, Networks and Quality Assurance,
20 and Data Analytics Divisions.
21 Thank you to all of our panelists for joining us
22 today.

1 Today we'll be discussing data available for
2 monitoring access to care in Medicaid across three access
3 domains: provider availability and accessibility,
4 beneficiary utilization, and beneficiary perceptions and
5 experiences. As we go through each domain, we'll ask
6 panelists to discuss what are the most important gaps and
7 limitations of existing data and what approach could help
8 address them. Panelists will have about one or two minutes
9 to respond to each question. I know that's not a lot of
10 time, but we'll also have a half-hour of discussion at the
11 end of the presentation to discuss with Commissioners. So
12 if there's anything you'd like to raise, we can come back
13 to it.
14 We'll start with provider availability and
15 accessibility. This domain measures potential access to
16 care, including provider supply, provider participation in
17 Medicaid, and accessibility. States and CMS use different
18 data sources to monitor provider availability, including
19 provider licensure data, directories, claims data, secret
20 shopper audits, and provider surveys. However,
21 interviewees said it's often difficult to measure
22 accessibility factors, including whether providers are

1 accepting new Medicaid patients, how many Medicaid patients
2 they actually treat, wait times, and language and
3 disability accessibility.
4 Some interviewee suggestions to improve data
5 include issuing guidance to monitor provider availability
6 more consistently across states, and surveying providers or
7 conducting secret shopper audits to assess provider
8 acceptance of Medicaid patients, wait times, and
9 accessibility.
10 Now we'll go to our panelists. Dr. Kenney, can
11 you start us off by discussing the most important gaps in
12 the existing data in this domain and any approaches that
13 could help address them?
14 * DR. KENNEY: I'd be glad to, and I want to thank
15 you for inviting me to participate.
16 I wanted to start by proposing some overarching
17 suggestions for MACPAC to consider that actually apply
18 across all three domains.
19 First, I think it's really important that MACPAC
20 identify a mechanism for incorporating input from Medicaid
21 enrollees themselves. I think it's really important that
22 the measures that you endorse as ones that should be

1 prioritized be ones that enrollees value.

2 Second, wherever MACPAC lands, I would suggest
3 the importance of building in transparency and explicit
4 accountability that apply to both Medicaid programs and
5 their managed care plans so that this doesn't lead to just
6 one more report that sits on a website. In my view, the
7 point of access monitoring is to assess whether Medicaid
8 enrollees have access to high-quality, timely health care
9 that meets their health care needs and to trigger follow-up
10 actions that would rectify problems that are revealed.

11 And as if that's not enough, I think to be
12 meaningful from an equity standpoint, it's essential that
13 we be monitoring access for groups that have been
14 historically marginalized.

15 And, finally, I would suggest building a process
16 that allows for modification and updating over time,
17 including dropping measures that aren't proving useful, and
18 adapting to changes in the service delivery system and our
19 available data sources, and as we learn what matters.

20 In terms of a specific suggestion I would have on
21 the access and availability provider domain, I would
22 prioritize efforts that focus on real-time monitoring of

1 provider availability and accessibility using secret
2 shopper and related approaches to assess the accuracy of
3 provider networks, particularly for specialty care, for
4 both fee-for-service and managed care so we know whether
5 providers are actually taking new Medicaid patients, we
6 understand how long wait times are for both urgent and
7 nonurgent appointments, and we also have a picture of how
8 well providers are accommodating different patient needs.
9 And I would highlight, in terms of a gap, our
10 need to revisit time and distance standards for services
11 that will continue being available through telehealth.
12 Thank you.
13 [Pause.]
14 CHAIR BELLA: Ashley, I think you might be on
15 mute.
16 MS. SEMANSKEE: Oh, thanks, Melanie. Thank you,
17 Dr. Kenney.
18 Now I'm going to ask Dr. Caldwell if you have any
19 further comments from an HCBS perspective.
20 * DR. CALDWELL: Yeah, hi, everyone, and thanks for
21 the opportunity to talk about home and community-based
22 services. Let me just start by stating the obvious. I

1 think, you know, measuring access in HCBS is really
2 challenging, and I think that's why we put this part of the
3 Medicaid program off for so long.
4 But, you know, when I think about this domain and
5 HCBS, I think a good starting place of my thinking on where
6 to focus is really on the direct care workforce. So,
7 conceptually, when I think about this domain, you know, I
8 think the most important thing we're trying to get at is
9 whether there's an adequate supply of direct care workers
10 to meet the current needs of HCBS beneficiaries and then,
11 you know, future needs of beneficiaries.
12 But, of course, that's difficult to measure. I
13 think, you know, we don't -- some states might be able to
14 tell you how many direct care workers there are in the
15 state, and it depends if they have things like
16 certification or registry or background checks. But in
17 other states, it might be really challenging even for them
18 to tell you how many direct care workers there are. So
19 that, you know, is a real challenge.
20 One thing I've heard many advocates suggest is to
21 have CMS and the Department of Labor to work together to
22 try to reclassify the way DOL currently collects data on

1 the worker, the direct care workforce. There's some issues
2 that don't really align well with the Medicaid HCBS
3 program, so I've heard that suggested as a future direction
4 to try to get better data from DOL.
5 And then, lastly, I think I would just raise one
6 issue here. What is the comparison group? Because
7 Medicaid is the primary payer of HCBS, and like some people
8 that I know say it's really the only game in town. So if
9 we were going to compare rates or payments, it's difficult
10 to know what to compare that to, patiently, you know,
11 Medicare home health, but that's a little bit of a
12 different thing, or, you know, the private market for
13 direct care workforce. But those are some additional
14 challenges.
15 Thank you.
16 MS. SEMANSKEE: Thank you, Dr. Caldwell.
17 Now, Mr. Cambron.
18 * MR. CAMBRON: Thank you, Ashley, and I thank
19 everyone for allowing me the opportunity to provide a
20 state's perspective. And I apologize. My camera seems to
21 be buffering. It's been coming in and out. Hopefully
22 everyone can hear me.

1 I would say of the three domains that we're
2 discussing today, I think availability and accessibility
3 seems to be the most feasible for a state to begin
4 considering access, particularly accessibility. The
5 straightforward provider-enrollee ratios and maps of
6 provider locations is still important and will always be an
7 important starting point. But as individual states begin
8 to go beyond this point, we might start to develop various
9 limitations that may be unique to each agency, state, or
10 even region of the country.
11 So, for example, the past year our agency's
12 analytics division has worked with our partner at the
13 University of Alabama to build a statistical model that
14 takes into account provider locations, how many patients a
15 provider sees, population density, drive time and distance,
16 et cetera, from a patient's home to the provider location.
17 We ultimately plan to operationalize this to
18 drive policy on targeted geographies for recruiting various
19 specialties and provider types in specific hot spots. I do
20 realize that this capability, this internal analytics
21 capability, might not exist in several states, however.
22 But certainly in Alabama, we also have our own limitations.

1 For example, in Alabama, providers do not have to take
2 Medicaid. But we know that a provider is accepting
3 Medicaid because they have applied for reimbursement.
4 However, what we do not know is if they'll accept more than
5 one Medicaid patient or if they will accept anyone that
6 walks in the door for that matter.
7 Also in our state, we don't have an all-payer
8 claims database, so it can be a challenge for us to
9 objectively determine if some of our providers have the
10 capacity to service our enrollees because we truly don't
11 know their payer mix and, therefore, enumerating the supply
12 of Medicaid providers can be challenging. So it would be
13 beneficial for us to have access to such a database or a
14 data set that gives us insights into the true panel sizes
15 of our providers and would really be beneficial in our
16 ability to make actual decisions in communities that need
17 help.
18 Another challenge we encounter is that providers
19 are allowed to self-report multiple provider types, so that
20 hinders the accuracy of data for analysis as well. But, in
21 general, when it comes to collecting additional data to
22 determine if a finer level of detail of provider

1 availability and accessibility is available, I think we
2 would love to -- from a state's perspective, from Alabama's
3 perspective, we would love to be able to collect and
4 utilize the data, for example, the secret shopper audits,
5 the all-payer claims database, as I mentioned. But I also
6 think the feasibility of this could be potentially
7 strained, particularly considering the resources and time
8 constraints associated with gathering, with analyzing the
9 data, and then ultimately incorporating the knowledge into
10 policy and into action.
11 MS. SEMANSKEE: Okay. Thank you, Mr. Cambron.
12 Next, we're going to move to our next domain,
13 which is beneficiary utilization. This domain includes
14 service use, the appropriateness of services, and health
15 outcomes. T-MSIS is the main source of utilization data,
16 but interviewees noted that it has some limitations in
17 terms of reliability and completeness and consistent
18 definitions that limits comparability across states and
19 populations. Interviewees also reported it is difficult to
20 measure appropriateness of care and health outcomes using
21 claims data.
22 Some interviewee suggestions to improve data

1 include improving the quality of T-MSIS data, including
2 further standardizing definitions of services and
3 providers; improving collection of race and ethnicity data;
4 or conducting chart reviews to compare treatment plans to
5 actual service use and identify any unmet needs; and
6 examining HEDIS measures or using an all-payer claims
7 database to compare access in private insurance and
8 Medicaid.

9 Dr. Kenney, can we start with you again with this
10 discussion?

11 DR. KENNEY: Yes, thank you. In this domain, I
12 would prioritize the continued investment in T-MSIS working
13 toward addressing the issues that Ashley flagged with
14 respect to standardizing coding of services and of
15 providers across and within states and increasing the
16 completeness and accuracy of the information on an
17 enrollee's race, ethnicity, and their primary language.

18 With T-MSIS becoming available in a much more
19 timely way than in the past and more and more states
20 providing complete and comparable information, I see T-MSIS
21 as an essential building block for monitoring access in
22 Medicaid within and across states. Initially, I would

1 prioritize measures that can be developed based on Medicaid
2 claims and encounter data alone, which include most of the
3 core adult and child measure sets, and AHRQ patient safety
4 measures, patient and quality measures. But given the
5 importance of using private sector benchmarks for Medicaid,
6 I would propose supplementing T-MSIS with hospital
7 discharge data, like what is available through AHRQ's
8 Healthcare Cost Utilization Project, or HCUP, so that we
9 can compare quality and utilization patterns at least for
10 inpatients with Medicaid coverage to those with private
11 coverage.
12 A colleague of mine has been using HCUP data to
13 study racial equity for a subset of inpatient safety
14 measures and is now assessing how those outcomes vary
15 between Medicaid and those with private health insurance,
16 and I think it's a really important track for us to be
17 pursuing.
18 Ultimately, we're going to want to supplement the
19 selected measures with selected measures that require chart
20 review or that pull information from EHRs. And we'll want
21 to understand whether and how any important access deficits
22 that are identified in Medicaid track back to specific

1 policy choices. Both are related to Medicaid policies with
2 respect to reimbursement or other factors that undermine
3 provider participation in Medicaid as well as policies in
4 other sectors that may be contributing to the segmentation
5 of providers who are serving Medicaid as opposed to
6 privately insured patients.
7 Thank you.
8 MS. SEMANSKEE: Okay. Thank you, Dr. Kenney.
9 Dr. Caldwell?
10 DR. CALDWELL: Yeah, for home and community-based
11 services, I think this is one of the most challenging
12 domains due to the relatively few data sources. So just
13 conceptually, what I think this domain should really get at
14 -- here's a couple ideas -- is service gaps. So, in other
15 words, if people are authorized for certain services or a
16 certain number of hours of services but they're not getting
17 them because they can't get a direct care worker, they
18 can't find a direct care worker, somebody doesn't show up,
19 so that gap, I think conceptually that would be the best
20 thing -- one of the best things to try to measure here.
21 The other idea that I would suggest is the
22 concept of, you know, turnover rates of direct care workers

1 and retention rates of direct care workers, which there are
2 some efforts in the developmental disabilities world to
3 measure those mainly at the agency level. I think it's
4 much harder in self-directed programs to kind of get at
5 that.
6 But, again, to go back to the data sources, you
7 know, T-MSIS I think is new and we don't really know the
8 validity, reliability of that for home and community-based
9 services. It could potentially be a good direction, you
10 know, perhaps looking at the T-MSIS data in combination
11 with, I guess, the person's service plan to see how many
12 hours they should have been getting and then see, you know,
13 what they actually got. Maybe that's a future direction.
14 But I would also suggest that some of these
15 things could be got at a little differently through
16 beneficiary surveys, which I'll talk about. That's the
17 next domain.
18 MS. SEMANSKEE: Okay. Thank you, Dr. Caldwell.
19 Mr. Cambron?
20 MR. CAMBRON: Thank you, Ashley. I would echo
21 some of the statements that were on the slides and my
22 fellow panelists, especially when considering the

1 limitations of T-MSIS data to measure this. Missing,
2 incompetent, non-standardized, and at times unreliable data
3 will always or at least for the foreseeable future be an
4 issue with relying on T-MSIS data alone. However, I do
5 believe that utilizing quality measures calculated with
6 this data is utilized often enough that it seems that would
7 be appropriate upon improving these processes and metrics
8 as a natural first step for state agencies.
9 So, for example, several quality measures that we
10 measure in Alabama from the adult and child core set that
11 we measure and report address beneficiary service
12 utilization by measuring various rates ranging from well-
13 child visits to access to primary care to family planning
14 services, among others.
15 We also work with our PCCM-E entities. We have a
16 1915(b) program, a care coordination program, and we use
17 these metrics to target geographic hot spots to improve
18 measures for the state with a focus specifically on
19 childhood obesity, substance abuse, and infant mortality.
20 We're not a managed care state. Again, we have
21 the PCCM-E entity. But when we were preparing to become a
22 managed care state five years ago, we were preparing to

1 gather encounter data, chart reviews, among other things,
2 where we would rely greatly on our MCOs. We were also
3 considering the appropriate metrics of utilizations that
4 would be passed on to the MCOs and ultimately how to
5 incorporate these data gathering access into their work
6 flows and even their incentives. And as mentioned earlier,
7 an all-payer database does not exist in the state, so while
8 it would be interesting to consider a beneficiary's
9 utilization, at least at this time it would be best for us
10 to compare it to a national database.
11 And I would also just finally echo Dr. Kenney's
12 sentiments on hospital discharge data. That is also
13 something that we're working on in the state to develop a
14 statewide system with our Department of Public Health, and
15 ultimately I think that would be a good comparable
16 utilization metric.
17 MS. SEMANSKEE: Thank you, Mr. Cambron. Now we
18 will move on to our last domain, which is beneficiary
19 perceptions and experiences. This domain includes patient
20 experience, barriers to care and unmet needs, culturally
21 competent care, and perceived quality of care.
22 Existing data includes complaints and grievances,

1 CAHPS surveys conducted by managed care plans, state
2 beneficiary surveys, and qualitative data, which may
3 include focus groups, interviews, or advisory groups.
4 However, interviewees noted that such data may not be
5 representative of access more generally.
6 Some interviewees suggestions to improve data
7 include fielding a federal beneficiary survey to measure
8 access and unmet needs consistently across states,
9 highlighting or requiring certain access measures that
10 states should include in their CAHPS core set of state
11 surveys, and collecting more qualitative data to supplement
12 survey data and target harder-to-reach populations.
13 Dr. Kenney, can we start with you again for this
14 domain?
15 DR. KENNEY: Yes, and we're closing, I think,
16 with the area where I think we have our most serious
17 limitations and where I think we've underinvested most
18 seriously.
19 Very complete information on the experiences that
20 Medicaid enrollees have, with Medicaid coverage and the
21 services it pays for. While we have some important federal
22 data sources that provide national estimates on unmet

1 needs, financial burdens, and perceptions and experiences
2 with care for Medicaid enrollees as well as comparable
3 estimates for those with private health insurance, we have
4 very little information along those lines for individual
5 states.
6 While T-MSIS is rich, it provides us with very
7 little understanding of the extent to which enrollees are
8 experiencing unmet or delayed health care needs. We don't
9 observe out-of-pocket spending burdens, satisfaction, or
10 experiences accessing care, the quality of communication
11 with providers, and whether there is effective languages
12 access.
13 We also know very little about the experiences
14 that enrollees have with respect to unfair treatment when
15 they access care and when they seek health care. New work
16 that colleagues here at Urban are doing jointly with me is
17 finding -- and this is work underway -- that at a national
18 level Medicaid beneficiaries feel they are treated unfairly
19 when seeking health care because of their health insurance
20 coverage at higher rates than other adults with private
21 health insurance coverage, and that black adults, and to a
22 lesser extent Latinx adults, report rates of unfair

1 treatment at higher rates than white adults among Medicaid
2 enrollees.
3 This is concerning for a number of reasons, not
4 the least of which is that we are finding that those who
5 experience unfair treatment report that they are
6 experiencing that, also report that it is having adverse
7 effects on their health and on their health care.
8 The one-time fielding of the nationwide Medicaid
9 CAHPS survey in each state, in 2014 and 2015, proved that
10 it is possible, it is feasible for us to collect robust
11 survey data from Medicaid enrollees in each state. And I
12 think that is really important for all of us to remember
13 because I think there were a lot of questions about whether
14 that was even feasible.
15 But we also could be building on our existing
16 state-level Medicaid CAHPS surveys to improve their
17 representativeness, their reliability, the scope of
18 information that is being collected, and to do it in a
19 holistic way that would include fee for service.
20 But no matter what path we take, I would argue
21 that this domain is essential. We absolutely need to be
22 collecting information directly from Medicaid enrollees and

1 tracking the kind of outcomes that reflect their
2 experiences and their perceptions to inform changes in
3 policy and practice that might be required in Medicaid to
4 improve those experiences and outcomes.
5 Thank you.
6 MS. SEMANSKEE: Thank you, Dr. Kenney. Dr.
7 Caldwell?
8 DR. CALDWELL: Yeah, I also echo, you know, this
9 is absolutely essential to home and community-based
10 services, just because of really the person-centered nature
11 of HCBS. This is really the only way to get at some of
12 these questions.
13 And what is interesting is actually, in the HCBS
14 arena, we actually do some good things, and there are some
15 things that we could build on and get broader adoption on.
16 But, you know, we have some good beneficiary surveys that
17 are done in states and most notably it's National Core
18 Indicators and the National Core Indicators Aging and
19 Disabilities surveys, and there is also an HCBS CAHPS.
20 So, the NCI and the NCIAD, you know, the NCI is
21 mainly focused on people with developmental disabilities,
22 and there are about 47 states that actually use this survey

1 pretty routinely. And the National Core Indicators Aging
2 and Disabilities survey, that is newer, and about half of
3 the states are using it right now. And then the HCBS CAHPS
4 is something that CMS really invested in and developed with
5 AHRQ. It is a really good tool. It hasn't been widely
6 adopted yet, but a few states have been using it, and CMS
7 is really providing a lot of technical assistance to try to
8 get more states to adopt that.
9 And in both of these surveys there are some
10 really good questions that really get at the workforce, and
11 they get at things like are your staff reliable and
12 helpful? Do they treat you with dignity and respect? Do
13 they show up when they are supposed to? Do they change too
14 often, so trying to get at that turnover concept. And do
15 you feel that they have the right level of training, is a
16 question in NCI.
17 So I think there are some building blocks there
18 that get more states to use these surveys, and in addition,
19 we could think about other questions that we might want to
20 add to these surveys to, for example, get at that issue of
21 gaps in care, like, you know, did you ever go without care
22 because you couldn't find a direct care worker or the

1 agency couldn't find a direct care worker? I think there
2 are additional questions that could get at some of those
3 concepts.
4 That's all. Thanks.
5 MS. SEMANSKEE: Thank you, Dr. Caldwell. Mr.
6 Cambron?
7 MR. CAMBRON: I would also agree with the
8 previous sentiments that this domain is the most
9 underinvested of the three, and I also agree with some of
10 the sentiments in the slides, particularly the notion that
11 the perceptions of our beneficiaries is very important in
12 addressing access, because these insights are difficult, if
13 not impossible to gather from claims or T-MSIS data.
14 I do think utilizing CAHPS surveys is the most
15 logical way for us, at least, to immediately improve the
16 measurement of this domain. In Alabama, we work with,
17 again, a state university to administer and collect CAHPS
18 data to capture beneficiary experience at the statewide
19 level. I do think that if we were to institute this
20 approach we would need to modify our sampling approaches
21 for the CAHPS survey so that the findings are actionable at
22 the community level. By that I mean using a more complex

1 sampling approach to oversample certain populations to
2 evaluate provider capacity, for example, and in some cases
3 at the census tract level, and particularly in
4 underrepresented communities.
5 We also administer an NCIAD survey, but again, it
6 is also conducted at a statewide level, so we would also
7 have that same challenge. And with any challenge like that
8 there comes the issue of resources. So that is something
9 that we are always balancing, particularly given our level
10 of funding.
11 Also I would close with saying in Alabama we do
12 capture many of the other data that was mentioned, for
13 example, complaints and grievances. We do focus groups
14 with our beneficiaries. So we do capture a lot of that
15 data and use them with respect to certain policy or program
16 areas. But again, when it comes to considering these and
17 other qualitative data sources, our concern is with how to
18 standardize the subjective nature of the data to ultimately
19 a metric that can be benchmarked against other states or
20 other geographies. That said, I think our state could
21 benefit from this and would appreciate some guidance on
22 reporting and considering this data.

1 MS. SEMANSKEE: Thank you, Mr. Cambron, and thank
2 you to all of our panelists. At this point we will turn it
3 over to the Commission for further discussion with the
4 panelists.
5 CHAIR BELLA: Thank you, Ashley, and thank you
6 very much to the panelists. People have been very anxious
7 to have this discussion with you, so you've really given us
8 a lot to think about and to ask you further about.
9 I'm going to open it up to the Commission. Who
10 would like to start with questions for the panelists?
11 Darin?
12 COMMISSIONER GORDON: Thank you all. This has
13 been really helpful. I have two questions and they are in
14 like discrete parts of the sections that you addressed, so
15 I will start with the first one. I am not sure who feels
16 best to answer. Not everyone has to answer but I would
17 like your perspective.
18 When we looked at secret shopper there were some
19 challenges with it, given our model, but I would be curious
20 from the speakers, from the panelists' perspective, have
21 you seen, in your research or as you worked with other
22 states, challenges with the secret shopper approach?

1 Let's not all speak at once.
2 MR. CAMBRON: Again, I'll speak. This is Barry
3 Cambron. Thanks for the question. Again, I would say one
4 of the primary challenges of using that approach in our
5 state is funding. You know, we have a certain investment
6 that we use to target certain populations. And so again,
7 we definitely see the value in that, and again, how do we
8 make it actionable? How do we make it generalizable to the
9 population, and then with respect to access, to certain
10 geographies? So it's part funding but it's also part
11 methodology and standardization.
12 COMMISSIONER GORDON: Thank you for that. I will
13 show my cards a little bit about some of the experiences we
14 had, and again, I am just trying to figure out if it was a
15 unique, discrete issue or if it is in other markets or
16 entities. When you do actually have member assignment, for
17 example, to particular primary care providers, [audio
18 interruption] panel and a secret shopper seeks to access
19 that particular provider services and they are told that
20 they can't get it because they are not in their panel, that
21 creates a bit of a challenge, but yet we wanted that
22 relationship and having that assignment or approach, but

1 that was one of the challenges we had, what we had seen.
2 And I don't know if folks have figured out ways to get
3 around that.
4 The other was that the multiple health plans, and
5 depending on which health plan you are that provider may be
6 in network with you but they may not be in network with
7 another provider, and so it's relevant whenever you're
8 doing secret shopper. But again, the reaction I've gotten
9 so far makes me feel it may have just been very unique or
10 discrete and our states have figured out how to get around
11 those issues.
12 CHAIR BELLA: Darin, I think you said you had
13 another question too?
14 COMMISSIONER GORDON: I do. I just wanted to
15 give a little pause to make sure nobody wanted to react to
16 that thought.
17 MR. CAMBRON: This is Barry Cambron. I guess my
18 only reaction to that second part is, you know, in Alabama,
19 again, we are not managed care, but when we shifted, in
20 2019, to this PCCM-E program, the 1915(b) program, we also
21 switched from a former program, what we call Patient First,
22 where we did have panel assignments for our primary care

1 physicians. With this switch to this new waiver, that
2 switched to an attribution process, and it moved to an
3 attribution process, which rewarded providers bonus
4 payments based on incentives for quality of care, for cost
5 effectiveness, but based attribution, which there is a
6 fairly complex scoring algorithm that went into that.
7 So it is interesting to kind of hear that as it
8 relates to other states, kind of gaming the system if you
9 will -- those are my words -- for panels, but it would be
10 interesting to kind of understand those experiences a
11 little bit more. But we are three years into attribution
12 now, and for the most part I think providers are very
13 accepting of that.
14 COMMISSIONER GORDON: If there are not any more
15 comments on that one I will move to my other one, which is
16 really around -- I didn't hear much discussion around
17 leveraging electronic visit verification systems for real-
18 time reactions from consumers. While maybe not as
19 developed, and I guess with the rigor of like a survey,
20 some of the other survey issues that were discussed, I
21 would like to hear some reaction from the panel if they
22 have seen that approach take hold or if there are concerns

1 or issues with leveraging that technology.

2 DR. CALDWELL: Well, this is Joe, and I was
3 trying so much to avoid that topic. But, you know, I think
4 it's something to consider for home and community-based
5 services like, you know, going forward in the future. You
6 know, it was never really designed, I think, as a data
7 collection kind of quality system, but some states are
8 thinking about that when they're designing these systems.
9 So I think that issue about the service gaps, I think, you
10 know, it could be a way to get at that, if people were
11 supposed to be getting services but they didn't.

12 But the way it's rolled out, there is so much
13 variation across states in different systems that they're
14 using, I think it would be hard to get standardization
15 around that. But within states, certainly some states are,
16 I think, trying to do that.

17 DR. KENNEY: May I say something about the secret
18 shopper piece, just to turn it around and say that to my
19 knowledge I haven't seen a lot of reports of experiences
20 states have had using this method, and it strikes me as a
21 place where there could be real gains if those experiences
22 were shared and a set of best practices that kind of get

1 through some of the very real operational constraints
2 around the question of panels and kind of how to actually
3 get at what's going on.
4 I would just say I'm happy to follow up and
5 connect you guys with some of the researchers who have been
6 thinking about this from a research perspective. That is
7 very different, I think, but I think it could inform what
8 states are doing. But also think there are state
9 experiences that just haven't been surfaced.
10 COMMISSIONER GORDON: Thank you.
11 CHAIR BELLA: All right. Thank you. Stacey,
12 then Martha, then Brian, then Dennis, then Fred, then
13 Heidi, then Tricia.
14 COMMISSIONER LAMPKIN: Wow, I'm glad I got my
15 hand up quickly. Thank you, Ashley, and thank you,
16 panelists, for coming today. This is such a timely, such
17 an important topic. It is intersecting with so much that's
18 happening in my professional life and I imagine all of
19 ours, especially as we state programs are grappling with
20 some investigating health equity type issues and all kinds
21 of stuff.
22 I have two questions. The first, I think, is for

1 you, Dr. Kenney, and it's kind of triggered by your comment
2 about prioritizing collecting real-time access and
3 availability. So this was that domain one. And I wondered
4 to what extent we even have static pictures of some of
5 these elements. Do we have a sense of how many programs
6 around the country routinely collect information on which
7 providers have extended office hours, for example, are
8 taking new patients, either in MCO network adequacy
9 reporting or in provider enrollment, anything like that?
10 Do we know?

11 DR. KENNEY: I guess it's a collective of people
12 you have on the Commission and probably several who are
13 watching have this information. But the last time I looked
14 systematically at this was 2015 and 2016, and it was
15 actually hard to know what we had and what was being
16 reported kind of consistently, and to your point, how fresh
17 that information was. So I am not on top of that at this
18 point in time to know what the current picture is.

19 COMMISSIONER LAMPKIN: Okay. Thank you. I mean,
20 my own sense was that routine network adequacy reporting by
21 MCOs might have somewhat better chance of having at least
22 being not as out of date as some other provider enrollment

1 or other sources. But I wasn't sure if states were
2 including that in their reporting.
3 My other question, I think, is for you, Dr.
4 Caldwell, and it relates to that second domain, beneficiary
5 utilization, and kind of how to interpret the utilization
6 metrics that we can even derive from the plans' data. And
7 you made a comment about comparing individual service plans
8 to what we can see in the data, and I wondered whether
9 those are typically in digital form and encoded in a way
10 that they can be paired to claims data, or is that a
11 barrier right now that they are paper or manual?
12 DR. CALDWELL: Yeah. It's a great question, and
13 I don't know exactly.
14 In the managed care space, I've worked with some
15 managed care plans that can readily share those care plans
16 pretty easily, and I suspect some states can. But I also
17 suspect that a lot can't. They're sort of at the provider
18 level, that the state doesn't have, like, ready access to
19 that person's care plan or whatever. So someone could go
20 in and do an audit or something and try to look at, for
21 example, like a sample of care plans, but that's my sense.
22 COMMISSIONER LAMPKIN: Thank you.

1 CHAIR BELLA: All right. Martha, then Brian.
2 Fred, I did see you as well -- and Bob.
3 COMMISSIONER CARTER: Thank you, and I want to
4 particularly thank Dr. Kenney and really all the panelists
5 for emphasizing the need to get input from enrollees,
6 Medicaid enrollees. I think that's so critical.
7 So from experience of fielding patient experience
8 surveys in an FQHC and then more recently doing a survey of
9 people enrolled in programs for medication, assisted
10 treatment for opioid use disorder, I found that if you
11 don't offer a paper-and-pencil option, you leave out a
12 large number of the population and for lots of reasons.
13 People don't have access to -- you know, internet access.
14 They don't want to pay for the time that it's going to take
15 to fill out the survey.
16 Also, I understand that paper surveys are more
17 expensive, and the very rich data that you can get from
18 written-in responses, the qualitative data and not just
19 were people respectful, but the patient's whole story about
20 what happened.
21 So I want to understand -- you all talked about
22 patient surveys, but I want to understand to what level

1 states are trying to incorporate paper-and-pencil surveys
2 and using qualitative data to really get at the depth and
3 the richness of what patients have to tell us.
4 MR. CAMBRON: I can address this first from a
5 state perspective. In Alabama, for our CAHPS survey, we do
6 utilize multiple modes of administering the CAHPS survey,
7 including paper. In fact, the majority of our responses
8 were for -- most of our eligibility groups are paper form,
9 with the realization that it is more expensive. But there
10 are broad areas in our state with lack of proper broadband
11 access. So it's almost a necessity, but we do, in fact,
12 build in the quantitative, and we build in the qualitative
13 written feedback from our recipients. And it's something
14 that we utilize on a quarterly basis, if necessary, for
15 policy decisions, but it's something we have an annual
16 survey that is presented to the commissioner. And both of
17 those components are taken into consideration, but it is a
18 necessity in our state, at least given the -- particularly
19 the rural areas of the state with lack of broadband access
20 or proper broadband access.
21 DR. CALDWELL: Yeah. This is Joe. I would even
22 raise the bar a little more.

1 You know, a lot of the home- and community-based
2 survey, beneficiary surveys are done in person in the
3 individual's home. So, before COVID, NCI, NCIAD, those
4 were all in-person surveys, and of course, that's
5 expensive. And that's part of the conversation here is
6 like who is paying for this. Is it the state, or should it
7 be more federal assistance with the cost of this?
8 But, you know, I do know it makes a huge
9 difference for the HCBS population. It's a hard population
10 to reach by phone. There's a lot of older people. There's
11 people with dementia and Alzheimer's.
12 I know on some of the states that have done the
13 HCBS CAHPS, from what I've heard, the response rates have
14 been extremely, extremely low for older adults and for
15 people with developmental disabilities. So you do have to
16 question what quality of data you're getting with those
17 response rates.
18 So, yeah, it's complicated, and it does take
19 resources. And I think the question is, you know, who
20 shares in that responsibility for the resources.
21 DR. KENNEY: But I would only add maybe a note of
22 hope, which is that I think the COVID experience with so

1 many enrollees accessing telehealth through their phones
2 suggests that there's really room for survey methodologists
3 to innovate and for us to think more creatively about how
4 to allow people to provide survey information.

5 And then I think you're absolutely right. That's
6 not enough, and we need to develop ways of understanding
7 where our blind spots are. And I do think qualitative data
8 collection can really provide the core insights to help us
9 understand the limitations better of the data that we are
10 able to collect easily or efficiently but also to give us
11 an understanding of the layers and the context and the
12 consequences, which again are very hard to parse in a
13 survey methodology.

14 CHAIR BELLA: Thank you.

15 COMMISSIONER CARTER: Can I ask another quick
16 question, Melanie? Or I can save it. We'll go on. If we
17 have time to come back.

18 CHAIR BELLA: Thank you, Martha. I was just
19 getting ready to say we have at least six Commissioners who
20 have questions, and out of respect for the panel's time, we
21 have about 13 minutes left with them. So, if you could
22 keep that in mind, we're going to Brian, then Dennis, then

1 Fred.

2 COMMISSIONER BURWELL: I have more of a comment
3 than a question. I'd like to thank the three panelists for
4 excellent presentations.

5 I would particularly like to thank Joe for his
6 observations about measuring access and quality in HCBS. I
7 thought many of his observations were spot on.

8 I want to talk about the relationship of this to
9 another initiative I'm involved in which is the LTSS
10 scorecards sponsored by AARP. The advisory panel who
11 oversees this, the scorecard, has -- had struggled with
12 measures of access and quality for the HCBS population,
13 largely due to the fact that while many states are making
14 significant efforts of measuring access and quality,
15 there's very little uniformity across states in the
16 measures that they're using and the surveys and et cetera.
17 And while I'm generally opposed to federal mandates, if the
18 federal government is going to spend $150 billion on HCBS
19 capacity, I think they have every right to mandate quality
20 measures for HCBS using the standard set of measures, and
21 my recommendation is to start very simply.

22 Another problem that is often encountered is the

1 government tends to overreach and ask for too many measures
2 or too complex measures. I would keep it simple in terms
3 of measuring access for HCBS, a mandate that all states
4 collect those data and report them in a common format to
5 see them to the federal government.
6 That's it for me.
7 CHAIR BELLA: Thank you, Brian.
8 Dennis and then Fred and then Heidi.
9 COMMISSIONER HEAPHY: Yeah. I thank you.
10 As someone who uses personal care attendants,
11 this is very close to me and folks in my community. I
12 could spend 30 minutes more talking about this, but I want
13 to really thank the panel for everything you said. I'm
14 sitting here thinking that consumer voices are really
15 important in this conversation so that people aren't
16 treated like objects or just medical patients rather than
17 folks seeking to live quality lives in the community. And
18 it really means the difference between independent and
19 institutionalization.
20 So, as someone who has experienced gaps in care
21 where we've actually gone without people showing up and
22 high turnover rates in quality of care, I also am concerned

1 about that being used as a means of overly medicalizing or
2 even institutionalizing folks in our home using -- and I --
3 told me this wasn't going to come up either, but EVV as a
4 potential means of actually reducing to us an opportunity
5 to engage in the community or access a barrier to personal
6 care attendant services because there are a lot of folks
7 out there who are concerned about being tracked at the
8 different -- but I didn't want to get into that, but it was
9 raised.

10 And, you know, the importance of meaningful
11 measures to the community -- and by meaningful measures,
12 I'm thinking about measurements of community engagement.
13 But I'm going to get to questions for the panelists, and
14 I'm wondering if maybe Joe or others can answer this
15 question, and that's why is it important to make sure HCBS
16 is included in recommendations to measure access?

17 Go ahead, Joe.

18 DR. CALDWELL: Well, I would echo some of Brian's
19 comments. I mean, it is a huge part of the Medicaid
20 program. It's like a third of Medicaid spending is on
21 LTSS, and HCBS continues to grow and grow. So it's just
22 critical.

1 The other thing is, you know, just from your
2 comments, Dennis, and from what I hear -- and I know you
3 guys have a panel tomorrow on the direct care workforce,
4 but that's really reached a crisis situation. It was
5 exacerbated by COVID. It existed before, and so that gets
6 at the heart of access. If you can't get a worker, then
7 there is no service. There is no access.
8 This also ties into Civil Rights and Olmstead.
9 If people end up in institutions because they can't get
10 workers in the community, there's some real Civil Rights
11 violations there and concerns for states.
12 Thanks for the question, Dennis.
13 COMMISSIONER HEAPHY: Thanks.
14 I've got just two quick other ones. First, what
15 recommendations could MACPAC make to CMS and Congress to
16 improve monitoring and measuring HCBS across the life span
17 and populations that have experienced discrimination?
18 CHAIR BELLA: Dennis, why don't you get both of
19 your questions out, and then we'll get --
20 COMMISSIONER HEAPHY: Sure. The other is for Mr.
21 Cambron, and that's because you do both CAHPS and NCIAD,
22 use both instruments. I'm wondering what the benefits are

1 of using both and the cost-benefit analysis that went into
2 that.
3 MR. CAMBRON: Recently, we had been using -- I
4 don't necessarily that a cost-benefit analysis went into
5 it. We had been using CAHPS for a number of years, and we
6 only recently started implementing NCIAD and potential
7 other HCBS measures as this state, like many others, has
8 become to invest in our HCBS services. So that's kind of
9 the answer to that question.
10 My other answer to your question about what
11 recommendations or guidance can we ask of CMS is
12 specifically around network adequacy. Are there best
13 methods, or what are some standardizations of how do we
14 measure a network for HCBS providers when largely they're
15 going into our recipients' and beneficiaries' homes? I
16 think from a state perspective, we would be interested in
17 that guidance.
18 CHAIR BELLA: Thank you.
19 Joe or Jenny, would you like to comment?
20 DR. CALDWELL: Yeah. I mean, the HCBS issues are
21 really complicated. I think to kind of maybe just push the
22 ball forward a little bit, I think you need to bring

1 together some sort of, like, HHS advisory committee that
2 brings together the beneficiaries and providers and the
3 states and measure experts and really try to nail down on
4 this a little bit more and come up -- like, I think what
5 Brian said, the few kind of basic core measures that could
6 really -- you could hold all states accountable for, and
7 then they could go beyond that and do their own sort of
8 thing. But you would get at least some standardization to
9 look at this across states.
10 CHAIR BELLA: Jenny, did you want to comment?
11 [No response.]
12 CHAIR BELLA: Okay. All right. Thank you.
13 Thank you, Dennis. We'll go to Fred, Heidi, Tricia, and
14 Bob, and not to put any pressure on you, but we have the
15 panelists for about five more minutes.
16 COMMISSIONER CERISE: Okay. Then I'll go real
17 quick. Thanks, Melanie.
18 On the provider availability metric, Jenny, you
19 talked about secret shoppers. That seems to be a tough
20 one, just a tougher one to get at, but one group that does
21 always have strong opinions about this is the PCPs, and
22 they can tell you if they have access to specialists or

1 not. And I'm wondering how that factors into these
2 analyses.
3 DR. KENNEY: Quickly ,I would say that the
4 specialty access piece, I think, could be monitored through
5 surveys of PCPs. I ab think that's a viable approach to
6 that.
7 CHAIR BELLA: Thank you. Thank you, Fred.
8 Heidi, Tricia, and Bob.
9 COMMISSIONER ALLEN: I thank the panel. As a
10 Medicaid access researcher, this is super dear to my heart.
11 I want to return back to what Dr. Kenney said
12 about beneficiary experience informing policy and what a
13 feedback loop would look like. I'm very cognizant of the
14 fact that as a Medicaid access researcher, it's very hard
15 to get access to data. It's very resource-intensive to do
16 sophisticated, multimodal surveys with enrollees, but we do
17 do it. It just takes a really long time and takes a lot of
18 money, and that Medicaid programs need something that's
19 more timely.
20 My question to you, Dr. Kenney, is what dataset
21 or what data collection effort do you think would be the
22 most efficacious at bringing timely information to

1 policymakers about not only the standing status of their
2 Medicaid programs but also things that they may be
3 instituting like work requirements as a recent example or
4 other program changes, measuring the impact of those
5 changes?
6 DR. KENNEY: A million-dollar question, Dr.
7 Allen. I would say I think we need to institutionalize
8 regular surveys of Medicaid enrollees, and I'm not going to
9 minimize how challenging that is. They are heterogeneous.
10 Their needs vary significantly across enrollee category and
11 age.
12 But I just don't think that we're going to answer
13 some of the big-picture policy questions or have an
14 understanding of how things are actually working on the
15 ground for enrollees to provide us with the information we
16 need to improve the programs and improve the outcomes and,
17 to Brian Burwell's point, make good on the investment, the
18 considerable public resources that are going there.
19 So I think it's doable if we put our minds to it
20 and if we provide the resources for it, and I think it's a
21 virtuous cycle because I think if it provides information
22 that leads to change and then that leads to improvement,

1 there's much more investment in the data themselves in
2 making sure that they're reflective of the experiences on
3 the ground.
4 CHAIR BELLA: Thank you.
5 Tricia?
6 COMMISSIONER BROOKS: Yes. Thank you to all of
7 you.
8 This question is a quick one for Jenny because
9 it's something that she and I have talked a little bit
10 about, and that is recognizing that it's been more than a
11 decade in the process of developing T-MSIS, and we're now
12 finally getting some usable data. There are concerns about
13 the cost of accessing that data for researchers. Could you
14 just say a few words about that? Because I think it's an
15 important issue to raise to the Commission.
16 DR. KENNEY: Tricia, I would say that the cost of
17 entry is quite steep, and to the extent that we want
18 researchers all around the country and folks working in
19 state government to be using those data and providing the
20 kind of insights we can get from them and identifying where
21 there are problems and that kind of feedback loop in terms
22 of the data quality, I think we really have to lower those

1 entry costs. I happen to work at an institution that gets
2 grant funding, and we can build in data access costs in
3 many of our grants. But that said, we would be doing more
4 work with those data if the costs were lower for getting
5 access.

6 DR. CALDWELL: This is Joe. I just have to
7 totally agree with that as a researcher. You know, we've
8 been trying to look at the impacts of COVID and trying to
9 get T-MSIS data. And, you know, you're looking at hundreds
10 of thousands of dollars to get this data, and I don't have
11 the money. And this is just to hit home the point. I went
12 to ACL to get the money, so one federal agency gave me
13 money to buy data from another federal agency within the
14 same department. It's mind-boggling, you know? But it's a
15 huge barrier to researchers.

16 CHAIR BELLA: We have one question left. Can the
17 three of you stay for -- and, Martha, I'm sorry. We may
18 not be able to circle back to you. But, Bob, I wanted to
19 give you a chance to ask your question.

20 COMMISSIONER DUNCAN: Thank you. I appreciate
21 it. Again, thanks to all of you for participating.

22 Dr. Kenney, you mentioned proactive measures and

1 real-time ability to audit. Mr. Cambron shared a couple of
2 measures as it relates to children like well-child checkups
3 and access to primary care. Are there any other proactive
4 measures that you would recommend as it relates to children
5 and adolescents' access?
6 DR. KENNEY: I am so concerned about access to
7 mental health care that I would really put an emphasis
8 there, but also just the pragmatic part of me would also
9 look to the data that we get from inpatient visits and
10 emergency room use. Those tend to clear out quickly so we
11 can get access to fairly complete information in a really
12 timely way, and I think they can be leading indicators of
13 things that are going wrong on the outpatient side and
14 places where they could serve as kind of early warning
15 systems, too.
16 CHAIR BELLA: Joe, did you have a comment, or
17 Barry?
18 MR. CAMBRON: My only comment is that I
19 completely agree that, you know, we obviously are limited
20 when we use administrative claims data for certainly
21 measuring access before our quality measures, at least for
22 our state, having a statewide post-hospital discharge

1 system would be beneficial in so many regards, particularly
2 with respect to monitoring.
3 CHAIR BELLA: Well, thank you. I would ask if
4 any of the three of you have any parting words of wisdom
5 while also saying that our doors are always open should you
6 want to come back and answer the question about if you were
7 us, what would you recommend. But are there any final
8 comments that any of the three of you would like to make?
9 [No response.]
10 CHAIR BELLA: Okay. Well, we really appreciate
11 the time and the input you've given us. As you can see
12 this is something we plan to spend a lot of time on, so we
13 may come back with some questions and again would encourage
14 you to not be shy about coming back to us if you have some
15 other ideas leaving this session. So thank you very much
16 for joining us today.
17 MR. CAMBRON: Thank you for the opportunity.
18 DR. KENNEY: Thank you very much.
19 CHAIR BELLA: Ashley, thank you for leading us
20 through that panel and for getting those folks here with us
21 today.
22 We're going to take the next 30 minutes or so and

1 talk amongst ourselves about what we heard, what else we
2 might want to hear, and we'll also make a little bit of
3 time for public comment before we break for lunch.
4 Who would like to kick off -- Martha, I'll go to
5 you because I know we didn't get back to you. Would you
6 like to make any overarching comments to fellow
7 Commissioners?
8 **### FURTHER DISCUSSION BY COMMISSION**
9 * COMMISSIONER CARTER: It seems clear that we need
10 better systems and probably more money to adequately hear
11 from Medicaid enrollees. That came out loud and clear in
12 this panel and, you know, really is consistent with my own
13 experience.
14 I think I can save my question because I know
15 there were a couple other people who had questions, so
16 maybe we should go there first.
17 CHAIR BELLA: Okay. Who else has comments?
18 Tricia?
19 COMMISSIONER BROOKS: I always have trouble
20 finding that mute button. Our center has been doing a lot
21 of work on MCO accountability and transparency, and it's
22 amazing the lack of quality data that is out there that's

1 available for assessing quality. At one point, Louisiana,
2 when Ruth Kennedy was the Medicaid director, was in charge,
3 they had planned to develop a centralized repository for
4 grievances and complaints rather than those going directly
5 to the MCO, that at least the state could aggregate that
6 data, and then they would send the complaint or the
7 grievance appropriately for the MCO to have that first line
8 of defense. But it would allow the state to actually look
9 across the full spectrum and aggregate the data but also be
10 able to assess where there were deficiencies in one plan
11 versus another, do that comparative analysis. And we ran
12 out of time. I was going to ask Barry from Alabama how
13 they do it, because in a fee-for-service state, you know,
14 it would be totally different. But I do think -- Louisiana
15 I think dropped that plan at some point. I'm not sure why.
16 Ruth was gone at the time. But I do think it's a concept
17 that has merit simply because of the lack of transparency
18 and access to data on an MCO basis.
19 CHAIR BELLA: Thank you, Tricia.
20 Other comments? Verlon?
21 COMMISSIONER JOHNSON: Sorry, I'm like Tricia. I
22 could not find the mute button.

1 So, yeah, this was a very helpful panel, and as I
2 had questions, you all were answering them, so it was
3 really good to hear a lot of the answers from the panel,
4 and also very interesting, too, to see just how much these
5 different domains tie so much together.
6 I did appreciate each of the panelists saying how
7 important the last part was, which was beneficiary
8 perceptions and experiences. So as I thought about that
9 and listened to what I heard, what I didn't hear, though,
10 and what I'd be interested in learning more about is, as we
11 look at the need for addressing health care equity and we
12 see what Dr. Kenney said in terms of making sure that as
13 they looked at the data, that you see that Blacks and
14 Latinos experience Medicaid a little bit differently, I
15 wanted to get a little bit more deeper into what other
16 states are doing and look at the data collection methods to
17 ensure that's happening. So I'd just be curious to learn a
18 little bit more about that from that perspective.
19 CHAIR BELLA: Thank you. Dennis?
20 COMMISSIONER HEAPHY: Sorry about that. I think
21 we could have spent a lot more time on the topics and
22 looking at direct access to medical services versus HCBS

1 services. And I'm not sure if that's -- what we can do
2 with that, but that to me was a big takeaway. I wanted to
3 ask questions about both, but I chose to focus on HCBS.
4 And I do think, again, like with everybody else, the real
5 importance of beneficiary voice in all these conversations
6 and making sure that the states have the funding that they
7 need to actually make that possible is key.
8 I also want to make the point that was raised
9 about making sure researchers have access to the
10 information, because we really need that research to make
11 sure that things are working well. Thanks.
12 CHAIR BELLA: Thank you, Dennis. Martha?
13 COMMISSIONER CARTER: So I am still trying to
14 formulate this question. I may need some help with this.
15 I'm looking at network adequacy standards for primary care,
16 and because a majority now of physicians are employed --
17 and I don't have the number for nurse practitioners and
18 PAs, but, you know, it's somewhere around 70 percent of
19 physicians are employed. And patients aren't always in
20 panels, and so they recognize their practice that they go
21 to, patients could say, "I go to family care," but they --
22 and sometimes they would know, yes, my PCP is Dr. So-and-So

1 or Nurse Practitioner So-and-So. How does that phenomenon
2 get factored into these real specific provider
3 questionnaires that say, "Do you accept Medicaid?" You
4 know, because there is often a team approach. You know,
5 they're in an employed situation. There's a team, perhaps
6 not -- maybe the employment issue doesn't matter as much,
7 but there's certainly a group often of clinicians that take
8 care of a group of patients. And so we miss that
9 phenomenon when we just do these simple questionnaires
10 about "What are your hours?" and "Do you accept Medicaid
11 patients?"
12 So how is that factored in? And how do you use
13 that information? If somebody can help me fine-tune that
14 question -- I'm trying to -- you know, I know the
15 phenomenon because I've filled out those provider
16 questionnaires, and they just don't tell the whole story.
17 If I'm not available, there's somebody else that is. So
18 what do we do with that?
19 CHAIR BELLA: Ashley or Martha or Linn, do you
20 want to comment on that or do you want to take that back as
21 one of the things we want to explore a little bit more?
22 MS. SEMANSKEE: I think we can take that back and

1 get back to you, Martha. We did hear that the definition
2 of primary care might vary across states, and that's
3 another challenge in comparing network adequacy across
4 states, because primary care may be defined differently
5 from state to state.
6 MS. HEBERLEIN: Yeah, and some of the national
7 surveys -- like we've used the NAMCS and the NIRS for some
8 of our provider acceptance work. They do ask, "Are you
9 part of a group practice? How are you employed?" and those
10 sort of different employment and group and team practice
11 arrangements. And they do get at "Do you take new Medicaid
12 patients?" But they don't get at like if you, Martha, are
13 not available to see a patient, can you pass that patient
14 off to somebody else? So it doesn't get down to the level
15 that you're looking at.
16 COMMISSIONER CARTER: Yeah, and, you know, some
17 states, some practices assign patients directly to a nurse
18 practitioner or PA. They have their own patient load. And
19 some practices, all the patients are assigned to the
20 physician, and so there's a team approach. So, you know,
21 there's just a lot of variation in how coverage happens,
22 and I think -- you know, really what I think is these are

1 just outdated questions. I think Dr. Kenney kind of
2 alluded to getting rid of measures -- I think it was she --
3 getting rid of measures that don't -- that aren't
4 meaningful anymore or we don't know how to interpret the
5 data in a way that's meaningful. I think that's where this
6 is going.
7 CHAIR BELLA: Thank you, Martha. Darin, then
8 Bill, then Laura. And, Heidi, I am going to come to you,
9 too, since this is your thing.
10 COMMISSIONER GORDON: One of the things that was
11 discussed in the comments and, you know, we've had material
12 as well, but I think it's one that we have to put more
13 thought to on how to best approach it. But with the
14 proliferation of telehealth and how we think about that in
15 the context of some of these different things, again, it
16 was discussed, we didn't really kind of flesh out how
17 should we think about that, how should we approach it when
18 we're looking at access.
19 The other thing, I try to keep -- it's kind of my
20 question around a panel, you know, those who have panel
21 assignment, when we're thinking about measures, thinking
22 about its applicability across multiple delivery models,

1 because I think if we -- I think we can miss it on either
2 direction if we take a singular approach and not recognize
3 some of those differences and some of the ramifications or
4 some of the things that may make the data look -- or maybe
5 not look, but maybe we interpret the data wrongly because
6 we don't understand the applicability of the measure with
7 that delivery model. So I think there has to be some
8 recognition of that.

9 Then, lastly, I've brought this up before, and I
10 think Martha is probably tired of hearing me say it, but,
11 you know, you do have this issue. We see it -- I've talked
12 to, you know, when I was still in public service, talked to
13 peers in other states, and they saw the same thing, where
14 you have certain specialists in certain communities where
15 there isn't competition that will not be in network but
16 will see Medicaid beneficiaries, kind of getting to --
17 talking about some of the deficiencies and secret shoppers,
18 if you would have called that specialist, they would have
19 said, no, they're not taking Medicaid. If the health plan
20 would have called that specialist and said, "We have
21 someone, we need to get them in in this period of time,"
22 they would say yes.

1 So I don't know how you get to that dynamic, and
2 it's not unique just purely to Medicaid. In some markets
3 it may be, but I know in some of our markets in Tennessee,
4 that was true even on the commercial side. So, you know,
5 understanding that they're a different way, you know,
6 they're all about controlling their panels, the proportion
7 of their panel that's coming from different payer sources.
8 Those are some dynamics that, you know, have to be -- you
9 have to get at it a different way, and some of the
10 panelists did talk about, again, looking at are people
11 actually getting services and accessing services. So that
12 has to be a component of this because, otherwise, I don't
13 know how you get at that dynamic that does exist in some
14 markets.
15 Thank you.
16 CHAIR BELLA: Bill, then Laura, then Heidi, then
17 Fred.
18 COMMISSIONER SCANLON: All right. Thanks. I
19 wanted to offer something for us to think about as we move
20 forward under what we're going to say about the importance
21 of this and sort of the possible recommendations. This
22 panel was incredibly similar to discussions that I heard

1 when I was on the National Committee on Vital Health
2 Statistics and on MedPAC repeated times, and that was more
3 than ten years ago, some of the same issues that existed
4 sort of for a very long time. At MedPAC, there was a
5 continuing discussion about we absolutely have to have
6 encounter data for Medicare Advantage plans. And I left
7 MedPAC in 2010 and subsequently finally encounter data
8 started to flow from the Medicare Advantage plans to CMS,
9 and so there could be some look at sort of what was
10 happening with those plans. Yet in the March report this
11 year, MedPAC says they've looked at the encounter data, and
12 it still has substantial gaps and really can't be used for
13 very good sort of analysis.
14 So this is 2021, and when you think about sort of
15 the flow of information in 2021, health care is essentially
16 in the Dark Ages. And we could talk about since all of us,
17 because of COVID, we've probably gotten something delivered
18 from Amazon, and, you know, it's tracked to the minute, so
19 to speak, and people would just roll their eyes and say,
20 "Well, that's Amazon." Yet every morning, Monday through
21 Saturday, I get an email from the post office, not the
22 quintessential modern organization, that has images of the

1 mail that's going to be in my mailbox that afternoon. If
2 the post office can do this, why can't this $3 trillion
3 sector handle this kind of information flow? That's
4 something I think we need to be thinking about.
5 The second thing I think we need to think about
6 is how can we be innovation, and part of it goes to this
7 idea of measures. And if we had panel providers here, they
8 would talk about the incredible burden there is from having
9 multiple measures of different sort of forms coming from
10 different requesters and how hard it is to sort of fulfill
11 all the demands for these different measures. And I think
12 that's because we're asking for the wrong thing. We should
13 be asking for the data, and we should be able to build the
14 measures that we need, and we can retire the measures that
15 we know are no longer good without burdening providers to
16 change their systems, and we can be developing new measures
17 that are going to give us insight into what actually is
18 happening.
19 I really think that at some point that in my time
20 in health policy we have a breakthrough here and that we're
21 starting to see some really meaningful progress in terms of
22 using information to be able to assess exactly what's

1 happening with respect to delivery of services and the
2 benefits that are going to individuals that need those
3 services.
4 Thank you.
5 CHAIR BELLA: Thank you, Bill. Laura, then
6 Heidi.
7 Laura, I think, has some camera issues. Heidi,
8 do you have a comment, or am I just putting you on the
9 spot?
10 COMMISSIONER ALLEN: No. I have a million
11 comments. I could talk about this all day.
12 So one thing I would like to say is that if we
13 could think about the money issue, of the barriers for
14 researchers who want to study access getting access to the
15 public datasets that currently exist. It's not just money.
16 It's the time it takes to raise the money, and the funders
17 that can fund the kind of money that's required for the
18 research.
19 So, you know, if I wanted to do a big,
20 particularly longitudinal, multistate survey, or if I
21 wanted to use existing T-MSIS data, I would have to
22 probably apply for NIH funding, because that's kind of the

1 level of funding that you need to support a project like
2 that. And that is going to take me a year and a half to
3 get through the grant application process. So that
4 introduces so many delays to this issue of timeliness and
5 timely information to states.
6 So anything that we can do to think about how --
7 you know, I'm wondering. Like does the federal government
8 make money from the fees that it charges researchers, and
9 I'm assuming they really don't. Could it be something that
10 would be rather cost effective to considerably reduce or
11 waive if the researchers commit to providing access to
12 Medicaid programs information about their access. So
13 that's just one thing.
14 The other thing is I agree with Bill that we
15 really need to be more sophisticated. And one of the
16 things, when you do survey research is how do you select
17 your sampling frame? And ideally you would use claims data
18 to identify people who have indications in their claims
19 that they have chronic disease, or if they have cancer,
20 that they have mental health or substance abuse issues, and
21 then be able to send them surveys that ask them detailed
22 questions about their access to care and their use to care.

1 But there is really no way to marry that use of claims data
2 to get at a sampling frame.
3 And I also am thinking about the possibility of
4 encouraging things like poll surveys, where they are very
5 short, frequent surveys that ask people about their
6 experiences, and whether that would be a low-cost way of
7 engaging beneficiaries.
8 I have a lot of facts, but those are just a few.
9 CHAIR BELLA: Thank you, Heidi. Laura.
10 COMMISSIONER SCOTT: Can you hear me now?
11 CHAIR BELLA: Yes.
12 COMMISSIONER SCOTT: Well, I was just going where
13 Bill and Heidi echoed, around innovation, and maybe
14 thinking outside the typical data sources of where we can
15 pull this information up from, such as boards or
16 credentialing organizations, and then how do you pull it in
17 with the other information we already have. You could
18 imagine almost like a health information exchange or an
19 exchange of provider information that can tell us more
20 about availability and accessibility and then answer some
21 of these other questions that people are asking. But it
22 was really just to echo Bill's comment around innovation

1 and the way we are going about getting this information.
2 CHAIR BELLA: Thank you, Laura. Fred, and then
3 Brian, and then I think we'll take public comments.
4 COMMISSIONER HEAPHY: Melanie, if I could just --
5 this is Dennis. I wanted to make a comment at the end.
6 CHAIR BELLA: Okay.
7 COMMISSIONER CERISE: A bit of a similar comment
8 to the past few. I think looking at the outcomes that we
9 want to get is probably going to be more productive in
10 concentrating efforts there, however we go about that. We
11 know, as Bill said, we can get very sophisticated in terms
12 of looking at outcomes measures. You can look at census
13 tract. You can look by health plan. You can get very
14 detailed, if we were to perfect some of those measures.
15 I think trying to get at it from looking at
16 provider networks and directories and things like that gets
17 much more difficult, just because it's harder to interpret
18 that information. And, you know, as I mentioned in my
19 earlier comment, you can ask the PCPs and they can tell you
20 behavioral health access, they all will say this is the
21 thing that they can't get, and then you can get more detail
22 from that.

1 But in terms of kind of prioritizing, in my mind
2 it would be less so on trying to get at the network
3 adequacy issue from surveying providers or looking at
4 adequacy that way, but looking at are the services actually
5 getting delivered, and whether that's through claims or
6 whether that's through going to the beneficiaries
7 themselves to see what their experiences are.
8 CHAIR BELLA: Thank you, Fred. Brian?
9 COMMISSIONER BURWELL: I'll be quick. Just if we
10 are going to push forward with measuring access in HCBS I
11 think I would really like to see us look at it through the
12 lens of delivery models, like Darin was saying,
13 particularly fee for service versus MLTSS. My intuition
14 tells me that the MLTSS model has been very beneficial to
15 increasing access to HCBS services. We do see waiting
16 lists managing a direct care workforce network than we
17 observe in the fee for service system. So I would just
18 like us to keep that in mind as we do this research.
19 CHAIR BELLA: Thank you, Brian. Dennis?
20 COMMISSIONER HEAPHY: Yeah, just very quick. It
21 is very urgent right now, we're almost near crisis stage
22 with HCBS services, direct-to-worker access, and Joe's idea

1 of a committee at HHS to bring together and examine this is
2 something that I think is really important. So I would
3 echo Joe's recommendation.
4 CHAIR BELLA: Thank you, Dennis.
5 CHAIR BELLA: I am going to see if there is
6 public comment and then I can come back and pick up any
7 remaining Commissioner comment. And I have a question for
8 the crew.
9 But let's go to the public. If you would like to
10 make a comment, please use the hand function in your
11 GoToWebinar. And for folks making a comment, please
12 introduce yourself and the organization you are
13 representing, and a quick reminder that comments are
14 requested to be three minutes or less, please.
15 I see Camille. Welcome, Camille.
16 **### PUBLIC COMMENT**
17 * MS. DOBSON: I was waiting to be unmuted. Thank
18 you.
19 Camille Dobson, Deputy Executive Director of
20 ADvancing States. We are the membership association for
21 aging and disability agencies that deliver HCBS.
22 I have about a million thoughts about what you're

1 talking about today but I'll try and focus on a couple
2 about, I think Tricia mentioned about the lack of -- about
3 data access, and I know that a number of states put out
4 data, not involved for researchers on report cards, but
5 most importantly CMS is requiring managed care states to
6 report grievance and appeals data in the new annual program
7 reports. So there might be sources of that information on
8 an ongoing basis.
9 Around access for HCBS, we know that time and
10 distance standards that work for acute care don't work in
11 HCBS since most people don't travel to services in that
12 setting. I think innovation in measuring access is
13 happening in managed care, really not in fee for service,
14 and one of the best measures that I think the leading
15 states use is addressing [inaudible] care from what's
16 authorized to what's delivered, and I think Tennessee and a
17 couple of other states, Arizona, have been really
18 innovative in what they're doing with the plans to address
19 those issues.
20 Joe mentioned NCIAD. We're the measure steward
21 for that, beneficiary quality-of-life surveys for older
22 adults and people with disabilities. We do, in fact, have

1 about seven managed care states that use the survey, and
2 almost all of them actually stratify their sample by MCO.
3 So I would encourage you, if you're interested in looking
4 at that, MCO-specific results on our NCIAD.org website.
5 And then last but not least around the
6 recommended measure set. This has been a topic of much
7 discussion. I think we agree, in theory, that HCBS
8 measures should start to be measuring the same thing, but I
9 think where we differ, I think, is the desire to have one
10 stable set. Because the states have invested so much of
11 their own money in resources in the National Core
12 Indicators model, what we have been suggesting to CMS is
13 that they have a specific domain to measure but allow the
14 choices of the tool to measure beneficiary experience in
15 the domain to the states, which will allow the states to
16 continue to reap the benefits of the investments that
17 they've made.
18 I think that's it. Thanks for letting me comment
19 today.
20 CHAIR BELLA: Thank you, Camille. I don't see
21 any other hands.
22 I just have a question. In December, I know

1 we're going to have another panel. But I'm thinking a lot
2 about the comments about getting enrollee inputs, and then
3 I'm also thinking about the importance of getting their
4 input but also the importance of this being information
5 they can use. And so in December, when we're talking about
6 considerations, will we be talking about -- so we hear how
7 states use data and how providers and researchers use data.
8 Will we be also thinking about how to make this a tool that
9 actual enrollees can use?
10 MS. SEMANSKEE: Yes, we can definitely talk about
11 that in December and we will also hear more from what we
12 heard in interviews about how to make sure the development
13 of a new system and measures is a transparent process that
14 brings in consumer voices, perspectives to providers.
15 CHAIR BELLA: Okay. Wonderful. Any last
16 questions or comments from Commissioners?
17 [No response.]
18 CHAIR BELLA: Martha, Linn, or Ashley, anything
19 else you need form us?
20 MS. SEMANSKEE: No. This has been very helpful.
21 Thank you, everyone.
22 CHAIR BELLA: Well, thank you. I think you can

1 tell we are happy to be talking about this at the next
2 several meetings, so thank you for this and we will look
3 forward to you bringing it back in December.
4 Okay. Believe it or not, we are at our breaking
5 point already. Time flies, huh? So we have an hour break.
6 We will come back at 1:00 Eastern time and talk about Money
7 Follows the Person report. So thank you all, and if I
8 could ask that you are back at 1 p.m. promptly we will get
9 started then. Thank you.
10 * [Whereupon, at 12:01 p.m., the meeting was
11 recessed, to reconvene at 1:00 p.m. this same day.]
12
13
14
15
16
17
18
19
20
21
22

1 AFTERNOON SESSION

2 [1:00 p.m.]

3 CHAIR BELLA: Welcome back, everyone. We'll just
4 take another minute or so.

5 [Pause.]

6 CHAIR BELLA: Okay. It looks like everybody is
7 popping on, and I know we don't have a ton of time for
8 this, and there's a lot of information. So, Kristal and
9 Tamara, welcome. Thank you for bringing this back to us
10 this month, and I will turn it over to you to get us
11 started.

12 **### MANDATED STUDY ON MONEY FOLLOWS THE PERSON**
13 **QUALIFIED RESIDENCE CRITERIA: RESULTS FROM**
14 **ANALYTIC WORK**

15 * DR. VARDAMAN: Great. Thank you.

16 Good morning, Commissioners, or good afternoon.

17 Last month, I brought to you some information on
18 plans that we have for conducting analytic work related to
19 MACPAC's mandated study on the Money Follows the Person
20 program. Today Tamara and I are going to bring you the
21 results of that work. We'll start with some background and
22 then discuss some data on MFP transitions. We'll then move

1 into the results of the survey we conducted of MFP program
2 directors and discuss the themes from some stakeholder
3 interviews. We'll then review the policy options and
4 potential next steps for this work.
5 I won't spend a lot of time reviewing the
6 background here, since we did cover quite a bit of that
7 last month, but just to recap, beneficiaries who transition
8 through the MFP program must go to a qualified residence,
9 and qualified residences include a home owned or leased by
10 the beneficiary or their family member, an apartment with
11 an individual lease, or a community-based setting in which
12 no more than four unrelated individuals reside.
13 The home- and community-based services settings
14 rule is intended to ensure that HCBS settings are different
15 from institutions, and it was published in 2014. The
16 settings rule focuses on the nature and quality of
17 beneficiaries' experiences rather than the physical
18 location, and the implementation of the rule includes
19 heightened scrutiny of certain settings that have isolating
20 characteristics.
21 It's currently being implemented by states and
22 providers, and providers must be in compliance by March

1 17th, 2023, to continue to receive HCBS payment.
2 In general, more settings are allowed under the
3 HCBS settings rule than under MFP's qualified residence
4 criteria. MACPAC has been directed by Congress to review
5 the settings that are available to MFP participants,
6 settings that are available under the settings rule and if
7 deemed appropriate to recommend policies to align the
8 qualified residence criteria with the settings rule.
9 So the first work we've done here is to review
10 MFP transitions. We reviewed published data on the
11 program, and CMS also provided us with some unpublished
12 data on MFP transitions for 2015 through the first half of
13 2021. The data show that MFP has largely transitioned
14 people age 65 and older and those with physical
15 disabilities. Also, MFP transitions declined from 2016 to
16 2019 with a small increase in 2020. This decline coincided
17 with the expected sunset of MFP.
18 As you may recall, the program was expected to
19 wind down, with states expected to end transitions in 2018,
20 but in early 2019, Congress began authorizing new funds.
21 We saw the decline in transitions coincided with the
22 decline in state participation but have heard that some

1 states may restate transitions now that new funding is
2 available through fiscal year 2023, and as a reminder,
3 states can spend those 2023 award funds for a few
4 additional years until they're exhausted.
5 In terms of the settings into which MFP
6 participants have gone, we found that from 2015 through
7 2021, about nearly two-thirds of participants transitioned
8 to an apartment or home. About 20 percent transitioned to
9 a congregate setting, like assisted living or a group home,
10 and given some concerns that we heard early on around
11 assisted living settings and their ability to be a
12 residence for MFP participants to transition into, we took
13 a closer look at the data for adults age 65 and older. And
14 for that group, about 18 percent who transitioned from a
15 nursing facility moved to assisted living.
16 Next, I'll go over the results of a survey that
17 we conducted of MFP program directors. Twenty-eight
18 program directors responded to our survey. Just over half
19 reported that the qualified residence criteria had been a
20 barrier to transitions, and we asked them to provide more
21 detail on what populations for which this had been a
22 particular problem. They most frequently talked about

1 transitioning individuals to assisted living and also
2 challenges transitioning people with behavioral health
3 conditions.
4 About 70 percent of the program directors
5 supported aligning the criteria with the settings rule, and
6 a few others said that they supported allowing some
7 additional settings to be eligible. When we asked about
8 what settings to be permitted that aren't currently, one of
9 the most frequently raised issues was around raising the
10 four-person limit.
11 And I'll turn it over now to Tamara who is going
12 to go over the results of our stakeholder interviews.
13 * MS. HUSON: Thanks, Kristal.
14 So we conducted 29 stakeholder interviews from
15 August through October of this year with state and federal
16 officials, advocates, providers, and researchers.
17 Stakeholders included organizations representing
18 individuals with intellectual and developmental
19 disabilities, behavioral health conditions, and people age
20 65 and older.
21 Next slide, please.
22 Stakeholders had mixed opinions on whether the

1 MFP qualified residence criteria should be changed to match
2 the HCBS settings rule standard. Stakeholders are about
3 evenly split on this question, but they did not fit neatly
4 into groups for and against alignment.
5 Next slide, please.
6 Stakeholders in favor of alignment said three key
7 reasons. First, they thought that having a single set of
8 standards would avoid confusion or operational challenges.
9 Second, some stakeholders thought the more flexible
10 criteria in the settings rule could maximize MFP
11 transitions. Some states predicted they can make more
12 transitions, particularly if there was more flexibility
13 around the four-bed limit and assisted living rule. And,
14 third, some stakeholders said the settings rule allows for
15 more choice for individuals with disabilities than the MFP
16 criteria. These interviewees discussed how settings that
17 don't qualify for MFP, like farmsteads and intentional
18 communities, may be allowed under the settings rule and may
19 be appropriate settings for some individuals.
20 Next slide.
21 We also heard three main arguments against
22 alignment. First, some stakeholders prefer the MFP

1 qualified residence criteria because of its clear and
2 forceable criteria, then the higher bar is set compared to
3 the settings rule. Although some interviewees acknowledge
4 that this higher standard could limit the settings
5 available for MFP transition, they viewed it as a necessary
6 limitation to improve HCBS and meet the goals of the MFP
7 program.
8 Second, some stakeholders view the four-bed limit
9 as a necessary restriction because it may mean better
10 quality of life with more opportunities for community
11 integration and choice of activities for beneficiaries.
12 And, finally, dissatisfaction with the settings
13 rule implementation made several stakeholders, particularly
14 disability advocates, weary of changing the MFP criteria.
15 Multiple advocates wanted more oversight from CMS and were
16 concerned that without CMS specifically rejecting certain
17 settings, settings that do not meet the principles of the
18 settings rule would continue to receive payment. For
19 example, stakeholders are concerned about assisted living
20 facilities located on the same campus as nursing
21 facilities. Advocates did not want CMS to allow such
22 settings for MFP transitions because they do not think such

1 settings are truly integrated into the community and do not
2 meet the program's goal.
3 Next slide, please.
4 Most stakeholders do not see the need to
5 differentiate the MFP criteria for different types of
6 individuals. Many interviewees acknowledge that some
7 settings are more ideal for specific populations; for
8 example, assisted living for people age 65 and older and
9 group homes for people with ID/DD.
10 However, most stakeholders did not feel strongly
11 that the residence criteria needs to reflect variation.
12 Several interviewees said that ideally, MFP transitions are
13 person-centered. The different guidance for different
14 populations is not necessary.
15 Another common theme we heard was how the
16 qualified residence criteria limit transitions to assisted
17 living in such states, particularly requirement for full
18 kitchens and individual leases. However, some states
19 regularly use assisted living for MFP.
20 Next slide.
21 We also asked stakeholders about other challenges
22 to MFP transitions. For one, we heard from almost all

1 stakeholders how transitions are limited by other factors;
2 most notably, inadequate housing and workforce shortages.
3 Stakeholders also commonly cited the length-of-
4 stay requirement as a barrier to transitioning individuals
5 through MFP. The length-of-stay requirement for MFP
6 transitions was recently shortened from 90 to 60 days, and
7 most interviewees expressed a positive view of this change.
8 Many states, experts, and advocates, however, wanted to
9 shorten the length of stay further, such as to 30 days.
10 And, finally, we heard how the uncertainty of MFP
11 funding makes it difficult for states to operate the
12 program. All the states that we interviewed shared the
13 short-term funding extensions and uncertainty about the
14 future caused problems retaining MFP staff and maintaining
15 connections with community-based organizations and
16 providers that help facilitate transitions. The repeated
17 short-term extensions of the program may have decreased
18 state capacity for transition.
19 Next slide, please.
20 So, next, we'll get into the policy options.
21 Next slide, please.
22 We identified three policy options for the

1 Commission's consideration. However, our findings do not
2 clearly support either retaining or changing the existing
3 criteria. While the results and stakeholder themes
4 revealed detailed arguments for both sides, stakeholder
5 interviews did not overwhelmingly support one position. It
6 was also difficult to group stakeholders into clear
7 categories.

8 As a reminder, the Commission is not required to
9 make recommendations of the mandated report. As such, we
10 could write a descriptive report weighing the advantages
11 and disadvantages maintaining the existing MFP criteria and
12 the potential effects of alignment with the settings rule
13 without making a recommendation.

14 Next slide.

15 The first policy option we've identified is that
16 MACPAC could choose to express support for the existing MFP
17 criteria without making recommendations. Stakeholders in
18 favor of maintaining MFP's qualified residence criteria
19 said that they preferred the higher bar for MFP transitions
20 for the settings rule and thought it might actually shift
21 some states to align or implementation of the settings rule
22 to be more similar or the same as the qualified residence

1 criteria.

2 The implication of this option is that the two
3 standards would remain in place, and states would continue
4 to implement both. And we would expect to see similar
5 numbers of transitions, if no other policy changes were
6 made.

7 Next slide.

8 The second option is to align MFP qualified
9 residence criteria with the HCBS settings rule. Support
10 for alignment included the majority of MFP program
11 directors and about a third of stakeholders. Those would
12 unify the requirements and could open up more settings
13 eligible for MFP transition. It would also remove
14 administrative barriers to state implementation, and it
15 would remove MFP's four-person bed limit.

16 Some stakeholders said the specific bed limit in
17 MFP criteria was arbitrary. One state, for example, said
18 that group homes in their state found five beds to be the
19 most financially sustainable model.

20 Next slide.

21 The final policy option is to expand MFP to some
22 HCBS settings that do not currently qualify. Most notably,

1 it could relax the parameters for assisted living so it is
2 more readily available for MFP transitions.
3 In our interviews, we heard that variation and
4 state regulations for assisting living facilities can make
5 it challenging in some states to transition individuals to
6 these facilities.
7 Another consideration is to eliminate or raise
8 the bed limit in MFP criteria. Six states commented in the
9 survey of raising this limit. However, we do not have the
10 information needed to define specific parameters, such as
11 what different bed limit it would be that still ensures a
12 high quality of life for beneficiaries.
13 The implications for this policy include that it
14 could increase MFP transitions. However, it might also
15 increase the complexity for safe and implementing the two
16 sets of standards. There are also other barriers for the
17 use of certain settings, such as state variations and
18 regulations for assisted living facilities, the lack of
19 affordable and accessible housing, and workforce shortages,
20 which affect the availability of alternative settings.
21 Finally, this might require guidance from CMS.
22 Next slide.

1 Staff welcomes feedback from Commissioners on the
2 analyses that we have presented today. Commissioners will
3 need to decide whether there is sufficient evidence to make
4 a recommendation. If Commissioners decide that there is,
5 staff will develop draft recommendations for the December
6 meeting and return in January with the draft chapter and a
7 vote on recommendations. If not, staff will return with a
8 descriptive chapter in January, and we anticipate
9 publishing the chapter in the March report to Congress.
10 And, at this time, I will turn it back over to
11 the Chair. Thank you.
12 CHAIR BELLA: Thank you both. We really
13 appreciate it. You've done a great job laying out what our
14 options are.
15 I'd like to start first by asking for comments
16 from Commissioners who have a position on making a
17 recommendation, and I'd like to hear where folks are, and
18 then we can sort of coalesce the rest of the Commissioners.
19 Darin?
20 COMMISSIONER GORDON: I'd be for making a
21 recommendation in this area. Looking at some of the
22 decline in the numbers, it looks like something needs to be

1 done, and I think status quo isn't necessarily helping.
2 I'm not saying this is the only limiting factor maybe to
3 some of the transitions, but some of the responses from the
4 survey would indicate that it is a factor.
5 CHAIR BELLA: So just to push you, which
6 recommendation would you like to make?
7 COMMISSIONER GORDON: I'm opposed to, like, some
8 of the prior slide or one of the last slides where it was
9 talking about just increase to the bed limit because I
10 think that's going to be arbitrary and capricious. I don't
11 know how we pick the right bed limit, given some of the
12 variation in states, as was noted in the comments.
13 I would be more into aligning the definitions and
14 just stop there at this point.
15 CHAIR BELLA: Thank you, Darin.
16 I see Brian. I see your hand.
17 COMMISSIONER BURWELL: I'm in favor of making a
18 recommendation, and my recommendation would be to align the
19 standards between the two programs so that there's only one
20 standard for community-based -- allowable community-based
21 settings. I think that is also along the lines of my
22 feeling that the MFP program should be mainstreamed into

1 the home- and community-based waiver program and not -- or
2 into HCBS services in general and not operated as a
3 separate program.
4 CHAIR BELLA: Thank you, Brian.
5 Can we go back to the recommendations slides? I
6 think maybe this would be the second-to-last slide. Maybe
7 after this one. Oh, sorry. Before this one and the one
8 before this one. Okay.
9 Toby. Thank you on the slide. Toby?
10 COMMISSIONER DOUGLAS: Yeah. Before I weigh in
11 on whether I want to do a recommendation, I'm just
12 wondering if we can peel back a little bit more around
13 those who are against to understand. Is it really about
14 MFP or concern they had in general, anyway, with the HCBS
15 setting rule? I'm just trying to -- because I'm assuming
16 there were those who weren't supportive of the changes in
17 the first place. It just seems rationally to align, to be
18 consistent, but understanding why they viewed this
19 differently than anything else and if it was just more
20 about HCBS rather than Money Follows the Person.
21 DR. VARDAMAN: Sure. So I can take that. Well,
22 there were some people who felt that the four-person limit

1 -- or maybe not just the four-person limit but a small
2 setting was more in the spirit of MFP than some of the
3 types of settings that will be eligible for HCBS payment
4 under the settings rule. So that MFP is a higher bar, and
5 as Tamara mentioned, some of them felt like that was a
6 necessary higher bar.
7 So, for example, one of the areas that came up in
8 a couple interviews for assisted living settings that are
9 on the campus or adjacent to a nursing facility, that is
10 something where that will be allowable under the settings
11 rule, but people didn't feel like that was something that
12 should be up to the level for MFP. They felt like MFP
13 should be a higher bar.
14 There were concerns that were specifically around
15 the implementation of the settings rule. A couple years
16 ago, we did some work interviewing stakeholders around the
17 settings for implementation. At that time, CMS had made
18 some changes in guidance, which gave some more discretion
19 to states in the implementation of the settings rule and
20 how those settings that have isolating factors were going
21 to be judged, and it removed some specific examples of the
22 kinds of settings they were concerned about and tried to

1 focus more on the qualifies of settings. And some of the
2 stakeholders we talked to viewed that as kind of lessening
3 the strength of the settings rule, and so that played into
4 their concerns about whether the MFP criteria should be
5 aligned with the settings rule because they felt like the
6 spirit of the settings rule had kind of been changed based
7 on some of that guidance. So that played into those
8 concerns. So, hopefully, that's helpful.
9 COMMISSIONER DOUGLAS: Thank you.
10 CHAIR BELLA: Did you have a comment then, Toby,
11 or are you going to keep thinking about it?
12 COMMISSIONER DOUGLAS: I'm thinking about it
13 still. I'm going to listen to others. Thanks.
14 CHAIR BELLA: That's fair. I'm thinking about it
15 still too, so that's fair. Dennis, and then Verlon.
16 COMMISSIONER HEAPHY: I'm really opposed to
17 raising the four-person bed limit, because everybody
18 they're -- hold on one second. Sorry -- they're concerned
19 about some group home functioning like small nursing
20 facility institutions and how the people don't actually
21 have independence in those settings, and they function sort
22 of as one unit. And so the four-bed limit actually

1 supports the opportunity for people to have greater choice
2 and workforce flexibility.
3 And that there are states, like Washington State
4 does have flexibility in making sure that folks have the
5 option of going into assisted living facilities,
6 particularly for folks who are old. And so the CMS
7 flexibility guidance really supports states having some
8 choice in how they work with MFP, but I'd be really opposed
9 to the four-person bed limit.
10 And just in terms of the administrative barriers,
11 I honestly think I need more information about those
12 challenges that the states are facing with that. I don't
13 know what others feel.
14 CHAIR BELLA: Dennis, do you have a sense of why,
15 like do you have a view on why the MFP transitions might be
16 declining, and if this is a barrier to movement? Are you
17 hearing that?
18 COMMISSIONER HEAPHY: I know that Massachusetts
19 has created its own program that's focused on folks with
20 traumatic brain injuries, I believe. And I need to gather
21 my thoughts and say it quite clearly. I don't want to just
22 spew something out there. I want to make sure I articulate

1 it clearly. So just give me a few minutes.

2 CHAIR BELLA: Okay. No problem. Verlon?

3 DR. VARDAMAN: Melanie, can I jump in with a

4 comment there?

5 CHAIR BELLA: Yeah. Sure, Kristal.

6 DR. VARDAMAN: So, we did hear from states, you

7 know, as we talked to some states, about the changes in the

8 expected sunset, that some states have transitioned, as

9 Dennis mentioned, their transition programs into their

10 waiver programs or their managed care programs. States

11 were expected to, required to come up with a sustainability

12 plan as to what they were going to do once the MFP funding

13 expired, and so some states had already started that

14 process of transitioning their transition services to other

15 programs before the funding ended towards the end of 2018.

16 And so again, we've heard some states may restart

17 some MFP programs in order to take advantage of the

18 flexibility and funding there, but some have already ended

19 those transitions during that lapse in funding.

20 CHAIR BELLA: Thank you. Verlon?

21 COMMISSIONER JOHNSON: Thank you. So after

22 listening to all the different options I too will support

1 aligning the criteria. I feel the other two options won't
2 get us past where we are right now. I think that by just
3 making a recommendation I don't think that would be a huge
4 impact.
5 And then I think expanding it to those other
6 criteria that don't align at this point to some extent, I
7 don't really feel like that would have -- it seems like
8 that would be very complicated to do. So I would really be
9 more in favor of supporting aligning the criteria. It
10 really does feel like it would be more streamlined, less
11 administrative burden for the states, of course, but it
12 also feels to me like there would be more choice for
13 beneficiaries and could really ease the transition, I
14 think, in terms of getting them to the right place. So
15 that would be my support.
16 CHAIR BELLA: Thank you. Toby.
17 COMMISSIONER DOUGLAS: I'm sorry I'm asking all
18 these questions. Kristal, I should have asked this before,
19 but remind me why should it be a higher bar? Why did the
20 stakeholders see MFP as a higher bar with the same goal?
21 Whether it's on the front end or back end, the goal, right,
22 is for transitions to community-based settings. So I'm

1 just trying to understand that rationale.

2 DR. VARDAMAN: Sure. So we talked to some people
3 who have been involved in MFPs since the beginning, and, of
4 course, it preceded the settings rule, and they talked
5 about MFP as the purpose being to really drive the most
6 integrated settings possible. And so for them, again,
7 while the settings rule presents a standard that all
8 settings have to meet, they felt that MFP was really about
9 getting people into highly integrated community settings,
10 things like, you know, small group homes, individual homes
11 and apartments, as opposed to some of the larger congregate
12 settings that would be meeting what they thought as the
13 minimum standard of the settings rule.

14 COMMISSIONER HEAPHY: This is Dennis again. And
15 just to really this -- by the disability community is a
16 civil rights issue, and I think -- thanks for saying that,
17 Kristal, at least with the most integrated setting
18 possible. And that sometimes what's easiest for the state
19 is not necessarily in keeping with what the civil rights
20 are with folks with disabilities. And so that's why the
21 MFP bar was set where it was, in order to assure that
22 that's there, and then CMS putting those flexibilities to

1 support the ability of states to do innovative things,
2 particularly around assisted living for older folks.
3 And so, yeah, I think we have to have view it
4 through that lens as well, and not just see this as a
5 simple policy recommendation but recognize that MFP is as
6 much about civil rights at institutions as it is about just
7 general HCBS.
8 COMMISSIONER DOUGLAS: Meaning it's different
9 than if someone was at risk of nursing facility, it's a
10 different criteria in your mind than if they're already in
11 an institutional setting we have to look at it differently?
12 COMMISSIONER HEAPHY: I think that if someone is
13 in a community setting that's supporting increased support
14 of HCBS around that person is what's important, but getting
15 people out of institutions, the deinstitutionalization
16 piece is important in terms of not just getting somebody
17 out into the community but making sure they're going to
18 least restrictive settings. And I don't think I'm
19 answering your question correctly, but yes, like if someone
20 needs more supportive service around them in the community
21 that's very different than someone who is not able to get
22 out of an institution.

1 I don't think I answered your question.
2 DR. VARDAMAN: If I could follow up with an
3 example that we were seeing. For example, one interviewee
4 discussed how, under the settings rule, someone could
5 transition from, again, a nursing facility to an assisted
6 living setting on the same campus, but that might not be --
7 assuming that setting may not be eligible for MFP otherwise
8 wouldn't be allowable under the MFP criteria. And so their
9 argument was that that change from one building to another
10 wasn't as meaningful as from one building to a community
11 apartment. So maybe that's helpful.
12 COMMISSIONER HEAPHY: So I have something. I'm
13 going to give you an example of one that's positive, that
14 the disability community supported in Massachusetts, where
15 there's a nursing facility in the state that is primarily
16 for folks with multiple sclerosis, and they sought support
17 from the disability community for creating a small,
18 multifamily apartment building on their campus that would
19 include increased housing opportunities for folks with
20 disabilities in that complex. It would be affordable
21 housing but they would have a disproportionate number of
22 units available to folks with disabilities.

1 Now that, we thought, was a positive thing as
2 opposed to, as I think Kristal just said, moving people
3 from one building to another, which is not what you would
4 want to see.
5 CHAIR BELLA: I have a question about the one
6 building to another. If it's a less restrictive, more
7 integrated setting, it's still a building but I'm trying to
8 understand, they are categorized differently because they
9 are less restrictions and more -- I mean, there's a
10 difference between a SNF and an assisted living facility,
11 and I'm trying to understand if the person wanted it, in
12 that example, wouldn't that still be in line with person-
13 centered preferences?
14 DR. VARDAMAN: I think the other side of the
15 argument we did hear from a number of stakeholders, again,
16 it was very divided what we heard from stakeholders. And
17 so on the other hand that is also an argument we heard,
18 that beneficiary choice was a concern for some others,
19 saying that, you know, a setting that, as you say, may not
20 be an institution but at least gets someone further along
21 towards integrated settings, even if it's not as integrated
22 as apartment or individual homes. It was a very mixed

1 group of stakeholder interviews.

2 CHAIR BELLA: Did we hear from actual users of
3 the services that they have been kept in institutions
4 because of any of the MFP different criteria? Like do we
5 have examples of people who haven't been able to move, and
6 who have said, "I wish I could have moved, but I have been
7 caught in this"? Because that, to me, would be pretty
8 compelling.

9 DR. VARDAMAN: We could follow up with states
10 that we spoke with to see if they have any specific
11 examples. The kinds of things that came up in our
12 interviews were mostly with states, in terms of barriers
13 were things like one state that talked specifically about
14 assisted living settings without full kitchen, and that
15 just had microwaves and refrigerators, not being allowable,
16 and that was a specific example of the kind of setting they
17 would be able to transition someone into if the criteria
18 were changed.

19 So we didn't hear from individual participants or
20 people who were institutionalized who were not able to
21 transition into MFP, but we could follow up with states and
22 advocates about that.

1 CHAIR BELLA: Heidi?
2 COMMISSIONER ALLEN: I found the argument about
3 the four-bed limit being pretty compelling, in as much as
4 people's estimating that five was actually kind of the
5 sweet spot for making it a financially viable model, and
6 that four was rather arbitrary, and that this ruled out
7 people coming up with intentional living situations, like
8 intentional community, where groups of people are choosing
9 to support each other and care about each other in a living
10 situation if you make it financially insolvable to have the
11 supports you need with the number of beds, and that seems
12 to me like, you know, really limiting choice.
13 CHAIR BELLA: Kristal, did you have anything to
14 say? I think you heard that from one person. I'm not sure
15 how widespread that was. Do you have any comment there?
16 DR. VARDAMAN: Yes. Again, we heard from
17 advocates on both sides of the issue, so we did hear from a
18 number of advocates representing people with IDD that were
19 more associated with the intentional living communities,
20 and that was one of their concerns, was that the MFP
21 criteria right now are a barrier to going to those kind of
22 settings, which can include things like gated communities,

1 groups of townhomes that are purchased for a group of
2 people who have disabilities, to live in close proximity,
3 also farmsteads. Those are the kinds of intentional
4 communities they were concerned about.
5 CHAIR BELLA: Dennis?
6 COMMISSIONER HEAPHY: Yeah. I know there are
7 families that come together and try to create group homes
8 for their family members, and so they would seek to have
9 that four-person limit raised to five or six persons.
10 But I think it's getting back to, I guess, two
11 fundamental things. One is if a building is still on the
12 campus of the nursing home, even if they have more freedom
13 within that building, that's still not integrated in the
14 community. It's not as if they're moving into an apartment
15 building that's near stores and shopping and places where
16 they can go and participate in the community more fully.
17 And then in terms of the number of folks in a
18 unit, there is a big concern about group homes that grow
19 larger than four becoming mini nursing facilities and how
20 they function. And so rather than really being up through
21 the people living in communities and having participation
22 in the community, they actually just become -- everyone has

1 to eat at the same time, everyone has to go to the store at
2 the same time, get their medical appointments at the same
3 time, because everything revolves around staffing rather
4 than actually the independence of the individuals.
5 And so I don't know if four or five is arbitrary
6 or not but there is a reason why that number, that the
7 folks don't want that number lifted. And so the idea is
8 that states are just trying to meet their Olmstead
9 requirements, but moving folks out into the community and
10 be more flexible rules, then I don't think that's a
11 compelling argument for the alignment.
12 CHAIR BELLA: Yeah. I mean, I think what I'm
13 hearing is the compelling reason would be because we're
14 trying to transition people out and looking to reduce any
15 barriers to that transition.
16 COMMISSIONER HEAPHY: And I guess what I'm saying
17 is what are we transitioning them to. And so is it just
18 about getting people out of institutions or is it actually
19 providing them opportunities to be settings that are in the
20 community as opposed to just the ends justifying what
21 people actually are going to receive.
22 So yes, if we institutionalize everybody, and

1 even though they're not necessarily in the settings that
2 are, you know, that maximize their ability to be in the
3 community, we've done what Olmstead requires us to do.
4 CHAIR BELLA: Toby?
5 COMMISSIONER DOUGLAS: Yeah. I'm just struggling
6 --
7 CHAIR BELLA: Somehow, I think you muted
8 yourself.
9 COMMISSIONER DOUGLAS: I said a lot of good
10 things there. I was saying, first, I appreciate, Dennis,
11 everything you're saying, but I'm struggling still on how
12 that aligns with the HCBS setting rule, because we've
13 already set a standard for states to be able to reimburse,
14 to pay for services in the settings that you're saying that
15 might not be meeting the standard. So you have those who
16 never went into an institution getting this level that
17 you're talking about, but we're setting a higher standard
18 for those who are in institution to ever be in that same
19 setting.
20 So how do we reconcile that, under what you're
21 saying?
22 COMMISSIONER HEAPHY: I would say that the folks

1 who are more likely to be at risk of going into settings
2 are living in fully integrated settings already, and so
3 that's why they are at risk, because they may not be
4 getting all the services they actually need in the
5 community. So living in an integrated setting but not
6 getting access to those services that they require. And
7 it's far easier for someone to transition into a nursing
8 home than it is to transition out of a nursing home.
9 And there's also a tremendous amount of funds and
10 effort that go into moving folks out of nursing homes. So
11 it's not that even creating other settings would make it
12 that easy. It's an incredible amount of time and work that
13 goes into it, to support people's transitions out of
14 nursing homes. So it's not as if it would magically
15 happen.
16 I would love to hear from organizations that
17 actually engage in this work of transitioning folks out of
18 nursing homes into the community or other facilities and
19 see what their perspectives are. I don't know. The folks
20 who did the research, did you speak specifically to those
21 stakeholders who were engaged in that process and what
22 their perspectives were?

1 DR. VARDAMAN: We spoke with the MFP program
2 directors but we did not speak with, for example,
3 transition coordinators. So I think that sounds like that
4 would be helpful, and we could circle back with states and
5 see if they can put us in contact with some transition
6 coordinators who are on the ground, figuring out where to
7 transition the patients into.
8 COMMISSIONER HEAPHY: Yeah, I think that would be
9 really critical to this conversation before making a
10 recommendation.
11 CHAIR BELLA: Other folks? Other Commissioners?
12 [No response.]
13 CHAIR BELLA: You may have said this in the
14 beginning, but I've already forgotten. When is our report
15 due?
16 DR. VARDAMAN: So the deadline is actually tied
17 to the final deadline for the settings rule implementation,
18 which has been extended a couple of times over the years.
19 So it's currently March 17, 2023, so we do have some time
20 to fulfill the mandate. But given a lot of the activity
21 around, you know, the settings rule and HCBS, we were
22 trying to move this along in the cycle.

1 CHAIR BELLA: Okay.

2 EXECUTIVE DIRECTOR SCHWARTZ: Melanie, can I ask
3 a question?

4 CHAIR BELLA: Sure.

5 EXECUTIVE DIRECTOR SCHWARTZ: Kristal, I guess
6 the thing that I have trouble sorting out here and maybe
7 other people do, which is MFP is not the only mechanism
8 source of funds that could be used for getting people out
9 of institutions into HCBS settings, right? Isn't it just a
10 specific funding stream with a specific set of supports,
11 but it's not exclusive? Is that correct?

12 DR. VARDAMAN: Right, so states can build
13 transition services into their waivers, and so, again, as
14 some states have ended MFP, that's what they're doing.
15 They're moving services back into their waivers. So MFP
16 provides the added funding that they can use to support
17 other investments in the HCBS infrastructure. And so I
18 think that was also part of the discussion, was that, you
19 know, while states can transition people through other
20 means, that extra funding is something they felt like
21 states needed to earn by, you know, meeting a higher bar.

22 EXECUTIVE DIRECTOR SCHWARTZ: And the motivating

1 force behind the original design of MFP was not just a
2 general push around rebalancing, right? It was around the
3 concerns of specific communities, of beneficiaries wanting
4 to transition into these specific settings. Is that
5 correct?
6 DR. VARDAMAN: Right, to incentivize transitions
7 into these settings in a way that would help support as
8 well as investments in HCBS infrastructure.
9 EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thank you.
10 That helps me.
11 CHAIR BELLA: Okay. You can see that I think
12 people are really trying to get their heads around
13 understanding that there are lots of different perspectives
14 here that we're trying to balance. I think what would be
15 helpful is if you could go back and explore the opportunity
16 to get some more direct feedback in the areas that we
17 talked about, to see if that's even possible, since we have
18 a little bit of time. I know you need us probably to come
19 out clearer on a recommendation sooner rather than later to
20 hit the March report. But if we have some time, I think
21 it's worth seeing what else you might be able to get from
22 the sources we've talked about and then coming back to us

1 and seeing where that takes us. Does that work for
2 everyone? I think you're hearing people -- there is
3 interest in exploring being able to support making a
4 recommendation without doing so in a way that diminishes
5 the goals of MFP to begin with. But I also think it's
6 important for us to go back and see if we can get some of
7 those other points of view.

8 DR. VARDAMAN: That's fair.

9 CHAIR BELLA: Does anyone have any last comments?

10 [No response.]

11 CHAIR BELLA: Thank you very much. We will --

12 COMMISSIONER HEAPHY: This is Dennis. I'm not a
13 purist about this. I just want to say I was one of the
14 people that came out in support of the nursing facility
15 actually having this apartment building on the campus, and
16 so I'm not a puritanical, one-way-or-no-other-way person,
17 but for me this is about what does this mean across the
18 country when already we have, you know, different
19 understandings of accessibility and what the civil rights
20 are of people with disabilities and what independence
21 actually means. So I think it's much bigger than just one
22 model or another, if that makes sense to folks.

1 CHAIR BELLA: Thank you, Dennis. Okay. Kristal
2 and Tamara, thank you very much. We will look forward to
3 having you come back to us on this issue. Thank you to the
4 Commissioners for your comments.
5 We are going to move to our next session, which
6 is on vaccines for adults. This is another one that is a
7 continuation, continued discussion that we've been having
8 as a Commission. Chris and Amy are going to join us.
9 Similarly, I'm going to ask for Commissioners, when we
10 start the discussion, to kind of indicate where you are
11 leaning in terms of making a recommendation and be very
12 specific about what else you would need to know in order to
13 be able to make a recommendation in the ways in which you
14 would like to do so, if that is where you're landing.
15 Amy and Chris, I will turn it to you.
16 **### VACCINES FOR ADULTS ENROLLED IN MEDICAID:**
17 **INTERVIEW FINDINGS**
18 * MS. ZETTLE: Great. Thank you, and good
19 afternoon. Today's session is a continuation of our work
20 to examine access to vaccines for adults who are enrolled
21 in Medicaid. We're going to share some findings from
22 recent interviews and present an assessment of policy

1 options.

2 Next slide.

3 So first I'll begin with a brief background on
4 vaccine coverage and access in Medicaid. I'll then walk
5 through the methodological approach to our interview
6 project and discuss the findings. Then I'll present an
7 assessment of the policy options based on the framework
8 that we discussed last month. And, lastly, we'll discuss
9 next steps.

10 Vaccines are not a mandatory benefit for all
11 adults in Medicaid. For those in the new adult group,
12 preventive services are covered without cost sharing. This
13 includes all vaccines that are recommended by the Advisory
14 Committee on Immunization Practices, ACIP. However, for
15 all other adults in Medicaid, states can decide whether to
16 cover recommended vaccines and whether to apply cost
17 sharing requirements. This group includes individuals with
18 disabilities, pregnant women, parents, and they account for
19 about 40 percent of all Medicaid enrollees. About half of
20 states, 24 out of 49 states surveyed by the CDC, covered
21 all ACIP-recommended vaccines.

22 Next slide.

1 So last month, we shared an analysis which
2 estimated the adult vaccination rate by payer. We found
3 that Medicaid beneficiaries generally had lower vaccination
4 rates than those with private insurance. The difference
5 was fairly stark in some cases. For example, Tdap, the
6 vaccination rate for privately insured was almost 13
7 percentage points higher than for Medicaid. And for
8 tetanus the vaccination rate was about 10 percentage points
9 higher. The only case where Medicaid enrollees actually
10 had a higher vaccination rate was for pneumococcal, and we
11 think that this likely reflects the difference in health
12 status among Medicaid beneficiaries. That vaccine is only
13 recommended for those under 65 if they have certain medical
14 conditions.
15 I also just wanted to point out, as was
16 highlighted last month by some Commissioners, that we don't
17 expect to see 100 percent vaccination rates across this
18 table. With the exception of a flu vaccine, which is
19 recommended annually for nearly all adults, most routine
20 vaccinations are not annual and they're based on health and
21 age. So, for example, hepatitis A vaccine would be
22 recommended for those who are at high risk for contracting

1 the disease. So what we're really trying to highlight here
2 is that difference in the lower rates among those enrolled
3 in Medicaid.
4 Next slide.
5 Over the last several months, we've interviewed
6 state and federal officials Medicaid managed care plans,
7 providers, vaccine manufacturers, immunization experts, and
8 a consumer group. We selected states which had a wide
9 range of coverage and payment policies, and we interviewed
10 MCOs operating in those states. We asked about the
11 development of coverage and payment policies and tried to
12 understand why some states would choose to or choose to not
13 cover all recommended vaccines.
14 Across all interviews, we discussed the barriers
15 to vaccine access for adults, and then we discussed the
16 tradeoffs of different federal policy options that could
17 potentially improve coverage and access.
18 Next slide.
19 Now I'll just share some high-level findings from
20 these interviews. Stakeholders believed that lower rate of
21 vaccinations in Medicaid stem from limited coverage,
22 payment policies, and beneficiary-specific barriers.

1 First, nearly all interviewees thought that
2 ensuring coverage to recommended vaccines was necessary to
3 improve the vaccination rates in Medicaid. Also, many
4 argued that low Medicaid payments are preventing providers
5 from administering vaccines, and this was thereby reducing
6 access.
7 Also to improve access, many interviewees thought
8 that adults need vaccines to become available across
9 multiple sites of care and that beneficiaries need
10 additional education and support.
11 Next slide.
12 There was broad consensus that the problem of low
13 vaccination rates in Medicaid is multi-faceted and,
14 therefore, a solution should be as well. Most agreed,
15 however, that the first step to improving vaccinations in
16 Medicaid is to ensure that all Medicaid enrollees have
17 coverage of recommended vaccines.
18 Next slide.
19 We laid out two pathways for expanding coverage
20 and shared several policy options here. First, the federal
21 government could incentivize states to provide coverage.
22 That would be the top of the slide, those blue options. Or

1 they could make coverage of recommended vaccines mandatory.
2 So, starting with the blue, as a reminder, states are
3 already incentivized financially to provide preventive
4 services, and they receive a one-percentage-point increase
5 in their FMAP if all preventive services are covered.
6 So one option would be to increase the FMAP
7 amount to further incentivized preventive services.
8 Another option could be to target an FMAP increase to
9 vaccines specifically.
10 For this approach, most stakeholders did not
11 think that a financial incentive alone would ensure that
12 Medicaid enrollees have coverage of recommended vaccines.
13 Even with very strong financial incentives, many believe
14 that there would still be gaps in coverage for some
15 populations and vaccines.
16 So now turning to mandatory coverage options in
17 the green here, interviewees discussed three potential
18 options. The first would be making vaccines a mandatory
19 benefit, and states would then be required to cover all
20 vaccines that are recommended for individuals in the
21 Medicaid program.
22 The second option would be to add vaccines to the

1 Medicaid Drug Rebate Program. This would essentially make
2 all recommended vaccines mandatory as all states
3 participate in the program. In exchange for covering these
4 vaccines, the mandatory rebate would be applied.
5 The last option would be to create a federal
6 purchasing program, something similar to the Vaccines for
7 Children program, where the federal government would
8 actually purchase the vaccines and states would enroll
9 participating providers to administer those vaccines.
10 Under this policy option, all Medicaid enrollees would have
11 coverage, so, again, another way to expand coverage.
12 So of these three options, many interviewees
13 thought that the federal purchasing program would have the
14 greatest potential for improving vaccination rates just as
15 the VFC program played a large role in improving rates
16 among children. But interviewees raised significant
17 concerns about operational complexities and increases in
18 federal spending to operate the program.
19 There was some interest in adding vaccines to
20 drug rebate programs since it would expand coverage, and
21 state officials appreciated that it would help contain
22 costs by applying that mandatory rebate. There was,

1 however, strong opposition from vaccine manufacturers who
2 raised concerns that this could actually discourage vaccine
3 development and thereby reduce beneficiary access.
4 So when looking across these three options, most
5 interviewees preferred making vaccines a mandatory benefit
6 due to its simplicity and ability to be paired with some
7 other policies that could address additional barriers
8 beyond coverage.
9 Next slide.
10 As noted earlier, interviewees thought that
11 policy changes should be multi-faceted, and there was broad
12 agreement that coverage alone wouldn't be sufficient.
13 Stakeholders stressed that vaccine access could be improved
14 by expanding the types of providers that Medicaid pays to
15 administer vaccines and ensuring that participating
16 providers receive adequately payment for administration.
17 Next slide.
18 I'll walk through some approaches to improving
19 access, and we'll start with adequate payment in the blue
20 here. So payment adequacy for vaccines and for vaccine
21 administration was one of the biggest concerns among
22 stakeholders. We understand both from our literature

1 review and from the interviews that Medicaid payments may
2 not always be covering the cost of providers purchasing the
3 vaccine and also the administration of vaccines.
4 Interviewees noted that low payment discourages
5 providers from offering vaccines to adults, which has
6 created significant barriers to access. So to help address
7 this issue, there are a couple potential policy options --
8 the three laid out here in blue.
9 The first is increasing the FMAP for vaccine
10 administration. This could in turn result in states
11 increasing their vaccine administration fee for providers.
12 We recently saw this approach for COVID-19 vaccines where
13 the American Rescue Plan Act provided a 100 percent FMAP on
14 administration. In this case, the vast majority of states
15 did pay an increased rate at the Medicare level to
16 administer COVID-19 vaccines.
17 The second option would be the federal government
18 could leverage the CDC federal contract price for vaccines.
19 This would allow Medicaid providers to purchase the vaccine
20 at a discounted rate, reducing that financial burden on
21 providers.
22 And then the third option is returning to the

1 federal purchasing program idea. This policy option
2 addresses coverage, but it could also help to remove the
3 burden on providers who have to purchase the vaccines up
4 front since this would then be -- they wouldn't need to be
5 purchased by providers. They would just be provided by the
6 federal government. However, similar to the previous
7 option, this policy doesn't necessarily address low
8 provider payments for administration but, rather, focuses
9 on payment for the vaccine itself.
10 So of these three options, there was strong
11 interest in increasing the FMAP for vaccine administration.
12 Interviewees thought that if this were paired with a policy
13 to expand coverage, it could be effective at improving
14 vaccination rates in Medicaid.
15 There was also some interest in a federal
16 contract price though most believed that it probably
17 wouldn't have a significant impact on rates unless it was
18 paired with other options as well.
19 So moving along our flow chart here to the green,
20 another way to increase access, according to our
21 interviewees, is to expand the types of providers that are
22 administering vaccines. Interviewees routinely noted that

1 adults access care in very different ways than children,
2 and this is particularly important for vaccines, because
3 they don't always have a medical home. And so they access
4 care through pharmacies, emergency rooms, and specialists.
5 And interviewees thought that having a wider range of
6 providers who have vaccines and can administer vaccines
7 would really improve access and increase vaccination rates.
8 There was particularly broad support for
9 increases the use of pharmacists in Medicaid, and a few
10 thought that it would be helpful to have some federal
11 guidance to encourage the use of pharmacists in providing
12 adult vaccinations in Medicaid.
13 Interviewees also suggested that beneficiaries
14 need more support and education on the importance of
15 vaccines. Interviews explained that since the vaccine
16 schedule for adults is both age and risk-based, it can be
17 challenging to know when as an adult you actually need a
18 vaccine or when it's recommended for you. More support may
19 be needed to reach beneficiaries and encourage them to get
20 vaccinated.
21 There was also a conversation among some
22 interviews that vaccine hesitancy may be on the rise right

1 now.

2 Next slide.

3 So we have a couple policy options that could
4 help improve beneficiary support. One approach would be to
5 encourage providers to provide vaccine counseling, so some
6 experts noted, especially with the rise of vaccine
7 hesitancy, that it may take a couple conversations with
8 beneficiaries before they agree to get a vaccine. And they
9 argued that we should be paying doctors and providers to
10 have those conversations with beneficiaries.

11 There was mixed support for this policy. Some
12 were concerns about delinking the payment of an actual
13 administration of a vaccine since that could increase costs
14 but may not necessarily lead to increased vaccinations.
15 Beneficiary advocates and other experts also noted that
16 Medicaid could be doing even more to encourage Medicaid
17 enrollees to become vaccinated. This could include using
18 Medicaid resources for public health campaigns or targeted
19 outreach and sending reminders to beneficiaries about
20 upcoming recommended vaccines.

21 In September, we presented a framework for
22 assessing potential policy options, and this framework

1 included looking at how each policy option could affect
2 vaccination rates, state and federal spending, racial
3 disparities, and their potential effect on operational
4 complexities associated with the policy option.
5 So, when we were conducting our interviews, we
6 asked each interviewee to assess these policy options based
7 on the criteria in the framework, and this table summarizes
8 the feedback that we received from interviewees.
9 These options, as we walk through, they're not
10 mutually exclusive nor are they exhaustive. In fact,
11 several interviewees gave us additional policy options that
12 we've just discussed, but we'll start here with these. And
13 I can start with the first policy option here, mandatory
14 coverage of vaccines.
15 This was the preferred approach of many of the
16 interviewees that we spoke to as a way to expand coverage
17 for vaccines. We expect that it would increase vaccination
18 rates. So those who currently don't have coverage of
19 vaccines that are recommended for them, they would gain
20 coverage. As a result, this would likely increase state
21 and federal spending, and we heard that it wouldn't be
22 particularly complex to implement. All states are

1 currently covering some vaccines, and so this would simply
2 require that the states cover all of those that are
3 recommended.
4 The next option is coverage of vaccines through
5 the Medicaid Drug Rebate Program. This is similar in that
6 it would extend coverage, making recommended vaccines
7 available to individuals in the Medicaid program. States
8 would be required to cover vaccines. However, it could
9 potentially decrease state and federal spending because
10 vaccine costs could be reduced through the rebates.
11 However, of course, if utilization increases substantially,
12 then those savings from the rebates could be offset by the
13 increased utilization.
14 This is as little bit more challenging to
15 implement than the previous option, just that states and
16 many manufacturers would have to operationalize these
17 rebates for vaccines.
18 I then just want to jump down to the federal
19 purchasing program, since this is the other mandatory
20 option to expand coverage. As you can see, this had the
21 greatest potential for improving rates and addressing
22 disparities, since interviewees assumed looking back at the

1 VFC's success at both of those things, but it would also
2 increase federal spending. And it would have the highest
3 operational complexity as well.

4 On the third row, we looked at federal funding
5 for vaccines. This one could be implemented a couple
6 different ways. This is that voluntary approach where the
7 FMAP could be increased to incentivize states to cover, and
8 so interviewees thought that it would probably have a
9 limited effect on vaccination rates. And, depending on the
10 take-up rate, it could shift spending onto the federal
11 government from the states. Based on conversations with
12 states, it isn't particularly complicated or complex to
13 implement.

14 This policy could also be used and paired with a
15 coverage policy in order to increase that FMAP for
16 administration rates for providers. If it, again, were
17 just implemented individually without any other policies,
18 we think it would also have a limited effect on vaccination
19 rates, and again, the same is true for that federal
20 contracting price option, which is the last one on this
21 table. If we were just implementing this individually,
22 interviewees thought that it would have a low impact on

1 vaccination rates, although it would decrease federal and
2 state spending. They also noted that it would be a little
3 bit complex to implement since providers would still
4 purchase the vaccine and then would later need to get some
5 sort of discount based on that negotiated rate.
6 Next slide.
7 So now all of these policy options could really
8 vary depending on which vaccines were included and whether
9 cost sharing would be allowed. The vast majority of the
10 interviewees that we spoke to strongly supported following
11 the clinical recommendations set forward by ACIP, which
12 recommends vaccines based on age and clinical factors, and
13 they also noted that cost sharing was a major barrier, and
14 that interviewees -- they really argued that it should be
15 prohibited if we want to encourage vaccinations.
16 Lastly, I just wanted to note that several
17 interviewees noted challenges with immunization information
18 systems. These are the systems that are the central
19 databases that record immunization doses administered by
20 providers, and when we spoke with state medical directors
21 and MCOs, they just noted that these systems need quite a
22 bit of an improvement. And there are some data timeliness

1 issues. There are some issues with interoperability, and
2 so I just wanted to mention this as an additional
3 consideration, since some of the interviewees suggested
4 that you may want to think about how the federal government
5 might support improvements in this area.
6 So, next steps, we'd like to get your feedback,
7 as the Chair had already indicated, on these policy options
8 to understand which ones you might want to consider as a
9 potential recommendation. You could start by thinking
10 about policy options to expand coverage and then possibly
11 turn to some of these other policy options that we walked
12 through that could potentially be layered on as well.
13 Then we would appreciate if you have any
14 suggestions for additional information that you would need
15 to move forward.
16 The Commission would like to make recommendations
17 and include them in the March report. We would then
18 present draft recommendations to you all in December and
19 would return in January with a draft chapter, and the
20 Commission would then vote on those recommendations.
21 We are also planning to return in December with a
22 complementary set of datapoints to the survey analysis that

1 we presented last month, and this is really just to sort of
2 use the claims data to estimate state-level vaccination
3 rates, again, as sort of a complementary analysis to the
4 vaccination rates that we had already estimated.
5 So, with that, I will turn it back over to the
6 Commission.
7 CHAIR BELLA: Thank you, Amy and Chris.
8 Kisha, do you want to lead us through this part?
9 VICE CHAIR DAVIS: Thanks. Thanks, Amy.
10 You know, I think you've laid out -- done a
11 really great job of laying out the options almost in a
12 choose-your-own-adventure kind of map for us, and I thought
13 let's start back. I think if we go to Slide 9 and start
14 with the conversation around expanding coverage, and then
15 we can march through the separate policy options.
16 So does anyone have comments here on -- thoughts
17 around expanding coverage, incentivizing versus mandating?
18 I see Darin, Heidi, Laura, and Fred.
19 Go ahead, Darin.
20 COMMISSIONER GORDON: Thank you.
21 This is helpful, and I agree this is choose your
22 own adventure.

1 I have a question. You talk about the increased
2 FMAP for preventive services, and that's probably the
3 easier one to gage. How many states currently qualify for
4 that -- or I should say are taking advantage of that? Do
5 we know?
6 MS. ZETTLE: Yes. Let me just pull that up. I
7 think we have that here. My apologies.
8 Chris, if you find it before me, feel free --
9 MR. PARK: Yeah. I think it was about 12 that
10 reported that in the CDC survey, but one or two of the
11 states that we talked to in our interviews actually
12 provided coverage of all vaccines without cost sharing.
13 But they had yet to apply for the enhanced match because
14 they didn't have systems in place.
15 COMMISSIONER GORDON: Gotcha. Okay. That's
16 where -- you were going where I was going. I was trying to
17 get an understanding of really increasing the match there
18 was really going to -- one, would it really change the
19 number of states that are covering the preventive services
20 but, two, really what that gap was, and yet I vaguely
21 recall that I had heard back then that some states thought
22 they did qualify but, to your point, had some system

1 issues.

2 So, with that said, I tend to lean toward kind of
3 the targeted FMAP increase for vaccines, and one that I had
4 not thought of until I read your material and one that's on
5 your grid of showing kind of the impacts, high, medium,
6 low, that created a federal purchasing program, I was
7 surprised about some of the impact there. But I think
8 that's very intriguing.

9 My concern about making the vaccines mandatory
10 benefit goes back to something I've been pretty consistent
11 on, which is increasing states then. So, if there are
12 other policy levers to pull that mitigate that, such as the
13 ones I was suggesting, I think those should be things we
14 should consider more heavily than others.

15 Thank you.

16 VICE CHAIR DAVIS: Thanks, Darin.

17 Heidi?

18 COMMISSIONER ALLEN: I think that having
19 different levels of coverage for the expansion population
20 and other categories of enrollees is really confusing for
21 beneficiaries and providers. So I would recommend a
22 mandate of the ACIP-recommended vaccines.

1 VICE CHAIR DAVIS: Thank you, Heidi.

2 Laura?

3 COMMISSIONER HERRERA SCOTT: I echo Heidi's
4 comment. I would recommend the mandate. I mean, going
5 back to the complexity issue that was on one of the later
6 slides, it would be the easiest to implement. You have
7 almost half of the states there already. I think on a
8 previous slide, it said 24 out of 49 states.

9 It would be interesting to know of the 25 states
10 that haven't recommended all, what vaccines are already in
11 scope for those states? Because you had high spend on the
12 state and federal, and it may not be as high once you get
13 into market by markets, and then understanding the cost of
14 vaccine-preventable diseases on the utilization side could
15 offset that cost.

16 VICE CHAIR DAVIS: Thank you, Laura.

17 For Amy and Chris, I don't know if you have that
18 at your fingertips but maybe something for the December
19 meeting?

20 MS. ZETTLE: Yeah. I can speak to that a little
21 bit. I think that's right. So, of the states that don't
22 cover all, most of them are covered. Most of the vaccines

1 are covered. So, flu, Tdap -- and I'm pulling up our
2 spreadsheet here, but some of the HPV, Hib, the shingles
3 vaccine, so there are a couple where it's maybe 9 out of
4 the 13 are covered but not all 13. So we can break that
5 down a little bit more for you all in December if that is
6 helpful.
7 VICE CHAIR DAVIS: Thank you.
8 And we've got Fred.
9 COMMISSIONER CERISE: All right. Coming off
10 mute.
11 I would be okay, I think, with a mandate,
12 although I don't think you can -- if we go that way, I
13 don't think you can separate that from the cost issue at
14 all, I mean, similar to what Darin was saying. So I'd have
15 a couple if concerns around that.
16 One is I would like to hear, so we could use
17 Peter back on the Commission, because I would like to hear
18 from ACIP to understand how they factor. And I know cost
19 is a consideration in their recommendations, but I think
20 for most of these, it's not a matter of how much money you
21 save if you did it but what's the cost of -- what's the
22 added cost.

1 I know that they factor that in. If we were to
2 use that, however, as the approval to require vaccine, I
3 think I'd want to understand how much they consider in
4 terms of is there a threshold for dollar per QALY that they
5 look at in their approval process and would want to
6 understand a little bit more about how they do that
7 assessment.
8 So I would be in favor of a mandate, but -- and
9 we can talk about this more, I'm sure, in the next section.
10 When you get into the cost limitations or how you manage
11 cost, I think it would be very important that we pair that
12 with something on that end.
13 I guess I have a question about -- in that line,
14 not to get ahead of ourselves, but about the federal
15 purchasing program. I believe that the VFC program covers
16 Medicaid and uninsured and underinsured. It's pretty broad
17 there, and would we be looking at something similar here,
18 or are we talking about a federal program that provides it
19 to whatever the outlets are but strictly for Medicaid?
20 MS. ZETTLE: Yeah. So that's a great question.
21 While there were interviewees who did advocate for it to go
22 broader than Medicaid, we would just be talking about it

1 more as looking at VFC as to how they purchase -- how the
2 federal government purchases, but it would only apply to
3 adults enrolled in Medicaid specifically. It wouldn't go
4 beyond Medicaid.

5 VICE CHAIR DAVIS: Thanks.

6 Stacey, and then I see you, Martha. And then
7 we've heard several folks who have come down kind of in
8 favor of the mandate. If there's any others who are
9 sitting on the other side of that too, we'd also like to
10 hear from them.

11 COMMISSIONER LAMPKIN: Thanks, Kisha, and that
12 was exactly what I was going to do because it seems to me
13 that if we were taking up this question on another optional
14 benefit, how do we improve access to adult dental care, for
15 example? A mandate would be one of the options we'd be
16 looking at there too, and just about any of these optional
17 benefits that we look at, putting a mandate on the states
18 would improve the access and take-up of the services, and
19 yet it's a federal-state program where states have the
20 ability to prioritize how they want to cover optional
21 services. And so stepping on that here, would this be the
22 service that we would prioritize for a mandate among all

1 the optional benefits? I don't know.

2 And so, for that reason, at least based on what I
3 know right now, I think I would prefer other incentive-
4 based solutions rather than straight-up mandate.

5 VICE CHAIR DAVIS: Thanks, Stacey.

6 Martha?

7 COMMISSIONER CARTER: Thank you, Stacey, for
8 saying that. That's really thought-provoking.

9 I find myself on this side of mandatory coverage,
10 but perhaps the broadest reach would be adding vaccines to
11 the Medicaid Drug Rebate Program because that would reach
12 our target, which is Medicaid, but also make those vaccines
13 available to uninsured people, just because that's what the
14 program is. Then it's available in 340B, and it can be
15 used broadly. So that would be one option to consider as a
16 recommendation.

17 I want to just make another point here. I've had
18 email conversation with the staff, but I want to just make
19 the point again of the community health centers. About 18
20 million adults age 18 to 64 receive care at health centers,
21 and the way the health centers are paid for vaccines is
22 problematic. And I know the staff has committed to doing

1 some more work on this.

2 If a patient receives one of these vaccines

3 outside of a face-to-face visit with a provider, then it's

4 not considered a visit and not billable under the PPS rate.

5 Now, some vaccines, there's a reconciliation on

6 the cost report, but that is quite delayed. It can be 18

7 months or longer before that is all reconciled.

8 So I think I would like the Commission to at

9 least address in some fashion the problem that FQHCs have

10 in accessing and administering vaccines in a way that they

11 can afford.

12 That's all.

13 VICE CHAIR DAVIS: Thank you, Martha, for

14 bringing that up. It's a great point that we certainly

15 want to keep in mind.

16 Other thoughts around -- as we're thinking about

17 coverage and paying for it and some of these options here

18 that they have laid out for us in terms of mandatory

19 benefit, but adding to MDRP, creating federal purchasing

20 programs, other thoughts there before we move on to talk a

21 little bit more about access? We've got about 15 minutes

22 left for this conversation.

1 Yeah, Heidi.

2 COMMISSIONER ALLEN: I would just add that these
3 are important for public health, and that I thought that
4 the part in the materials about Oregon's Health Evidence
5 Review Commission and how they rate vaccines in like the
6 top five of all health services in terms of being cost
7 effective. And, you know, Oregon also takes into
8 consideration vulnerability of population, public health
9 impact, all of these kinds of other really important
10 things. And I think that if you're going to make a benefit
11 mandatory and you're going to look at which ones are the
12 most important, I think vaccines really are in that
13 category of being extremely cost effective.

14 And we haven't moved to the part of the
15 conversation where we talk about how to make it more
16 affordable for states, but I would welcome that part of the
17 conversation if we were to go forward with a mandate.

18 COMMISSIONER DAVIS: Thank you, Heidi. Well,
19 let's move forward a little bit and talk a little bit more
20 about the access conversation, which I think was Slide 11,
21 commentary around policy options for ensuring access to
22 vaccines. And I think we've touched on this in various

1 ways before, around adequate payment, provider networks,
2 and how that really impacts an individual's ability to even
3 be able to get to the vaccine, regardless of whether it's
4 covered.
5 Yeah, Laura.
6 COMMISSIONER SCOTT: So I think the thing that
7 certainly helped, that someone mentioned earlier, was the
8 fact that I think every state -- but someone can correct me
9 -- has pharmacists now are allowed to give vaccines. And
10 so between the primary care provider and access through the
11 pharmacy benefit and getting it at your local Rite Aid,
12 Walmart, you know, wherever you go, that would certainly
13 solve a lot of the access issues.
14 COMMISSIONER DAVIS: Okay. And I think I come
15 down in that camp too. Vaccines don't have to be a turf
16 war, and I think sometimes they're made out to be. And
17 really, as a public health program, making it easy and
18 accessible to get them, wherever they can, whether that's
19 at the health fair, the pharmacy, the doctor's office, the
20 community health center, really trying to remove as many
21 barriers as we can to making that accessible.
22 Any other thoughts here? We can move on then to

1 policy options. I think it's Slide 13, around additional
2 support for beneficiaries. And I think we'll kind of come
3 back to that table that sums it all up, to talk about
4 policy considerations. But any concerns or additional
5 thoughts here as we think about how to better educate folks
6 just about the need for vaccines and accessing them? Fred.
7 COMMISSIONER CERISE: Just a quick comment on
8 payment for counseling. There are so many preventive
9 services that are out there, and I'm afraid if you start
10 separating payment for each counseling session those will
11 really add up. And so my initial reaction is not to
12 separate that from the vaccine distribution itself.
13 COMMISSIONER DAVIS: Let's kind of move and start
14 talking about the different policy options, as we look at
15 it as a whole, which I think is on Slide 15. You know, as
16 we're moving towards recommendations in December, and in
17 December we want to be looking at some draft
18 recommendations, previewing a chapter in January to go in
19 the March report, are there things that are off the table
20 here and things that we need more information about? What
21 would help folks feel comfortable about making
22 recommendations around vaccinations?

1 I hear folks coalescing around a mandate,
2 concerns about cost and what that would look like and
3 needing additional information on there. But what else
4 would you want to take off the table, or what additional
5 information do you think we need to be able to start
6 reviewing recommendations in December?
7 COMMISSIONER CARTER: Kisha, I think including
8 in our narrative some cost benefit analysis would be good,
9 just the savings accrued to the health care system when we
10 avoid pneumonia, tetanus, shingles, et cetera, flu. I
11 think that would be a compelling piece of information to
12 include.
13 COMMISSIONER DAVIS: Thank you, Martha. Fred,
14 and then Melanie.
15 COMMISSIONER CERISE: Yeah. I guess I would try
16 to clarify, the mandatory one is, I think, the report said
17 was the easy one. That's the one that has increased state
18 and federal spending on it. I probably would not just stop
19 it at that one. I realize we've got some mixing and
20 matching we can do.
21 I would probably try to clarify the drug rebate
22 one to reference the medium decrease on both of those.

1 Certainly, if utilization goes up, as you would expect, do
2 we really think that those would be decreases in state and
3 federal spending? If we feel like we play that out and
4 model that and see the increased utilization and we see a
5 flat or a decrease, certainly that would be an appealing
6 option.

7 And then the federal purchasing program, where I
8 know it's got high complexity associated with that. We do
9 it with VFC. If you look at making an impact -- I know
10 it's different than COVID, but if you look at like making a
11 big campaign to push centralizing where you provide access
12 and making the vaccine easily available, in terms of impact
13 I would keep that on the list for consideration, at least
14 at this point.

15 COMMISSIONER CERISE: Thanks, Fred. Melanie?

16 CHAIR BELLA: Yeah. I have a comment and then
17 Dennis does as well, Kisha. And maybe Fred was just
18 getting to it. Amy, I was just going to ask, I've read it
19 and I'm thinking about it, but I still can't get my head
20 around why the federal purchasing program is high on all
21 the good things, right -- improving the rates, reducing
22 disparities. I mean, a good thing is in having more

1 organizational complexity. But do we believe that all the
2 barriers to beneficiaries, their concerns, their hesitancy,
3 and all the barriers with providers' ability to provide,
4 like all of those get taken care of so much more in this
5 option than in other options that allows us to think it
6 would do a better job at reducing disparities, for example?
7 MS. ZETTLE: Yeah, so it would address coverage.
8 What it doesn't address is the adequate payment issue for
9 providers. So it takes the kind of up-front cost off the
10 table, where if you're a participating provider, now all of
11 a sudden the federal government is supplying your vaccines
12 and, therefore, I think that's why so many of the
13 interviewees were pretty optimistic about it improving
14 rates, because now providers who maybe didn't want to pay
15 the up-front cost in purchasing the vaccines and having to
16 deal with that now would all of a sudden have vaccines
17 available to them.
18 But it doesn't address their administration
19 payment, which we did hear from medical directors in an
20 interview across a number of states, that admin rates are a
21 concern in the VFC program as well, and getting providers
22 to participate. You know, we did also hear from some folks

1 that the complexities associated with VFC may feel even
2 more complicated because adults don't have the same demand
3 for vaccines that children have. So applying those same
4 requirements and complexities on the adult providers may
5 not be worth it for adults.
6 So I don't want to say, to answer your question,
7 that these are sort of initial -- this would potentially
8 have the greatest improvement, but I don't want to say that
9 it's a vastly higher improvement.
10 And then -- sorry, and then I'll stop, but the
11 last thing I'll just say is again, these were kind of rated
12 individually. So, if you took mandatory coverage and
13 paired that with a policy option to address payment
14 adequacy and cost to the state, could that potentially have
15 the same impact as a federal purchasing program, which is
16 what many of our interviewees thought.
17 Does that answer your question?
18 CHAIR BELLA: It does, yeah. That's really
19 helpful. Thank you.
20 COMMISSIONER DAVIS: I see Fred. Is it to this
21 same point?
22 COMMISSIONER CERISE: Yeah, can I add a quick

1 follow-up to that? I wondering if the high increase in
2 federal spending, I guess because the states don't have a
3 share, but assume that they would also have significant
4 negotiating position to get better pricing on the drugs as
5 well. And then the group I hadn't seen in here is public
6 health, and if it's complex for a lot of individual
7 providers could you centralize some of that distribution
8 through public health entities? And that's another group
9 I'd like to hear from as we weigh these options, because
10 obviously they have a lot of experience with this.
11 COMMISSIONER DAVIS: I think you also can't
12 underestimate that burden that we see in the VFC. You
13 know, working in a clinic, if it was a VFC provider it was
14 an administrative challenge, and that's for children who
15 are getting a lot of vaccines. And that alone can be a
16 barrier, especially in an adult population where there's
17 smaller demand, where practices may just not want to put up
18 with the hassle of doing it for a smaller population and a
19 lower demand.
20 Dennis?
21 COMMISSIONER HEAPHY: Yeah, thanks. I wanted to
22 follow up on Fred's point. He said some of the things I

1 was going to say. I just also wanted to turn to the
2 providers. I'm thinking of all those pharmacies out there
3 that are providing vaccines. Have you seen cost decreases
4 and provisions of vaccines nationally when folks are
5 getting the vaccines through pharmacies rather than going
6 through medical providers? Like what's the cost
7 differences? Is there a way of actually increasing savings
8 by folks who are more from a public health perspective on
9 bringing the vaccines into the community? I guess it's
10 sort of two questions there.
11 MS. ZETTLE: Yeah. We didn't ask that question
12 specifically, but I don't know if, Chris, since you're
13 looking at some of the claims data, I think the admin rate
14 would potentially be the same whether it's a pharmacist or
15 a provider. Is that right, Chris?
16 MR. PARK: Yeah. I think, first of all, we don't
17 have the data to assess the cost in terms of what it takes
18 in effort for the pharmacist versus a physician to
19 administer, but we do see some variation across states in
20 how they pay for vaccine administration. Some states they
21 allow the pharmacist to bill similar to a physician, and so
22 they'll get that vaccine administration rate. Then in some

1 states, or for some health plans, they treat it like a drug
2 claim, so they get like a dispensing fee that would be
3 similar to what they would if they dispensed just a normal
4 outpatient prescription drug.
5 And so it would be hard to say whether that would
6 be a cheaper alternative, but I think what stood out in all
7 of our discussions, most interviewees thought that
8 pharmacies are an important part of the network.
9 COMMISSIONER HEAPHY: This is Dennis. Just to
10 follow up on that then, might that be something that could
11 be considered in the policy recommendations, to get more
12 information as to how pharmacists are paid versus medical
13 providers when somebody is going in for an appointment?
14 MR. PARK: Sure. We can take a look at that.
15 It'll be hard --
16 COMMISSIONER HEAPHY: If it's of value.
17 MR. PARK: -- to really get a -- yeah, it'll be
18 hard to get a comprehensive picture, but we can start
19 trying to see what's out there, if there's a good resource
20 that kind of summarizes that.
21 COMMISSIONER HEAPHY: Good. I just think if it's
22 out in the community people are going to get it, than if

1 they going through a doctor's appointment. I would think
2 that would be cheaper. I'm surprised that it's not.
3 COMMISSIONER DAVIS: Thank you, Dennis. You know
4 -- oh, go ahead, Tricia.
5 COMMISSIONER BROOKS: All right. I hide that too
6 often. Just two really quickies. Under the federal
7 purchasing program that would not be mandated, so it would
8 continue to be a state option. And it took many years for
9 all of the states to take advantage of the Vaccine for
10 Children program, so I guess I find it interesting that it
11 has a high ability to improve vaccination rates.
12 And the second point is really a question, and
13 that is, is there a downside to doing this through the
14 Medicaid drug rebate program?
15 MS. ZETTLE: So when we spoke with stakeholders
16 and interviewees, vaccine manufacturers indicated
17 opposition to this approach, in that they thought that it
18 could potentially reduce investment and innovation in the
19 vaccine space, so they were concerned about access if this
20 were applied.
21 Other arguments that we heard against were in the
22 VFC program rebates aren't applied on the children's side,

1 and so therefore it would be inconsistent to apply it on
2 the adult side. And we also heard about sort of market
3 complexities, given best price and sort of what
4 implications it would have in the broader marketplace.
5 MR. PARK: Yeah, and I was just going to add onto
6 that with a discussion with some of the drug manufacturers.
7 They were much more willing to consider the federal
8 contract price, since this is already being done for VFC
9 and for the 317 immunization program, where they've already
10 done some contracting, and it's pretty contained. You
11 know, it doesn't necessarily apply to commercial payers and
12 things like that. So I think they are more willing to
13 consider that option versus the MDRP.
14 COMMISSIONER BROOKS: But it has the least impact
15 on vaccination rates and racial disparities.
16 MS. ZETTLE: I might just clarify -- oh, I was
17 just going to clarify. We rated these -- and this is kind
18 of complicated to see, but we rated these sort of if
19 implemented on its own. So, if you were to pursue the
20 mandatory coverage and then pair it with the concerns
21 around cost to states, you could potentially pair the
22 federal contract price with another option to expand

1 coverage, and then that would essentially reduce the extent
2 to which state and federal spending would increase, if that
3 makes sense.
4 COMMISSIONER DAVIS: Thank you. Any other final
5 comments before we wrap up on this session? Go ahead,
6 Martha.
7 COMMISSIONER CARTER: I think it might be helpful
8 to dig deeper into these two options of the Medicaid Drug
9 Rebate Program and federal purchasing program, if anybody
10 has done any modeling about the increase in uptake of
11 vaccines with these two different options, or, you know,
12 maybe to address the vaccine manufacturers' concern.
13 What's the balance if they distribute a lot more vaccines,
14 because of the drug rebate program? So just to dig a
15 little deeper maybe into those two options for us.
16 COMMISSIONER DAVIS: Thank you, Martha. You
17 know, as we wrap up this session I think maybe coming back
18 in December and looking again at this table as things are
19 paired up, as we're thinking about vaccines, if it's
20 mandatory coverage plus MDRP plus federal purchasing price
21 and how that might shift some of where these fall out. And
22 looking at some of that cost benefit analysis I think will

1 help to get us there.

2 Amy and Chris, do you have what you need? Any

3 other questions from the Commissioners?

4 MS. ZETTLE: No. This has been helpful. I

5 appreciate the conversation. Thank you.

6 COMMISSIONER DAVIS: Thank you both. All right,

7 Melanie. I will turn it back to you.

8 CHAIR BELLA: Great. Thank you. Thank you, Amy

9 and Chris and Kisha.

10 CHAIR BELLA: We are going to go to public

11 comment now on the last two sessions, and then we'll take a

12 break and come back and do DSH. We'll see how that timing

13 works out. But I would invite anyone in the audience who

14 wants to speak, please use your hand. And I will remind

15 you, please introduce yourself and the organization you're

16 with, and please keep your comments to three minutes or

17 less.

18 It looks like we have someone, one person.

19 **### PUBLIC COMMENT**

20 * MS. HUGHES: Netta, you have been unmuted. You

21 may ask your question or make your comment.

22 [Pause.]

1 MS. HUGHES: Netta, if you could click the
2 microphone icon under the orange arrow on the upper right
3 side of your screen.
4 [Pause.]
5 CHAIR BELLA: Can we go ahead and move to
6 Courtney? It looks like we lost Netta.
7 MS. HUGHES: Yes. Courtney's been unmuted.
8 Courtney, you are able to unmute.
9 MS. KING: Hi. This is Courtney King. I'm the
10 Alaska Medicaid state plan and policy person. And I wasn't
11 planning on commenting but I felt moved to, based on the
12 Money Follows the Person discussion.
13 First, I'd like to say I fully appreciate Dennis'
14 position, and he articulated something that's very
15 difficult to parse in a lot of ways. And I guess what I'd
16 like to say is that it's a nuance to us, who aren't service
17 recipients, in terms of the requirements for MFP and the
18 placements being more limited than the settings
19 requirement.
20 But I think what's important to remember is that,
21 you know, the intent is to create an intentional transition
22 to noninstitutional settings that are actually integrated

1 into the community, and the difference between that, in my
2 mind, and those who have not been institutionalized is that
3 the people who are currently living in the community are
4 more, as Dennis said, more apt to be integrated and have
5 accessible services.

6 And so I guess I would like to just, having
7 worked in the residential world I understand the fiscal
8 policies behind five beds versus four, but I also
9 understand what Dennis mentioned about it's a shift to
10 being more like institutional living because of the
11 schedules and everything, and the staffing patterns
12 required by state statutes and regulations.

13 So I think that it's just important to really
14 dial into the issue of the intention and the spirit and the
15 nuance of the difference between those two things, and that
16 I would urge you to preserve those.

17 CHAIR BELLA: Thank you. We'll give it another
18 second but it does not look like we have any more folks who
19 would like to comment, in which case we're going to take a
20 bit of an abbreviated break. I'm going to ask everyone to
21 be back at 2:50 Eastern time, so you have about 10 minutes.
22 Please get back promptly so we can begin DSH, to round out

1 our day. We'll see you all back here about 10 minutes.
2 Thank you.
3 [Recess.]
4 CHAIR BELLA: All right. Welcome, Aaron and
5 Jerry. You guys are here to take us into the home stretch
6 with DSH. In just a second, I'll ask you to go ahead and
7 get started as everybody is rejoining. So welcome.
8 [Pause.]
9 CHAIR BELLA: Okay. Welcome back, everyone.
10 Welcome, Aaron and Jerry. We are into the home stretch
11 with our DSH session, so I will invite the two of you to
12 get started.
13 **### REQUIRED ANNUAL ANALYSIS OF DISPROPORTIONATE**
14 **SHARE HOSPITAL ALLOTMENTS TO STATES**
15 * MR. PERVIN: Thanks, Melanie.
16 COMMISSIONER HEAPHY: Sorry, did I...
17 MR. PERVIN: I'm going to go ahead and get
18 started. Hello, Commissioners. Today Jerry and I will be
19 presenting the draft chapter of our statutorily required
20 analysis of disproportionate share hospital, or DSH,
21 allotment.
22 Next slide.

1 I'm going to start with a little bit of
2 background on DSH policy and then move on to our analyses
3 which look at the relationship of federal DSH allotments
4 and three different measures of need. Jerry will present
5 on rates and levels of the uninsured while I'll present on
6 the amounts and sources of uncompensated care within each
7 state and the number of hospitals with high levels of
8 uncompensated care that provide essential community
9 services. Then I'll discuss congressional changes to DSH
10 allotments during the public health emergency and end by
11 summarizing the key chapter points and next steps.
12 Next slide.
13 I wanted to start with a little bit of background
14 on DSH. As a reminder, under the Medicaid statute, states
15 are required to make supplemental payments to hospitals
16 that treat a high proportion of Medicaid and low-income
17 patients. These supplemental payments are known as
18 disproportionate share or DSH payments. DSH payments are
19 limited by state DSH allotments which vary widely by state.
20 Allotments for these payments are based on DSH
21 spending in 1992 and adjusted for inflation. States have
22 wide latitude to distribute DSH payments to virtually any

1 hospital in the state, but total DSH payments to a hospital
2 cannot exceed certain types of uncompensated care that the
3 hospital provides.
4 The Patient Protection and Affordable Care Act,
5 or ACA, scheduled a series of allotment reductions. The
6 ACA reductions are scheduled for $8 billion per year from
7 2024 to 2027. In 2024, federal reductions will be 58
8 percent of their unreduced allotment amounts. There are no
9 reductions scheduled in 2028 and beyond, which means
10 allotments will revert to their unreduced amounts.
11 I will now turn it over to Jerry to discuss rates
12 and levels of the uninsured.
13 * MR. MI: Thanks, Aaron.
14 In this year's report, we looked at the number of
15 uninsured individuals in two ways. We first used the
16 Current Population Survey, or CPS. According to the CPS,
17 28 million people, or 8.6 percent of the United States
18 population, were uninsured in 2020 -- virtually unchanged
19 since 2018. Similar to prior years, the uninsured rate in
20 2020 was highest in adults below age 65, individuals of
21 Hispanic origin, and individuals with incomes below the
22 federal poverty level, or FPL.

1 In 2020, the uninsured rate in states that did
2 not expand Medicaid under the ACA was nearly twice as high
3 as the uninsured rate in states that did expand Medicaid.
4 CPS is an annual survey that asks whether
5 individuals had any insurance coverage in the prior year.
6 However, it did not look at how the uninsured rate changed
7 over the course of the COVID-19 pandemic. To better
8 understand the effects of the pandemic on the uninsured
9 rate, we also used the Census Household Pulse Survey, a
10 biweekly survey designed to measure household experiences
11 during the pandemic. We found that at the beginning of the
12 pandemic, from April 2020 through July 2020, the uninsured
13 rate among survey respondents significantly increased.
14 The pandemic also had a large effect on household
15 finances. By August 2020, 70 percent of uninsured
16 respondents reported that they or a family member had
17 experienced a loss of income. Forty percent of uninsured
18 respondents reported a household income below 100 percent
19 FPL.
20 Between August 2020 and July 2021, the uninsured
21 rate in the sample declined significantly while the
22 Medicaid coverage rate increased significantly. Medicaid

1 enrollment commonly increases during periods of recession.
2 This is due to the countercyclical nature of the Medicaid
3 program. In addition, the increase in Medicaid enrollment
4 may also be due to the continuous coverage provisions of
5 the Families First Coronavirus Response Act that prohibited
6 states from disenrolling Medicaid beneficiaries during the
7 COVID-19 public health emergency.
8 Now I'm going to hand it back to Aaron.
9 MR. PERVIN: Thanks, Jerry. Can you also turn to
10 the next slide? Thanks.
11 As a reminder, hospitals can receive DSH payments
12 up to their level of uncompensated care. Under DSH,
13 uncompensated care is defined as unpaid costs of care for
14 uninsured individuals and the difference in cost and
15 payments from Medicaid-eligible beneficiaries, also known
16 as Medicaid shortfall.
17 The most recent available data on uncompensated
18 care for all hospitals comes from the 2019 Medicare cost
19 reports, which defines uncompensated care as charity care
20 plus bad debt. Hospitals reported a total of $41 billion
21 in charity care and bad debt in 2019, which represents 4.2
22 percent of hospital operating expenses, which is virtually

1 unchanged from 2017.

2 Recent research that is relevant also came out
3 this past year which showed that Medicaid expansion lowered
4 hospital level unpaid costs of care for the uninsured among
5 states that expanded between 2011 and 2017. These findings
6 are consistent with our state-level estimates, which showed
7 that hospitals in expansion states reported half of charity
8 care and bad debt when compared to non-expansion states in
9 2019.

10 Next slide.

11 Medicaid shortfall is the difference between a
12 hospital cost of care for Medicaid-enrolled patients and
13 the total payments it receives for those services. Because
14 Medicare cost reports do not include reliable information
15 on shortfall, we use the annual American Hospital
16 Association survey for a national estimate. The latest AHA
17 survey indicates that Medicaid shortfall totaled $19
18 billion in 2019, which is a decline of $1 billion from
19 2018. Other reports also highlighted the changing DSH
20 definition of shortfall given various court rulings between
21 2017 and 2020. It should be noted that Congress tried to
22 put this to rest in last year's budget bill which changed

1 how third-party payments are treated within shortfall
2 calculations. The new definition of shortfall will no
3 longer include Medicaid beneficiaries who have principal
4 coverage through a third party. We believe that this will
5 cause the DSH payment limit to increase for hospitals that
6 serve a high share of Medicaid patients with private
7 coverage, such as children's hospitals, and decrease the
8 DSH payment limit for hospitals that serve a large share of
9 patients dually eligible for Medicare and Medicaid. To
10 partially mitigate some of this, Congress did introduce an
11 exemption for hospitals that serve the highest share of
12 those who are dually eligible. This definition goes into
13 effect for payments in this fiscal year.
14 Next slide.
15 For the final statutory requirement, we use data
16 from the Medicare cost reports and the AHA annual survey to
17 report on the number of deemed DSH hospitals that provide
18 essential community services using the same definition
19 MACPAC has used in prior years. As a reminder, deemed DSH
20 are DSH hospitals with high Medicaid or low-income
21 utilization. These hospitals are statutorily required to
22 receive Medicaid DSH payments. When using Medicaid DSH

1 audit data, we found that 733 hospitals met deemed DSH
2 criteria in state fiscal year 2017; 91 percent of these
3 hospitals provided at least one essential community service
4 while 56 percent provided three or more compared to 34
5 percent of non-deemed DSH hospitals.
6 Next slide.
7 Furthermore, as part of the COVID-19 pandemic
8 public health emergency, Congress made some small changes
9 to how federal DSH allotments are calculated. The American
10 Rescue Plan temporarily increased federal allotments.
11 Combined state and federal DSH funding will remain the
12 same, with the federal government providing an enhanced
13 federal match. These increases allotments will be in
14 effect until the fiscal year after the public health
15 emergency ends.
16 Next slide.
17 In summary, the draft chapter in your reading
18 materials mostly reiterated our findings from prior years
19 regarding different measures of need that Congress has
20 asked us to consider. We find that DSH allotments share no
21 relationship with the number of uninsured in each state,
22 the amount of state-level uncompensated care, and the

1 number of hospitals with high levels of uncompensated care
2 that also provide essential community services. The
3 chapter as opposed to describes congressional changes that
4 we discussed earlier, namely, changes in the definition of
5 Medicaid shortfall and the temporary bump in federal
6 allotments.
7 Next slide.
8 We wanted to end with a series of next steps.
9 First, upon review by Commissioners, this chapter will be
10 published in the MACPAC March report to Congress, and staff
11 will continue to monitor congressional action on DSH
12 between now and publication of the March report.
13 Thank you, and I look forward to your questions.
14 CHAIR BELLA: Thank you both. I'm going to turn
15 it over to Commissioners for comments or questions. Fred,
16 I'm going to put you on the spot. Any comment or question?
17 COMMISSIONER CERISE: So I'll make -- I have a
18 question. That is, if you look at the DSH cuts that have
19 been put up year after year after year, you're starting to
20 compress the time you can do it, but the amount is the
21 same. I mean, it starts to seem impractical. Are you
22 getting any indication on an interest in addressing how to

1 either spread those over a longer period of time or, you
2 know, any of the previous recommendations that we put
3 forward around that?
4 MR. PERVIN: Oh, sure. So we have heard from
5 stakeholders about the worry about the DSH allotment
6 reductions that are scheduled for fiscal year 2024.
7 However, we haven't heard from Congress any indication or
8 any willingness to change how the allotment reductions are
9 scheduled between 2024 and 2028. Just as a reminder to
10 past Commissioners, previous recommendations to Congress,
11 including changing the schedule of those reductions to make
12 sure that they're not as drastic and are not cut at such a
13 drastic level, and instead implement them more gradually
14 with smaller cuts in beginning years and then larger cuts
15 [audio interruption].
16 COMMISSIONER CERISE: Is there any sense that --
17 we put this chapter on another part of our -- I guess it's
18 a statutory requirement, Anne. Is that right? We put out
19 this report annually.
20 EXECUTIVE DIRECTOR SCHWARTZ: That's right,
21 COMMISSIONER CERISE: I guess I know the answer,
22 but, you know, we've been saying the same thing year after

1 year that there's really no -- there's little association
2 between, you know, state allocation and the amount of
3 uninsured and, you know, within states, the distribution
4 among providers in relationship to the uninsured, even look
5 at the graph, you know, and even within there, there's --
6 it's so hard to identify what's going on at some points.
7 And you put a footnote in there about, you know, provider
8 contributions as part of those payments, and it obscures it
9 a bit more.

10 Is there any indication that this expectation is
11 either going to change or, you know, Anne, because it's in
12 our statute, we'll just do this year after year? Because
13 the report's looking very similar every year -- right? --
14 in that we say the same thing.

15 EXECUTIVE DIRECTOR SCHWARTZ: I guess --

16 MR. PERVIN: I can -- sorry. Go ahead, Anne.

17 EXECUTIVE DIRECTOR SCHWARTZ: I would say two
18 things. Yes, it does look the same year after year because
19 there haven't been any major policy changes, and just as a
20 matter of course, we don't focus on trying to make it
21 incredibly interesting every year. We try to just get the
22 job done. But I would say there's two things that are at

1 work for people watching Congress. One is this is an
2 incredibly difficult problem for Congress because it
3 involves a redistribution with winners and losers across
4 states, and that's always just hard politically. Even if
5 you, you know, think that the general gist of the policy is
6 appropriate, winners and losers are very difficult to deal
7 with.

8 The second is that my guess is that Congress will
9 reengage on this as the FY24 deadline approaches. They've
10 obviously had a ton of other things that they have been
11 focusing on over the past couple months, and in some ways
12 it's a relief for them not to have this added into the mix
13 as well. But my guess is that sometime in FY23, we're
14 going to be in a position to dust off our old work and look
15 at it again using newer data, but until then, probably not
16 a lot of appetite.

17 COMMISSIONER CERISE: Yeah, and I would just add
18 that we're statutorily required to report this until 2025,
19 which is, you know, a year after the DSH allotments are
20 scheduled to be reduced.

21 CHAIR BELLA: Great. Thank you. Others?

22 [No response.]

1 CHAIR BELLA: Fred, you very politely said what I
2 think a lot of us wonder year after year. And, Aaron and
3 Jerry, we appreciate you doing the work, and those who have
4 come before you.
5 COMMISSIONER CERISE: It's interesting to me, you
6 know, this is my business. It actually kind of gets --
7 with the number of other supplemental payments that are in
8 the mix now, those have grown a lot. It becomes less, I
9 guess, critical than it was at one point when it was like
10 the supplemental payment, you know? And so states just
11 have a lot of other options to address things through
12 supplementals. It's not just DSH.
13 Anyhow, listen, like I said, it's interesting to
14 me, but there's not a lot of action that we're going to
15 take on it right now.
16 CHAIR BELLA: Great. Are there other comments?
17 And folks can also feel free to share thoughts on the
18 chapter.
19 I see no hands. I'm going to go to the public to
20 ask -- oh, Toby?
21 COMMISSIONER DOUGLAS: Yeah, I was just more
22 planting a seed when we think of the future on this, back

1 to Anne's point on policy. We are going to have to think
2 through implications as the framework, the Build Back
3 Better Act, goes forward, the non-expansion states won't be
4 uninsured or Medicaid for their low-income population, so
5 how would that count in future formulas and how would that
6 be incorporated into it will be something that needs to be
7 accounted for.
8 CHAIR BELLA: Thank you, Toby. Did I miss any
9 other Commissioners? I'm looking at the usual suspects who
10 I usually miss. Okay. Let's go to the public --
11 COMMISSIONER HEAPHY: This is Dennis. I just
12 really appreciated the chapter because I didn't realize how
13 complex this is and how different states implement DSH in
14 so many variable ways that I'm glad that nothing has been
15 done so far because if you pull one string, a lot of other
16 things may come apart. So I really appreciated the chapter
17 and the overview of DSH, so thank you.
18 CHAIR BELLA: Thank you, Dennis. There's much
19 more of that if you're interested in the historical
20 chapters. Light bedtime reading.
21 Okay. I'm going to go to the public. Then I'll
22 come back to see if any Commissioners have any last

1 comments. If anyone in the public would like to comment,
2 please use your hands indicator and tell us your name, your
3 organization, and please keep your comments to three
4 minutes or less.
5 **### PUBLIC COMMENT**
6 * MS. HUGHES: Julie has been unmuted.
7 MS. KOZMINSKI: Hi, everyone. My name is Julie
8 Kozminski. I'm a senior policy analyst at America's
9 Essential Hospitals. I want to thank the Commission for
10 the opportunity to comment and for their continued focus on
11 the issue of Medicaid DSH. I would also like to thank the
12 Commission and its staff for its continued hard work on the
13 annual Medicaid DSH payment study and look forward to its
14 release.
15 Medicaid DSH support ensures our hospitals can
16 serve all patients and provide vital services such as top-
17 level trauma care, burn care, and neonatal intensive care.
18 Our hospitals were able to increase capacity, extend
19 telehealth service in response to the COVID-19 pandemic
20 while operating with financial losses. Medicaid DSH is
21 absolutely vital to essential hospitals across the country.
22 It is our commitment to care for the underserved. Forty

1 percent of our patients are uninsured or Medicaid
2 beneficiaries. Essential hospitals had an aggregate of 2.9
3 percent operating margin in 2019. Without Medicaid DSH,
4 their margins would have been an unsustainable negative 1.5
5 percent.
6 Our overall goal, as always, is to ensure that
7 essential hospitals have the financial resources they need
8 to keep their doors open and provide services to all
9 patients, particularly low-income and other marginalized
10 people. This is consistent with Congress' stated intent
11 with the DSH statute. We welcome the opportunity to work
12 with the Commission as they continue their work and prepare
13 for the release of the annual report on Medicaid DSH,
14 recognizing the need for more updated information on
15 hospital impact.
16 Thank you.
17 CHAIR BELLA: Thank you, Julie.
18 I don't see anyone else who would like to
19 comment. Any further thoughts from Commissioners?
20 [No response.]
21 CHAIR BELLA: Okay. Aaron and Jerry, thank you
22 for this work. We are now done with day one. Thank you,

1 everyone, for your engagement.

2 The public meeting will start tomorrow at 10:30

3 with a session on integrating care for duals, continuation

4 of our work in that area. I invite you all to rejoin us

5 tomorrow morning, and thank you to Commissioners, to Anne

6 and staff, and we will see you in the morning. Thank you,

7 everyone.

8 * [Whereupon, at 3:12 p.m., the meeting was

9 recessed, to reconvene at 10:30 a.m. on Friday, October 29,

10 2021.]

11

12

13

14

15

16

17

18

19

20

21

22

PUBLIC MEETING

Via GoToWebinar

Friday, October 29, 2021
10:32 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

Session 5: Raising the bar and supporting state efforts to integrate care for dually eligible beneficiaries

Kirstin Blom, Principal Analyst and Contracting Officer...169

Ashley Semanskee, Analyst

Session 6: Response to Senate Finance Committee request for information on behavioral health priorities

Joanne Jee, Policy Director and Congressional Liaison...204

Public Comment..221

Session 7: Panel Discussion: The workforce for home- and community-based services

Introduction:

Tamara Huson, Analyst................................226

Panelists:

Robert Espinoza, PHI National........................229

Bill Kennard, Office of Healthcare Workforce Development, Arizona Healthcare Cost Containment System...237

Bea Rector, Aging and Long-Term Support Administration, Department of Social and Health Services, Washington State.........................245

Further discussion by the Commission....................279

Public Comment..291

Adjourn Day 2...294

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

2 [10:32 a.m.]

3 CHAIR BELLA: Good morning, everybody. Thank you
4 for joining us on Day Two of our October MACPAC meeting. I
5 can think of no better way to kick off a Friday morning
6 than to talk about raising the bar on integration for
7 duals, and so we will jump right in. I will hand it over
8 to Ashley and Kirstin to get us started.

9 **### RAISING THE BAR AND SUPPORTING STATE EFFORTS TO**
10 **INTEGRATE CARE FOR DUALLY ELIGIBLE BENEFICIARIES**

11 * MS. BLOM: Thank you, Melanie.
12 Good morning, everyone. I'm going to talk about
13 integrating Medicaid and Medicare coverage for people who
14 are dually eligible by sharing some insights from a
15 roundtable discussion that we convened with states and
16 policy experts last month. At the roundtable, we discussed
17 raising the bar on integrated care and how the federal
18 government could support states in their efforts to design
19 and implement integrated models.
20 Today I'll quickly recap our most recent work on
21 integrated care, and then I'll focus on the roundtable
22 itself. I'll describe the roundtable's purpose and then

1 walk through the main themes that we heard from states, and
2 finally, I'll preview several policy options for
3 Commissioners to consider based on those themes.
4 So, as you know, integrating Medicaid and
5 Medicare for duals has been an area of focus for the
6 Commission for a few years now, and we've published a
7 number of chapters on this topic, most recently in June.
8 That chapter focused on strategies available to states to
9 increase integration and enrollment through their contracts
10 with Medicare Advantage dual-eligible special needs plans,
11 or D-SNPs. D-SNPs are one of the most widely available
12 models that states can use to integrate care, and they're
13 present in 43 states.
14 In our June chapter, one of the key questions
15 that we raised was what federal policies could support
16 states in moving toward more integrated care.
17 And to get at that question, we organized a
18 roundtable to hear from states directly about factors
19 affecting their decision-making on integrated care, the
20 barriers that they face, the types of integrated models
21 that might be most appropriate for different state
22 contexts, as well as how federal support could help them

1 move toward higher levels of integration.
2 The value of this roundtable was really in the
3 conversation among states and the insights that that
4 conversation generated. I'd like to thank the states that
5 participated with us for sharing their insights and being
6 so forthcoming.
7 Also, a thank-you to Mathematica for conducting
8 this roundtable. They facilitated a great discussion for
9 us, and I hope that some of them as well as some of the
10 states that participated might be listening in.
11 We invited these eight states, selected because
12 they had demonstrated an interest in integrating care and
13 were at similar integration levels, ranging from minimal to
14 moderate. We also invited several experts to lend their
15 expertise as stakeholders that states rely on for advice on
16 integrated care, and then two Commissioners, Chair Melanie
17 Bella and Dennis Heaphy also attended.
18 Apart from the themes, which I'll walk through
19 starting on the next slide, there were several overarching
20 takeaways from the discussion. First, we heard that states
21 need federal support to overcome barriers to integration.
22 The support could be technical assistance or financing.

1 Second, there could be more focus on beneficiary
2 experience in integrated care. States emphasized the need
3 to look at integrated care from the beneficiary's
4 perspective, to understand the experience of receiving care
5 through an integrated model and to work toward
6 improvements.
7 Third, having all benefits covered by one managed
8 care plan does not necessarily mean that a beneficiary's
9 care is better coordinated at the service delivery level or
10 that the individual's experience navigating and receiving
11 care is improved over prior coverage. It's important, we
12 were told from states, to consider a variety of care
13 delivery models that might effectively coordinate Medicaid
14 and Medicare services, including but not limited to managed
15 care models.
16 And, fourth, in some states, dually eligible
17 beneficiaries have expressed a preference for fee-for-
18 service coverage or are statutorily exempt from mandatory
19 Medicaid managed care. So exploring options in fee-for-
20 service might enable states to reach other beneficiaries.
21 Over two half days of discussion, we heard
22 insights from states about factors affecting their

1 decisions on integration, and we grouped them into these
2 four themes: key factors that lead states to adopt
3 integrated care, factors inhibiting their progress, ways
4 that states could address barriers, and how federal support
5 could facilitate integration.

6 Starting with the first theme, roundtable
7 participants identified several factors key for states to
8 adopt integrated care. They are listed here. Obviously,
9 there's a lot behind each of these. So I'm going to focus
10 on the first three, but I'm happy to take questions later
11 on any of them.

12 Experience enrolling dually eligible
13 beneficiaries into Medicaid managed care is key because it
14 lets states build upon that existing infrastructure to set
15 up an integrated model. Almost all integrated models today
16 are managed care models. States without Medicaid managed
17 care for duals may be looking for strategies that do not
18 rely on Medicaid managed care. For example, Washington
19 used Medicaid health homes as its Medicaid vehicle for
20 integrating -- with Medicare.

21 We also heard that states are concerned about
22 access to integrated care for beneficiaries that are

1 statutorily exempt from mandatory Medicaid managed care,
2 such as American Indians and Alaska Natives. If exempt
3 individuals choose to receive Medicaid through fee-for-
4 service, they would not be able to enroll in a D-SNP for
5 their Medicare coverage in states that have exclusively
6 aligned enrollments, which is where enrollment in a D-SNP
7 requires enrollment in an affiliated Medicaid managed care
8 plan.
9 Our second theme is about factors inhibiting
10 state progress toward integration. Under this theme,
11 states talked about constraints on staff capacity and
12 resources, including competing responsibilities and limited
13 bandwidth to focus on integrated care. States told us that
14 most state Medicaid agency staff does not have experience
15 with Medicare arrangements, and states typically do not
16 have anyone assigned exclusively to work on integrated
17 care. They also noted that limited beneficiary knowledge
18 of the benefits of integrated care as well as the
19 beneficiary preference for existing coverage can stand in
20 the way of enrollment in integrated models.
21 In addition, states noted that Medicare data are
22 needed to make the case for integrated care, particularly

1 among state leaders who may not be familiar with Medicare
2 or with how the Medicare Advantage program works and the
3 coverage that might be offered under a D-SNP.
4 We also heard that opposition to managed care
5 from providers, beneficiary advocates, and other
6 stakeholders like the nursing facility industry can make it
7 difficult to design an integrated model that relies on
8 managed care, and sometimes opposition might occur simply
9 because a certain arrangement is longstanding and
10 stakeholders are concerned about making changes.
11 We asked states to think about ways to address
12 the barriers described in the last theme. They came up
13 with these steps based on their experience or opportunities
14 they are hoping to take advantage of in the future. To
15 highlight a couple, states emphasized the importance of
16 having a state lead or leads to shepherd integration
17 efforts forward. For example, we heard from Washington
18 that they relied on a core group of staff invested in the
19 integration effort to do things like draft decision papers
20 for state leadership.
21 Several states mentioned future plans to enhance
22 their contracts with D-SNPs by incorporating requirements

1 for integration using their MIPPA authority. For example,
2 some states are interested in using default enrollment
3 where Medicaid beneficiaries who are becoming eligible for
4 Medicare would automatically be enrolled in a D-SNP that's
5 affiliated, that is owned by the same parent company, with
6 their current Medicaid managed care plan, something that
7 states are already authorized to do under current law.
8 The fourth theme is about federal support.
9 States expressed interests in different forms of federal
10 support that would help them raise the bar on integrated
11 care. They talked primarily about technical assistance and
12 financial support.
13 States said they were interested in intensive
14 state-specific technical assistance. We heard that states
15 value the technical assistance that they already have
16 available from places like the Medicare-Medicaid
17 Coordination Office, but they would like to add one-on-one
18 training between the federal government and the state that
19 would be state-specific.
20 States would also like peer-to-peer technical
21 assistance such as learning collaboratives where they could
22 learn from other states that are similarly situated to

1 them, such as states with similar Medicaid managed care
2 arrangements or states with similar levels of integration.
3 In terms of financing, states expressed an
4 interest in both short- and long-term federal financial
5 support. Short-term funding of five years or less, they
6 noted could help states fund up-front costs associated with
7 standing up an integrated model like hiring dedicated staff
8 or establishing an ombudsman, and then long-term funding
9 could take the form of like an enhanced FMAP that states
10 could receive perhaps by meeting specific goals such as
11 around enrollment targets.
12 And then they talked a little bit about other
13 types of support. They mentioned, for example, allowing a
14 Medicaid eligibility deeming period when a Medicaid
15 beneficiary first becomes eligible for Medicare but before
16 the Medicaid redetermination has occurred in order to limit
17 the gaps in Medicaid coverage that sometimes occur for new
18 duals. That would especially be a concern for states
19 looking to implement default enrollment where there's a 60-
20 day advanced notice that the D-SNP has to provide to the
21 beneficiary, and the redetermination of Medicaid has to
22 occur before that.

1 So, based on what we heard at the roundtable and
2 building on sort of the insights and the nuance that all
3 the states provided to us about their decision-making, it's
4 clear that many states are going to need to invest
5 significant time and resources to make integrated care more
6 available and increase enrollment. There are obviously a
7 range of policy options that Commissioners could consider
8 to support states in these efforts, and over these next two
9 slides, I'm going to preview several. These are ordered
10 from least to most comprehensive, and they can also stand
11 alone or be grouped together, depending on the Commission's
12 goals, bearing in mind where states are now and the level
13 of effort that they need to move forward.
14 Option 1 is make additional federal financing
15 available to states that want to advance integrated care.
16 This option would reinforce our June 2020 recommendation,
17 which was to provide additional federal funds to enhance
18 state capacity to develop expertise in Medicare and
19 implement new models.
20 Option 2 is to require that every state develop a
21 strategy to integrate care. This requirement might be
22 something along the lines of the Medicaid quality strategy

1 that each state is already required to establish.

2 Option 3, require that states establish an
3 ombudsman for integrated care programs. This could be very
4 similar to what was done under the Financial Alignment
5 Initiative, which had a similar requirement.

6 Option 4, require that states contracting with D-
7 SNPs select at least one MIPPA contracting strategy and
8 include it at their next contract renewal. These
9 strategies were described in our report in June of this
10 year, and they're all currently available authority.

11 Option 5, require that states only contract with
12 D-SNPs designated as HIDE or FIDE SNPs. These are highly
13 integrated or fully integrated dual-eligible special needs
14 plans, subtypes of D-SNPs that have higher levels of
15 integration. This option would probably require a grace
16 period to give states and the Medicare Advantage program
17 time to set up alternative coverage because it would
18 effectively eliminate coordination-only D-SNPs, displacing
19 perhaps a significant number of duals.

20 Then Option 6, require that every state fully
21 integrate care for full-benefit dually eligible
22 beneficiaries. There are existing models out there that

1 could meet this requirement, such as FIDE SNPs, but this
2 would be a heavy lift for many states, and you might want
3 to consider a ramp-up to allow states sort of to make
4 gradual progress in this direction.
5 So staff are looking for feedback from
6 Commissioners on these options, perhaps starting with any
7 that you'd like to take off of this list. After hearing
8 your feedback, our plan will be to go back and take a more
9 focused look at your selected options, talk to states and
10 other stakeholders, including beneficiaries to develop
11 these options, all with an eye toward potentially including
12 them in our June 2022 report as potential recommendations.
13 In terms of timing, if we decide to proceed with
14 recommendations, the Commission will need to vote on those
15 in April of next year. So that would give us a couple of
16 Commission meetings between now and April for us to bring
17 back to you more fully developed options and have a
18 discussion around those, probably sometime this winter.
19 And then just as a final note, many of you might
20 be aware that the CMS Innovation Center, or CMMI, recently
21 released a new strategy that has an effect on duals. I
22 just wanted to note that we are looking at that for

1 potential tie-ins with our work, and we're keeping an eye
2 on it, especially as more details come out. But, as of
3 right now, the strategy would require by 2030 that all
4 Medicare beneficiaries and the vast majority of Medicaid
5 beneficiaries be in a care relationship with a provider,
6 accountable for quality and total cost of care.
7 So, with that, I'll stop, and we're happy to take
8 any questions from you guys. Thank you.
9 CHAIR BELLA: Thank you, Kirstin.
10 Could you go back to the slide with the policy
11 options, please? I'm going to put sort of a -- not a sort
12 of -- a straw-person out there, which is to say -- could we
13 go back to the one before, please? It will come as no
14 surprise to any of you that I would like to see us make
15 recommendations in June. We've been working on this issue.
16 This will be our third year now. I'd like for us to put a
17 stake in the ground that Options 1 and 2 are definitely
18 things that we would consider, and I'd like to hear if any
19 Commissioners have any concerns with those. That would be
20 to, again, sort of repeat the recommendation that we made
21 in June of 2020 to support states with additional federal
22 funding. We are not specific as to what form that takes

1 for various reasons.

2 Option 2 is to push every state to have a

3 strategy to integrate care. As you all know, states are

4 required to have a quality strategy. There's no reason

5 that we don't send a message that states should be thinking

6 about this and particularly if they get some support

7 through Option 1.

8 Option 3 is a critical component of any

9 integrated care program. It presupposes that states have

10 an integrated care program, but I could also easily see why

11 we would want to signal that that is important.

12 And then 4, 5, and 6 deserve some healthy debate.

13 So let me start with 1 and 2. Does anyone have

14 any comments or concerns or hesitation on Options 1 and 2?

15 Darin.

16 COMMISSIONER GORDON: I don't have any

17 hesitation. I think that's kind of like the next step

18 helping, one, support states, but also, I thought your

19 example of we require states to have a quality strategy, I

20 think it would be helpful for, you know, helping support

21 states and encouraging that they also come up with what

22 their integration strategy is.

1 I haven't found a state that isn't interested,
2 but as the surveys indicated, there's been some challenges
3 with it.
4 But with 1, it may help support No. 2. I do
5 think the others presuppose that you actually have
6 implemented some kind of integration strategy, which I kind
7 of consider as like a next phase, but I think Option 1 and
8 Option 2, I think, are really good next steps based on all
9 the stuff we have talked about up to this point.
10 CHAIR BELLA: Thank you, Darin.
11 Bill?
12 COMMISSIONER SCANLON: I would have hesitation
13 not knowing what "develop a strategy" means in the sense of
14 what is that ultimately going to be. You can have a
15 strategy, but if you don't implement it, what does that
16 accomplish?
17 I raise that because the issue of having a
18 stronger mandate, I'd have to think about are there states
19 that you might think are exceptions because of their
20 circumstances that they couldn't easily -- or it wouldn't
21 necessarily be in their best interest to comply with a
22 broader or stronger mandate, and then what would your

1 provisions be to sort of allow that to happen?

2 So I'd have to think through those things before

3 I could say I'd be fully on board on this kind of a

4 recommendation.

5 CHAIR BELLA: Okay. But it's something that

6 sounds like you're saying "I would need more information

7 around some specificity about what that would look like."

8 COMMISSIONER SCANLON: Correct.

9 CHAIR BELLA: That's something we can take back

10 as feedback.

11 Other comments on 1 and 2?

12 [No response.]

13 CHAIR BELLA: Does anyone have any concerns? I

14 see heads nodding. Unfortunately, the record doesn't note

15 nodding heads.

16 Let's move on to thoughts on Option 3. Bob?

17 COMMISSIONER DUNCAN: I was just going to say for

18 the record, I have no concerns.

19 CHAIR BELLA: Thank you. Yours was one of the

20 nodding heads. I appreciate the affirmation.

21 All right. Let's talk about Option 3. How do

22 people feel about that? Again, this is not a -- what you

1 say here is attributed and locked into you forever. We're
2 just trying to get things on the table that are worth
3 further exploration.
4 Heidi?
5 COMMISSIONER ALLEN: Oh, I assume that Option 3
6 would be bringing the beneficiary voice into the process.
7 Is that correct? Is that the purpose of Option 3?
8 CHAIR BELLA: Yeah. The purpose is to have sort
9 of a go-to, dedicated resource that's looking out for
10 beneficiaries as they're trying to make choices and
11 understand what these different things are and trying to
12 protect the interest and rights of beneficiaries.
13 COMMISSIONER ALLEN: That sounds really important
14 to me.
15 CHAIR BELLA: Tricia and then Toby.
16 COMMISSIONER BROOKS: I had to find that mute
17 button.
18 Yes. Thanks for this. This is helpful.
19 Do any states currently have an ombudsman that's
20 dedicated to integrated care programs? Do we know how many
21 states?
22 CHAIR BELLA: I know that yes -- the answer is

1 yes. I don't know how many.

2 Kirstin, you may.

3 MS. BLOM: I know that the states that are
4 participating in the FAI have an ombudsman, and then some
5 states like Virginia, which transitioned out of the FAI,
6 maintained the ombudsman feature in their new integrated
7 model.

8 COMMISSIONER BROOKS: And is that a person that's
9 dedicated to that role, or is it integrated in other
10 ombudsman activities?

11 MS. BLOM: I know in Virginia, it's their long-
12 term care ombudsman. That was already existing, and that
13 person -- or that entity is fulfilling the role for the
14 integrated model.

15 COMMISSIONER BROOKS: I think it would be helpful
16 to nail that down a little more specifically so that we
17 have some examples to point to.

18 CHAIR BELLA: I think some states, it's
19 dedicated, Tricia, and maybe in some cases, it's been
20 mixed. And I think if we wanted to weigh in on that, we
21 certainly could, but we can bring back some more
22 information.

1 COMMISSIONER BROOKS: Thank you.

2 CHAIR BELLA: Toby?

3 COMMISSIONER DOUGLAS: It was the same question,
4 so no more on that.

5 CHAIR BELLA: Stacey.

6 COMMISSIONER LAMPKIN: So, what would an
7 ombudsman, a dedicated ombudsman look like in a state that
8 had, at least for a period of time, a low integration
9 model? I suppose at a minimum they could talk to
10 beneficiaries about Medicare fee for service versus
11 Medicare Advantage opportunities, even if Medicaid services
12 were just exclusively fee for service. I'm wondering about
13 the relevance of this for all states, if it's a requirement
14 for all states.

15 CHAIR BELLA: Yeah, I think that has to do with
16 kind of coming back with some more specificity around when
17 we say for integrated programs, when does that requirement
18 kick in in a given state to have the ombuds program.

19 Kirstin and Ashley, I don't know if you already
20 have given that thought or if this is at the more kind of
21 conceptual of the importance of having such a role.

22 MS. BLOM: It is more conceptual. I mean, I

1 think one of the states that we talked to mentioned tying
2 it to the D-SNP, but that's still to be determined for us.
3 CHAIR BELLA: Okay. I think you have heard a
4 couple of requests, some interest, some requests for some
5 additional information that we can bring back to the
6 Commission. Can we go to the next slide, please?
7 COMMISSIONER HEAPHY: Melanie, this is Dennis.
8 Could we go back one second?
9 CHAIR BELLA: Sure. Can we go back to the prior
10 slide, please?
11 COMMISSIONER HEAPHY: I see Option 3 as actually
12 rolled into Option 2, that a requirement of the development
13 of the strategy to integrate would be the establishment of
14 an integrated ombudsman program.
15 MS. BLOM: Yeah, I mean, that would potentially
16 be -- that's one idea.
17 CHAIR BELLA: Darin?
18 COMMISSIONER GORDON: Dennis, are you saying that
19 Option 2 would require a state develop a strategy including
20 how they would provide for an ombudsman or, you know, some
21 kind of member-facing resource to help folks navigate?
22 COMMISSIONER HEAPHY: Yep, correct.

1 COMMISSIONER GORDON: I gotcha.
2 CHAIR BELLA: Verlon.
3 COMMISSIONER JOHNSON: So along that point, and I
4 think someone else mentioned it, would we then -- I guess
5 for me, for Option 2, I always feel like it's important to
6 have parameters in place for that, and I think that was one
7 of the other Commissioners' questions. So just making sure
8 that there are some true ideas around what that looks like,
9 and to Dennis' point, making sure that Option 3 is
10 included, because like you, Dennis, I would have thought
11 that would have been part of Option 2, which is in part of
12 their strategy.
13 CHAIR BELLA: Great. Darin?
14 COMMISSIONER GORDON: Kirstin, the way that you
15 have it laid out here, I guess, you know, the way that I
16 was processing until Dennis made that point, which makes
17 total sense, I was processing almost like where a state is
18 at. Like Option 1 and 2 I can kind of see as like pre -- I
19 haven't set anything up yet. It's helping me, as a state,
20 move down the path. Option 3, the way that I was reading
21 it -- and you tell me if this is what you all were
22 intending -- and then if you kind of cross the chasm there

1 and you actually stand up and integrate a program, here are
2 some requirements within that integrated program. Kind of
3 planning versus now if you're standing one up it must have
4 these things.
5 That's how you all were thinking, but, I mean, I
6 think Dennis' point is good, building out what we need, you
7 know, putting some parameters were a strategy must include
8 can have them planning for that because there is an
9 expectation that there would be one if you stood one up.
10 So was I understanding how you all were
11 presenting it as an option there, differentiating kind of
12 planning versus implemented?
13 MS. BLOM: Yes. We were originally thinking
14 about Option 3 being like where states have already set
15 something up, but I think it works well also to have that
16 be a component of Option 2, for states who haven't done
17 anything yet, so it kind of could go in both options.
18 CHAIR BELLA: Well, and Option 2 is like every
19 state, and so it would push the states that are just doing
20 coordination only to say by this date we want to be HIDE or
21 FIDE or whatever the newest acronym will be, in like 2025.
22 Right?

1 COMMISSIONER HEAPHY: Yes.
2 CHAIR BELLA: Okay. Let's --
3 COMMISSIONER HEAPHY: This is Dennis. One more.
4 I apologize. I'm wondering, could there be more guidance
5 provided if number 1 and number 2 were brought together, in
6 terms of providing technical support to the states to
7 develop a state strategy to integrate car?
8 CHAIR BELLA: I think let's look at putting some
9 parameters around 2 that includes addressing 3 as part of
10 your strategy when you would have a program, and let's look
11 at whether 1 is sort of tied to 2 or 1 is standalone for
12 some other things that might be supported as well, and kind
13 of bring a couple of those options back.
14 Tricia?
15 COMMISSIONER BROOKS: Yeah, I don't think it's
16 necessary for us to merge everything into a single
17 recommendation because we know how incremental change is
18 the way things often happen. So I guess I'm happy to see
19 these elements, you know, not for us to work too hard to
20 merge them together.
21 CHAIR BELLA: Okay. I think we've given this
22 enough feedback on the first three for now, that Kirstin

1 and Ashley can do the work necessary to come back to us on
2 those. Let's move to the last bucket of options.
3 Question on number 4. So of the states that are
4 doing D-SNPs today, how many of them would you say are not
5 doing one of the contracting strategies? I mean, how much
6 of a difference is this going to make, is what I'm trying
7 to assess?
8 MS. BLOM: So I think we are talking about the
9 non-coordination-only D-SNPs, and most D-SNPs are in the
10 coordination-only bucket. Ashley, do you agree?
11 MS. SEMANSKEE: Yes, I would agree. I think this
12 would affect the minimal and low integration states.
13 CHAIR BELLA: And I just want to reinforce that
14 the beauty of leaving number 1 also as a standalone is that
15 states will need support if they are doing Options 4, 5, or
16 6 too. So I think we need to think about supporting the
17 strategy that is supporting then the incremental steps for
18 states that are doing more.
19 How do people feel about -- I do just want to say
20 one more thing. The thing that really struck me from that
21 roundtable was not a single state said they didn't want to
22 be doing something in this area, but the states said, it

1 was on their list and then COVID hit, and then the HCBS
2 funding opportunity hit, and then the redeterminations are
3 coming back. And so it's sort of like and then, and then,
4 and then. And so it is something that continues to get
5 bumped, which I think also reinforces why it would be
6 important to say all states have to have a strategy, but
7 also recognize this is competing with so many other things
8 for them.

9 How do folks feel about Option 4, 5, or 6?
10 Darin, and then Laura.

11 COMMISSIONER GORDON: And I need a little bit on
12 this one. I'm just thinking back at like our journey into
13 this, when we were standing up D-SNPs. It wasn't a quick
14 process, because, you know, the plans obviously have to go
15 through the certification to be able to allow to do it and
16 standing it up, and meeting all the expectations on the
17 Medicare side.

18 When I left we had some plans moving toward FIDE
19 SNPs but I just didn't know how quickly something like that
20 could happen. So even if you just say, let's say you have
21 a state that has D-SNPs stood up and you say they all have
22 to be designated HIDE or FIDE SNPs, my sense is there's a

1 process by which to do that. That's really kind of outside
2 of the state control, right? I mean, the plan then has to
3 work with Medicare and go through that whole process. I
4 don't know how quick that is or how complicated that is.
5 Just appropriately appreciate and understand, we can say it
6 but then there's a lot of things that are outside of the
7 state's control to actually make that happen quickly.
8 CHAIR BELLA: Are you talking about Option 5?
9 COMMISSIONER GORDON: Yes, I'm sorry. I thought
10 I said that, yes.
11 CHAIR BELLA: I mean, I actually think Option 5
12 is more in the states' control, is how quickly can they
13 stand up a behavioral health or a long-term care
14 capitation, right? We're always subject to like the
15 Medicare cycles, but this one feels like it's really,
16 what's the states' ability or will or kind of the authority
17 to do that for behavioral health and long-term care?
18 COMMISSIONER GORDON: Yeah, which then gets into
19 other issues, you know, concerns about advocates of not
20 integrating some of those services and bringing those over
21 there. But, okay. Well, that's helpful. You feel it's
22 more in the states' control. I was thinking -- you're

1 right, we're always going to be dealing with the Medicare
2 cycle. I just didn't know how much more of a lift to get
3 to a FIDE SNP if you're just currently with D-SNPs in your
4 market.
5 Option 4, I will say, I mean, you and I have had
6 this conversation over the years about in talking to other
7 Medicaid directors who had admitted, they are like, "Yeah,
8 we have MIPPA. One track's [inaudible]." You know, we
9 haven't leveraged it as a mechanism to move the needle. I
10 remember one Medicaid director told me, he was like,
11 "Darin, I never really looked at those. I just signed off
12 on them."
13 So I like the intentionality behind it, but this
14 kind of goes to that earlier comment when we said you have
15 a plan, I mean, do we need more -- I would need more of an
16 understanding of what we mean, at least one, the
17 contracting strategy. What are we putting in that bucket?
18 CHAIR BELLA: Yeah. And for the benefit of new
19 Commissioners too, last year what we did was to really lay
20 out a menu of D-SNP strategies and levers that states could
21 use. And so this would go back, Darin, to that work, to
22 say here was the bucket of things that we thought were

1 state levers, and I think it would be focused in those
2 areas and pushing states to take one of those. Is that
3 right, Kirstin and Ashley?
4 MS. BLOM: Definitely.
5 COMMISSIONER GORDON: That's helpful. Would it,
6 in any way -- I guess it would not, in any way, prevent new
7 strategies that states come up with via the MIPPA vehicle.
8 Okay. So that's fair.
9 CHAIR BELLA: Laura, and then Brian, and then
10 Kisha.
11 COMMISSIONER SCOTT: So I think I need more
12 information on these sets of policy options to understand
13 the outcomes tide to HIDE/FIDE. So what's the lift we're
14 going to get by moving form D-SNP to HIDE/FIDE, and even
15 the complexity of having HIDE/FIDE. I'm thinking similar
16 to the vaccination table we saw yesterday when we were
17 thinking about the levers and the different -- what's the
18 increase, up or down, for each of those things. But if
19 there's some way to have a table like that as we think
20 about the complexity to do, the cost to do, and outcomes,
21 quality outcomes, total cost of care. You pick the
22 outcomes, comparing that.

1 CHAIR BELLA: That's a great way to think about
2 it, if we can do that. Thank you, Laura.
3 Brian, Kisha, then Stacey.
4 COMMISSIONER BURWELL: This is kind of outside
5 the six options. I'm kind of surprised that the states
6 didn't bring up issues around aligned enrollment in the
7 roundtable. In terms of kind of raising the bar, I think
8 one option is to give states greater authority to enroll
9 dual eligible in an aligned plan, particularly enrolling
10 Medicare beneficiaries or dual eligibles if they are in a
11 Medicaid plan in an aligned Medicare plan. They have some
12 limited authority, streamlined enrollment, but that
13 authority is still -- states cannot automatically enroll
14 many dual eligible in an aligned Medicare plan and then
15 also provisions around lock-in. Once somebody is enrolled
16 in a plan how long a state can keep them in the plan before
17 they either opt out or switch plans. I'm just surprised
18 that that didn't come up as a policy issue for discussion
19 in the roundtable.
20 CHAIR BELLA: I think probably, Brian, because
21 the states that were doing it weren't in a position to be
22 able to exercise those flexibilities.

1 COMMISSIONER BURWELL: I have no experience with
2 that.
3 CHAIR BELLA: Right, because it certainly has
4 come up with states that are further down the integration
5 continuum, and Kirstin and Ashley and Kristal brought that
6 up last year, if I remember correctly. But these states I
7 don't think would have been at that point yet.
8 COMMISSIONER BURWELL: that kind of makes sense.
9 CHAIR BELLA: Kisha, and then Stacey.
10 COMMISSIONER DAVIS: Thanks. Just looking
11 specifically at number 5, which seems a lot easier said
12 than done. I'm just curious as to the impact and lift of
13 transitioning folks from Medicare Advantage plans to HIDE
14 and FIDE, and time frame and just kind of what the longer
15 implications of that would be.
16 The other thing I think about, just in general,
17 is, you know, for the duals population, the most vulnerable
18 of the vulnerable patients, and just having an eye on
19 disparity of people that are being left out, are we
20 creating winners and losers amongst patients in the
21 transition and how that plays out for the beneficiaries as
22 well.

1 CHAIR BELLA: Do either of you want to comment on
2 that, or just take it back?
3 MS. BLOM: I think, yeah, we'll take it back, but
4 we definitely think this would be a heavy lift. These
5 options are available to states now. You know, I think
6 there are 16 states with HIDE SNPs and a smaller number
7 that have FIDE SNPs. So there's obviously some work to be
8 done there.
9 CHAIR BELLA: MedPAC and MACPAC have both done
10 some work on what this would look like in terms of where
11 people would need to move from and what their options would
12 be. It's older, but maybe with the new data book coming
13 out we can take another look at that too.
14 Stacey, and then Toby.
15 COMMISSIONER LAMPKIN: Thanks. I'm generally
16 very enthusiastic about the opportunities to leverage the
17 D-SNP model better more to move in this direction. And I
18 also realize that none of these three options require use
19 of the D-SNP model, in particular, and we acknowledge even
20 managed fee for service as a service delivery model that
21 may be used in places.
22 But I'm wondering to what extent is any of this

1 vulnerable to changes in Medicare Advantage reimbursement
2 models that make the model less feasible on the Medicare
3 side. And maybe that's not important, but it is a question
4 in my mind and/or also states that have significant
5 portions of the state where it's not feasible, even in
6 current reimbursement levels, maybe because of the
7 reimbursement available in that part of the state.
8 MS. BLOM: Yeah, I don't have a good answer for
9 that, but I think your point is well taken. Our focus has
10 kind of shifted to D-SNPs because they're just so much more
11 prevalent than any of the other options. So, you know,
12 that's our motivation, but your point is well taken.
13 CHAIR BELLA: Yeah, although the chapter does
14 include a healthy focus on managed fee for service or some
15 other model for states that have some shared savings in
16 order to do something that won't be managed care, which we
17 don't want to forget.
18 Toby?
19 COMMISSIONER DOUGLAS: on Option 4, at first I
20 was thinking this would be a good path, but the more I
21 wonder if it gets back to this number 2 and laying out a
22 strategy, and this may be for 4 and 5, of including within

1 the strategy framework of their plan what they're doing
2 with MIPPA and their path on requirements and the same on
3 how they would move to HIDE and FIDE over a time period. I
4 don't think we're ready yet, or states, and maybe that
5 would give us more visibility into what their plans could
6 be.
7 CHAIR BELLA: Well, if we wanted to be really
8 bold we would recommend 6. We would put a date on it. We
9 would require their strategy to get to it by that date, and
10 then people would either use --
11 COMMISSIONER DOUGLAS: Yeah, that's another
12 alternative. Are you adding an Option 7?
13 CHAIR BELLA: Managed fee for service. I'm just
14 putting it out there.
15 COMMISSIONER GORDON: Yeah. To Toby's point,
16 though, you know, again -- and I'm looking at the material,
17 I mean, we do, on Option 4, I mean just restate the things
18 from the June report, the six items. I mean, I think if
19 you were to do 4 you would just have to provide that
20 specificity, here are the examples of the ones we are
21 thinking about. But I don't think that necessarily --
22 Melanie, you're way out there, I still think that the

1 stepwise fashion helps move states along and supports them
2 on their journey, because it sounds like, from the
3 interviews, there was interest, just hurdles.
4 COMMISSIONER HEAPHY: I agree with Darin and
5 Tricia, and I'm wondering if it's not possible to say that
6 we're looking for incremental steps that will lead to every
7 state being fully integrated by a certain year.
8 Otherwise it won't happen.
9 COMMISSIONER DOUGLAS: They laid that out in the
10 plan.
11 COMMISSIONER HEAPHY: Yes.
12 COMMISSIONER GORDON: Or it will happen, Dennis,
13 and not necessarily well because we're not building the
14 processes and structures and capabilities along the way to
15 be successful.
16 COMMISSIONER HEAPHY: And I agree with you on
17 that. I wouldn't say next year. I'm thinking a longer
18 trajectory, but to create a trajectory to help plans to
19 move along.
20 CHAIR BELLA: Other comments?
21 [No response.]
22 CHAIR BELLA: Okay. Kirstin and Ashley, what I'm

1 hearing is some massaging of some of these things, see how
2 some things might fit together. Let's not forget about the
3 non-managed care states. Let's think about how we can make
4 these demonstrate sort of our intent to raise the bar in a
5 reasonably aggressive yet reasonably incremental fashion
6 and move toward -- move integration in each state and kind
7 of massage all of that and then bring it back to us. Does
8 that work?
9 MS. BLOM: Yeah, that sounds good. I think we
10 can definitely do that, and we'll talk with Anne about that
11 and bring something back to you guys.
12 CHAIR BELLA: And see if we can replicate some
13 sort of table like the vaccine table so we can look at
14 impacts and lists and costs and complexity and beneficiary
15 issues and all those things.
16 MS. BLOM: Yeah.
17 CHAIR BELLA: No problem, right? You can have
18 that by next week. Excellent.
19 [Laughter.]
20 CHAIR BELLA: Okay. Anybody have any last
21 comments on this session?
22 [No response.]

1 CHAIR BELLA: All right. Thank you both and
2 thanks to the Commissioners.
3 We will take public comment at the end of this
4 next session before we break for lunch. So we're going to
5 transition into a session talking about the Senate Finance
6 Committee request for information on behavioral health
7 priorities, and let's see if we have -- are we ready to
8 roll on that one? I don't see -- yeah, Joanne, there you
9 are. Wonderful. Thank you for joining us. Take it away.
10 **### RESPONSE TO SENATE FINANCE COMMITTEE REQUEST FOR**
11 **INFORMATION ON BEHAVIORAL HEALTH PRIORITIES**
12 * MS. JEE: All right. Good morning,
13 Commissioners. During this next session, I will be going
14 over MACPAC's draft response to the Senate Finance
15 Committee letter requesting information on behavioral
16 health priorities.
17 So I'm just going to go through what the letter
18 authors request of respondents in their RFI. I'll go
19 through quickly the high points of the information that's
20 included in our draft response letter, and then I'll end
21 with just a reminder to you all on the kind of feedback
22 we're looking for and very quickly just go over next steps

1 for staff.

2 All right. So last month, the Senate Finance
3 Committee Chair Ron Wyden and Ranking Member Mike Crapo
4 issued a letter, a request for information to behavioral
5 health stakeholders and the community seeking input on
6 evidence-based approaches for enhancing behavioral health
7 care in Medicare, Medicaid, CHIP, and the exchanges. They
8 specifically asked respondents to respond in the five areas
9 that are listed here on Slide 3. Responses are due back to
10 the Committee by November 1st.

11 So our draft response summarizes MACPAC's body of
12 work and your discussions related to behavioral health. As
13 you know, Medicaid and CHIP play a very important role in
14 financing and providing access to behavioral health care.
15 In some places where your discussions have led to
16 recommendations, we have noted those recommendations in the
17 draft letter as well.

18 The letter opens with some contextual information
19 that illustrates the need for addressing behavioral health
20 in Medicaid and CHIP and notes the importance of addressing
21 barriers that lead to disparities in access to care and
22 outcomes specifically with respect to race and ethnicity,

1 disability, and rural residency.
2 So the first area that the committee asked for
3 feedback on is strengthening the workforce, and our
4 response addresses two primary areas. The first is
5 provider shortage and maldistribution. We provide some
6 data from the HRSA mental health workforce shortage
7 projections and the Mental Health Care Health Professional
8 Shortage Areas, or HPSAs. And we note that SUD treatment
9 facilities are more likely to provide certain kinds of
10 services such as outpatient services compared to the sort
11 of more intense services such as partial hospitalization.
12 We also note here that Medicaid's ability to
13 address some of these shortage and maldistribution issues
14 is somewhat limited compared to the ability of other
15 programs such as those of HRSA.
16 The draft letter then goes on to address provider
17 acceptance of Medicaid. We provide information from our
18 prior analysis of survey data that found that mental health
19 providers, including psychiatrists and specialty substance
20 use disorder, or SUD, facilities, are less likely to accept
21 Medicaid compared to other forms of insurance. We talk
22 about some barriers that might affect this, including low

1 payment rates and, for SUD providers, credentialing
2 requirements and inadequate IT systems which can affect
3 their ability to bill insurers.
4 The letter then goes on to address integration,
5 coordination, and access. With respect to integration, we
6 note the work that the Commission is doing on electronic
7 health records, or EHRs, and certified EHR technology, or
8 CEHRT, as well as barriers to adoption of that technology.
9 You will recall from last month's panel session,
10 there are several barriers such as lack of funding to
11 investing in technology and staff training; but that there
12 also are state efforts to promote the use of EHR and CHERT.
13 And as you know, there is much more work to come in this
14 area from Aaron in the coming months.
15 The draft response then provides an overview of
16 challenges associated with the differences between privacy
17 rules, specifically 42 CFR Part 2, which governs privacy
18 rules for SUD patient information, and HIPAA, which is the
19 broader privacy rule that governs disclosure of protected
20 health information.
21 We note that the March 2020 CARES Act made
22 legislative changes that will more closely align Part 2

1 with HIPAA, specifically for consent and disclosure.
2 However, HHS has yet to issue regulations to implement
3 these changes.
4 Moving on to access, our draft response
5 summarizes work related to institutions for mental
6 diseases, otherwise known as IMDs, crisis services, SUD and
7 opioid treatment program, or OTP, services, as well as
8 coverage and services for adults in the criminal justice
9 system.
10 To highlight just a few things, our letter notes
11 the Commission's June 2021 recommendation for guidance and
12 technical assistance to states related to financing the
13 continuum of crisis services.
14 With respect to SUD and OTP services, we note the
15 more recent and temporary flexibilities implemented to
16 improve access to those services in response to the
17 pandemic. And we point out findings related to racial and
18 ethnic disparities in terms of services for adults in the
19 criminal justice system. For example, Black beneficiaries
20 under community supervision with behavioral health
21 conditions received treatment at lower rates than their
22 white peers. We also note our ongoing work in this area to

1 examine the behavioral health needs and treatment among
2 Medicaid-eligible individuals leaving prison or jail and
3 state approaches to coordinate their care upon reentry into
4 the community.
5 All right. The next section addressed in the
6 letter is mental health parity. Here we note our finding
7 that the federal parity law does not appear to have
8 substantially increased access to behavioral health
9 services for those with Medicaid or CHIP coverage. And
10 just so I'm clear here, we're referring to the Paul
11 Wellstone and Pete Domenici Mental Health Parity and
12 Addiction Equity Act of 2008, which is a lot of words, but
13 it's more commonly referred to as MHPAEA. And we note that
14 this outcome is in part due to the design of MHPAEA, but
15 also because there have been operational challenges
16 associated with things such as conducting the parity
17 analysis which make it hard to identify where there have
18 been parity violations.
19 Okay. Then we move on to discuss telehealth, and
20 we talk about the role of telehealth in facilitating access
21 to behavioral health care, particularly for SUD during the
22 pandemic. We note flexibilities that were put in place,

1 for example, under the Ryan Haight Act, to permit
2 prescribing of controlled substances such as buprenorphine
3 for SUD treatment via synchronous telehealth without first
4 requiring an in-person visit.

5 We also note that SAMHSA is permitting OTPs, or
6 opioid treatment programs, to prescribe buprenorphine to
7 new patients via telehealth, including audio-only
8 telehealth. And so that's a change from what was
9 previously allowed.

10 The draft notes that barriers to reliable
11 broadband, especially in rural areas, and technology,
12 especially for low-income individuals, can impede access to
13 telehealth services. And we acknowledge that the issues of
14 telehealth and prescribing are not concerns that are
15 limited just to Medicaid, and so solutions to address those
16 things probably also live outside of Medicaid.

17 And, finally, the draft response discusses the
18 importance of having comprehensive and reliable data on
19 telehealth and Medicaid to really understand sort of what
20 the experience has been and the effects.

21 We also talk about the importance of having
22 state-to-state information sharing and technical assistance

1 on the use of telehealth.

2 All right. So the final section of the draft
3 response, which is the final area that the Senate Finance
4 Committee asked respondents to speak to, is on the
5 behavioral health needs of children and young people. We
6 note that despite existing federal requirements to ensure
7 access to behavioral health care in Medicaid and CHIP,
8 children's behavioral health needs often go unmet.
9 Specifically, we note that there is a lack of home and
10 community-based behavioral health services. Despite
11 existing authorities to implement and design such services,
12 states aren't always doing that, and they're not always
13 aware of sort of the mechanisms and the authorities for
14 that.

15 In addition, another barrier is that there are
16 multiple state agencies involved in providing these
17 services to children, and so it can be challenging to bring
18 all of the groups together to come up with solutions.

19 The draft response also summarizes findings from
20 recent MACPAC analyses of the National Survey on Drug Use
21 and Health, or the NSDUH, to describe behavioral health
22 needs and utilization of children as well as some

1 demographic information, specifically for children who are
2 in the juvenile justice system or in the child welfare
3 system. Medicaid and CHIP cover about 60 percent of
4 children or youth age 12 to 17 who stayed overnight in jail
5 or juvenile detention, and about two-thirds of justice-
6 involved children or youth have behavioral health needs.
7 About 35 percent of juvenile justice-involved Medicaid
8 beneficiaries report having had a mental health treatment
9 while in jail or juvenile detention.
10 In addition, Medicaid and CHIP cover about 64
11 percent of children and youth age 12 to 17 in the child
12 welfare system, and children and youth in foster care are
13 more likely to experience behavioral health conditions.
14 Those children who are Medicaid and CHIP beneficiaries
15 report having high access to mental health treatment while
16 in foster care.
17 And, finally, this section of the draft response
18 notes the Commission's June 2021 recommendations. The
19 first was for joint CMS, SAMHSA, and Administration for
20 Children and Families, or ACF, guidance on the design and
21 implementation of benefits for children and youth with
22 significant mental health needs. And then the second was

1 for a coordinated education and technical assistance effort
2 to help states in improving access to home and community-
3 based behavioral health services.
4 All right. So those are the top lines of the
5 content of our draft letter. Your feedback on whether
6 there are other aspects of MACPAC work that could be
7 highlighted as well as the tone and clarity of the letter
8 would be useful today. Once we get your feedback, we'll
9 take it back, edit and revise the letter. As I said, the
10 letter is due on November 1st, which is Tuesday, so the
11 turn-around time for this is quite tight.
12 And then, finally, once we've sent the letter, we
13 will be posting it to the MACPAC website. That's it for
14 me.
15 EXECUTIVE DIRECTOR SCHWARTZ: I just want to pick
16 up, Joanne, that you and I have both gone into some kind of
17 calendar time warp because November 1st is actually Monday,
18 not Tuesday.
19 MS. JEE: Oh. Well, that's good to know. Thank
20 you.
21 CHAIR BELLA: No trick-or-treating for you guys.
22 You'll be focused on the letter. Okay. Joanne, thank you

1 very much.

2 Commissioners, there are many, many areas covered
3 in that letter. It's hard for me to believe we have many
4 that are not covered, but this is your opportunity to raise
5 any issues about substance or tone that is constructive and
6 can kind of further the cause for a Monday submission. So
7 Tricia, then Kisha, Bob. Tricia?

8 COMMISSIONER BROOKS: Thank you. I just wanted
9 to call attention to the fact that the American Academy of
10 Pediatrics, the American Academy of Child and Adolescent
11 Psychiatry, and the Children's Hospital Association put out
12 basically declaring a national state of emergency for
13 children's mental health.

14 One of the things that I feel like we could be a
15 little more specific on is making note of the importance of
16 school-based mental health services and expanding those
17 services. I know the draft talks about home and community-
18 based services. Of course, community includes schools, but
19 I think schools are really critical, particularly because
20 we know that education officials and teachers may detect
21 problems that parents do not readily see. So I would hope
22 that we could integrate something more specifically about

1 school-based mental health services.
2 CHAIR BELLA: Thank you. Kisha?
3 VICE CHAIR DAVIS: Thanks. I would definitely
4 agree with the points that Tricia just raised.
5 I think the letter is really good. You know,
6 it's amazing to look back at how comprehensively we have
7 been looking at these issues, and I think you do a good job
8 of highlighting that, you know, where the work and focus
9 has been. I think if anything that would make the letter
10 stronger would be really focus on problem statements and
11 solutions when we have them. And so when MACPAC has made a
12 recommendation on something in these areas, to really put
13 that up front and at the forefront so that it's easy to
14 see. And when there is a clear problem statement that
15 we're working through, that that's also very much up front,
16 like 42 CFR Part 2.
17 And I also will just say that I appreciate the
18 focus on the disparity there and how, you know, mental
19 health especially has disproportionately impacted
20 communities of color and how we talk about that in the
21 report.
22 CHAIR BELLA: Thank you, Kisha. Bob and then

1 Fred.

2 COMMISSIONER DUNCAN: I ditto the comments from
3 both Tricia and Kisha, and I also want to thank the staff
4 and my fellow Commissioners for the work that they have
5 done in advance to be able to respond to this letter. I
6 think the letter's excellent.

7 I would like to add, because I think in our June
8 '21 report, we have some strengthening around the issues
9 around pediatrics. When you look at the letter that the
10 Senator sent us, he highlights the impact of COVID on
11 adults. But in our June '21 report, we show the highlights
12 and impact on children and adolescents. So I think that
13 needs to be called out because I think it strengthens our
14 recommendations.

15 And also, again, going back towards a little bit
16 where Tricia was, we also call out in the report the
17 importance of early intervention and how we can get in
18 early and identify these children and adolescents so that
19 we provide better outcomes both for the system and for
20 themselves. So thank you.

21 COMMISSIONER CERISE: Yeah. Also, I think it's a
22 great letter, and given the fact that it's due on Monday,

1 what else can you say? Right? But I appreciate the review
2 of the data, and I think that's helpful.
3 If there's an area that stands out to me, kind of
4 a theme, we focus on Medicaid for obvious reasons, but so
5 many of these problems and fixes just cross agencies and
6 payers. On one of your areas of Medicaid acceptance where
7 you noted that just 35 percent of the psychiatrists
8 accepted new patients, the other part of that is equally
9 striking, and that is only 62 percent accept Medicare
10 commercial. So there's a problem that crosses payers here,
11 and the solutions have to cross payers as well.
12 If there's an opportunity to emphasize that --
13 and I'll give you one example in the crisis response
14 section where we talk about the need for federal funding to
15 support state-level activities. People in crisis, you
16 don't identify them as Medicaid or Medicare or commercial,
17 but the system has to be able to support all of those. So
18 it necessarily calls for support from Medicare and Medicaid
19 and commercial and all of that, and those have to be driven
20 by public entities and policymakers.
21 So you make this point in the foster care
22 section. I think it's good. We're talking about getting

1 the agencies together, but I think a call for HRSA and CMS
2 and SAMHSA in their state-level correlates are going to
3 have to take a more active role in building systems of care
4 to address this because I just don't see it happening in
5 the piecemeal, chopped-up delivery system that we've built
6 over time.
7 I like the way you've pulled in our prior
8 recommendations in the work, but if there's a theme for an
9 opportunity to emphasize that, we really have to look
10 behind the Medicaid or agency-by-agency fixes but to get
11 the people together, because so much of it just spans the
12 payers.
13 And as complex populations need a system, that is
14 not going to build themselves. We have to be more
15 directive about it.
16 CHAIR BELLA: Thank you, Fred.
17 Toby?
18 COMMISSIONER DOUGLAS: I echo everyone else's
19 comments. This is a great letter.
20 I do want to say again on the school-based, it is
21 really important. I don't know if we want to include it,
22 but for example, California -- and this is a huge piece

1 where California -- what California is actually doing now
2 is investing in the way they're viewing the expansion of
3 prevention, early intervention is through school, and
4 investing in partnerships between the plans and the
5 schools, so just something that we can call out as
6 examples.
7 On foster care, again, it has really good
8 information on that. I wonder if there is some type --
9 nothing really listed around how that is an area where
10 states do need a lot of help, technical assistance, on that
11 population. Clearly, that would be where the
12 recommendation -- align with our recommendations for all
13 the entities to work together on guidance, but if we want
14 to call it out earlier in the letter about the unique needs
15 and area for states needing technical assistance.
16 Thanks.
17 CHAIR BELLA: Thank you, Toby.
18 There are a couple folks, I can't tell if you had
19 a hand up or not. Darin and Verlon, did you have comments?
20 [No response.]
21 CHAIR BELLA: No. Okay.
22 COMMISSIONER GORDON: No. I just was

1 acknowledging some of the comments that were made as they
2 were going along, but I don't have any additional comments.
3 CHAIR BELLA: Okay. Thank you.
4 Dennis?
5 COMMISSIONER HEAPHY: Yeah. I noticed that there
6 weren't demographics based on if there's any data on
7 children, and I just want to raise that, as I was curious
8 about that one, probably a reason why you didn't include it
9 there, but I was interested in that. I'd be interested in
10 that data.
11 And the other question I had was stigma is
12 mentioned in the footnotes but not in the body of the
13 letter, and I was wondering because as I was reading the
14 letter, it doesn't give that nuance, I think, to
15 contextualize why that opposition is there by folks with
16 behavioral health needs to have all the records shared.
17 I want to rewrite the letter. So, if it's too
18 late to do, that's fine, but I just want it noted that
19 without that context, folks might not understand why that
20 concern is there.
21 CHAIR BELLA: Thank you, Dennis.
22 Any other comments?

1 [No response.]

2 CHAIR BELLA: Okay. You can keep thinking about
3 it because I'm going to go to the public for comment and
4 then come back to the Commissioners.

5 I'm going to open it up for public comment on
6 this session or the dual eligible integration session from
7 earlier. If anyone would like to comment, please use your
8 raised-hand feature, and please introduce yourself and your
9 organization. And keep your comments to three minutes or
10 less. We'll open that up now.

11 Can we unmute Hilary or allow Hilary to speak,
12 please?

13 **### PUBLIC COMMENT**

14 * MS. DANIEL: Hi. Good morning. My name is
15 Hilary Daniel. I'm with the Children's Hospital
16 Association. I wanted to take this opportunity to thank
17 the Commission for including recommendations for children
18 and young people as part of your response to the Finance
19 Committee RFI as well as the additional discussion the
20 Commissioners just had about including additional pediatric
21 considerations in your letter.

22 I have a couple of comments. The first is that

1 the deadline for comments has been extended until November
2 15th. So, hopefully, that's happy news for Joanne.
3 The other comment is to really reiterate the
4 pandemic has exacerbated existing mental health challenges
5 facing kids and demand for pediatric mental health services
6 has risen significantly. In the first six months of 2021,
7 Children's Hospitals have reported a 45 percent increase in
8 the number of self-induced suicide cases in 5- to 17-year-
9 olds compared to the same period in 2019. So it is vital
10 that children's needs are not only considered across issue
11 areas in potential proposed reforms but that policies are
12 also advanced that are tailored to their unique needs.
13 As Tricia mentioned, we recently joined the
14 American Academy of Pediatrics and American Academy of
15 Child and Adolescent Psychiatry to declare a national state
16 of emergency in child and adolescent mental health.
17 We also want to sound the alarm for kids'
18 initiatives to raise awareness of these issues among
19 policymakers because these efforts really underscore the
20 need for immediate and ongoing advocacy to address the
21 current mental health crisis among kids, strengthen the
22 pediatric workforce, and ensure kids have access to vital

1 evidence-based mental health services across a continuum of
2 care.
3 So thank you again for the opportunity to provide
4 comments.
5 CHAIR BELLA: Thank you, Hilary. I'm sure the
6 acknowledgement of the extra time is especially
7 appreciated.
8 Anyone else would like to make any comments?
9 [No response.]
10 CHAIR BELLA: I am not seeing any hands.
11 Let me go back to the Commissioners. Any
12 additional comments on the letter?
13 [No response.]
14 CHAIR BELLA: Joanne, do you have any comments or
15 questions, anything else you need from any of us?
16 MS. JEE: No. I really appreciate the comments.
17 I'll go back and look at the letter and look at the public
18 record and see sort of where we can sort of strengthen the
19 letter in the areas that the Commissioners have identified.
20 COMMISSIONER HEAPHY: This is Dennis.
21 I have a question, I guess, for other
22 Commissioners as well, as to thoughts on including stigma

1 directly in the letter since we've got that extension. Is
2 that something that could be considered, or is that
3 something that folks don't feel need to be in the body of
4 the letter?
5 MS. JEE: Sorry. Could you repeat that? I'm
6 sorry, Dennis. I didn't quite catch that.
7 COMMISSIONER HEAPHY: In the footnote, it did
8 mention stigma, but it's not directly mentioned in the
9 letter itself, in the body of the letter itself. So, for
10 me, I think it would be helpful to contextualize why the
11 opposition is there from the behavioral health community to
12 actually the opening up of information to all providers.
13 MS. JEE: Yeah. I think we can take some of the
14 text from the note and bring it up to the body. That
15 should probably be fine.
16 COMMISSIONER HEAPHY: Thank you.
17 CHAIR BELLA: Any other comments? Anne, do you
18 have any comments, or are you good?
19 EXECUTIVE DIRECTOR SCHWARTZ: I'm good. I was
20 excited to hear the extension, but I want to confirm that.
21 Yes. We just got confirmation. So thank you,
22 Hilary, for helping us out there.

1 COMMISSIONER DUNCAN: Anne and Joanne can now
2 trick-or-treat.
3 CHAIR BELLA: Great. Yes. They have MACPAC
4 costumes. Wait until you see them.
5 Okay. We are ahead of ourselves. Unfortunately,
6 we can't start the next session any earlier because we have
7 panelists joining us. So you all have a break until one
8 o'clock Eastern time. Please be back promptly. We will
9 come back and end the day with a panel on the workforce
10 issues around home- and community-based services.
11 So thank you for your engagement this morning.
12 We'll see you back here at one o'clock.
13 * [Whereupon, at 11:42 a.m., the meeting was
14 recessed for lunch, to reconvene at 1:00 p.m., this same
15 day.]
16
17
18
19
20
21
22
23

1 AFTERNOON SESSION

2 [1:01 p.m.]

3 CHAIR BELLA: Welcome back, everyone. We will

4 just take a few more seconds for everyone to gather.

5 [Pause.]

6 CHAIR BELLA: Okay. Welcome back. Thank you,

7 everybody. We are in our final session where we are going

8 to hear from a panel about workforce for home- and

9 community-based services, and then following the panel we

10 will have time to discuss what we heard as a commission.

11 So, Tamara, I'm going to turn it to you, and I'm going to

12 say thank you in advance to our panelists and we are really

13 looking forward to this.

14 **### PANEL DISCUSSION: THE WORKFORCE FOR HOME- AND**

15 **COMMUNITY-BASED SERVICES**

16 * MS. HUSON: Thank you, Melanie, and good

17 afternoon, Commissioners. A common theme in much of our

18 recent work related to long-term services and supports has

19 been how there is a shortage of workers providing home- and

20 community-based services, or HCBS. In our recent work on

21 rebalancing, done for MACPAC by RTI International and the

22 Center for Health Care Strategies, persistent and growing

1 LTSS workforce shortages were frequently cited as a primary
2 barrier to expanding HCBS. And in our work on HCBS waiver
3 waiting lists, stakeholders suggested that even if waiting
4 lists were eliminated or reduced there may not be adequate
5 provider capacity to meet the increased demand for HCBS.
6 We use the term "HCBS workforce" generally to
7 encompass the direct care workforce, which is made up of
8 personal care aides, home health aides, and nursing
9 assistants, independent providers, who are individuals that
10 are employed directly by beneficiaries through consumer
11 direction, and direct support professionals, which are
12 workers who support individuals with intellectual and
13 developmental disabilities.
14 The shortage of these HCBS workers is due to
15 multiple factors, including low wages, limited
16 opportunities for career advancement, and high turnover.
17 States have been working to address these issues, including
18 using funding from the American Rescue Plan Act to invest
19 in the HCBS workforce. You will hear from two states today
20 about their experiences.
21 After the conclusion of the panel you will have
22 an additional 30 minutes to further discuss what you heard

1 and next steps for our work in this area. Staff are
2 currently developing an issue brief based on a review of
3 the literature and stakeholder interviews. We expect to
4 publish the issue brief on the MACPAC website this winter.
5 We would appreciate Commissioner feedback on particular
6 areas of interest that can inform our literature review and
7 interviews or development of the issue brief.
8 And now I will give brief introductions of our
9 panelists before I turn it over to them.
10 We will start with Robert Espinoza. He is the
11 Vice President of Policy at PHI, where he oversees its
12 national advocacy, research, and public education division
13 on the direct care workforce. He is a nationally
14 recognized expert and frequent speaker on aging, long-term
15 care workforce, and equity issues.
16 Next, we will hear from Bill Kennard. He is the
17 administrator for the Office of Healthcare Workforce
18 Development within the Arizona Healthcare Cost Containment
19 System. He is responsible for managing the workforce
20 monitoring, assessment, planning, and development
21 activities of Arizona's four health plans' workforce
22 development operations.

1 And finally we will hear from Bea Rector, who is
2 the Director of the Home and Community Services Division
3 within the Aging and Long-Term Support Administration in
4 Washington State's Department of Social and Health
5 Services. She is responsible for planning and
6 administering federal and state services for individuals
7 with functional impairments and their caregivers, using
8 Medicaid, Older Americans Act, grant, and state funds.
9 And with that I will turn it over to Robert
10 Espinoza to get us started. Thank you.
11 * MR. ESPINOZA: Thank you, Tamara, and thank you,
12 everyone at MACPAC, for hosting this conversation and for
13 inviting me to share my thoughts and PHI's analysis on this
14 workforce and on this topic. It is a very timely
15 discussion, given the announcement yesterday of a Build
16 Back Better framework that could invest up to $150 billion
17 in expanding HCBS and improving direct care jobs, among
18 other measures. So I'm hoping what I share in the
19 conversation that follows really builds on both the
20 opportunity and some of the challenges that are still
21 present as we think about structuring the system.
22 I think most of you know this from my bio and the

1 introduction but I am the Vice President of Policy at PHI,
2 and we are a 30-year organization invested in strengthening
3 the direct care workforce, and we do that work through
4 research, through advocacy, and through designing workforce
5 innovations related to training and to advancement of a
6 whole range of measures.
7 Let me speak a little bit first about the
8 workforce and some of the challenges we are seeing, and
9 then I am going to share some thoughts about this moment,
10 especially as it relates to states, and hopefully answer
11 any questions in this really important discussion.
12 Just to situate the point, and Tamara shared some
13 points that I think substantiate these facts, by definition
14 we define direct care workers as workers who support older
15 adults, people with disabilities, and people with
16 disabilities in a variety of long-term care settings.
17 Their titles do vary by occupation, they vary by state, and
18 they vary by employer or by institutional provider. And a
19 colleague of mine recently said that this is an example of
20 why this workforce is so devalued in this sector, that we
21 can't even agree on a definition or a standard set of
22 competencies and requirements that would really span the

1 various settings in which they worked.

2 Our data does show that there are about 4.6
3 million direct care workers in the U.S., and already this
4 workforce is larger than any other single occupation in the
5 U.S. When we take into consideration the number of new
6 jobs that will be created in the decade that follows, as
7 well as the fact that many workers are either retiring or
8 leaving direct care for other occupations, we estimate that
9 there will be about 7.4 million job openings in direct care
10 between now and 2029. So a big question, I think, for our
11 sector, for states around the country is how will we fill
12 these job openings unless we both improve jobs for workers
13 and also reimagine how services and supports are delivered.

14 Just a few points as foundation for the arguments
15 I will be making in my opening remarks. One is that when
16 you look at compensation, in particular, we see that these
17 workers earn a median wage of around $12 an hour, and when
18 you look at how that wage has changed over the last ten
19 years, it is really only about 20 cents higher than it was
20 ten years ago, adjusted for inflation, and that is just
21 startling for those of us who know how cost of living has
22 increased but also the value of these workers.

1 When you take into consideration the number of
2 workers who are relegated to part-time work, either by
3 their employer or by the economy, our research shows that a
4 little over 40 percent of direct care workers live in or
5 near poverty, and that is a crushing reality for many
6 workers. It is also one of the driving reasons that many
7 workers don't take these jobs or don't stay in these jobs.
8 One thing to note is that increasingly what we
9 are seeing is not just an argument for a living wage for
10 these workers but a competitive wage that allows employers
11 and consumers to offer a wage that can compete with retail
12 or fast food, and last fall we did a major, 50-state study
13 on this question and we found that in every single state
14 plus D.C. the median wage for direct care was lower than
15 the median wage for occupations with similar entry-level
16 requirements, like retail or janitors, as two examples, and
17 in many states it was lower than occupations with lower
18 entry-level requirements. So that should give us a picture
19 of why it has become so difficult for employers, including
20 consumers, to find and retain workers and why turnover is
21 so high.
22 Another key question for us is about financing,

1 and I think many of you can, of course, attest to this and
2 speak in depth about it. But in general, we see that this
3 is a major barrier for why so many employers, including
4 consumers, offer or improve jobs. We see limited Medicaid
5 funding, inadequate Medicaid funding, insufficient
6 reimbursement rates.

7 The COVID-19 pandemic has made this all the more
8 difficult in that we see increased and strained Medicaid
9 budgets at the state level, and this affects both the
10 services that are being offered but also the ability to
11 improve these jobs. And, of course, demand for these
12 workers has also increased, and in many states really
13 tragic stories of long-term care settings needing to close
14 their doors. They are really struggling to survive based
15 on this reality because they cannot recruit and retain
16 enough workers.

17 The other point I will make here is that we
18 released a new study two weeks ago with the UCSF
19 Healthforce workforce research center, which looked at
20 workers who were displaced during the COVID economy, not
21 just in direct care but in similar occupations. And what
22 we found is that by the end of last year very few, or what

1 we would say an immeasurably small number of workers from
2 either direct care or other occupations actually re-entered
3 direct care or entered direct care. So there is something
4 about direct care that continues to push away and not
5 attract workers who could take these jobs.
6 I want to share just a few thoughts that relate
7 to our state conversation and focus the second half of my
8 comments on that. One is that I do think it is important
9 that we situate this conversation not just in the crisis of
10 the workforce shortage but also the incredible
11 opportunities that we have in front of us. One is the
12 amount of funding that could potentially reach many states,
13 not all states, who apply for it through the American
14 Rescue Plan Act. And I've had a chance to look through a
15 number of the proposed spending plans that states put
16 through and we actually informed a number of those plans in
17 certain states. And what we see are just a number of
18 sizeable and really important one-year investments in the
19 direct care workforce.
20 Now the argument, of course, here is that it is a
21 one-year investment so beyond that it is difficult for us
22 to see that as transformational. And yet many of the

1 proposals that states offered, and are still fleshing out
2 depending on the funding that gets received, could be
3 transformation and long-term in nature. So that's an
4 incredible opportunity. And should Build Back Better
5 invest the $150 billion plus additional funding in
6 workforce development and equity issues in rural areas, et
7 cetera, there are a number of ways in which those measures
8 can be used by states to address various aspects of the
9 direct care workforce crisis, which, by the way, is not all
10 about wages. It can be about equity and rural strategies
11 and technology, et cetera, also training, advancement, data
12 collection, innovation, and so on.
13 We know, for example, that wages are essential to
14 transforming this workforce, but there are a wide range of
15 other measures that could also be transformation, and I'm
16 looking forward to discussing that with my fellow panelists
17 and with all of you.
18 The other piece is that we know that short-term
19 investments can also have a large payoff in the long term,
20 and we've seen some opportunities both in the spending
21 plans but in many conversations we've had with state
22 leaders about these kinds of investments. One is about

1 building the training infrastructure that would really
2 allow a much stronger training approach for the full direct
3 care workforce, including home health aides, nursing
4 assistants, personal care aides, independent providers, and
5 direct support professionals, and that would allow just a
6 better training delivery system that would ensure that
7 workers have the skills and the knowledge and the
8 competencies to succeed, but also that consumers receive
9 the supports that they deserve.

10 The other is the important work that states can
11 place in better researching and understanding what workers
12 themselves believe are their needs, their experiences, and
13 what they deserve in order to take and stay in these jobs.
14 We did a partnership a year ago with three managed care
15 plans in Arizona who provided rich insights on all of that.
16 And we see opportunities for us to do that as well as more
17 funding for innovations like technology, recruitment and
18 retention, virtual training, and also for developing these
19 smart, multi-pronged plans for how a state can address
20 that. We've seen at least 16 plans in this regard around
21 the country since 2003, and I think it is a great way in
22 which a short-term investment can have long-term

1 transformational change.

2 The final point I'll make, and I'll close up my
3 remarks with this and pass it on to my fellow panelists, is
4 that we at PHI also have a range of service lines where we
5 work closely with states to develop these kinds of
6 strategies, from surveys to rigorous landscape studies, to
7 data-driven business cases, to invest more funding,
8 recruitment and retention funding, training, and so much
9 more. And I'm happy to talk, either during this
10 presentation or offline, about those service lines.

11 Again, I look forward to hearing my fellow
12 panelists' comments and to the discussion that follows, and
13 your questions in particular. Thank you.

14 [Pause.]

15 CHAIR BELLA: Thank you. Tamara, do we have Bill
16 next? Okay, wonderful. Welcome.

17 * MR. KENNARD: Yes. Well, thank you and good
18 afternoon to you on the East Coast. I'm Bill Kennard, and
19 it's an honor for me to be here representing AHCCCS, the
20 Arizona Health Care Cost Containment System, and to present
21 Arizona's approach to workforce development to the
22 Commission.

1 Today I'll be talking about three things. First,
2 AHCCCS's approach to workforce development and how we are
3 using our managed care model as a platform for developing
4 Arizona's health care workforce. Next, I'll describe the
5 HCBS workforce and the challenges Arizona is facing in
6 recruiting and retaining workers in this segment and the
7 emerging strategy for addressing these challenges. And
8 finally, I will present a very high-level overview of the
9 workforce development initiatives that we proposed in
10 Arizona's ARPA plan.
11 I'd like to begin with a quick overview of
12 AHCCCS's managed care system. So AHCCCS operates under an
13 1115(b) waiver. This waiver enables our managed care
14 model, the HCBS program, as well as other Medicaid services
15 provided to members with behavioral health needs.
16 The overwhelming majority of the 2.3 million
17 Arizonans who are AHCCCS members are served within the
18 managed care system. In the Arizona model, AHCCCS
19 contracts directly with MCOs, or health plans as we refer
20 to them here. Health plans, in turn, inform and manage
21 provider networks by contracting directly with provider
22 organizations. And with the exception of our fee for

1 service system where AHCCCS manages the health services
2 delivered to the 22 tribal nations, AHCCCS does not
3 contract directly with provider organizations, nor do we
4 employ or contract with direct service staff.
5 Currently, AHCCCS contracts with 15 health plans.
6 Seven health plans manage networks that serve the
7 integrated health and acute and behavioral health needs of
8 over 2 million adults and children. Three health plans are
9 regional behavioral health networks. RBHAs, as we call
10 them, serve 47,000 adults and children with qualifying
11 diagnoses and experiences.
12 The Arizona Department of Child Safety recently
13 became the newest health plan. In addition to the child
14 safety mission, DCS manages the statewide comprehensive
15 health service program for foster children.
16 And finally, services for the 65,000 members
17 served by our long-term care system, over 70 percent who
18 receive services in their own homes, are managed by three
19 health plans who serve members needing support due to age
20 or physical disability, and one, the Division of
21 Developmental Disabilities, a sister state agency, is
22 responsible for managing the network of providers serving

1 members with developmental disabilities.

2 AHCCCS's approach to workforce development is
3 based upon the belief that to fulfill our mission we not
4 only need sufficient workforce capacity, we also need
5 capable, competent and committed workers, and we also need
6 to be using the best in workforce development practices,
7 processes, and technologies to do it.

8 And towards this end, in 2017, AHCCCS required
9 all health plans to hire a workforce development
10 administrator to stand up a workforce development
11 operation. And to support this requirement, AHCCCS created
12 ACOM 407. 407 is a contractor operations management policy
13 that describe the requirements and functions of the
14 workforce development operation. These functions include
15 producing an annual workforce development plan, collecting
16 workforce data, conducting workforce assessments, and
17 monitoring workforce capacity and capability requirements.

18 In addition, there are two other requirements in
19 the policy that are showing very promising results. One is
20 that health plans must integrate the workforce development
21 operation with the network quality management and cultural
22 competency departments in the health plan. We didn't want

1 the workforce development operation at AHCCCS, nor at the
2 health plans, to be a part of a silo.
3 And the second is the workforce development
4 operations of all health plans must work as a cooperative
5 alliance on workforce issues that are common to their
6 shared workforces. So this means that in addition to
7 developing a workforce within their networks, workforce
8 development, that is, administrators of all health plans,
9 actively collaborate with their colleagues to monitor,
10 assess, plan, and act together to strengthen their common
11 workforces. And, in 2022, we plan to expand that concept
12 to all workforces across all alliance business.
13 We're still in the early stages, but to date,
14 those collaborative efforts have resulted in the
15 development of a common dataset of workforce metrics and a
16 common portal for providers to enter that data, a contract
17 with PHI to survey our in-home care, our DCW workforce
18 regarding retention and job satisfaction issues, and the
19 beginnings of a strategic plan informed by that survey
20 designed to mobilize our collective efforts to mitigate
21 Arizona's long-term care workforce challenges.
22 Now, turning to the HCBS workforce, in Arizona,

1 approximately 20,000 personnel that we call DCWs, direct
2 care workers, provide in-home services to members who are
3 elderly or have developmental and physical disabilities.
4 About 50 percent of that workforce are paid family
5 caregivers. All DCWs, including those who care for family
6 members, are either employed by or contract with a provider
7 organization.
8 All DCWs must demonstrate competencies that are
9 required by Arizona's two-level training and competency
10 testing program. This program consists of a Level 1
11 fundamentals caregiving course and competency test and a
12 Level 2 program that's divided into two, depending upon the
13 focus of the caregiver's work, aging and physical
14 disabilities or developmental disabilities.
15 The DCW training and testing program is available
16 only through AHCCCS-approved training and testing agencies.
17 These agencies can be an independent training company, a
18 provider organization, or an educational institution. All
19 training curricula must align with the published DCW
20 competencies. Agencies may adapt or use the model training
21 curriculum available on our AHCCCS website, and they must
22 use the standardized DCW test.

1 Recently, 27 high school career and technical
2 education programs became training agencies joining a
3 number of community college-based DCW training programs,
4 thus, that are enhancing our capabilities and our
5 recruitment possibilities as well.
6 Arizona's DCW workforce faces challenges that are
7 all too familiar to the field. The survey commissioned by
8 the four ALTCS health plans and conducted by PHI concluded
9 that counting new jobs and job openings created as workers
10 leave the field, we will need to fill nearly 130,000 paid
11 caregiver jobs by 2026. We found that the median wage for
12 DCWs is $12.65 per hour, which is above Arizona's current
13 minimum wage and slightly higher than the median wages of
14 nearby states and national, yet despite that bit of good
15 news, Arizona's minimum wage law has had the effect of the
16 tightening competition for workers among HCBS providers as
17 well as other industries.
18 And let's see. Another finding was that the
19 pandemic really introduced new concerns about paid
20 caregiver safety and economic well-being while exacerbating
21 existing recruitment and retention strategies, and
22 retention, always a challenge, is being called a crisis by

1 some providers with the phenomenon of really a sudden,
2 unexpected set of resignations really becoming more common.
3 Recruitment and the time required to fill positions has
4 also become more difficult and lengthier.
5 The survey, though, suggested that in addition to
6 increased compensation, there are other impactful solutions
7 that we can implement to mitigate these workforce
8 challenges. Robert just spoke to many of them, first of
9 all, certainly, during the public health emergency to
10 provide increased support to our DCWs to prevent that
11 burnout, to prevent those circumstances that oftentimes
12 require them to resign suddenly and unexpectedly; to begin
13 promoting in a more decisive way diversity, equity, and
14 inclusion, to improve AHCCCS to additional hours and full-
15 time schedules, to increase our recruitment of works both
16 online and to leverage personal connections, to augment our
17 recruitment efforts, to implement more supportive
18 supervisory practices and to promote advancement
19 opportunities and create new career pathways, expand
20 training opportunities, and to include DCW voices when
21 evaluating interventions. The survey actually also
22 informed many of AHCCCS's initiatives that are proposed in

1 our ARPA spending plan.

2 In the time I have remaining, I really can't do
3 justice to the full breadth and scope of the ARPA plan to
4 empower families, our funding initiatives, and to improve
5 the use of technologies and tools, but I can call out a
6 few.

7 One, we intend to focus on DCW career development
8 and develop a specialized career pathway to technology
9 platform. We endeavor to explore the creation of a career
10 route within the DCW role. We intend to increase the
11 AHCCCS to ongoing training and development opportunities
12 that we find were correlated highly with people's intention
13 to leave their positions as DCWs and to improve AHCCCS to
14 supportive supervision.

15 You know, I wish to thank you again for this
16 opportunity to address the Commission, and I'll be happy to
17 take any questions the Commissioners may have.

18 CHAIR BELLA: Thank you very much.

19 Bea, welcome. Thanks for being here. Look
20 forward to hearing from you.

21 * MS. RECTOR: Thank you so much. My name is Bea
22 Rector, and again, I am in the State of Washington, and I

1 administer with staff the state's long-term services and
2 support system.
3 And there are approximately 92,000 direct service
4 workers assisting clients with activities of daily living
5 in Washington in their own home and in community settings
6 such as adult family homes and assisted living facilities.
7 This includes both home care aides and nursing assistants.
8 The makeup of our direct service worker
9 population leans towards a demographic, just as it does
10 nationally, of females with a median age of 46, and the
11 workforce is largely women and people of color and
12 immigrants.
13 Our state serves about 90 percent of the Medicaid
14 clients in their own homes and in community-based settings.
15 So we have several decades of experience and expertise in
16 developing provider networks and a workforce that can meet
17 the needs of the very diverse population of individuals who
18 rely on home and community-based services for their daily
19 needs.
20 It's important to note that the services provided
21 by this workforce are highly personal in nature, and the
22 soft and hard skills that are learned in this work can be

1 leveraged to advance within the field of direct caregiving
2 or to branch off to other careers in human services, health
3 care, and small business ownership, and we need to do a lot
4 more to really publicize and make visible and known the
5 career lattices or career ladders that this kind of direct
6 care worker job can create.
7 We also know that from our experience and
8 expertise, we really can envision a lot of what has been
9 talked about by the other panelists in terms of innovative
10 new funding strategies and how those could be used to
11 develop a larger, more skilled workforce that is fully
12 integrated into a client's care team.
13 In Washington State, home care aides have robust
14 high-quality training requirements. These training
15 requirements apply across all settings in home, adult
16 family home, and assisted living. They also apply,
17 regardless of funding source, to workers who serve in
18 Medicaid or in private pay. Newly hired workers must
19 complete five hours of safety and orientation before they
20 begin work with a client. They also must do a name and
21 date-of-birth background check, and we also have FBI
22 fingerprint background check requirements for our long-term

1 care workforce.

2 The rest of the training can be accessed while
3 somebody is working, which is very important in terms of
4 access to training and making sure that people can work
5 while they're completing those requirements. If they do
6 not complete the required training and certification within
7 a statutory time frame, they are no longer qualified to be
8 a paid provider. So our required training in addition to
9 that five hours of safety and orientation is 70 hours of
10 skills, population knowledge, communication training, self-
11 care, adult protective services information, et cetera.
12 For a large part of the population, training is provided at
13 no cost, and because it's required, individuals are paid
14 for the training while they complete it.

15 The training is localized and offered in 13
16 different languages. The curriculum is overseen by the
17 state, and both instructors and curriculums must be
18 approved by our state, and there is a significant focus on
19 person-centered care in the training curriculum.

20 To further professionalize direct service
21 workforce, there is an additional requirement that 12 hours
22 of continuing education credits be earned each year by

1 caregivers. This is standard support to workforce that's
2 continually refreshing skills and attaining industry best
3 practices.
4 Long-term care workers must also be certified
5 within 200 days of employment by passing a certification
6 exam administered through the state department of health.
7 There are exemptions from certification and a lower number
8 of hours of training required for individuals who are
9 parents or adult children of the person to whom they're
10 providing care. Their level of training is 7 hours for a
11 parent and 30 hours for an adult child. There are also
12 some exemptions for individuals who provide only small
13 hours if intermittent care in a month to a single person or
14 less than 300 hours a year of respite.
15 As Robert mentioned, there's a lot that can be
16 done with temporary funding and at the national level to
17 create infrastructures, to support access to high-quality
18 training, and particularly as we learned through the
19 pandemic that a lot can be done virtually, I think there's
20 a lot of economies of scale that could be gained through
21 good learning management systems and training curriculum
22 that are available across states.

1 The current minimum wage in Washington is higher
2 than the national minimum wage. We're currently at $13.69
3 per hour, and that will increase to $14.49 in January. In
4 Seattle, the state's largest city, the minimum wage will be
5 $16.69 in January. Minimum wages have increased by 26
6 percent since July of 2018, and there's an annual inflation
7 indicator that raises minimum wage on an annual basis.
8 Keeping pace with raises in minimum wage has been
9 a significant challenge for the state under Medicaid as
10 well as for our long-term care providers.
11 Across settings, our average hourly wage for a
12 nursing assistant is currently $18.50 in Washington, and
13 for a home care aide, it's $16.09. Those wages could be
14 between $1 and $3 lower or higher, depending on the
15 setting, the seniority of the worker, and practices of the
16 employer.
17 As we work to recruit into direct care jobs, we
18 find competition from a variety of markets, and Robert
19 mentioned these warehouse and labor markets, janitors,
20 cleaners, retail, fast-food industry, and the ability for
21 people to enter those jobs, which tend to be less stressful
22 jobs, potentially more predictable in terms of the hours of

1 work people can gain a week, it really creates an
2 environment where direct care workers could choose an
3 easier path and often are supported with longevity in their
4 career field by those employers.
5 In Washington, the self-directed care workers
6 elected to unionize, and the governor is the employer for
7 purposes of collective bargaining. We are in the process
8 of moving that self-directed workforce to a private
9 employer relationship.
10 We also have owners of adult family homes who are
11 unionized in our state, and their representative, the Adult
12 Family Home Council, bargains on their behalf with the
13 State of Washington for daily rates paid under Medicaid.
14 In the self-directed CBA, hourly wages range from
15 $16.85 to start and go up to $19.21 an hour based on
16 lifetime hours of work. There's also an hourly pay
17 differential for completion of certification and another
18 differential if people complete another 70-hour advanced
19 training.
20 In addition, this workforce is eligible for
21 overtime for hours worked over 40, paid time off that
22 accrues at 1 hour for every 25 hours worked, and they can

1 accrue up to 130 hours of paid time off. And for the first
2 time in the last CBA, there were two holidays bargained at
3 time-and-a-half pay.
4 We also have been supporting a $2.46-an-hour
5 hazard pay for this workforce that's been working
6 throughout the public health emergency. This, in part, is
7 funded through the FFCRA funding that created an enhanced
8 FMAP during the public health emergency.
9 The collective bargaining agreement also provides
10 benefits to bargaining unit members that are administered
11 through Taft-Hartley trusts. There is health care
12 insurance for workers that work at least 80 hours per month
13 with a very low employee premium of $25 a month to
14 participate, and that includes both vision and dental
15 benefits.
16 We also have a first-in-the-nation retirement
17 benefit for our in-home workers, where the state pays 80
18 cents for every hour worked into a defined contribution
19 plan. Our in-home self-directed workers also have access
20 to peer mentors, which support retention of the caregiving
21 workforce, and a client-worker match registry, where
22 clients can post jobs and workers can identify client jobs

1 that they're interested in.

2 And our Adult Family Home Council also
3 administers a training network to support their business
4 owners and employers with training and workforce
5 development for adult family homes.

6 In Washington, the legislature also passed a
7 parity law that requires the state to create a formula to
8 pass through wages and benefits earned in the self-directed
9 CBA to direct care workers employed by Medicaid-funded home
10 care agencies, and this was done really to ensure that all
11 boats rise and to create a more even wage and benefit
12 environment for this critical workforce.

13 We also have rate methodologies under Medicaid
14 for the residential settings that account for average wages
15 and benefits of direct care workers. However, these models
16 are significantly underfunded in Medicaid, and therefore,
17 the employers struggle with the level of wages and benefits
18 necessary to attract and retain workers.

19 So we have been really fortunate in Washington to
20 make a lot of advances in wages and benefits for segments
21 of our direct care workforce, but we still have a
22 significant crisis in workforce shortage. So we really see

1 the need to continue to innovate and create visibility and
2 investments in workforce development if we want to meet the
3 increasing demand for services that is being driven largely
4 by the aging of our nation and our state's population.
5 We have a couple of initiatives that I just want
6 to quickly highlight that are workforce initiatives. We
7 have developed a high school home care aide training
8 program in partnership with the state-level office of
9 superintendent of public instruction. The training program
10 is a 90-hour course that fits into a semester calendar, and
11 when completed, the student will have a home care aide
12 credential, and the training program also earns the student
13 high school credit towards graduation. So they're really
14 covering two requirements at the same time.
15 Like what Bill talked about and Robert talked
16 about, we do believe that supportive supervision is
17 critically important to retaining the workforce, and so we
18 are developing some retention programs and supportive
19 supervision programs in partnership with our employers and
20 direct care workers.
21 We do believe that the visibility of the direct
22 service workforce needs to be increased, particularly

1 within the workforce council and boards and health care
2 providers so that everyone understands the competencies and
3 the values of the workforce, and that we're all working
4 together to try to really reduce the gap in supply and
5 demand of the workforce.
6 Our agency wants to work with the Workforce
7 Development Council systems here in the state. The system
8 manages the Workforce Initiative and Opportunity Act
9 dollars. Requirements are set at the federal level to
10 mandate that program funding can only be used for
11 professions that have a family-sustaining wage. We really
12 feel like we need to open up a conversation about
13 restructuring that mandate to remedy the long-term care
14 staffing crisis and provide caring professionals for the
15 vulnerable populations that need those services and
16 supports.
17 We believe that some policy changes at the
18 federal level would be very helpful to help create these
19 necessary partnerships.
20 We also believe that data and workforce data is a
21 struggle that all of the states deal with, and we'd like to
22 see more done to simplify reporting and to assist in

1 analysis of supply, demand, and turnover of the workforce.
2 And our agency also envisions a potential pilot
3 that would mitigate the public benefits cliff for
4 individuals entering direct service workforce from TANF,
5 and this pilot could really provide a three-fold remedy for
6 developing the workforce, reducing poverty, and creating
7 savings for state public benefit agencies and for the
8 federal government.
9 So, in closing, there's a lot of work to be done,
10 both nationally and by states, to ensure that we can meet
11 the preferences of individuals to be served in their own
12 homes and their community residential settings by a
13 workforce that's competent, compassionate, and delivers
14 person-centered care. We've made significant investments
15 in our ARPA spending plan around vendor rate increases,
16 worker wages increases, increasing the number of hours that
17 clients will be eligible to receive, and we look forward to
18 this ongoing discussion.
19 VICE CHAIR DAVIS: Thank you, everyone. Thank
20 you to our speakers.
21 I anticipate a lot of comments, and so folks can
22 start lining up. You know, Bea, I just want to take a

1 moment to really applaud the efforts that you've done to
2 develop the workforce, especially really thinking of it as
3 a profession and creating those ladders of -- you know,
4 ladders to advance, but also just being seen as something
5 that is valuable, because it does create so much value. So
6 thank you for that.
7 Any comments from the Commissioners? I see
8 Martha.
9 COMMISSIONER CARTER: Thank you for that great
10 presentation. That was really informative.
11 Both of the states represented have described
12 developing training programs in your state, and sort of to
13 Kisha's point, in your opinion, would it be helpful to have
14 some national standards, to have some national level
15 training requirements? Right now the states are really
16 owning that training, right? And so in order to maybe
17 improve flexibility for workers to travel and to maybe make
18 it easier on the state, would that be something that you
19 think should be developed? Or do you think it's best
20 developed state by state?
21 MR. ESPINOZA: Can I take a first stab at that
22 question if possible? I think the response is absolutely.

1 I mean, this is one of the key recommendations PHI made in
2 a recent federal policy report in the section on training
3 and building the training infrastructure is would it create
4 first kind of a national competency-based training standard
5 for direct care workers that would identify the core
6 competencies that are needed across settings, and within
7 that standard, some kind of strategy that would help us
8 understand how to make the workforce more versatile and how
9 to make jobs and training requirements more stackable and
10 portable. And this was a challenge we saw during the
11 COVID-19 pandemic in the first few months, which is we
12 would see a hot spot emerge. In certain cities or in
13 certain states, the workforce would become strained, and
14 then the question for many states would be: Can we find
15 workers from nearby states, like in New York City, where
16 New Jersey is across -- you know, is a five-minute drive
17 away?

18 The challenge is no because training requirements
19 are different across states, and they're often different
20 within settings as well, and so -- and occupations. So I
21 think the challenge here is making sure that we have that
22 national federal leadership, that it starts with some type

1 of training standard rooted in core competencies, and then
2 it works with states to figure out how to arrive there and
3 where there are differences and then what's needed in the
4 infrastructure in terms of supports for methods so that the
5 training is adult learner centered, it's kind of
6 modernized, the kinds of conditions that we're seeing more
7 and more in the clientele, and that it's efficient and that
8 we're thinking about both in-person and also virtual
9 training approaches that will make the training that much
10 more efficient.
11 But it's a great question. It's a major barrier
12 that we face at the national level for sure.
13 MS. RECTOR: Yeah, and what I would add to that -
14 - this is Bea -- is, yes, I totally agree with that, and
15 the thing that I would want to make sure doesn't happen is
16 that it become overmedicalized. You know, home and
17 community-based services and particularly self-directed
18 care where people are served in their home and they're
19 hiring a family or friend, you know, there needs to be
20 recognition that that's a vital part of the workforce. In
21 Washington, about 80 percent of the self-directed workforce
22 is a family member of the person that they're providing

1 care to.

2 So I'm not sure that the same training standards
3 always need to apply to every single-family caregiver, you
4 know, which is why we have some tiers of still required
5 training, but not necessarily the credential at the end.
6 So hopefully there could still be some flexibility about
7 how states apply maybe those national requirements at the
8 state level. And I also think it's really important on the
9 population-specific kind of skills and knowledge that that
10 be able to be driven in part by the consumer themselves,
11 particularly when they -- you know, in a self-directed
12 environment.

13 The other thing that we learned when we
14 implemented this requirement is it is a huge barrier if
15 training and the certification is only offered in the
16 English language. This population is extremely diverse,
17 and so, again, we learned the hard way through a lot of
18 people not being able to make it through training or not
19 being able to pass the certification due to language
20 barriers, that we needed to give more time to people. We
21 needed to make sure the training actually was localized but
22 so is the certification exam into multiple languages and

1 that be done really thoughtfully; and that those
2 competencies, you know, we have a skill-based test and then
3 we have kind of a knowledge-based test, and both of those
4 are extremely important in terms of the soft and hard
5 skills necessary to do this work well.
6 MR. KENNARD: And if I could, just to add a point
7 on both Robert and Bea's excellent points, we would agree
8 as well in Arizona it would be helpful. We know that just
9 around Bea's comment around the medicalized part of the
10 training, we just recently had some legislation which
11 enabled some reciprocity between our in-home caregivers,
12 the training and competencies for them, and our assisted
13 living caregivers covered by a different licensing body.
14 And that was much more nursing theory oriented than it was
15 in our approach in in-home care. It was really much more
16 medical, much more theoretical, and ours is much more
17 competency-based.
18 And as we kind of go through actually here a
19 revision right now of the competencies and the training
20 methodologies, I think one of our industry groups that's
21 really leading that effort is really kind of saying, you
22 know, in addition to the mechanics of caregiving, what we

1 really need to ensure that our practitioners have or our
2 caregivers have is they really need to have those
3 interpersonal skills, those processing skills that enable
4 the person to kind of, you know, be connected to the person
5 they're giving care to so that they're really able to
6 empower them even when they're performing very intimate and
7 kind of do-for kinds of activities.
8 So I think that the nature of those national
9 standards, if they were competency-based, you know, I think
10 it would be welcome.
11 VICE CHAIR DAVIS: Thank you. I see Brian, then
12 Fred, then Dennis, and then Tricia.
13 COMMISSIONER BURWELL: I have a comment and two
14 questions. I just want to emphasize that the two states
15 that we've heard from today are exemplary models of
16 workforce development under Medicaid. I don't want my
17 fellow Commissioners to believe that that level of
18 workforce development is present in a lot of states. These
19 are really exceptional states in terms of how much they've
20 invested in the workforce, and I compliment them. But I
21 think the true story nationwide is far -- is not as happy
22 as we have heard today.

1 I have two questions. One is kind of the impact
2 of unionization on workforce issues. I know in the state
3 of Washington there was a unionized movement, and I believe
4 most of the direct care workers are unionized. I would
5 just like to hear from the panelists what they believe the
6 impact of that will be, and is that a trend that we think
7 will continue?
8 My second question, I've always had an interest
9 in the public market versus the private market. We are
10 still just talking about Medicaid, and there's a huge
11 private market for caregivers out there, and it is growing.
12 And I wonder how much that is a competitive market to the
13 Medicaid-financed workforce that generally pays higher.
14 MS. RECTOR: Yeah, so this is Bea. I can
15 certainly take a stab at that. You're right, Brian, that,
16 you know, there is a high presence of unionized workforce
17 in our direct service workers in Washington, and prior to
18 that -- and I've worked in the system for about 30 years.
19 You know, at the state level, when you were asking and
20 going through the budget build process to try to increase a
21 vendor rate, for example, or an hourly wage to a self-
22 directed workforce, in our state currently, every penny

1 that we raise is a 670 -- it's huge dollars, because we
2 have 670 million hours in a year. So what I'm saying is
3 that, you know, through kind of the government building
4 budget process, it was really hard, because when we would
5 ask for five cents, which isn't enough, it, you know, was
6 really millions of dollars, tens of millions, potentially
7 hundreds of millions.
8 So the union has been a really important partner
9 because they've given a voice to that workforce and have
10 been really active, you know, both at the governor's build
11 process but also at the legislative process, and have
12 really been able to move forward some significant
13 investments as well as kind of the professionalizing of the
14 workforce.
15 So I know not every state environment is the same
16 related to that, but it is something that in Washington has
17 been a real successful partnership.
18 On the private-public funding question, you know,
19 we really struggle. Assisted living is a great example in
20 our state. You know, typically Medicaid's paying about 60
21 percent of nursing facility cost, probably at least 60
22 percent of in-home, 60 percent of adult family home. But

1 in our state, because of our Medicaid reimbursement rates,
2 we're only at 25 percent Medicaid in assisted living, and
3 there's a lot of new building going on, but it's almost all
4 private pay. And because of the rates that they're able to
5 charge in private pay, those facilities that largely are
6 private pay in nature have been able to compete well for
7 the limited direct care workforce, and it does create the
8 pinch on Medicaid and people trying to access those
9 services that are low income.
10 MR. ESPINOZA: If I can add some thoughts to
11 Bea's points, to both of your questions, on the union
12 question there hasn't been a lot of independent research
13 comparing union and non-unionized jobs that would give us a
14 better sense of the differences. We did a little bit of
15 research about two years ago, and it showed that unionized
16 workers made about $13 in wages versus $11 non-union. So
17 that's one metric or one data point. But we think it
18 merits more analysis.
19 The other point is that, however, when we have
20 studied major job quality measures around the country, many
21 of the most impressive numbers in Washington State, New
22 York, California, et cetera, did have unions in the lead in

1 some regard. So I think it's important to acknowledge the
2 role of the union in the sector, also recognizing that in
3 most states collective bargaining is not strong and unions
4 are not present, so we still need other strategies to
5 improve jobs in regards to that.
6 I think it's a good question about the workforce
7 challenge affecting the employers in the private-pay
8 market. We will say to our practice side, we have many
9 employers in that market, and many of them are struggling
10 with recruitment and retention challenges as well, even
11 though what they're typically able to give a worker is
12 better than what many employers in the Medicaid-funded
13 working offer. So I do think that this general crisis
14 about quality or lack thereof and the recruitment and
15 retention challenges is something that is affecting
16 everyone with unique differences that probably need to be
17 better understood.
18 MR. KENNARD: Yeah, I would say the same thing
19 about the funding. We see equal challenges in the private
20 and public sector, mixed public-private sector around
21 recruitment and retention issues, despite perhaps wage
22 inequities. Of course, in Arizona, the unions really are

1 not a strong and they've never been a particularly strong
2 influence here.
3 MS. RECTOR: And if I could just add one thing,
4 you know, one of the challenges if you're going to create,
5 you know, health benefits, access to vision, dental, and
6 even training in some regard, you want to create economies
7 of scale. And in home- and community-based services,
8 there's so many independent contractors, you know, whether
9 it's a self-directed worker or whether it's a small adult
10 family home that only serves six clients, there needs to
11 become ways to be able to pool resources, you know, and
12 create purchasing power for those small employers or
13 individuals in this workforce that want access to
14 affordable benefit structures or affordable training. And
15 so the union and the Taft-Hartley trusts have been a way in
16 our state to kind of create that economy of scale to
17 purchase for numbers of people.
18 And I also just want to correct my math on the
19 fly there. So for every penny, it's $670,000, so almost,
20 you know, $1 million for every penny raise. So, you know,
21 in large systems, small investments become large
22 investments pretty quickly at the statewide level.

1 VICE CHAIR DAVIS: Remind me of that scale. We
2 do want to do a time check, so we have about five minutes
3 left with our guests, and we'll have an additional 30
4 minutes afterwards for Commissioners to discuss. But if
5 you could keep your questions pointed or if they are
6 directed at one person. So we have Fred and then Dennis
7 and then Tricia.
8 COMMISSIONER CERISE: Thanks, Kisha. Thanks to
9 the panel, all of you, and I appreciate the work that
10 you're doing. It's tough work, and it's really impressive
11 what you're doing.
12 Tell me, over the past couple of years, as
13 everybody has been struggling for staff, how much worse it
14 has been for you. And I hear that some of the temporary
15 funding is helpful in that you can make some investments
16 there, but it does seem like -- you know, salaries are
17 important. And how worried are you that you're going to
18 make investments short term in salaries and then you're not
19 going to be able to sustain that?
20 MS. RECTOR: This is Bea. I mean, we're really
21 worried about that. Our legislature was pretty careful in
22 use of ARPA funds because it was one-time and time-limited

1 where, you know, they were pretty cautious about wanting to
2 create a bow wave that they would have to deal with in the
3 future. We did do that hazard pay using the FFCRA, and
4 there's a lot of concern about, you know, when the PHE is
5 over and that hazard pay is not able to be somehow absorbed
6 into ongoing wage increases that we're going to lose a
7 significant number of people out of the workforce.
8 And, in addition, we are seeing, particularly in
9 our home care agencies, that our per caps are shrinking,
10 and the reason is that there's just not the workforce to
11 serve the hours that the clients are eligible to receive.
12 So it is getting worse.
13 COMMISSIONER HEAPHY: Wake up. Wake --
14 MR. KENNARD: That has been our experience in
15 Arizona as well, if anything, just the pandemic I think
16 exacerbated it.
17 COMMISSIONER HEAPHY: The workforce part-time.
18 Go to sleep.
19 VICE CHAIR DAVIS: Go ahead, Bill,
20 MR. KENNARD: No, I mean, I think really it did
21 exacerbate the challenges that we were having generally,
22 and it just made everything -- anything like the sudden

1 resignations, the stress and burnout, I mean, just all of
2 those things that kind of happen anyway just began to
3 happen on a larger scale. So I think that that has been
4 our big experience on this.
5 As for the issue just about sustainability, you
6 know, post-ARPA, certainly our state is really kind of very
7 cautious about how to use those funds. We want to deploy
8 them as much as possible so that they do have an immediate
9 impact on reimbursement and that kind of thing, but we also
10 want to do so advisedly so that, you know, there's not a
11 cliff in 2024 or something.
12 VICE CHAIR DAVIS: Thank you. If our panelists
13 have a little bit of flexibility, we've got three more
14 folks with questions: Dennis, then Tricia, and, Darin, I
15 think I saw your hand, too. If you have flexibility to
16 stay for a few more questions, we'd love to have you. And
17 if you have to drop off, we certainly understand that as
18 well. We'll go to you, Dennis.
19 COMMISSIONER HEAPHY: Thank you, and sorry for
20 that interruption. I was talking to myself. So I guess
21 one -- I've got two questions, one is for PHI. In your
22 research and the unique demographics of the population that

1 work in this field, have we discovered why folks either
2 work part-time or prefer working part-time? And then my
3 second question, which is for everyone, is: How do you
4 define competency and skills when the populations are so
5 complex and so different by setting, by age, by need?
6 MR. ESPINOZA: Yeah, those are great questions.
7 I'll offer my thoughts and then I'm also curious what Bill
8 and Bea have to say.
9 On the demographic questions, we have looked at
10 part-time more closely, reasons for part-time work more
11 closely. We have a research brief on our site that goes
12 into the detail of it. In general, what we have found is
13 that roughly 1 in 3 direct care workers are choosing to
14 work part-time, and the reasons include family
15 responsibilities, some of them are nearing retirement age,
16 some of them have other jobs. I mean, there are choices
17 that they are making to work part-time, in general.
18 But by and far, most workers are relegated to
19 part-time work either because their employer doesn't offer
20 full-time work, and oftentimes employers make that decision
21 because they want to avoid paying benefits and so on, and
22 the other is the economy hasn't funded the employers at the

1 level that they need to, to be able to offer that full-time
2 work, and those are related. Our research brief has more
3 specific data on all of that, but those tend to be the two
4 general areas of decision-making.

5 In terms of competencies and skills, this is one
6 of the major challenges and it's why I mentioned that I
7 think it would be important at the national level to at
8 least define the core competencies with the understanding
9 that different occupations in different states may have
10 kind of additional or nuance to that. Because there are a
11 wide range of kind of competency sets that have been
12 produced, typically from the public or private sector, that
13 are out in circulation, and some of those, you know,
14 training requirements will use those competency sets to
15 determine training requirements in different states and for
16 different occupations.

17 But they really vary, and a lot of them haven't
18 been updated in years, so they don't always reflect the
19 current realities of many clients or workers. Like some
20 competencies that are missing in those sets are
21 competencies related to person-centered care, competencies
22 related to social isolation and loneliness, or identifying

1 social determinants of health, LGBT competence, cultural
2 and linguistic competence. All of these -- dementia, which
3 has become a bigger piece of so many workers' jobs.
4 And so I do think it's important that we think
5 about a modern competency set, core competency set, that
6 would at least be established at the national level, and
7 then kind of complemented at the state level, so to speak.
8 So those are my initial thoughts.
9 COMMISSIONER HEAPHY: Thanks. Other folks? Bea
10 or Bill?
11 MS. RECTOR: I would just echo what Robert said.
12 You know, our training, our home care aide, is portable, so
13 it's adult family home, in-home, and assisted living. And
14 so a lot of the competencies are around person-
15 centeredness, communication skills, interpersonal skills,
16 the skills around activities of daily living, you know, can
17 you safely transfer somebody, med management, and safety
18 around medication administration and those types of things
19 is where the competencies are.
20 And then there are some flexible hours within the
21 70 hours so that employers and/or community instructors can
22 really do a deeper dive in particular populations, whether

1 that be people within intellectual or developmental
2 disabilities, people with dementia, mental health, you
3 know, those types of things, people with challenging
4 behaviors, which is a growing part of the population that's
5 being served as well.
6 MR. KENNARD: And I'd say, just on competencies,
7 what our trade agencies and our committee that is looking
8 to actually revise and update the competencies and the
9 training program, what they have really focused on is just
10 those interpersonal skills, and not just kind of the
11 conversational skills but really those discrimination
12 skills that kind of enable you, as the caregiver, to kind
13 of sense if a person wants to do more, wants to do less in
14 terms of their own care, even if they can't express it.
15 So they're really to try to improve the
16 sensitivity that our caregivers have when engaging people.
17 How to determine when things have changed. How to make a
18 simple plan. Those things that kind of empower the person
19 receiving care, in addition to the really important things,
20 the mechanics, if you will, the fundamentals of caregiving.
21 But we're looking at how to expand those interpersonal and
22 those kinds of processing skills with our caregiver staff.

1 COMMISSIONER HEAPHY: Thank you.

2 COMMISSIONER DAVIS: Thank you. Tricia, and then
3 Darin, and then we'll transition.

4 COMMISSIONER BROOKS: Sorry to keep you all over.
5 This was really an excellent panel. Obviously, Brian is
6 correct that the work going on in Arizona and Washington
7 are ahead of the curve.

8 My question -- and I think both of you got to a
9 little bit of this in the last question, but most of the
10 individuals receiving HCBS services are adults, but there
11 are children in need of home- and community-based services.
12 What do you see as being unique challenges, needs of this
13 population, and how training and workforce development
14 plays into being better prepared to serve children?

15 MS. RECTOR: Yeah, I think that's a great
16 question, and because we offer our services through state
17 plans, you know, there are individuals who are medically
18 fragile and typically the children's population is more
19 medically fragile or has intellectual and developmental
20 disabilities than maybe the average adult population that's
21 receiving long-term services and supports.

22 And I think oftentimes that interpersonal skill,

1 not just with the child receiving the service but you have
2 the whole family that's involved, and the parents that are
3 involved in children, and that can be true in an adult
4 situation as well, but certainly is more amplified.

5 And then how do you support children while
6 they're also going to school, because the personal care
7 aide can go to school with the child or to extracurricular
8 activities, and that whole community integration piece,
9 which is critically important for adults but certainly you
10 want children to also be able to fully integrate in their
11 lives and their schools, with their families, et cetera.

12 So I think it is a challenge, and it is a small
13 proportion of the population, and I think that's the other
14 issue. When you standardize there is this push and pull
15 between standardization but also keeping enough flexibility
16 to be able to do deeper dives in specialized need
17 populations like children.

18 MR. KENNARD: And that is an excellent question,
19 and I think in Arizona, actually, right now, we are looking
20 at doing two things. One is kind of extending the paid
21 caregiver, family, caring for children that we started
22 during the pandemic and continuing that. The other thing

1 we're looking at, and even are developing some policy, just
2 the feasibility about, is how can we make a licensed health
3 aide, extend that to family members as well.
4 And as we kind of looked at both of those areas
5 we really looked at what's the experience the family member
6 are providing, you know, oftentimes really complex medical
7 care to their family members. And essentially, it's access
8 to supervision, particularly when you've got a question,
9 good question, and access to micro-trainings that might be
10 helpful to the person.
11 So I think those are some of the things that
12 we're kind of looking at right now.
13 MR. ESPINOZA: Ideally, the item I would offer
14 and add to Bea and Bill's comments, are that it does
15 underscore the importance of training in relational skills,
16 since so much of the work that workers do often is about
17 communication, it's about conflict resolution, it's about
18 working with family members and other members of the care
19 team to ensure that those services and supports are
20 offered. And unfortunately too often we've heard of those
21 skills as soft skills, when, in fact, they are not. They
22 are foundational to a worker being able to succeed and

1 mediate those services and supports.

2 So just making sure that we emphasize and

3 properly fund relational skill training in this work.

4 COMMISSIONER DAVIS: Okay. Thank you, and Darin,

5 we'll go to you for the final.

6 COMMISSIONER GORDON: Yeah. Well, I'm going to

7 abbreviate my question and I'll talk about the rest of it

8 afterwards, with the group. But a quick question, simple

9 answer for Bea and Bill, hopefully, in the interest of you

10 all's time more than ours.

11 Do your states pay for training? Bea, you were

12 talking about training requirements. I'm just curious. Or

13 are those individuals paid while they're doing the

14 training?

15 MS. RECTOR: Yes, they are in Washington,

16 especially if they are already working with an employer and

17 it's a required training. Having said that, it is also

18 possible for an individual who is not working to just go

19 and pay for the training themselves and go through that

20 training and certification. But because it is a

21 certification that allows somebody to work while they're

22 gaining the certification it's much more common in our

1 state for somebody to become employed and work while they
2 complete the training and be paid for training while
3 they're going through it.
4 COMMISSIONER GORDON: Gotcha.
5 MR. KENNARD: Ditto for Arizona. I think we've
6 seen, certainly during the pandemic, as the workforce
7 shortage has occurred really the practical application of
8 it is that most agencies actually do provide the training,
9 and less people actually are paying for training on their
10 own.
11 COMMISSIONER GORDON: Thank you.
12 COMMISSIONER DAVIS: Thank you. Well, thank you
13 to our guests. It was just a really great conversation,
14 and thanks for being generous with your time.
15 **### FURTHER DISCUSSION BY THE COMMISSION**
16 * COMMISSIONER DAVIS: We are going to quick
17 transition now to the Commissioners. We have about 20
18 minutes now for additional comments. Just a reminder, we
19 are not working towards recommendations here. This will go
20 into an issue brief, and so are there other areas of focus
21 in terms of information that we'd like to see or interviews
22 that we'd like to have.

1 So I see Darin, and then Laura, Brian.

2 COMMISSIONER GORDON: Two things. When we do
3 look at this, just something that as Bea was talking I
4 think highlighted the point that we do need to think about
5 self-directed versus agency home- and community-based
6 direct care workers. So there are some different dynamics
7 there, and Washington has some pretty astonishing numbers
8 on what percent is actually through a self-directed model,
9 and I think we just have to look at it through those
10 lenses. I think there is obviously a lot of overlap.

11 I would also appreciate, the question I was going
12 to ask but we were running out of time, it would be good to
13 get some more additional information on what Washington is
14 doing with that pilot program with regards to the public
15 benefit cliff, in essence, that they are trying to not let
16 that be a barrier for some folks accessing, or going down
17 the path to being a direct care worker. That's pretty
18 interesting, pretty creative, and I would like to know a
19 little bit more detail because that may be something we
20 could look at on a broader scale. Thank you.

21 COMMISSIONER DAVIS: Thanks, Darin. We're going
22 to Brian next, but he looks like he maybe had to step away,

1 and Tricia was after that. It looks like maybe she had to
2 step away. Oh no, Laura was next. Sorry. Go ahead.
3 COMMISSIONER SCOTT: Just a couple of comments
4 for consideration. So given some of the training
5 standardization discussion, whether we've looked to other
6 non-medical workforce such as community health workers and
7 some of the ways that states tackle that, and at least
8 setting the floor for what kind of requirements in hours
9 and training that someone would need to do that job.
10 That's one.
11 And then the second comment is, given that
12 there's not enough workforce to meet the demand, what I
13 haven't heard is what are the implications of that demand
14 not being met, and whether there is increases in health
15 care utilization, endangerment of the patient, abuse, you
16 know, as people become burnt out. But what are the
17 implications of not having enough workforce, if that's been
18 explored or could be included in the publication.
19 COMMISSIONER DAVIS: Thanks, Laura. Dennis, I
20 also want to give you the opportunity if you want to jump
21 in here.
22 COMMISSIONER HEAPHY: Thanks. Give me one

1 second.

2 COMMISSIONER DAVIS: Let's go to Tricia and then

3 we'll come back. Sorry. I didn't actually see a hand. Go

4 ahead, Verlon.

5 COMMISSIONER JOHNSON: Sorry. Okay, thanks. I

6 always have problems with that Mute button.

7 Just to Brian's point earlier, and I think

8 someone has echoed it too, as well, is that this an

9 excellent presentation. I know when I've looked at this

10 issue before I've always looked at what Arizona and

11 Washington were doing, along with some other states. And

12 so are we going to have an opportunity to hear, or I'm

13 going to ask Tamara, have you talked to other states who

14 may not be as advanced in the area, to get a little bit

15 more of their pain points as well, to kind of help us round

16 out a little bit more about ideas we want to present?

17 MS. HUSON: So I would just comment that we do

18 have an interview scheduled next month with another state,

19 but we could think about maybe adding a couple of

20 additional interviews to get more state perspectives.

21 COMMISSIONER JOHNSON: Okay. That would be

22 great. And then also, I know, I think Arizona brought up

1 the point that 50 percent of the direct service workers are
2 paid family caregivers, and I'm just kind of curious to
3 know a little bit more about, does that increased support
4 of family caregivers, is that a differentiator for a state?
5 We did hear some of the challenges that I think they found
6 with that in terms of training and supervision, but I'm
7 always curious to know what that means and how a state may
8 want to capitalize on that kind of opportunity too, as
9 well. Thank you.
10 COMMISSIONER DAVIS: Anne, did you want to jump
11 in here?
12 EXECUTIVE DIRECTOR SCHWARTZ: Yes. I just wanted
13 to mention, in response to Laura's comment around community
14 health workers, that we are finishing up a project on
15 Medicaid use of community health workers, which we should
16 have for publication relatively soon. I think the focus of
17 that work is quite different because it's more about how
18 states are using community health workers and not so much
19 around payment and retention issues. But stay tuned for
20 that.
21 COMMISSIONER DAVIS: Thanks, Anne. Dennis?
22 COMMISSIONER HEAPHY: Thanks. I've got a number

1 of questions. Given the variability in tasks that in-home
2 workers do, like, for instance, in Massachusetts folks that
3 are in the consumer-driven programs, day care developed
4 program injections be done by a personal care attendant,
5 but that's not the case with a managed care company, an
6 agency. So I'm wondering, if we get more information about
7 the differences between the consumer as employer model in
8 different states versus the agency model.
9 I also think it would be helpful -- Massachusetts
10 is a little bit of an outlier in how we work, but I do
11 think it would be helpful to talk to Massachusetts as well,
12 because we have some shortage of supply but not the
13 shortage I think other states have. And, in addition, I
14 think it would be very helpful to speak to, bring into the
15 conversation representatives from NCIL, National Council on
16 Independent Living, and also the disability -- the
17 government agency. I can get you the name later -- but
18 yeah, into this conversation. Because the population is so
19 variable and the needs and ability to actually care for
20 someone with dementia versus someone who is 30 years old
21 and has a spinal cord injury versus someone who is 10 years
22 old and has complex medical needs as well as behavioral

1 health needs.

2 And so I think it's really important for us to

3 take a big-picture look at this before we decide, yes,

4 training, or no training, and what that looks like.

5 I guess my other question is, do we know that

6 providing training or that testing in itself leads to

7 increases in wages of in-home care providers, because I

8 know in Massachusetts the way in-home care providers were

9 able to gain increased income, because the disability

10 community and the union work together with the state to

11 have that come about.

12 VICE CHAIR DAVIS: Thank you, Dennis.

13 COMMISSIONER HEAPHY: Thanks.

14 VICE CHAIR DAVIS: Brian, did you still have a

15 comment?

16 COMMISSIONER BURWELL: Yes.

17 Going through the ARPA spending plans, it is a

18 huge amount being invested in workforce development with

19 the ARPA funding. I don't know if we want to do something.

20 It's just a lot of information and data, and it's not just

21 wage increases. It's also training and all kinds of

22 related workforce development initiatives. I don't know if

1 we'd want to try to categorize those. I'm sure that there
2 will be other people doing the same thing.
3 There's some interesting things going on, and
4 also, the short-term, long-term issue comes up because most
5 of these wage increases are temporary by legislation. So a
6 number of states will be forced to cut back on those
7 increases after the ARPA funding is depleted in March 2024.
8 Also, the different increases for different types
9 of direct care workers, different types of waiver
10 populations, different models, it would be interesting to
11 kind of peel the onion back about why that is, why have
12 states chosen to raise wages for one type of direct care
13 worker and not others. It may be an equalization objective
14 or something. I don't know, but there's a lot of
15 information to be gained by learning what states are doing,
16 and it's a lot of money.
17 VICE CHAIR DAVIS: Thank you, Brian.
18 Heidi?
19 COMMISSIONER ALLEN: I'm not totally sure how to
20 articulate this question, but I'm thinking about
21 intersections between the direct care workforce and people
22 on Medicaid and if we have a good understanding of what

1 percentage of the direct care workforce is on Medicaid and
2 in general what their health status is.
3 I have several family members who are direct care
4 workers in actually Washington state. One of the things
5 that strikes me about them and their work is that their
6 work requires a lot from them, and it's very physical, and
7 also that they themselves are in very poor health. I'm
8 wondering about -- I don't know what the policy
9 implications would be, but if there are things that could
10 be done to support the health of the direct care workforce
11 that would help them stay working longer with healthier --
12 where they themselves are able to have a longer employment
13 history.
14 VICE CHAIR DAVIS: Thanks.
15 Anne, did you have a comment on this?
16 EXECUTIVE DIRECTOR SCHWARTZ: Yes. I just wanted
17 to thank folks for all these ideas and thoughts. Some of
18 them are things that we can deal with in the short term.
19 Some of them would require a lot more analysis and
20 potentially more data collection. So I just want to send
21 an appropriate expectation of work that we might be able to
22 do within the next couple of months versus some things that

1 we might want to be looking at down the road, particularly
2 as we learn more about what state experience is using the
3 ARPA funds are versus what they're planning to do right
4 now. I just wanted to make sure that that was clear.
5 VICE CHAIR DAVIS: Thank you for bringing us back
6 to reality because if the question is what do we want to
7 study, there's a lot.
8 I will say even to that -- and I think this kind
9 of gets to your point, Heidi, of better understanding this
10 workforce in terms of demographics, how close they are to
11 poverty, how much of -- what percentage of that are
12 immigrants. Are there ways to better understand who is
13 making up that community of home- and community-based
14 service workers?
15 Any other last comments before we wrap up?
16 [No response.]
17 VICE CHAIR DAVIS: Tamara and Sabrina, you've
18 heard lots of directions. Any questions on what you've
19 heard or further clarification?
20 MS. HUSON: No. I think this is very helpful as
21 we continue to work on the issue brief, and maybe we'll
22 schedule some additional interviews that will help direct

1 that work. And to Anne's point, some might require follow-
2 on work, but thank you for all of your thoughts and
3 questions.
4 EXECUTIVE DIRECTOR SCHWARTZ: Yes. Also, Tamara
5 is getting married next week. So she's going to take some
6 time off. So, don't expect something super-duper quick
7 because there's some other priorities for her, in
8 particular.
9 VICE CHAIR DAVIS: Congratulations in advance.
10 And we'll turn back to Fred for a final word.
11 COMMISSIONER CERISE: Yeah. Just a quick follow -
12 - you know, Brian's point of what the ARPA funding is going
13 for, I am worried. If some of these funds are going for
14 kind of public health emergency-related incentives,
15 temporary funding increases, what that's going to look like
16 when that expires, and it would be, I think, helpful to
17 know what that's going to look like how much of that
18 funding is actually -- whether it's in their base rates or
19 it's in some incentive, when that comes off, it's going to
20 feel like a cut if states can't maintain it, you know, if
21 they can't maintain it some other way.
22 VICE CHAIR DAVIS: Yeah. I think, if there's

1 nothing else, I think that we do want to kind of address in
2 that issue brief is what the impact of that will be.
3 Any others?
4 [No response.]
5 VICE CHAIR DAVIS: Otherwise I think we will turn
6 it back to Melanie for public comment and to wrap up the
7 day.
8 CHAIR BELLA: Thanks, Tamara. Thanks, Sabrina,
9 and thank you, Kisha.
10 We will open it up for public comment. If you'd
11 like to speak, please use the hands indicator, and as a
12 reminder, please introduce yourself and the organization
13 you represent and to keep your comments to three minutes or
14 less.
15 [No response.]
16 CHAIR BELLA: So far, we have no hands. We'll
17 give it a little bit longer.
18 In the interim, I will remind folks that our next
19 meeting is in December, December 9th and 10th. We have a
20 very full agenda, already shaping up. So I would encourage
21 everyone to rejoin us then.
22 And it looks like we have no one who would like

1 to make public comment.

2 So any last questions, concerns, issues from

3 Commissioners?

4 [No response.]

5 CHAIR BELLA: Everyone is in a lunch stupor or

6 something. All right. Well --

7 COMMISSIONER HEAPHY: This is Dennis. Just one

8 comment.

9 MS. HUGHES: We have one hand, Melanie.

10 CHAIR BELLA: Oh, all right. Well, here we go.

11 Dennis, hang on one second. Let's take this

12 public comment. Then I'll come back to you.

13 **### PUBLIC COMMENT**

14 * MS. HUGHES: Sarah Potter, you've been unmuted.

15 MS. POTTER: Can you all hear me?

16 CHAIR BELLA: Yes.

17 MS. POTTER: Okay. Hi. My name is Sarah Potter.

18 I'm from North Carolina. I'm a parent of a 34-year-old son

19 with cerebral palsy and member of a direct support

20 professional workforce group who is made up of legislators,

21 providers, and family members because we have a severe

22 shortage of direct support professionals, which is what we

1 call them in our state.

2 And one of the difficulties I find is we all need
3 data. In order to prove how bad the crisis is or to direct
4 policy and find solutions to the problem, we need that
5 data, but the data costs money. And there is no money in
6 the budget for funding the collection of that data and no
7 clear guidance at the federal level on what should be
8 measured, how it should be measured, how it should be
9 recorded, and then who analyzes.

10 So, if I have any recommendation to you all as
11 advisory committee, it would be to come up with a
12 recommendation at a federal level to give states guidance
13 in how to collect the critical data because I just feel
14 like change doesn't happen if we don't have the numbers in
15 front of us that tell us how bad this crisis is and the
16 implications it's going to have for the future, because I
17 can tell you right now, I'm 71 years old, and I'm the only
18 one that takes care of my son. I haven't been paid, and I
19 don't know what's going to happen.

20 When you talk about what to consider when there
21 is no one there to take care of these people, I worry about
22 we're going to go back to a reliance on institutional

1 settings or congregate settings where it's going to cost a
2 lot more money than that. So, we have to take into account
3 what it's going to cost us if we don't provide for these
4 critical home- and community-based services.
5 And thank you for letting me speak.
6 VICE CHAIR DAVIS: Sarah, thank you for taking
7 the time to join us and for what you do for you son and
8 also for the service you provide in North Carolina and for
9 sharing your comments with us.
10 MS. POTTER: Thank you for letting me.
11 CHAIR BELLA: Okay. Well, we appreciate it very
12 much.
13 Dennis?
14 COMMISSIONER HEAPHY: I guess I'm really glad
15 that Sarah spoke before I did because I think I just want
16 to echo what she's saying is it's important that we take
17 this slowly and that we really get all the datapoints
18 together before any recommendations are made about what's
19 actually going to lead to a robust workforce that's paid a
20 living wage, so rather than like a quick-fix solution.
21 Thanks, Sarah. I really appreciate the point you made.
22 CHAIR BELLA: Okay. Any other comments?

1 [No response.]

2 CHAIR BELLA: All right. Anne, anything you have

3 to say?

4 EXECUTIVE DIRECTOR SCHWARTZ: Nope. Thank you.

5 CHAIR BELLA: Okay. I hope you all have a safe

6 weekend. Thanks to all the folks in the audience who

7 joined us. Thank you to the Commissioners. Thank you to

8 Jim, the staff, and Anne, and we will see you all,

9 hopefully, in December. Bye-bye.

10 * [Whereupon, at 2:29 p.m., the meeting was

11 adjourned.]

12

13

14

15

16

17

18

19

20

21