PUBLIC MEETING

Via GoToMeeting

Thursday, September 23, 2021
1:00 p.m.

COMMISSIONERS PRESENT:

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KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

Session 1: Plans for the 2021-2022 report cycle

Anne Schwartz, Executive Director....................4

Recess..12

Session 2: Beneficiary preferences for communications regarding eligibility, enrollment, and renewal

Martha Heberlein, Principal Analyst and Research Advisor

Tamara Huson, Analyst................................12

Sean Dryden, Perry Undem.............................21

Session 3: Associations between state eligibility processes and rates of churn and continuous coverage

Linn Jennings, Analyst...............................66

Rob Nelb, Principal Analyst..........................72

Public Comment......................................94

Recess...101

Session 4: Medicaid in the U.S. territories: considerations for long-term financing solutions

Kacey Buderi, Senior Analyst........................102

Session 5: Medicaid levers to address concerns about the primary and specialty care workforce

Joanne Jee, Policy Director.........................130

Public Comment...155

Adjourn Day 1..158

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

2 [1:00 p.m.]

3 CHAIR BELLA: All right. Welcome, everyone.
4 Thank you for joining. We are kicking off our first public
5 meeting of this new work session, so very excited to have
6 everyone here today.

7 We're going to start just talking about plans for
8 our 2021-2022 report cycle just to kind of give everyone a
9 grounding in that and a framework to understand what we'll
10 be working on and what we'll be prioritizing, and for that
11 Anne Schwartz is going to lead us through the discussion.
12 Anne, I'll turn it to you.

13 **### PLANS FOR THE 2021-2022 REPORT CYCLE**

14 * EXECUTIVE DIRECTOR SCHWARTZ: Thanks, Melanie.
15 Next slide, please.

16 So as Melanie said, what we wanted to do for the
17 benefit of the public is to give you a sense of what we're
18 going to be working on over the course of this report cycle
19 leading up to our March and June reports. What you see on
20 the agenda today is only a portion of what we'll be taking
21 on. So, I'm going to talk about how we select the topics
22 and then go into some of the specific topics we'll be

1 working on in a few buckets, and then also just to
2 reinforce opportunities for stakeholders to engage with the
3 Commission.
4 Next slide, please.
5 So the topics. This is probably the thing I get
6 asked the most when I go out and talk with groups and
7 actually also when we're interviewing folks to join our
8 team. The topics that are on MACPAC's agenda come from a
9 variety of sources. Obviously, we have to be responsive to
10 specific requests from Congress, which may come in a
11 statutory charge or could come in a letter or obviously the
12 direction of the Commissioners -- I'm getting a lot of
13 feedback.
14 CHAIR BELLA: Yes.
15 COMMISSIONER BURWELL: Yes.
16 EXECUTIVE DIRECTOR SCHWARTZ: Are you getting
17 feedback now?
18 CHAIR BELLA: No. That sounds good.
19 EXECUTIVE DIRECTOR SCHWARTZ: Okay. So, topics
20 may arise from specific requests from Congress or direction
21 of Commissioners during the course of the meetings. Many
22 of the topics that we work on span a number of report

1 cycles, so we may take on background information first and
2 then move into policy options and recommendations in the
3 subsequent cycle. Or we return to a new nuance from a body
4 of work that we had previously established.
5 We also try to be looking ahead to what's on the
6 legislative or regulatory agenda so that we'll be prepared
7 to be useful to Congress, to the Secretary, to the states.
8 In addition, staff help identify issues.
9 Next slide, please.
10 So, the criteria for inclusion are fairly broad.
11 Obviously, it has to be an issue that people care about,
12 significant to the Commissioners and the stakeholders.
13 Within our statutory authority, which is under Section 1900
14 of the Social Security Act, there's a broad swath of issues
15 related to Medicaid and CHIP policy identified there.
16 It should be clearly defined in terms of what is
17 the policy question, the policy problem that we're trying
18 to interrogate and solve, amenable to analysis in that data
19 exist and evidence exists for the Commission to consider
20 and weigh. It should not be normative because Congress
21 typically does not need help with the normative questions.
22 And so it can also be addressed through changes in policy,

1 and then finally that it's feasible given MACPAC's
2 resources.
3 Next slide.
4 So, as we develop our background plan, just for
5 our own internal purposes, these are the buckets in which
6 we have some work planned for this year and which you'll be
7 seeing over the course of the year. And this is not a
8 public document because it keeps changing and morphing as
9 we go along, but this is how we try to organize ourselves.
10 Next slide.
11 So obviously anything that's congressionally
12 mandated is a must-do, and there are two items for the year
13 ahead that are in this category. One is a requirement that
14 was given to us under the 2021 consolidated appropriations
15 bill for us to look at whether the criteria for qualified
16 residences under the Money Follows the Person demonstration
17 should be aligned with the home and community-based
18 settings rule. I notice there's an asterisk here and on
19 this slide and other slides, it means that it's something
20 we're going to be talking about today or tomorrow. And the
21 second congressionally mandated item is our annual report
22 on the relationship between DSH payments and the number of

1 uninsured or uncompensated care costs. This is actually a
2 feature of our statutory authority, and we're required to
3 do this annually through fiscal year 2024. We'll be
4 talking about DSH in October.
5 Next slide, please.
6 So, I won't go through and read this slide, but
7 these are a series of areas, again, with asterisks
8 identifying topics that are on the agenda for this meeting,
9 others that you will be hearing about later in the cycle,
10 all of which build on prior work that we've done. It could
11 have been in last year's report or, for example, the work
12 on vaccines that we'll be talking about tomorrow afternoon
13 has not been featured in any of our reports this year, but
14 we spent some time in the last meeting cycle talking about
15 these issues.
16 Next slide.
17 Then there are some areas of new work, again,
18 with the asterisks indicating what we will be talking about
19 at this meeting. I want to particularly point out work on
20 home and community-based services rebalancing is not on the
21 agenda today, but we have a fairly robust work plan that
22 we'll be talking about as we go through the year around

1 benefit design, around the direct care workforce, and I
2 know that's top of mind for many Medicaid watchers at the
3 moment.
4 Some of these projects here may come later in the
5 cycle as we've relatively recently engaged contractors to
6 help us do some of the analysis and information gathering,
7 so stay tuned on that front.
8 This slide also does not reflect other things
9 that may come up, for example, responses to proposed
10 regulations. We're also required to comment on HHS reports
11 to Congress, or any other events that may crop up over the
12 course of the year may get added as we go along during the
13 meeting cycle.
14 Next slide, please.
15 So just to remind folks, and then for those who
16 are new to following our work, we'll be meeting in October,
17 December, January, March, and April, and pretty much any
18 topic that is on the agenda will come up at least two, if
19 not three to four times over the cycle, as the Commission
20 narrows its work and gets more focused.
21 To the extent that we want to make
22 recommendations in the March and June report, those will

1 happen no later than January meeting for the March report
2 and April for the June report.
3 And I just want to share with those who are in
4 the public and following our meetings, we very much want to
5 hear from you if you have perspectives that would enrich
6 our work. If you have data, that's fantastic. The earlier
7 in the cycle you can get to us, the better the chance that
8 we'll be able to incorporate that into our work. And you
9 can do that by reaching out to key staff. If you're not
10 sure which staff to reach out to, you can reach out to me.
11 If you go to our website, there's "About MACPAC" and a
12 listing of the staff. It has all our email addresses
13 there. Or you can always send information to
14 comments@macpac.gov or comment during the public meeting.
15 Staff are taking meetings virtually, and that is an
16 invitation I also want to extend to stakeholders as well.
17 Next slide, please.
18 Well, this slide does not belong in my
19 presentation. You will see it again later.
20 I think that concludes my presentation, so if you
21 can take it down, Jim, that would be fine. Thank you.
22 Always a surprise in a public meeting.

1 Anyway, happy to take any questions from the
2 Commission, and I'll turn it back to you, Melanie.
3 CHAIR BELLA: Thank you, Anne.
4 I'll open it up. Does anyone have questions,
5 comments, clarifications from Anne?
6 [No response.]
7 CHAIR BELLA: This might be a first.
8 EXECUTIVE DIRECTOR SCHWARTZ: It's okay. We
9 don't need new items put on the agenda right now.
10 CHAIR BELLA: We don't need new items, but I
11 always want to make sure no one leaves the discussion with
12 a question they haven't asked.
13 [Pause.]
14 CHAIR BELLA: Okay. Well, we can move -- we do
15 have a panel on the next session, Anne, so I'm not sure
16 that we can start as early as this is. Do you know?
17 EXECUTIVE DIRECTOR SCHWARTZ: I think that we can
18 go ahead because staff will be doing -- let's see. We
19 still have 20 minutes. Maybe let's just take about a 10-
20 minute quick break here to pause, and then staff can start
21 because the first part of that presentation is from MACPAC
22 staff, not from our guest.

1 CHAIR BELLA: Okay. I will ask everyone to
2 rejoin at 1:20, and we'll get started with the next session
3 on beneficiary preferences for communications. Thank you.
4 * [Recess.]
5 CHAIR BELLA: All right. Welcome, everyone.
6 We'll go ahead and get started.
7 Martha and Tamara, nice to see you. Welcome. I
8 will turn it to you to get us started and provide the
9 context and then introduce our guests, and we'll hear from
10 him, and then we'll have some Commissioner discussion and
11 questions, so very excited for this session. It's all
12 yours.
13 **### BENEFICIARY PREFERENCES FOR COMMUNICATIONS**
14 **REGARDING ELIGIBILITY, ENROLLMENT, AND RENEWAL**
15 * MS. HUSON: All right. Thank you, and good
16 afternoon, Commissioners. I'm pleased to be here today to
17 share with you the findings of work that we've conducted
18 over the past six months on beneficiary preferences for
19 communication during the eligibility, enrollment, and
20 renewal processes.
21 So, we took a two-pronged approach to this work.
22 I will start off sharing the findings from our stakeholder

1 interviews, and then I'll pass it over to Sean Dryden from
2 PerryUndem to share the findings from the beneficiary focus
3 groups.
4 MACPAC contracted with PerryUndem so that we
5 could hear directly from beneficiaries about their
6 experiences and preferences for the use of technology
7 during these processes. I'll then wrap up the presentation
8 with a few overarching key themes that came out of these
9 two complementary streams of work.
10 But, first, a little bit of background on this
11 topic. State Medicaid agencies must allow individuals to
12 submit applications, renewal forms, and other necessary
13 information by phone, mail, in person, and online. All
14 states have online Medicaid applications, and in 22 states,
15 online applications are the predominant mode of submission.
16 Forty-three states also offer online accounts that can be
17 used to report changes, submit documentation, or renew
18 coverage.
19 States must provide applicants and beneficiaries
20 with timely and adequate written notice of any decision
21 affecting their eligibility. Notices must be written in
22 plain language and be accessible to individuals who are

1 limited English proficient and to individuals with
2 disabilities. States are also required to give
3 beneficiaries a choice to receive notices in electronic
4 format or by regular mail. In 33 states, beneficiaries can
5 opt to go paperless and receive notices electronically.
6 Most Medicaid enrollees own smartphones, and many
7 rely on their phone for internet access and to complete
8 tasks such as applying for benefits or applying for jobs.
9 Dependence on smartphones for online access is more common
10 among younger and lower-income individuals, with 26 percent
11 of households with incomes below $30,000 a year being
12 smartphone-dependent.
13 As such, it is particularly important that states
14 offer mobile-friendly websites, applications, and accounts.
15 Forty-four states allow individuals to submit applications
16 via a mobile device, yet only 20 have a mobile-friendly
17 design for their applications and only 23 states have
18 mobile-friendly designs for their online account.
19 Beneficiaries' abilities to use online tools is
20 limited by a lack of access to high-speed broadband service
21 at home, the affordability of internet service or devices
22 such as smartphones and computers, and a lack of mobile-

1 friendly applications and websites. For example, adults
2 with annual household income below $30,000 are less likely
3 than higher-income adults to use the internet, and almost
4 half do not own a computer or have broadband service.
5 People who are Black, Hispanic, and live in rural areas are
6 also less likely to go on the internet. Many states are
7 also not keeping pace with changing technology, so
8 beneficiaries may not have the option to use other forms of
9 communication such as receiving text messaging reminders at
10 renewal.
11 We conducted stakeholder interviews to gain a
12 richer understanding of communication practices across
13 states, such as facilitators and barriers to states
14 providing effective communication, and to learn how states
15 are leveraging technology. We conducted 28 interviews
16 between April and July of this year with state and federal
17 officials, beneficiary advocates, legal aid organizations,
18 provider organizations, nonprofits, and other national
19 experts. We spoke with state officials and state-level
20 groups in six states that differed in terms of geography
21 and use of technology. These six states were Florida,
22 Kentucky, Louisiana, Michigan, Missouri, and Texas.

1 This slide highlights some of the characteristics
2 of state use of technology that we considered when
3 selecting states for this project. We wanted to include
4 early adopters of online applications and electronic
5 notices, those taking innovative approaches to beneficiary
6 communication, as well as those using more traditional
7 methods and those that have made fewer improvements.
8 We targeted several states that are currently
9 working to expand the use of technology or have had recent
10 initiatives. For example, Louisiana recently conducted a
11 text messaging pilot and held a showcase to hear directly
12 from vendors about innovative strategies for communicating
13 with beneficiaries. Michigan and Missouri have worked with
14 a contractor called Civilla to update their applications
15 and notices.
16 One of the themes that we heard consistently in
17 all of our stakeholder interviews was how multiple modes of
18 communication, for application and accessing information,
19 are needed to reach beneficiaries who have different
20 communication preferences and different comfort levels with
21 technology. In five of the six states that we spoke with,
22 we learned that the online application was the most

1 frequently used, while in the sixth, paper and phone
2 options were the predominant methods. State officials and
3 other stakeholders, however, noted that all the available
4 methods for applying for Medicaid are used and that the
5 requirement that states offer these multiple options is
6 important for maximizing accessibility.
7 And we found the same was true for notices.
8 While not all states offer electronic notices in practice,
9 the ability for beneficiaries to receive notices online was
10 noted as an important tool for timely communication.
11 Electronic notices reach beneficiaries faster than paper
12 notices. And while paper notices are the primary way that
13 states send information on enrollment and renewal to
14 beneficiaries, many stakeholders noted issues with mailed
15 notices such as postal delays that result in beneficiaries
16 not receiving notices with adequate time to respond to
17 requests for information. Also, because Medicaid
18 beneficiaries may move frequently, states often struggle to
19 maintain accurate contact information, so notices may not
20 reach beneficiaries at all.
21 Ultimately, beneficiary preferences for mode of
22 communication and use of technology varied. For example,

1 stakeholders noted that more tech-savvy individuals may
2 choose the paperless option for notices while others still
3 prefer paper notices. We also heard that certain
4 populations such as older adults may not be computer
5 literate or comfortable using technology and, thus, prefer
6 paper or phone options, and focus group participants echoed
7 these comments, which you'll hear shortly.
8 State capacity for making improvements varies,
9 but all states faced constraints in adopting new
10 technology. State officials cited multiple barriers,
11 including constraints on funding, constraints on staff
12 time, having limited numbers of eligibility workers, and
13 changing state administration priorities.
14 Each of the six states we spoke with use
15 technology in different degrees. Florida and Texas, for
16 example, were early adopters of online applications and
17 electronic notices but have made few improvements since the
18 implementation of the Affordable Care Act. State officials
19 and others noted the enhanced federal funding from the ACA
20 to modernize systems as helpful, but that more recently,
21 state funding has constrained their ability to make
22 additional improvements.

1 On the other hand, Michigan and Louisiana are
2 examples of states that have made more recent changes and
3 are testing innovative approaches. Michigan had one of the
4 longest paper applications in the country but in 2015 began
5 working extensively with a contractor, Civilla, to redesign
6 its application. It rolled out its new application in
7 2017, which was 80 percent shorter, took most applicants
8 less than 20 minutes to complete, and decreased the time
9 caseworkers spent correcting errors by 75 percent. The
10 state applied what it learned from that effort to also
11 redesign its online multi-benefit application, and they
12 also found with the redesign that the amount of time it
13 took for applicants to complete it decreased by 50 percent.
14 As one other example, Louisiana conducted a text
15 messaging pilot with Code for America in 2019 to send text
16 message reminders to beneficiaries during the eligibility
17 and renewal processes, and after seeing good results from
18 the pilot, state officials said they plan to adopt the
19 functionality, although Louisiana has not yet implemented
20 the change. And for additional details and state examples,
21 you can see your meeting materials.
22 While we had not initially planned to probe

1 regarding the content and timing of notices, many of the
2 advocates, legal aid, and provider organizations that we
3 spoke with raised issues with notices, including their
4 readability and the time afforded to respond to requests
5 for information.

6 We heard from many stakeholders that
7 beneficiaries find notices confusing, and next steps are
8 often unclear to them, and therefore, they need help
9 interpreting or responding to notices. Such issues have
10 also been noted in prior MACPAC work.

11 CMS has put out model notices, most recently in
12 2017, but it's not clear if states are using them.

13 Stakeholders also raised concerns about the
14 amount of the time that people have to respond to requests
15 for information, which in four of the states we spoke with
16 was 10 calendar days, in one it was 10 business days, and
17 in the last it was 30 days. Stakeholders advocated for
18 making the time frame longer, ideally aligning with the 30
19 days that people have at renewal.

20 Furthermore, with paper notices, we heard from
21 many stakeholders that by the time a letter arrives in the
22 mail, it can leave people with just a few days to gather

1 documents like paystubs or bank statements, which can be
2 challenging. Notices can also get lost in the mail.
3 Interviewees noted that the use of electronic
4 notices addressed some but not all of their concerns
5 because, again, not all beneficiaries have access to or are
6 comfortable using technology.
7 And with that, I will now pass it over to Sean to
8 share with you the findings of the focus groups.
9 * MR. DRYDEN: Hi, everyone. Thanks, Tamara.
10 You can actually go to the next slide. I'll
11 start there.
12 So, let me just give a little background.
13 Oh, just on Slide 16. Yep. Okay, perfect.
14 So, MACPAC commissioned nine online video focus
15 groups with Medicaid beneficiaries or a caregiver
16 representative of Medicaid beneficiaries. These were
17 conducted from May to July 2021 by PerryUndem, which is
18 where I work, a nonpartisan research firm. We've worked
19 with MACPAC in the past.
20 This work, we thought it was really important to
21 try to hear the beneficiary voice and hear how they talk
22 about communication and all of those processes. We focused

1 on four states: Florida, Louisiana, Michigan, and Texas.
2 These states were selected to align with MACPAC's larger
3 work.
4 We held two groups each in each state, two groups
5 in English in Florida, in Louisiana, Michigan, and Texas,
6 and additionally, we held one group in Spanish with Latino
7 and Hispanic participants from both Texas and Florida.
8 Each focus group lasted about 90 minutes, and it
9 included five to seven participants. We tried to make --
10 and we're doing this as we do all kind of online research
11 now since the pandemic. We try to make it as accessible as
12 possible. Participants could join by phone or by video
13 from laptops, desktops, mobile phones. Still, we have to
14 acknowledge that this research might not be representative
15 of the larger Medicaid population because not all
16 beneficiaries have access to the kind of technology needed
17 to participate in either the focus group or the focus group
18 recruitment process, despite all efforts to try to hear as
19 diverse voices as we can.
20 On the next slide, let me just give a quick
21 background on kind of the mix of these beneficiaries. Each
22 group included a mix of participants based on gender, age,

1 city or town size, how long they've been in the Medicaid
2 program, as well as a mix of race and ethnicity.
3 We had a number of participants who have chronic
4 conditions, other who don't have chronic conditions. Some
5 of those who did talked about having diabetes, dealing with
6 high blood pressure, cholesterol, chronic pain, mental
7 health conditions, a number of other things, and many of
8 the folks that we spoke to are taking prescription
9 medications regularly. As I mentioned, the Spanish-
10 speaking Latino group had a mix of participants from
11 Florida and from Texas.
12 We had a mixture of folks. We had 7 of the 53
13 total participants who have just been enrolled since 2020,
14 another 21 who have been enrolled between 2015 and 2019,
15 and then 25 who have been enrolled since 2014 or earlier.
16 So, we had a real mix of Medicaid tenure.
17 We also, as I mentioned, had 10 caregivers.
18 These are folks who do not have -- or are not Medicaid
19 beneficiaries themselves. They are just close family
20 members, adult family members who assist either older
21 parents or other relatives with the Medicaid process in
22 terms of helping with enrollment, renewal, and everything

1 that comes along with that.

2 So, let's move to Slide 19.

3 So just general context around the Medicaid
4 program, beneficiaries appreciated Medicaid. They said it
5 provided health coverage that would otherwise be
6 unavailable to them. Most participants had a positive
7 impression of Medicaid. They said it allowed them to
8 access care at little to no cost. Nearly all of the
9 participants said they would like to continue with Medicaid
10 coverage, if possible, but we did hear some who were
11 worried about surpassing the income threshold required to
12 qualify if their circumstances changed.

13 Despite the largely positive impressions, we
14 heard some who expressed concerns about the program such as
15 some doctors not accepting Medicaid coverage, issues with
16 transportation and getting to providers, and a few talked
17 about how they were treated by some in the system,
18 providers or office staff or caseworkers, et cetera.

19 But a quote from a Florida man, which I think
20 summed up pretty well a lot of what we heard in these focus
21 groups, he said, "Overall, I'd say it's pretty positive.
22 I've had Medicaid my whole life. I was born disabled, so

1 I've gotten used to it, and I've been through a lot of
2 experiences where I've had to learn about the different
3 parts of Medicaid and what it can do, what it can't do.
4 Overall, it does what it needs to do, and it gets me what I
5 need."
6 On the next slide, I just wanted to briefly touch
7 on just the general comfort with technology from the
8 Medicaid beneficiaries and caregivers we spoke with.
9 Nearly all participants said they have smartphones, and
10 most had a laptop, desktop, or tablet. They generally felt
11 comfortable online, and most had little to no problems
12 using technology. Still, they found that online was not
13 always the fastest or most dependable way for them to
14 access information. Individuals said that sometimes their
15 technology or the internet access where they live could be
16 unreliable, which creates challenges. And despite the
17 comfort of the folks that we spoke to in these focus
18 groups, many participants also acknowledged that there are
19 others that do not have access or the ability to use
20 technology, and they were particularly worried about older
21 adults.
22 A Michigan woman said, "I still have a barrier,

1 but I had a flip phone, flip phone up until three months
2 ago. My children bought me a phone. It's not a smartphone
3 or whatever you call it, but I've been learning and
4 learning and learning. But I'm still on my landline. If I
5 could do without, I'll try to do without. I'm 61. It's
6 just sometimes you can't teach an old dog new tricks." So,
7 this kind of spoke to, I think, despite that comfort of
8 technology with the folks that we spoke to in the focus
9 groups, this overarching concern about some other
10 beneficiaries, particularly older adults, that might have
11 challenges with technology.
12 Next slide. Around the enrollment methods,
13 participants said that there should not be a one-size-fits-
14 all approach to the enrollment process. They said it was
15 important that people had different options for how to
16 enroll and renew in the Medicaid program. They thought
17 that people needed an option that works best for them.
18 Most participants applied either online or in person, with
19 just a few applying over the phone. We heard from
20 beneficiaries in the focus groups who used a combination of
21 approaches to complete the application process, possibly
22 starting online and calling over the phone and finishing in

1 person or some combination of all of those, but there were
2 beneficiaries that did not just use one method to get
3 through the whole process.
4 Generally, those who applied longer ago were more
5 likely to have applied by mail or in person. For the more
6 recent applicants, in our focus groups, they were most
7 likely to have done all or part of their application
8 online.
9 We heard from a Michigan woman who said, "I tried
10 to figure it out online first, and then if I couldn't
11 figure it out myself online, I would probably go and make a
12 phone call and just keep pressing zero until I get to talk
13 to somebody." So that was kind of the sentiment we heard,
14 this kind of first step of trying online, but if that
15 doesn't go well, they wanted other options to be able to
16 get through the process.
17 Next slide.
18 In terms of the ease of the enrollment process,
19 participants who applied for Medicaid online generally said
20 it was quick and easy. They were able to navigate the
21 process without too many issues. The online system for
22 folks was seen as a big improvement. For those who had

1 applied by other means initially but then had left the
2 program for months or a couple years and then started that
3 -- and then when they reapplied, it was an online process;
4 they felt that that online system was a big improvement
5 from the initial ways that they applied.

6 Those who said the enrollment process was more
7 difficult, frustrating, or time-consuming usually had
8 applied in person, by mail, or over the phone, but, still,
9 most of those folks did so without any real issues.

10 Participants who found enrolling more difficult,
11 regardless of the method in which they enrolled, often said
12 that there was too much information to provide or too many
13 questions to answer. So, it was less about the actual
14 method of online, in person, over the phone, and more about
15 the information that was required to kind of get through
16 the enrollment process.

17 We heard from a Louisiana man who said, "I feel
18 really good about it. It was easy; it was user friendly.
19 They didn't ask a lot of information that you didn't have
20 on hand. The format of the website was easy to use, so it
21 made it really easy."

22 Next slide.

1 So, in terms of the ease of the renewal process,
2 most described the renewal experience as pretty quick and
3 simple. Participants who were comfortable with technology
4 considered the online renewal system to be convenient.
5 They often said that the renewal process was easier than
6 the initial enrollment process. This was due to many
7 factors. Largely one of these that we heard was already
8 knowing the documents that they would need; they had gone
9 through this process once; they were more aware of what
10 they had to have to go through the renewal process.
11 Many of those who originally renewed on paper, in
12 person, or by mail felt that the online renewal system was
13 much more streamlined. As an example, they talked about
14 the information already being pre-populated when they went
15 through the renewal process online.
16 Some reported that they had automatic renewal,
17 but even those without the automatic renewal process
18 generally felt that their renewal went through quickly.
19 A Texas woman we heard from said, "I feel like
20 the renewal process was a lot easier than the initial
21 enrollment process. They didn't require as much from me.
22 It didn't take as much time, as much energy, effort,

1 thought. It was just a lot easier to renew than it was to
2 enroll."
3 Next slide.
4 In terms of enrollment and renewal challenges,
5 participants, as I mentioned, still experienced some
6 challenges. Most notably submitting documents was the
7 common issue. For example, participants spoke of having to
8 go to a library or resource center, possibly to print out
9 or fax or scan documents or having to do so from work.
10 Also, as I mentioned, gathering documents was difficult
11 too, with a few who mentioned having to seek documentation
12 from landlords or past employers. That was time-consuming
13 or challenging as they went through it.
14 A few also mentioned difficulties answering
15 questions on the application that did not seem to apply to
16 them or did not have an easy answer. These issues
17 sometimes delayed their application being completed or
18 accepted.
19 A Texas woman said, "Taking pictures of the
20 documents and trying to send it. The hardest part is
21 trying to make sure that it's a certain way because then
22 they say, ‘Oh, it's not uploaded right.' The computer will

1 actually not allow it to be uploaded if it's not clear, so
2 like that portion of it was kind of hard." So, again, just
3 these challenges with actually gathering and submitting the
4 documents were the main things that we heard from folks.
5 Next slide.
6 So, in terms of the issue of going paperless,
7 participants were worried that it would be a problem for
8 some beneficiaries if all Medicaid communications moved
9 online. So, although most states -- although states must
10 provide enrollees the option of going paperless,
11 participants pushed back against the idea of state Medicaid
12 programs requiring paperless communications with
13 beneficiaries. They noted that a paperless system would
14 disadvantage those who did not have access to technology or
15 were not familiar, comfortable, or able to use an online
16 process, particularly older adults. Many also liked having
17 a hard copy themselves for easy recordkeeping, ability to
18 maintain a paper trail. They worried that emails could go
19 to spam, get deleted, or be difficult to find and pull up.
20 We also heard from other beneficiaries who were
21 simply more comfortable with mail, making a phone call, or
22 going in person to manage their Medicaid.

1 A Louisiana man said, "I think a lot of us
2 younger crowd prefer online applications, but the big thing
3 is we're talking about health care. It's got to be
4 accessible for, you know, folks around the state that don't
5 have internet access, they can't afford a smartphone and
6 stuff like that. I think that is really important."
7 Last couple slides for me. A couple other
8 communications tidbits. Participants said they got hard
9 copy renewal reminders, but they also thought email and
10 text reminders would be helpful. Nearly all participants
11 received their renewal notices and reminders by mail. Some
12 got email notifications or text alerts to visit their
13 online accounts. Others said they would like their states
14 to send those alerts. Many also mentioned they'd like to
15 see more reminders of upcoming renewal deadlines to help
16 reduce the chance that they'd forget to take action. Many
17 had an online Medicaid account, but they said they rarely
18 used it for anything other than the renewal process.
19 Still, there was an overall sentiment that they felt
20 confident that they would be able to use their account for
21 other things if they needed to, but generally they didn't.
22 There was little familiarity with the state

1 Medicaid mobile apps in a couple of the states where it was
2 offered where we held focus groups, and only a few
3 participants had actually used these mobile apps.
4 I will skip the quote there and let's go to the
5 last slide.
6 So just in closing, as I wrap up, as I mentioned,
7 beneficiaries wanted a broad range of communication
8 options. Participants believed that all Medicaid
9 beneficiaries should have different enrollment and renewal
10 options available and accessible to them. They felt that
11 online access had made the Medicaid process easier and more
12 streamlined over the recent years, which they appreciated.
13 But they also valued having the option of in-person help,
14 talking to someone over the phone, or enrolling or renewing
15 through the mail. And for some, these options were
16 preferable. And as I touched on, they were also wary of
17 everything moving paperless because of concerns that some
18 people, usually not those in the focus groups but other
19 people, especially older adults, would be unable to access
20 online tools.
21 So as a final point, a Florida woman we heard
22 from said, "My mom is not computer savvy, so she still

1 needs these letters in the mail. She can't go online and
2 do the things that I do. It's not for everyone."
3 So, I will turn it back to Tamara for her final
4 slides, but I appreciate getting to share this with
5 everyone.
6 MS. HUSON: Okay. Thank you, Sean.
7 I have just two slides to kind of summarize our
8 key takeaways. So, the results of this work support the
9 current requirement of having multiple channels of
10 communication. Interviewees and focus group participants
11 alike all noted that, given varying preferences and comfort
12 levels with technology, individuals need multiple
13 mechanisms to apply and renew coverage. Improvements that
14 states have made are particularly helpful for those that
15 are tech savvy as they have access to a variety of tools
16 such as the online applications and accounts and electronic
17 notices that align with their preferences.
18 It's important to note, however, that paper-based
19 communication and ongoing assistance over the phone or in
20 person with caseworkers or community-based organizations
21 are necessary resources for many, particularly for those
22 with more complex circumstances.

1 Not all states are keeping pace with changing
2 technology. Most state officials noted an interest in
3 continued enhancements, and while some states are taking
4 active steps, others commented on limited state capacity
5 and implementation challenges as the principal barriers to
6 improving communication. And while no one particular
7 policy change was highlighted as a barrier to improving
8 communications, stakeholders raised some areas of concern
9 that may warrant further Commission work, such as improving
10 the content and timing of notices.
11 Staff would appreciate feedback on whether the
12 Commission is interested in pursuing additional work in
13 these or other areas.
14 Finally, we anticipate publishing an issue brief
15 summarizing the findings of our work and an accompanying
16 contractor report from PerryUndem detailing the findings
17 from the focus groups this fall.
18 And so with that, I will turn it back over to the
19 Chair. We're happy to answer questions, and we look
20 forward to your comments. Thank you.
21 CHAIR BELLA: Thank you, Tamara. And, Sean,
22 thank you for being here and for the work that you all did.

1 Really, really thought-provoking, I think, for us and
2 always good to hear from real people that are using the
3 program.
4 I have a few thoughts that I'm happy to hold and
5 turn it to the Commissioners for questions and comments.
6 Kisha, why don't you kick us off?
7 VICE CHAIR DAVIS: All right. Thanks. I just
8 want to say I really want to express appreciation for the
9 extent that you guys went to really capture the diversity
10 of patient voices. You know, doing a panel in Spanish,
11 making it -- you know, different levels of access
12 available, whether that be by mobile device or phone or
13 laptop and still recognizing even that, you know, creates a
14 challenge, especially because they're not in person.
15 Also, you know, this is really important work and
16 thinking about, you know, how we bring their voice in and
17 the different ways to communicate. And I think just an
18 overarching theme here is really bringing in the patient
19 voice into Medicaid and how we start to do that in a more
20 robust and standardized way. You know, we're seeing more -
21 - we have -- there's the Medicaid CAHPS survey, and that
22 was done, but it's still not on -- you know, that patient

1 voice is not brought in on a regular basis, and really we
2 need to -- you know, this a study to start to do that, and,
3 yes, it was to look at how we communicate enrollment. But
4 I think that really broader issue of how we're continually
5 and regularly bringing in that patient voice is an
6 important theme.
7 CHAIR BELLA: Thank you, Kisha. Darin?
8 COMMISSIONER GORDON: Yeah, I totally agree with
9 Kisha's comments. I did have a question, and I wasn't
10 clear from the summary. So, if a state was offering the
11 application process through multiple channels, including an
12 online or mobile pathway, were they also always offering a
13 similar pathway for reverification?
14 MR. DRYDEN: Tamara, do you want to answer that?
15 MS. HUSON: Yeah, I think I can answer that.
16 COMMISSIONER GORDON: I'm trying to -- basically
17 following through, not just of the initial application, but
18 also renewals using multiple channels. Or does that -- is
19 there a shift, like renewals they don't offer the same
20 number of channels to each of the members?
21 MS. HUSON: So states are required to offer all
22 the options, and all states have online applications. For

1 renewals specifically, I don't know that we have the actual
2 number of states that offer an online renewal option.
3 Martha, you can jump in if that's incorrect. But I do
4 believe that most states offer online renewal, and they're
5 also mailing home the paper reminders and oftentimes the
6 pre-populated form.

7 COMMISSIONER GORDON: I'm hypersensitive to
8 redetermination, obviously, since that's something that's
9 going to be front of mind for all of us as the PHE ends,
10 and I will remember back when we didn't have a system that
11 was capable of doing a lot of online or mobile options.
12 And most of the discussion I had heard even then was with
13 the initial application. But it seems from the comments
14 that Sean highlighted, you know, folks talking about the
15 renewal process generally was easier than the initial
16 process, but I was just curious whether or not they offered
17 as many channels at renewal than they do at initial
18 enrollment -- again, given the fact that, you know, we're
19 about to go through a massive redetermination process when
20 the PHE ends.

21 CHAIR BELLA: Maybe that's something you take
22 back and confirm for us outside of this discussion, if

1 that's okay. Does that work, Anne?

2 MS. HUSON: Absolutely.

3 CHAIR BELLA: Okay. Tricia and then Martha and

4 then Brian.

5 COMMISSIONER BROOKS: Thanks for this work, and

6 as you all know, it gets to the heart of the work that I

7 do.

8 I just wanted to respond to Darin's question.

9 When we conducted the full eligibility enrollment survey in

10 2020, which was the source for some of this data on the

11 slides you saw, of the 43 states that offer online

12 accounts, only 39 allow you to renew in that online

13 account. So, I do think that there are a handful of

14 states, Darin, that don't yet have a great online mechanism

15 for renewals because it would most likely fall into that

16 online account.

17 Now, we did not update these data in 2021 because

18 of the pandemic and knowing that processes were very

19 different, so a couple of states may have picked things up

20 from there. But I do think you're going to find a few

21 states falling short.

22 And then there are a couple of states that

1 actually don't offer all four pathways but really push
2 beneficiaries to doing it only online. Florida comes to
3 mind. I think Oklahoma does a lot of that. But I think
4 there's still work to be done. And when we asked the
5 states about the mobile friendliness of their applications,
6 online accounts, or whatever, some of them that say, sure,
7 you can submit mobilely, we don't do anything to stop, you
8 know, a smartphone or a smart device from sending in an
9 application, but without the mobile-friendly formatting,
10 there's no guarantee that that application or renewal is
11 going to be able to be used, particularly in a smartphone
12 environment. So there's still more work to be done on that
13 front as well.
14 CHAIR BELLA: Thank you, Tricia. Martha?
15 COMMISSIONER CARTER: I agree. I think this is a
16 really important area to look into. In addition to the
17 ways, sort of the technology, I was interested in looking
18 at readability, you know, if it's written in plain language
19 that the person can understand. I'm interested in looking
20 at how states are required to and are actually serving
21 people with limited English proficiency. Are they required
22 to have an interpreter, translation of materials? I think

1 this is -- you know, really getting the beneficiary voice
2 in here would mean that we would need to ask all those
3 questions: Braille, you know, hearing impaired. How are
4 those people really being served?
5 CHAIR BELLA: Thank you, Martha. Brian?
6 COMMISSIONER BURWELL: So I have a number of
7 questions. One, in addition to the enrollment -- or the
8 renewal process itself, did you try to get any information
9 about the degree of technical assistance that states offer
10 to renewal applicants, either -- I mean, are there
11 tutorials available at the online application that will run
12 people through the re-enrollment process in a very simple
13 manner that they can learn from? Also, I'm curious about
14 the quality of the information that people receive by
15 phone, if they have questions and have to, you know, do the
16 call center. I heard one thing about, "I keep pressing
17 zero until I get somebody." You know, how difficult is
18 that? And when you get somebody, what is the status -- you
19 know, what is the consumer experience when they get
20 somebody on the phone? Things like that. So that's kind
21 of one question as the technical assistance component.
22 Two, I personally -- this is not an area of my

1 expertise -- would like if we do an issue brief, provide
2 more basic background data about what is required in the
3 re-enrollment process. How often is -- what flexibility do
4 states have in terms of frequency of re-enrollment? Does
5 it vary by population, et cetera? Just kind of, you know,
6 what -- there's some automatic renewals, I understand.
7 Some people really don't have to apply for re-enrollment;
8 they are automatically renewed, for example, if they're
9 receiving SSI or something like that. So that I think
10 would be helpful to a reader of work like this.
11 CHAIR BELLA: Thank you, Brian.
12 Heidi?
13 COMMISSIONER ALLEN: I'm a survey researcher who
14 surveys low-income populations, and so this whole
15 discussion really resonates with me because it's a
16 challenge to get in touch with people, particularly
17 populations that move a lot.
18 And I'm wondering what states can learn from
19 survey researchers in terms of best practices for reaching
20 people, and one of the things that I'm curious about are
21 the more active efforts. So, I understand that people are
22 being contacted through text messages. I assume email.

1 I'm curious if the links are embedded in the emails or the
2 text messages that take them right to where they need to be
3 or is it just the notice that you have a message in your
4 online Medicaid portal and you need to go check it.
5 So the content of that, I think, really matters,
6 and then also the context of the maintenance of effort in
7 the public health emergency, I'm wondering if the methods
8 that are used in panel research to try to keep in touch
9 with people and give them lots of opportunities to update
10 addresses, lots of opportunities to get multiple contact
11 information, including one of the things we often use in
12 survey research is if we can't reach you, who knows how to
13 find you, so secondary contacts.
14 So, anyway, those are my thoughts.
15 CHAIR BELLA: Does anyone want to respond to
16 Heidi?
17 MR. DRYDEN: I'm sorry. I wanted to respond to
18 the previous question, just because I thought I could add a
19 couple things on that before.
20 In terms of the tutorials, I don't know if Tamara
21 or Martha know about what the actual -- how the states
22 function in terms of that stuff. We didn't hear really any

1 about that in the focus groups in terms of what's available
2 for folks.
3 The call center question, again, the sample size
4 gets really small, and it's qualitative to begin with, but
5 a few people used the call center, and with any call center
6 talk that we hear in any focus groups, I think it's very
7 mixed, and it kind of just depends on that person's
8 experience.
9 So, I'm not sure if you guys have larger data on
10 any of the surveys you've done and additional time to
11 explore that, but some people had good call center
12 experiences, some bad. I think it probably depended on
13 just who they were talking to, and I'm sure there's a lot
14 more to learn from that, state specifically, but I just
15 wanted to touch on that quickly.
16 CHAIR BELLA: Great. Martha or Tamara, do you
17 have anything to say on Heidi's point or questions about
18 any of that?
19 MS. HUSON: So we didn't look specifically at the
20 content of emails or text messages. However, we did speak
21 with Code for America who has conducted some of these text
22 messaging pilots, and they actually provide some templates

1 and samples and messages that they've sent. So I'd be
2 happy to share some of those resources with you, Heidi.
3 But you can see in some of those pilots that
4 they've done that they do link to the website for the
5 application or to the Medicaid website. And then what we
6 really talked about and heard from stakeholders is the
7 emails was more so, the use of emails to send notification
8 to beneficiaries, that they have a notice to view in their
9 online account because those emails cannot contain any
10 personal information in the email itself. They have to log
11 into the account, which is a secure portal, in order to get
12 that information.
13 CHAIR BELLA: Heidi, did you have any follow-up?
14 COMMISSIONER ALLEN: I would just say that
15 logging into portals, it just depends on how easy that they
16 make that. If they do it like a health care system where
17 you're required to have a code that comes via letter that
18 you then -- you know, the kind of more secure methodology,
19 I can see where that would be a barrier. And it seems like
20 the more direct that link is to their actual case the more
21 efficient that that would be.
22 MS. HUSON: And we did hear from a few

1 stakeholders -- oh, sorry, Martha. I was just going to say
2 we did hear from a few stakeholders issues around accessing
3 those accounts, around the identity proofing that's
4 required to have an account, and then we also heard issues
5 about people not remembering their usernames and passwords.
6 In one state, you were able to make multiple accounts, and
7 then you would get locked out. You wouldn't be able to see
8 your original application. So we did hear some issues
9 around that.
10 CHAIR BELLA: Martha, did you want to add
11 anything?
12 MS. HEBERLEIN: Yeah. The only thing I was going
13 to add is in the focus groups -- and, Sean, you should jump
14 in here -- that we also asked about online accounts and if
15 there was trouble logging in, and so we heard, I think,
16 slightly different things from the focus groups where some
17 folks did get locked out and had to get another account or
18 get a password reset. But a lot of folks said, "Oh, no, I
19 can keep going back into my account. I know it's the same
20 password I use for everything sort of thing." So I think
21 it was a mixed experience, and I think that that goes to
22 show a little bit more about the fact that some folks were

1 tech savvy and maybe know how to use the system and are
2 familiar, have a more comfort level with it. I think
3 there's also different states have set it up differently.
4 So there may be different issues, depending upon which
5 state you're in.
6 CHAIR BELLA: All right. Thank you.
7 Go ahead, Sean.
8 MR. DRYDEN: No, no.
9 CHAIR BELLA: Okay. Toby and then Laura.
10 COMMISSIONER DOUGLAS: Great presentation and
11 great information.
12 The question I have -- or partly a question,
13 partly statement -- relates more to if you saw any
14 differences between states with more of a county-based
15 eligibility versus state. I mean, clearly the technology
16 and the advances in technology have created more of a
17 unified process, but it would be interesting if there was
18 anything now or we should be teasing out more of how the
19 difference in the eligibility processes are going on in
20 terms of the people and who is accountable for doing it are
21 impacting that communication and the ability to communicate
22 in the right way.

1 I don't know if there's anything from the
2 interviews that that came out.
3 MS. HUSON: None of the six states that we
4 selected for this project have the county-based system,
5 although I'll ask Martha to jump in here because I believe
6 previous work that MACPAC has conducted may have looked at
7 a state with a county-based system in eligibility.
8 MS. HEBERLEIN: Yes. Some of the work we did
9 prior with SHADAC had looked at North Carolina and
10 California, which both -- well, depending on how you define
11 California as county-based, and they had -- we definitely
12 heard that there were different issues, depending upon --
13 in North Carolina specifically in terms of the state had
14 put in some sort of parameters around processing that --
15 [Pause.]
16 CHAIR BELLA: Martha, we lost you. We lost your
17 audio.
18 MS. HEBERLEIN: Sorry. It said I was muted by
19 the organizer, so sorry if that was my fault.
20 So I don't know what you heard, if anything.
21 I'll start from scratch. We had done some work prior with
22 SHADAC that looked at some states that had county-based

1 systems. So, in our prior study, we looked at California
2 and North Carolina, and North Carolina had -- the state had
3 put some parameters around how many errors could be found
4 in case processing, which some of the caseworkers made them
5 a little bit more wary about how they process because there
6 was a payback from the county to the state for errors. And
7 so I think there are some issues when you look at a county-
8 run system.

9 In Michigan, on the other hand, one of the
10 counties -- and I want to say it was Genesee; is that
11 right, Tamara? -- piloted a two-way text messaging system,
12 and so, in that case, it was a place where they could --
13 you know, sort of a laboratory where they tried out this
14 thing. They realized that the text messaging process or
15 technology that they were using was hard for caseworkers to
16 utilize because it was like a separate system that they
17 then had to do, but they utilized some of the things that
18 they learned from that, they incorporated into their
19 redesign of their application.

20 So I think it can cut in both ways, depending
21 upon how the state is -- what they're learning and how they
22 interact with their counties.

1 Does that help, Toby?

2 COMMISSIONER DOUGLAS: Yeah. I mean, I think
3 it's more this just goes to the complexity of this all and
4 more of a statement of just, you know, the level -- and
5 this is a wonderful study, and there's so much advances
6 that the technology as well as the regulations. But given
7 just still how eligibility is actually playing out at the
8 local level, there's more that needs to occur on how do we
9 communicate consistently across states.

10 CHAIR BELLA: Laura and then Fred.

11 COMMISSIONER HERRERA SCOTT: Hi. Thank you both
12 for the presentation. It was great information.

13 My question is, is there anything you can say
14 about the accuracy of the information based on the modality
15 and the timeliness to a decision? So was there any
16 difference of one online versus paper over the other?

17 MS. HUSON: So I don't think that we could say
18 definitively because we didn't measure that. However, just
19 sort of anecdotally, it seems like online applications are
20 processed faster.

21 In particular, I'll highlight an example from
22 Michigan. Michigan is currently working on an initiative

1 that they're calling Project One Day where they are trying
2 to receive an online application and in 24 hours be able to
3 determine if an individual or household is eligible, to be
4 able to have a determination in one day. So, I think that
5 sort of speaks to the fact that online tends to be faster,
6 but I don't think we have data kind of quantifying that.
7 CHAIR BELLA: Fred?
8 COMMISSIONER CERISE: Yeah. Sean or Tamara, did
9 you get a sense from the focus groups -- are any of those
10 people using other sources like resource centers to help
11 them with the online thing if almost half don't have
12 computers or almost 30 percent don't have smartphones? How
13 common is it for them to go to the community center or a
14 resource center to get help with that sort of stuff?
15 MR. DRYDEN: I can take that, and, Tamara, if you
16 want to jump in.
17 It wasn't a huge number of the people in these
18 focus groups, but again, I think probably that's partly the
19 sample for finding people. As much as we tried to reach
20 people across the board, we're finding people that are more
21 comfortable with technology have something at home that
22 they can use this for.

1 We did have some people who used resource
2 centers. Especially, we heard that in terms of when they
3 were having difficulty with documents, sometimes going to
4 print something -- I mean, people were going in for help,
5 but it wasn't a lot of the folks that we talked to.
6 I don't know, Tamara or Martha, if you remember.
7 I would say it's probably a smaller percentage of the
8 actual percentage of people that are needing to use these
9 resources centers, just because of the sample in these
10 focus groups, but we did have a subset of folks that used
11 resource centers when possible.
12 I'm sure there are some folks who didn't know
13 that was available to them as well and rather went through
14 the process over the phone or online and just kept going at
15 it until they were able to figure it out.
16 I don't know, Martha or Tamara, if you've heard
17 things from the focus groups or the stakeholder interviews.
18 MS. HUSON: Yeah, Sean. I think your comments on
19 the focus groups are right. I remember there was one
20 gentleman who applied at the clinic as opposed to a lot of
21 the other participants applied on their own or maybe a
22 couple with a family member.

1 And in the focus groups, I think one of the
2 questions that was asked, "If you do have an issue, what do
3 you do?" And a lot of people said they'll find their
4 family member. A lot of people said they would call when
5 they had questions. Some would go in person.
6 In our interviews, I think this came out a little
7 bit more because we did talk to provider organizations. We
8 spoke with some navigators who are the people assisting
9 applicants and beneficiaries, and so we heard from them
10 that they're oftentimes helping individuals who have the
11 greatest need for help. So maybe it's because they don't
12 have internet access or they have limited English
13 proficiency, and they might need a translator. So, we
14 definitely heard from many of the stakeholders, especially
15 the advocates and the legal aid and the provider
16 organizations about how important those community-based
17 organizations and those resource centers and the
18 caseworkers, how the navigators -- like how important those
19 resources are for a lot of people.
20 CHAIR BELLA: Dennis or Verlon. Verlon?
21 COMMISSIONER JOHNSON: Thanks. So, again, just
22 like everyone else said, I just want to say thank you for

1 this presentation. Communication is always really
2 important when it comes to health. That really helps us to
3 get to where we need to go.
4 I have a question more around states, and I think
5 we've gotten to it a little bit, but obviously, state
6 budgets are always very challenging. There are always key
7 things that they need to address, and so it's not
8 surprising that funding obviously is a barrier to, I think,
9 pursuing some different technology.
10 I am not a proponent of having technology for
11 technology's sake, just because it has all the bells and
12 whistles for different things, but kind of falling to the
13 other conversation, I'm just curious. In your interviews
14 and/or focus groups, do states have any ideas in terms of
15 some of the key things they like to think about in terms of
16 technology for moving forward in this effort?
17 And, again, I'm thinking about your comment that
18 you made about the apps, the Medicaid apps. People weren't
19 really -- mobile apps weren't really something that was
20 very much embraced, and so some of the states use that just
21 because there's an app for everything. But I'm just
22 curious if there were any other conversations around some

1 other thoughts in terms of how states may want to use some
2 additional funding to help them meet this need.
3 MS. HUSON: So, in our interviews with states,
4 state funding was certainly something that came up often as
5 a barrier. Some of the things that were sort of on states'
6 wish lists, for example, they expressed that they would
7 like to create a mobile app, and not very many states do
8 have mobile apps. I believe eight states have mobile apps
9 for their online accounts, and two states offer them for
10 their application. And in two of the four states that we
11 conducted focus groups, they do offer mobile apps, and just
12 sort of what we heard was that they're not used very often.
13 Some of the concerns from advocates that we heard
14 around mobile apps is that, you know, for individuals who
15 might have smartphones that don't have a lot of data or
16 that they don't have plans that offer a lot of data or they
17 don't much storage on their phone -- excuse me -- or they
18 don't have a plan with a lot of data, that downloading an
19 app might just not be feasible for them. So that's one
20 example.
21 States really are in different places where they
22 use technology. Missouri is another example who they're

1 working with that contractor, Civilla. So, they're
2 updating their application, but again, you can't do
3 everything at one time. So they would like to offer
4 electronic notices. So that's kind of like on their wish
5 list for the future.
6 Martha, if you have any other examples, if you
7 want to add anything, please feel free.
8 MS. HEBERLEIN: No. I think the other thing we
9 heard in terms of technology is just the timeline to get
10 some of this stuff done and the fact that there's so many
11 other things on the punch list of what they need to do to
12 their system, that sometimes these things fall down or
13 sometimes it's been on the list and priorities shift, or by
14 the time you get to it, it's outdated. So, I think it was
15 both a funding thing but also just all the other things
16 that they need to do.
17 COMMISSIONER JOHNSON: Thank you.
18 COMMISSIONER HEAPHY: This is Dennis.
19 This was great, and it's really helpful. I think
20 actually it echoes a lot of things that we hear in the
21 advocacy world, and I was wondering. I guess the group
22 they used, the group folks that then assembled, were

1 savvier than a lot of other folks in the Medicaid
2 population in terms of like -- because I didn't hear
3 anything about who were concerned about change in telephone
4 numbers or addresses, like the email addresses. A lot of
5 folks change their telephone numbers on a regular basis or
6 their email addresses on a fairly regular basis, and so I
7 didn't see anything in the report that said that that was a
8 concern raised. Was that or was that not something that
9 came up?
10 MR. DRYDEN: No. We really didn't hear anything
11 around that. We heard a little bit of change of address,
12 like physical address and stuff, in terms of people who
13 were moving more frequently and worried about whether they
14 were missing out on mailed notifications or forms, et
15 cetera, but we didn't really hear from folks about issues
16 around change of email address or phone numbers.
17 So, like you're saying, I think those are out
18 there, but we had people who were a little more savvy in
19 these focus groups, and that might just not have been a
20 challenge.
21 I don't know, Martha or Tamara, if you picked
22 that up in the interviews or talking to stakeholders.

1 MS. HUSON: Yeah. We heard similar things. I
2 think we heard more about change of mailing addresses as
3 being issues. I think a couple of stakeholders might have
4 noted concerns around phone numbers and email addresses,
5 and I think we heard a little bit more about the use of
6 email addresses related to the use of online accounts, but
7 I don't think it was something that rose to -- that we
8 heard a lot.
9 COMMISSIONER HEAPHY: So my last question goes to
10 Heidi's question earlier. Do you think it would be worth
11 doing a deeper dive to better understand a broader
12 population of folks to see what barriers they're facing in
13 terms of access to communication, either through enrollment
14 or reenrollment or not?
15 MS. HUSON: We can certainly probe for specific
16 issues or concerns that you think would be helpful for us
17 to address. You know, I think we'd maybe welcome more
18 feedback on that.
19 COMMISSIONER HEAPHY: Because I'm just wondering
20 about language and barriers, whether the race or ethnicity
21 of different populations might be -- representation or
22 educational backgrounds. And the reason I'm thinking

1 that's important is it's not just about Medicaid but all
2 the ancillary services people receive. So I'm thinking
3 simplifying the application by using SNAP as a way of
4 verifying people's eligibility for Medicaid. And so I'm
5 not being very clear in my question, but I'm just wondering
6 if there's more that can be done here to help us better
7 understand how to collect data, not just for this but for
8 other aspects of Medicaid.
9 MS. HEBERLEIN: Dennis, the one thing I would add
10 is not so much in the focus groups, but in the stakeholder
11 interviews we definitely heard from some of the assisters
12 that people -- language was an issue and a barrier. We
13 talked to some navigators like in Florida and some national
14 navigators who noted that as an issue. We also heard from
15 some folks in Michigan about that. Immigration status also
16 came up, and I would say disability in a lot of -- you
17 know, in terms of I know somebody before raised Braille --
18 perhaps it was Martha -- and just like the ability to
19 access sort of regardless of your situation. I think we
20 asked in the stakeholder interviews the states specifically
21 if they had any additional -- did they do anything special,
22 I guess, for people who needed additional accommodations?

1 And most of them replied that, you know, we followed the
2 ADA rules, we have a language access line, but there wasn't
3 any targeted efforts necessarily. Those efforts seemed to
4 be coming from the navigators in the community who worked
5 directly with the people. And I don't know, Tamara, if you
6 have other thoughts from some of those interviews.
7 MS. HUSON: Martha, I think you hit on all the
8 major points.
9 COMMISSIONER HEAPHY: Thank you.
10 CHAIR BELLA: Thank you, Dennis. Toby?
11 COMMISSIONER DOUGLAS: Yeah, one more quick
12 question. Was there any feedback on health plan
13 communication as it relates to renewals and the
14 intersection of what beneficiaries wanted from their health
15 plan and just kind of how they worked in tandem with the
16 states and counties -- or states in this case?
17 MS. HUSON: So we didn't really probe on that.
18 In this project we were looking more specifically at the
19 states' Medicaid agency and their communication. However,
20 of course, since many of the states are managed care,
21 communication with health plans did come up in some of our
22 interviews, particularly with the state officials. You

1 know, we heard, I think, in our interview with Texas
2 particularly around how they work with their MCOs to kind
3 of share information or they're trying to share
4 information. I think if we wanted to look at that, we'd
5 have to kind of do more work in that space. But, Martha,
6 if you want to add anything, please do.
7 CHAIR BELLA: Martha, if you're talking --
8 MS. HEBERLEIN: Oh, I'm muted again. I think I
9 move too fast. It doesn't recognize that I'm unmuted.
10 So, we did do some prior work, again, with
11 SHADAC, to look at some of the barriers that states and
12 beneficiaries faced, and we did talk a little bit about --
13 or looked to try to look at what role managed care plans
14 can play. And I think some of the issues that they raised
15 was like who's the holder of that information and what can
16 they -- you know, in terms of like bad addresses, for
17 example, so if they get an updated address from the
18 beneficiary, well, who's the system of record? And can the
19 Medicaid agency take that address because they're the ones
20 who own the eligibility file? So there is that issue. And
21 then there's also some issues that I think came up -- Darin
22 has brought it up before in terms of, you know, can managed

1 care companies reach out? And is that in violation of some
2 of their enrollment practices? And are they trying to keep
3 their enrollees versus, you know, are they trying to help
4 their enrollees stay in Medicaid, right?
5 And so I think there's different rules in
6 different states about what role managed care plans can
7 play in the enrollment and renewal process. But we didn't
8 do that for this particular study. It was more focused on
9 the eligibility, enrollment process and specifically with
10 communications from the state Medicaid agency directly.
11 COMMISSIONER DOUGLAS: Yeah. I mean, it's
12 obviously was bigger, but it gets to -- I mean, plans are
13 doing a ton of communication trying to figure out at the
14 same time the right mode, you know, holistically, and
15 sharing data.
16 CHAIR BELLA: Darin, did you have something to
17 say?
18 COMMISSIONER GORDON: Yeah, and a couple things
19 that were said, like bad addresses, I just want us to be
20 cognizant of -- I mean, all of this is much more
21 complicated than we like to make it sound from a systems
22 perspective. But, you know, we have found situations where

1 we would store -- our earlier systems would only store two
2 addresses, but our new systems had to store even more
3 addresses than that. But you get into -- you know, we
4 would get information from the Social Security
5 Administration that would override our addresses that we
6 felt really good about, and we wouldn't find out about it
7 because it's all built into the system, that they kept
8 overriding things we had verified. Their addresses were
9 bad. So you get into issues where you're trying to get a
10 lot of good information from multiple sources, but then
11 trying to figure out who has the best information makes it
12 a little complicated.
13 And to Martha's point on the plan's role, I do
14 think there is a role for them. I think, again, Martha has
15 heard me say this probably more than she'd like to hear,
16 but, you know, there's been situations, you know, many
17 years ago, not anything really recent, where -- and you can
18 see this on the Medicare Advantage side -- where there was
19 different targeting. In other words, it didn't help
20 everyone equally. They would focus on certain groups but
21 not other groups, situations where folks would target only,
22 you know, trying to do outreach to folks that were pregnant

1 in the first and second trimester but not in the third
2 trimester. So, I mean, that's why some states I think have
3 been cautious about how to engage the plans in a way that,
4 you know, while I don't think anybody would just naturally
5 go there, but, you know, depending on what are some of the
6 incentives that maybe someone deep within an organization
7 may make bad decisions, so you have to figure out how you
8 can get them engaged in a way that keeps that balance. And
9 I think some folks have found ways to do that. I think
10 that's a continuing improvement. They're doing it
11 methodically, not just, you know, inviting them in.
12 CHAIR BELLA: Okay. Any last comments?
13 [No response.]
14 CHAIR BELLA: All right. I want to thank all of
15 you again for the work. Something that really jumped out
16 at me was really the examples with Michigan and Louisiana,
17 and understanding sort of what the impetus was there, and
18 how do we spread that, tactical steps for other states, you
19 know, not just sort of conceptual steps, but also anything
20 where we can always be showing if there's an administrative
21 savings for making some of these changes I think would be
22 really helpful. But, clearly, it sounds like particularly

1 in Michigan what they've done is making -- has made and is
2 making a real difference. And so that seems promising, and
3 so it would be great that we're going to be putting out an
4 issue brief on this.
5 Do you need anything else from us at this point?
6 I think you're hearing strong support for an issue brief
7 and ongoing interest. If there's a place for us to make
8 recommendations and ongoing issues in this topic, it feels
9 like right now our biggest contribution is in the issue
10 brief though. But is there anything else you need from us
11 before we conclude?
12 MS. HUSON: I don't think so. Thank you.
13 CHAIR BELLA: Okay. Great. And, Sean, thank
14 you. Thank you for joining us and thank you again for your
15 work.
16 MR. DRYDEN: Thanks. It was great to be a part
17 of this.
18 CHAIR BELLA: Thank you. We are going to wrap up
19 and move into the next discussion, please. I would just
20 ask Commissioners to remember that when you're finished
21 speaking, if you could please put yourself on mute. I can
22 sort of see who has background noise, and I won't be afraid

1 to mute you. But I don't want anyone to be surprised if
2 that happens. So thank you in advance for that.
3 We are going into a session where we're going to
4 talk about something that is also of great interest and
5 sort of very top of mind for all of us right now, which is
6 churn and continuous coverage, and Rob and Linn are joining
7 us.
8 Linn, welcome. I think this might be the first
9 time we've heard from you, so welcome. We're excited to
10 hear what you guys have to say. So I will turn it over to
11 you to get us started, and we'll listen to your
12 presentation, and then we'll have plenty of discussion, I'm
13 sure. It's all yours.
14 **### ASSOCIATIONS BETWEEN STATE ELIGIBILITY PROCESSES**
15 **AND RATES OF CHURN AND CONTINUOUS COVERAGE**
16 * MX. JENNINGS: Thank you so much and good
17 afternoon, Commissioners. Rob and I are here to discuss
18 the findings from our analyses on the association between
19 state eligibility processes and rates of churn and
20 continuous coverage. So today I'll begin with some
21 background on the phenomenon of churn, and I'll summarize
22 our results on national rates of churn and continuous

1 coverage based on our analysis of new T-MSIS data from
2 2018. Then I'll turn it over to Rob to discuss state-level
3 variation that we observed related to the policy
4 differences that are listed on this slide, and the
5 implications of these findings for the Commission's future
6 work in this area.
7 Next slide.
8 So, this presentation continues the Commission's
9 prior work on eligibility and enrollment processes, which
10 is focused on ways to accurately determine eligibility
11 without creating unnecessary administrative tasks or
12 barriers to enrollment for eligible individuals. One topic
13 of particular concern is the phenomenon of churn, which
14 refers to beneficiaries who disenroll from Medicaid and
15 CHIP and then re-enroll in the program within a short
16 amount of time, and this is also more common in Medicaid
17 and CHIP than other types of health insurance.
18 Churn can occur when beneficiaries experience
19 income fluctuations that can make them ineligible for a
20 short period of time, and it can also be an indicator of
21 potential administrative burdens that disrupt coverage for
22 beneficiaries who would otherwise continue to meet income

1 and other eligibility. And these disruptions in coverage
2 result in unnecessary administrative costs for states and
3 delays in care for beneficiaries, which may increase health
4 costs in the long run.
5 Next slide.
6 In this project we looked at three state
7 eligibility and enrollment processes that have the
8 potential to affect churn and continuity of coverage.
9 First, we looked at 12-month continuous eligibility, which
10 has long been the state option for children. Currently
11 there are 23 states that have implemented this policy in
12 Medicaid and 25 states that have implemented it in CHIP.
13 Second, we looked at the effects of some of the
14 changes made by the Affordable Care Act to streamline
15 eligibility processes for beneficiaries under age 65
16 without disabilities whose income is determined based on
17 modified adjusted gross income, or MAGI. For MAGI
18 eligibility groups, current regulations require that states
19 conduct renewals no more than once every 12 months, and
20 that when they do so, they attempt to confirm eligibility
21 with electronic sources before requesting additional
22 information, and this process is known as ex parte or

1 administrative renewal.

2 Although states are required to implement the use
3 of automated renewal, there is variation by state, and as
4 of January 2020, the share of renewals that were automated
5 ranged from less than 25 percent in 11 states to more than
6 75 percent in 9 states.

7 Third, we looked at mid-year determinations. The
8 ACA requirement to conduct renewals for MAGI eligibility
9 groups not more than once every 12 months is different from
10 12-month continuous eligibility, and that states may
11 redetermine eligibility in the event of a mid-year change
12 in circumstance. And as of January 2020, 30 states are
13 proactively conducting data matches with quarterly wage
14 data and other sources to identify potential changes in
15 circumstance.

16 Beneficiaries are notified of these potential
17 changes and then can be disenrolled if they don't provide
18 additional income verification within a specified time
19 frame. Unlike annual renewals where beneficiaries are
20 required to have up to 30 days to respond, states are only
21 required to provide a minimum of 10 days' notice to respond
22 to patient changes in circumstances.

1 Next slide.

2 So, for our project to calculate rates of churn
3 and continuous coverage, we contracted with Mathematica to
4 examine enrollment data from T-MSIS. We examined
5 enrollment data from 2018 and then used data from 2017 to
6 2019 to allow us to look at enrollment spans across those
7 three years. I want to note that these data are from
8 before the COVID-19 public health emergency which included
9 a maintenance of effort of continuous eligibility
10 provision, and the most recent -- more recent data are not
11 yet available, so we can't provide estimates of churn or
12 continuous coverage during that time period.

13 Our analysis then focused on beneficiaries who
14 were only enrolled in one state, and we excluded those
15 enrolled in multiple, which amounts to about 6 percent of
16 the total enrollees that were otherwise in our study
17 states. And we also excluded beneficiaries with partial
18 Medicaid benefits.

19 For the overall analysis, we included 42 states
20 and D.C. that had usable data, and of those, 26 states also
21 had reliable race and ethnicity data so that we could use
22 those to examine racial and ethnic disparities.

1 Next slide.

2 And so this table shows our national results for
3 rates of churn and continuous coverage from 2018 and the
4 rates by eligibility group. So, in the table, 72.1 million
5 were included in our total study, and of those, 21 percent
6 disenrolled. And then of the 72.1 million, 8 percent
7 experienced churn and disenrolled in 2018 and then re-
8 enrolled within 12 months.

9 We also looked at different eligibility groups,
10 and we found that overall adults without disabilities were
11 more likely to churn at 9 percent and then adults age 65
12 and older were least likely to churn, and adults with
13 disabilities as well, both at 3 percent. And remember you
14 also have additional information about rates of churn by
15 eligibility group and race and ethnicity that aren't
16 included in this table.

17 For example, we found that children enrolled in
18 separate CHIP had higher rates of churn than those enrolled
19 in Medicaid, and that rates of churn were higher for black
20 and Hispanic beneficiaries compared to white beneficiaries.

21 In addition to churn rate, we also looked at
22 average length of coverage for beneficiaries and found

1 that, on average, enrollees had about 11.6 months of
2 continuous coverage, and this estimate is higher than
3 previous estimates that otherwise suggested that Medicaid
4 enrollees only had about 10 months continuous coverage.
5 These previous studies are different from ours in that they
6 used data that predate the ACA and that they only used one
7 year of data to calculate enrollment spans and don't
8 account for enrollment spans that spread across calendar
9 years.
10 I'm going to turn it over to Rob who will talk
11 about variations in state results related to policy
12 differences and future work.
13 * MR. NELB: Thanks, Linn. So, behind these
14 national averages, we observed wide variation in rates of
15 churn and continuous coverage by state, and on the slides
16 that follow, I'll discuss the extent to which some of the
17 policies that we examined may help explain some of the
18 state-level differences.
19 So first, starting with continuous eligibility,
20 this table shows rates of continuous coverage insurance for
21 children enrolled in Medicaid in states with 12-month
22 continuous eligibility and states without the policy. In

1 your memo, you have additional information about the
2 similar results that we observed for children enrolled in
3 separate CHIP programs.
4 You'll see in the first row that we found that
5 2.8 percent of children in states with 12-month continuous
6 eligibility were enrolled for fewer than 12 months, which
7 is about one-third lower than the rate we observed in
8 states without 12-month continuous eligibility.
9 This rate isn't quite 0 percent because, although
10 continuous eligibility helps prevent coverage loss due to a
11 change in family income, children can still lose coverage
12 if they age out of the program or if their families don't
13 pay the required premiums.
14 Next, we found a small but still positive effect
15 of continuous eligibility on increasing the average length
16 of coverage for children. This statistic is important to
17 keep in mind when estimating the potential costs of
18 policies to expand continuous eligibility. As Linn
19 mentioned, the average lengths of coverage that we observed
20 in our study were a bit larger than previous analyses of
21 this issue. One of the implications of this finding is
22 that our study suggests that the costs of expanding

1 continuous eligibility may be lower than previously
2 estimated.
3 Finally, looking at churn, we found that the
4 average share of beneficiaries who disenroll and re-
5 enrolled within 12 months was lower in states with 12-month
6 continuous eligibility compared to states without this
7 policy.
8 So, this next table provides similar findings
9 looking at states with and without mid-year data checks for
10 changes in circumstances. In your materials, you have
11 information about how these coverage statistics vary for
12 all full-benefit Medicaid enrollees, and in this table
13 we're presenting the results for adults enrolled in MAGI
14 eligibility groups who are mostly likely to be affected by
15 this policy.
16 Overall, we found that 14.5 percent of adults in
17 states with mid-year data checks disenrolled with fewer
18 than 12 months of coverage, which was higher than the rate
19 in states without mid-year data checks. Similarly, we
20 found that adults in states with mid-year data checks had
21 shorter lengths of coverage on average.
22 And, finally, perhaps most interestingly, we

1 found higher rates of churn for adults in states with
2 midyear data checks for changes in circumstances compared
3 to adults in states without this policy.
4 From our data, we're not able to tell whether
5 these individuals who churn had temporary income changes
6 that they made them ineligible for the program or not, but
7 it's also possible that some of these individuals churning
8 may have faced administrative barriers and remained
9 eligible but weren't able to submit the paperwork in time.
10 As Linn mentioned, states often provide a shorter
11 period of time to respond to notice about changes in
12 circumstances than they do to respond to notices about the
13 annual renewals.
14 Finally, this last figure looks at automated
15 renewals, and we found that greater use of automated or ex
16 parte renewal processes was associated with lower rates of
17 churn. This figure shows that our findings for all full
18 benefit Medicaid enrollees, and in your materials, you have
19 additional information about how these rates vary by
20 eligibility group.
21 Overall, we found a larger potential effect of
22 automated renewal for MAGI eligibility groups, adults and

1 children, and a lower potential effect of automated renewal
2 for non-MAGI eligibility groups, those individuals over age
3 65 and those eligible on the basis of a disability.
4 For these non-MAGI eligibility groups, states
5 often require asset tests or other eligibility requirements
6 that may be more difficult to automate.
7 So, we hope that this analysis is helpful for you
8 as you think about a future direction for our work in this
9 area. First, I want to point out a few limitations.
10 First, the associations that we observed do not
11 necessarily imply causation, and there may be other factors
12 that we didn't examine that also help explain some of the
13 state variation.
14 Second, from T-MSIS alone, we can't tell whether
15 beneficiaries who disenrolled transitioned to other sources
16 of coverage or became uninsured. MACPAC's prior analyses
17 using survey data from the Census suggests that most
18 beneficiaries losing Medicaid coverage do become uninsured,
19 but more research into this area is needed.
20 To help address this data gap, we're currently
21 exploring whether it's possible to link T-MSIS with federal
22 exchange data to better examine transitions in coverage

1 between public programs.

2 So, we look forward to hear feedback today on how
3 the findings from this analyses can help inform your future
4 work on eligibility and program integrity policies. This
5 slide highlights a number of potential areas for future
6 work that are discussed further in your memo.

7 Regarding the first option here about continuous
8 eligibility policies, it's important to note that Congress
9 is currently considering several policies in this area.
10 Most notably, in the current reconciliation bill, there's a
11 proposal to require 12-month continuous eligibility for
12 children. It's obviously too early to tell how this policy
13 may change in the legislative process, but we'll continue
14 to monitor it and keep it in mind as we consider our future
15 work in this area.

16 So that concludes our presentation for today.
17 Linn and I are happy to answer any questions you may have,
18 but mostly, we'll aim to be good listeners and hear your
19 feedback about the direction you want to take this work.

20 Thanks.

21 CHAIR BELLA: Thank you very much.

22 I'll start out with just one comment, which is if

1 I had a magic wand, I would love for this data to be able
2 to be linked to utilization and quality data so that we
3 could make a case about the correlation or the relationship
4 with continuity of coverage and actually reducing
5 expenditures as people churn on and come back off and
6 experience utilization bursts, perhaps when they're coming
7 back on. I don't think we can do that, but I'll just put
8 that on a wish list maybe that we could be driving towards
9 sometime.
10 And, Kisha, I'll ask, do you want to make any
11 comments in that regard? Because I think quality was of
12 top of mind for you too in this one.
13 VICE CHAIR DAVIS: Yeah. I think you just read
14 my mind, Melanie. A big plus one on that, you know, really
15 to be able to link are patient seeing different outcomes,
16 you know, is there a way to look and see ED utilization and
17 bounce-backs as that relates to churn on and off, I think
18 is really, really important.
19 You know, one of the big benefits that I saw for
20 this work -- and it seems like such a simple thing, but
21 apparently, it wasn't -- of being able to look beyond just
22 here and really being able to show that folks actually do

1 have more continuous enrollment than we thought, and so I
2 think that's something that we really want to highlight,
3 especially as we're looking at what the potential costs are
4 in advocating for continuous eligibility, that people are
5 on almost a year already, and so that really changes that
6 cost equation.
7 CHAIR BELLA: Thank you, Kisha.
8 I saw Martha, and I know I missed a few other
9 hands. Tricia, Toby, Heidi. Okay. Let's get started with
10 Martha, and then we'll go from there.
11 COMMISSIONER CARTER: Well, thanks. I think I
12 can focus this question.
13 I had a conversation with a local hospital
14 administrator. They have a 3.7 ASAM system-level substance
15 use disorder program, and their concern was about access to
16 continuous coverage and getting people reenrolled quickly.
17 And I think there's a corollary question here about
18 presumptive eligibility, because when you're doing
19 substance use disorder programming, you want to be there
20 when the person is ready.
21 So, this program was having difficulty getting
22 access to presumptive eligibility 24/7. Somebody comes in,

1 in crisis in the middle of the night, and they can't verify
2 that. They have to turn that person away until the next
3 day, which is not what you want to do with somebody in a
4 substance use disorder program.
5 So, I think there are clinical implications for
6 people dropping coverage, and I think that also one of the
7 questions is how quickly and how easily are people getting
8 back on, and what needs to happen for programs like this
9 inpatient SUD program to make it easy for them to get
10 people back in coverage and in the treatment that they
11 need?
12 That's a rambling question. That's not really
13 the question but sort of an issue I want to highlight
14 that's connected to this.
15 CHAIR BELLA: It's on your wish list, Martha.
16 Do you guys have any comments on that, or do you
17 want to take that comment as part of we think about other
18 areas we can --
19 MR. NELB: Yeah. I mean, I think your comments
20 of wanting to understand the health impacts of churn,
21 continuous coverage is really important.
22 I will say we are exploring the extent to which

1 we can use T-MSIS data to look at utilization-based
2 measures of quality. So perhaps we may be able to look at
3 something like ED utilization. It's harder to look at
4 other measures of quality, perhaps folks with substance use
5 disorder or diabetes management or something that isn't in
6 T-MSIS, but we'll keep an eye out and sort of keep those
7 comments top of mind.
8 COMMISSIONER CARTER: Rob, how about how quickly
9 people get back on?
10 MR. NELB: Yeah. We kind of looked at for those
11 individuals who churned, how quickly they came back on.
12 There are a large number that come back on within three
13 months or so, and then others do take a longer period of
14 time. We can take a closer look at the characteristics of
15 those individuals and think about how it's happening.
16 With the T-MSIS data, it's a little hard to tell
17 exactly how retroactive eligibility is being counted or
18 not. So, anyway, for some of these individuals that may
19 look like a short gap in coverage, the administrative data,
20 you know, it could still be a barrier to access to care.
21 So, it's something to keep in mind.
22 COMMISSIONER CARTER: Thanks.

1 CHAIR BELLA: Thank you.

2 Tricia, then Toby, then Heidi, then Laura, then
3 Fred.

4 COMMISSIONER BROOKS: Rob, I want to thank you so
5 much. I am really excited about your findings in terms of
6 most groups having longer periods of continuous coverage
7 than had been previously thought and in particular that you
8 guys used Mathematica for this because I think they got the
9 most experience with T-MSIS dataset in terms of looking at
10 the quality issues in T-MSIS for CMS. I think they have
11 the best ideas about how you would actually model this
12 work, and I hope that this work gets out there quickly and
13 can help inform the Congressional Budget Office on scoring
14 12-month continuous eligibility because that has had a very
15 high price tag on it previously.

16 I do want to call attention to just a couple of
17 things that I feel reflect some inequity between Medicaid
18 and CHIP and putting Medicaid at the disadvantage.

19 So, first of all, of the states that actually
20 provide 12-month continuous eligibility for all children,
21 there are six states that provided in CHIP only and another
22 three that provided for all kids in CHIP but just children

1 under a certain age threshold in Medicaid. Arguably, I
2 think our lowest-income children should get as many
3 protections as they can, and we already have in regs that
4 you can't favor higher-income children in CHIP over lower-
5 income children, but there's nothing that says you can't
6 favor higher-income kids in CHIP over Medicaid. And,
7 indeed, that happens.
8 In fact, in CHIP, states are actually not even
9 required to require beneficiaries to report changes. The
10 way the regs read is that if the state chooses to have
11 families report changes, then they must tell them about the
12 procedures for doing that. So, it's another area where you
13 see that inequity between Medicaid and CHIP.
14 Lastly, I will say -- and then I have one
15 question -- that there are a handful of states that are
16 interested in multiyear continuous eligibility for young
17 children, and in fact, I think we'll see an 1115 waiver
18 request from the state of Washington perhaps to be the
19 first out of the gate on this, and in particular, we know
20 how important those first few years of life are in terms of
21 getting a healthy start. You combine that with postpartum
22 coverage, and I think we've got some really positive steps

1 that could be made.

2 So, I would encourage us to think about in the
3 future when we're making recommendations to Congress that
4 we equalize these issues between Medicaid and CHIP and that
5 kids in CHIP should not be treated any better than kids in
6 Medicaid, and that preferably, it would be great to have a
7 SPA option for states to use multiyear continuous
8 eligibility, either for all children or at least for our
9 youngest children. So, it's another area I hope we'll
10 continue to pursue and think about as we make
11 recommendations.

12 Oh, and I had one question back on Slide 6. I
13 just want to clarify the data, if you can jump back there.
14 Hard to go backwards.

15 MR. NELB: There we go.

16 COMMISSIONER BROOKS: Okay. Thank you.

17 So, when you look at the fourth column, the
18 shared beneficiaries who reenrolled, I just want to make
19 sure that it's 8 percent of the total beneficiaries and not
20 8 percent of those that were disenrolled. Could you just
21 clarify that?

22 MR. NELB: Correct, yeah. The denominator here

1 is the 72.1 million, so 8 percent of the total.

2 COMMISSIONER BROOKS: Great. Thank you.

3 MR. NELB: Yeah.

4 CHAIR BELLA: Okay. Thank you, Tricia.

5 Toby and then Heidi.

6 COMMISSIONER DOUGLAS: First, great work, and I

7 think back to my days as a Medicaid director. This would be

8 wonderful information to have as well as it just shows a

9 lot of the changes from the ACA, the impact, so just

10 really, really good work.

11 A quick question on the CHIP, the stand-alone

12 CHIP, to make sure I understand. I can't remember which

13 slide it was, but on fewer than 12 months of continuous

14 coverage. Is the reason the main driver why stand-alone

15 CHIP has got a higher share -- is that from the premiums?

16 Is that what's driving it is that they're not paying their

17 premiums?

18 MR. NELB: Yeah. So, let's see. The data was in

19 your memo but not on the slides.

20 COMMISSIONER DOUGLAS: Oh, okay. I'm sorry.

21 MR. NELB: But, anyway, yeah. We did find higher

22 rates of churn in states with separate CHIP.

1 COMMISSIONER DOUGLAS: So, I guess this is just
2 another question, and I guess it's where you stand. But
3 the value of these premiums, especially as we're seeing the
4 continuous coverage of -- and, you know, Tricia is talking
5 about another inequity. So, you have stand-alone CHIP
6 versus Medicaid CHIP. So that the kids who are in Medicaid
7 are not paying premiums. Those in stand-alone CHIP are.
8 We're seeing differences in continuous coverage. What's
9 the value of those premiums versus the impact on outcomes
10 versus administration? There's a lot of things going on
11 there that we could untangle, but I think there has been a
12 longstanding view that premiums are part of the value
13 equation of getting health care coverage and why CHIP did
14 that, but I just wonder if we need to reassess some of
15 these things and look at what continuous coverage can do.
16 So that's my soapbox on that.
17 EXECUTIVE DIRECTOR SCHWARTZ: Can I just ask a
18 clarifying question? That's a potential answer, right,
19 Rob? We don't know for sure. So, if we wanted to really
20 look at the share of churn that's related to different
21 things, we would have to do a different kind of study. So,
22 it's a presumption on our part regarding --

1 COMMISSIONER DOUGLAS: Say more on what would be
2 the other -- and I guess we could look at -- can't you guys
3 look at the administrative reasons why they were
4 disenrolled during that period of time?
5 MR. NELB: So, in T-MSIS, we're just looking at
6 whether or not they were disenrolled or not, and then we
7 kind of have to infer the reasons. We can look at various
8 policies, and so we looked at the three here in this study,
9 but we could look at states with premiums in CHIP versus
10 those without. But there may be other reasons. For
11 example, perhaps higher-income individuals have more income
12 fluctuation to the income limits have a more narrow band in
13 CHIP than they do in Medicaid, and they can get to the
14 higher rates.
15 COMMISSIONER DOUGLAS: Yeah. I guess the
16 question is why we only see it on the other Medicaid side.
17 Yeah.
18 Is anything pulling aside the Medicaid, those
19 that you're characterizing as Medicaid of those that are
20 actually being funded through Medicaid CHIP? What's the
21 difference there? At least look at that.
22 MR. NELB: Yeah, yeah. We can look at the

1 Medicaid CHIP separate, yeah, and can do further -- look
2 into premiums if there's interest.
3 CHAIR BELLA: Okay. Thank you, Toby.
4 Heidi, then Laura, then Fred, then Bob.
5 COMMISSIONER ALLEN: Thank you, Linn and Robert.
6 This is really cool, and I love seeing the T-MSIS data
7 used. I'm excited to what this can offer us in the future.
8 I kind of want to return to your point, Robert,
9 about retroactive coverage. While retroactive coverage is
10 great for protecting people from financial arm that they
11 may have incurred while insured and making sure that
12 providers get paid, it's also a period of that time when
13 people don't know that they're covered. And so you would
14 expect less utilization and less benefit from that period
15 of time, and so, if there's any way to tease that out --
16 and there just may not be, but if there is, I do think that
17 that's worth doing.
18 And then I just want to point out, it's Table 4
19 in the documents that we were sent in the report, but I'm
20 not sure what slide it is. But it makes me question the
21 utility of maybe your checks when you see higher
22 disenrollment and higher reenrollment within 12 months. If

1 you didn't see the higher reenrollment in 12 months, then
2 what you would figure is that they're just catching people
3 who no longer need Medicaid and are no longer income-
4 eligible. But, when you see that increase in reenrollment
5 in less than 12 months, that tells you that people are
6 disenrolling probably unnecessarily, and that that's an
7 administrative cost, both the check and the reenrollment
8 that may not be worth doing when you look at the data.
9 Thanks.
10 CHAIR BELLA: Thank you, Heidi.
11 Laura?
12 COMMISSIONER HERRERA SCOTT: Hi. My question is,
13 on one of the slides, you shared that 26 of the states had
14 race and ethnicity data, and I didn't know if you had
15 looked at that at all in the churn. Are there any
16 disparities across states where that data was available?
17 MR. NELB: Yeah. Let's see. So, of the states
18 that had complete eligibility data, 26 also had complete
19 race and ethnicity data.
20 For this analysis, we just sort of looked at it
21 nationally because we didn't have as many states, and we
22 did find higher rates of churn among African Americans and

1 Latino beneficiaries. But we can explore whether we can
2 look further at those disparities by state.
3 CHAIR BELLA: That would be great to take a look
4 at that. Thank you, Laura, for that question. Fred and
5 then Bob.
6 COMMISSIONER CERISE: Yeah, and thanks, Rob.
7 This is great. Both Tricia and Martha kind of touched on
8 my question, and I'll just restate it and emphasize it. As
9 you look at -- one of the policy options you suggested was
10 perhaps looking at both the year eligibility and you go
11 beyond one-year continuous eligibility. You know, for
12 certain populations, that may be something worth looking
13 at. Martha talked about substance use. Tricia talked
14 about young children. And for those categories where you
15 know there's going to be ongoing utilization, and maybe
16 it's behavioral health, maybe it's chronic disease like
17 asthma or something like that, as we look at that option,
18 you know, there's nothing magic about one year. Or if
19 there are populations where it makes sense to give states
20 that option, I guess it would be something worth thinking
21 about.
22 CHAIR BELLA: Thank you, Fred. Bob?

1 COMMISSIONER DUNCAN: Thank you, and, again, Rob
2 and Linn, thank you so much for the work.
3 Melanie and Kisha, you touched a little bit on
4 one item I had: how we can get to the health outcomes and
5 the costs and expense associated with that. I know it's a
6 magic wand, but I will let you know I'm aware of a report
7 that the Association for Community Affiliated Plans has put
8 together that kind of measures pediatric specialty and
9 continuous eligibility, so I can send that to the group
10 afterwards.
11 But Heidi touched on the other component of this.
12 As we think about the costs associated particularly with
13 those mid-year, the administrative burden, I mean, we just
14 spent a session talking about all the modalities of having
15 to reach the members and the difficulty in that and just
16 the costs associated with that administration both from the
17 state and the HMO's standpoint, I have to imagine there
18 would be significant savings there as well as improved
19 health outcomes. Is there a way we can quantify that?
20 MR. NELB: We can certainly explore it. It's
21 hard to really get good data on -- we have information on
22 how much states spend on their eligibility systems overall,

1 but it's hard to attribute that to particular cases. But
2 we can certainly think they're getting information about --
3 you know, there may be some case-by-case information we can
4 get to shed some light into the tradeoffs there that you
5 note.

6 CHAIR BELLA: All right. We're going to go to
7 public comment in just a second. Are there any other
8 Commissioners that have comments?

9 COMMISSIONER HEAPHY: Yeah, this is Dennis. I
10 had highlights all over your section, but I'm going to
11 stick to a dream, I guess, and that is, a significant
12 number of folks with disabilities don't seek employment
13 because they're afraid of losing Medicaid eligibility, and
14 folks do, actually, if they work, then they just in this
15 churn cycle and they lose their Medicaid and then they have
16 to get back on. And for health plans, we know this in the
17 dual space, that there's a lot of money invested in folks
18 that is lost due to churn and people lose either Medicaid
19 or Medicare. And so is there any way that we can do some
20 sort of proxy or understanding of how the churn does affect
21 administrative costs in Medicaid by looking at other data
22 from the world of MCOs or ACOs? Since most states use MCOs

1 or ACOs anyway, these populations, we gather information
2 from them?
3 MR. NELB: We certainly can explore different
4 data sources that are out there. I guess in terms of
5 understanding the overall costs, there's administrative
6 costs by states and plans they may save from reducing
7 churn, but there's also increased cost of, you know, paying
8 a capitation payment when someone becomes eligible. So, we
9 can explore what information is out there. We can also do
10 deeper dives on particular eligibility groups. We included
11 full-benefit duals in the analysis and can take a closer
12 look at them if there's interest.
13 COMMISSIONER HEAPHY: Just because it's not just
14 about the administrative costs. It also is about the
15 medical costs incurred. Someone brought up both for
16 substance use disorder but then folks that have ongoing
17 treatment, as you said, I think it was diabetes, ongoing
18 services that people require, and once that's lost, if you
19 get back on, it's like starting all over again. This is a
20 huge issue. So thank you, guys.
21 CHAIR BELLA: All right. Why don't we go and see
22 if we have public comment, and then we'll close out on this

1 session with a few closing thoughts.

2 We are going to welcome the folks in the audience
3 to make comments on either of the sessions that we've had
4 to date. If you would like to make a comment, please do so
5 by hitting the indicator on your panel, and we will
6 recognize you. I would ask that you introduce yourself and
7 the organization that you're representing, and I would also
8 remind folks that we have a three-minute public comment
9 period, so I'll ask you to keep your comments to three
10 minutes or less, please.

11 I don't see any hands, but we'll give it a
12 minute.

13 All right. Great. It looks like we have Kelly.
14 Welcome, Kelly.

15 **### PUBLIC COMMENT**

16 * MS. HUGHES: Kelly, you are self-muted. If you'd
17 just click the microphone icon to unmute your line.

18 MS. WHITENER: Can you hear me now?

19 CHAIR BELLA: Yes.

20 MS. HUGHES: Yes.

21 MS. WHITENER: Excellent. Thank you. Sorry.
22 I'm not very familiar with GoToMeeting, so that was a

1 little bit of a struggle. Thank you for public comment.
2 I'm Kelly Whitener from Georgetown University Center for
3 Children and Families, and this was a really excellent
4 session. It's something we've spent a fair amount of time
5 looking into, but you guys got a lot further and had a lot
6 more interesting data than we were able to dig up on our
7 own, so thank you for that.
8 I noted that in the presentation from Linn and
9 some of the discussion that there's some recent ethnicity
10 data that's part of the Commissioners' materials but not
11 part of the public-facing slides, so I'd just like to put
12 in a plug to please issue that information in a public-
13 facing way as well. It would really help inform some of
14 our work, particularly for Latino children.
15 And that is all. Thank you very much.
16 CHAIR BELLA: Thank you, Kelly.
17 MS. HUGHES: Nataki, I have unmuted your line, so
18 you can just unmute yourself.
19 MS. MacMURRAY: Great. Good afternoon, everyone.
20 Thank you so much for the work that you've done. I did put
21 a couple of questions in the chat, but I had to step away
22 for a few minutes. I'm not sure if they were addressed or

1 not. But I had asked questions about do we know anything
2 about -- especially for the first presentation, do we know
3 anything about kind of the reasons how people are eligible
4 for Medicaid and how that may tie into or be associated
5 with whatever issues or challenges that they may have had
6 in applying for enrollment or re-enrollment? And as an
7 example, whether or not we know the current population or
8 the beneficiary population were applying because of mental
9 health or substance use disorders or if they had a chronic
10 condition such as diabetes or hypertension or anything --
11 any other kind of information that would give us a sense of
12 maybe why the process to enroll or re-enroll may have been
13 more challenging or not more challenging for them?
14 Anything that we can associate?
15 CHAIR BELLA: All right. Rob and Linn, do you
16 have any comments to address that?
17 MR. NELB: I don't, but we can take it back to
18 our colleagues that worked on that previous study and make
19 sure to address some of those issues in that issue brief
20 that we publish based on the focus groups.
21 EXECUTIVE DIRECTOR SCHWARTZ: Can I just add
22 that, you know, these are based on administrative data, and

1 we don't have personal reasons for enrollment. We just
2 have a determination of eligibility and enrollment. We
3 don't have other details on their reasons.
4 CHAIR BELLA: Sorry, Rob. You got put on the
5 spot there because you're the last one standing.
6 MR. NELB: No, it's okay. In T-MSIS, as I
7 mentioned before, we don't have the reasons for enrollment
8 or disenrollment.
9 CHAIR BELLA: All right. It looks like we have
10 two more folks that would like to make comments.
11 MS. HUGHES: Erin, I've unmuted your line. If
12 you'd like to unmute your own line on your side, make your
13 comment.
14 MS. BRANTLEY: Hi, can you hear me?
15 CHAIR BELLA: Yes.
16 MS. BRANTLEY: This is Erin Brantley from George
17 Washington University, and I've done work on this area with
18 Leighton Ku. I just have a clarifying question. This page
19 6, I'm really struck by the precise similarity across kids
20 and adults and the elderly in the average length of
21 coverage. And then if you look at the share of
22 beneficiaries who disenrolled, that's really wide

1 variation, more likely probably would expect, like a lot of
2 adults are jumping off and much fewer elderly. So, I'm
3 just wondering if Rob and Linn have insight into what's
4 going on there.
5 MR. NELB: Sure. So, we presented the length of
6 coverage statistics sort of in two different ways, in part
7 because some of those individuals who disenroll prior to 12
8 months, they maybe do so after having six months or more
9 coverage. So, I think sometimes the average length of
10 coverage statistic, you know, is higher for folks -- that
11 other statistic that we present of the percent of
12 individuals who disenroll less than 12 months is probably
13 the better measure of sort of the number of people who
14 would be affected by some of those continuous coverage
15 policies. I'm happy to follow up with you offline if you
16 have other questions about the data.
17 CHAIR BELLA: We have one person left, please.
18 MS. HUGHES: Kristen Golden Testa, you've been
19 unmuted.
20 MS. TESTA: Hi. Can you all hear me?
21 CHAIR BELLA: Yes.
22 MS. TESTA: This is Kristen Golden Testa. I'm

1 from California with the Children's Partnership, and I
2 really wanted to thank the Commission for putting together
3 this analysis and also for Tricia and Toby's comments
4 relating to multi-year coverage and looking at the utility
5 of premiums. In California, stakeholders are trying to
6 pursue this multi-year continuous coverage as well for
7 those zero to five and would greatly appreciate some
8 federal guidance and SPA would be perfect for us in
9 pursuing that.
10 In our research, we're finding it is around 10
11 percent of the zero to five kids are churning on and off.
12 What we're struggling with is trying to figure out the
13 average amount of time that those individuals are losing
14 coverage as well as bolstering our premise and our
15 assumption that these children are still eligible based on
16 income, even though they are falling off. So, anything
17 along the lines of that type of research would be very
18 helpful.
19 CHAIR BELLA: Thank you, Kristen.
20 COMMISSIONER DOUGLAS: Hey, Kristen.
21 MS. TESTA: Hi.
22 CHAIR BELLA: Okay. I'll give it just a second

1 to see if we have any more folks who would like to speak.
2 Could we put the last slide back up, the one that had the
3 policy for areas of potential next work?
4 The first one on there was continuous -- looking
5 at continuous eligibility. I think you're hearing strong
6 interest in looking at multi-year or continuous coverage.
7 First, before I go to that, I would say there are a few
8 data things I think we've asked you to go back and look at,
9 and you've heard us say we'd really like for you to be able
10 to do some things around outcomes and utilization with T-
11 MSIS. If we could go to the last slide that we had, that
12 would be wonderful. If not, that's fine.
13 So, I think strong interest there. There seems
14 to be a lot of interest also, obviously, and the more that
15 you can tell us race and ethnicity lines, that's an
16 important thing we need to be applying to all of this.
17 Definitely heard interest in trying to get the word out to
18 CBO that this multi-year analysis may change the view
19 that's been held in the past, at least need some additional
20 information into the debate. We didn't talk much about the
21 program integrity issues. That isn't really something that
22 came up, so it doesn't feel like that's -- it's certainly

1 always important, but it feels to me that the predominance
2 of interest in this is kind of on the top half of this
3 slide, and the relationship between the notices in the
4 prior session and the work we're learning about
5 communication I think is a real opportunity as well.
6 So, all in all, I would say this is something
7 that we definitely have strong interest. You've laid the
8 groundwork very well today. Do you need anything else from
9 us at this time, Rob?
10 MR. NELB: No. I think this is helpful. We'll
11 take your wish list of data requests to our partners and
12 see what information we can pull together on these topics.
13 We'll see from them, you know, exactly what the timing of
14 that is. Yeah, we'll try to -- we can definitely work with
15 you on those continuous eligibility options.
16 CHAIR BELLA: Okay. That sounds wonderful.
17 Well, thank you very much. We will conclude this session.
18 We are going to take a short break, a 15-minute break.
19 We'll come back at 3:30, please, and we will have a session
20 on the territories. So, thank you, everybody, and I'll see
21 you in 15 minutes.
22 * [Recess.]

1 CHAIR BELLA: Okay. We'll go ahead and get
2 started. Welcome, Kacey. Nice to see you. You know this
3 is a topic near and dear to our hearts, so we'll let you
4 jump right in when you're ready to go.

5 ### MEDICAID IN THE U.S. TERRITORIES: CONSIDERATIONS
6 FOR LONG-TERM FINANCING SOLUTIONS

7 * MS. BUDERI: Great. Thank you. So, in this
8 session we are going to be talking about the Medicaid
9 programs in the U.S. territories, and as Commissioners and
10 many others attending this meeting are aware, the
11 territories were facing a major reduction in federal
12 Medicaid funds, often referred to as a "Medicaid fiscal
13 cliff," slated to occur on October 1. However, since we
14 sent Commissioners' materials out, there have been some
15 major developments regarding the territories' federal
16 funding which makes the situation somewhat less dire than
17 described in your materials, and I'll be talking more about
18 that momentarily.

19 So, I'll begin by reviewing background
20 information on the territories' Medicaid programs,
21 including their program structures and their financing
22 structure and their spending. I'll talk about the

1 territories' current financing situation, including the
2 arrangement currently in effect for FY2020 to FY2021, and
3 explain the recent developments I just referred to. Then
4 I'll turn to some of the solutions under consideration for
5 the longer term, including those that involve permanent
6 changes to the territories' financing arrangement to make
7 it more state-like, and I'll go through some of the design
8 considerations for those.

9 Territories are generally considered states for
10 the purposes of Medicaid unless otherwise specified, but
11 their Medicaid programs differ from states and from one
12 another in several important ways. Guam, Puerto Rico, and
13 the U.S. Virgin Islands have similar program structures as
14 states. The Northern Mariana Islands and American Samoa
15 operate their programs under a 1902(j) waiver, which are
16 uniquely available to them and allow the Secretary to waive
17 almost any Medicaid requirement.

18 Territories face a number of unique challenges
19 that affect their programs. For example, their remote
20 locations often result in high costs for certain items and
21 services. Additionally, they must frequently send patients
22 far off island, for example, to the mainland U.S. or even

1 to New Zealand for services not available locally.

2 For anyone looking to learn more about territory
3 Medicaid programs, we've provided a link on this slide to
4 our fact sheets for each territory.

5 The territory Medicaid programs operate on a
6 capped allotment financing structure. This means that
7 unlike the states, which can access an unlimited amount of
8 federal dollars at the applicable matching rate,
9 territories may only do so up to an annual cap, which is
10 specified in Section 1108(g) of the Social Security Act.
11 This is called the "Section 1108 cap" or "Section 1108
12 allotment." Moreover, the federal medical assistance
13 percentage, or FMAP, is specified in statute at 55 percent,
14 which is much lower than what territories would receive if
15 their FMAPs were determined through the same formula that's
16 used for states, which is largely based on per capita
17 income. This arrangement has historically been
18 insufficient to fund territory Medicaid programs, and as a
19 result, territories have had to rely on time-limited
20 increases in federal Medicaid funds.

21 Spending varies by territory, and detailed
22 spending information is included in your materials, and for

1 the public, the same information is in MACPAC's territory-
2 specific fact sheets.
3 Puerto Rico is by far the largest territory when
4 it comes to spending; however, spending per full-year
5 equivalent enrollee is substantially lower in every
6 territory than in each of the 50 states or D.C.
7 With this slide, we can compare spending per
8 full-year equivalent enrollee in states versus the
9 territories, and so this is for fiscal year 2019. All the
10 way to the left over here, you have a box and whiskers
11 which shows where each of the 50 states and D.C. are, once
12 we backed out spending for long-term services and supports,
13 which the territories generally do not provide. So, the
14 lowest-spending state here spent about $3,800; the median-
15 spending state spent about $6,400; and then the highest-
16 spending state spent about $9,700. And, again, that's
17 excluding LTSS spending.
18 Over here you have territory spending per full-
19 year equivalent. The X's represent actual spending per
20 full-year equivalent in FY2019, which is a year where
21 territories had temporary additional federal funds
22 available to them at an enhanced matching rate. And the

1 triangles represent where spending would have been if
2 territories had been limited to their usual Section 1108
3 allotment for that year absent additional funds. And in an
4 example here, Guam, the highest-spending territory, spent
5 about $3,300 per full-year equivalent enrollee, but without
6 the additional federal funds, its Section 1108 allotment
7 would have allowed it to spend just $911 per full-year
8 equivalent enrollee. And you can compare that to what the
9 states are doing, less than a quarter of what the lowest-
10 spending state is doing and less than 10 percent of what
11 the highest-spending state is doing.
12 Congress has provided temporary increases in
13 federal funds and FMAPs on several prior occasions. Most
14 recently, through the Further Consolidated Appropriations
15 Act of 2020, Congress substantially raised each territory's
16 Section 1108 cap for fiscal years 2020 and 2021 and raised
17 the FMAPs for these fiscal years as well to 76 percent for
18 Puerto Rico and 83 percent for the other territories. And
19 then the Families First Coronavirus Response Act further
20 raised the allotments to help respond to COVID-19 and also
21 provided a 6.2-percentage-point FMAP bump during the public
22 health emergency, which was available to all states and

1 territories.

2 So now I'm going to touch on some of the late-
3 breaking developments regarding the allotments for fiscal
4 year 2022 and future years. So, Commissioners, in your
5 materials we noted that due to what appears to have been a
6 drafting error in making changes to Section 1108(g) to
7 provide temporary funding increases for FY2020 and 2021,
8 Congress changed the base years for calculating future
9 allotments for American Samoa, Northern Mariana Islands,
10 Guam, and the Virgin Islands. As of late last week, CMS
11 had notified Congress and the territories confirming that
12 it plans to interpret the language of Section 1108(g) in
13 such a way that uses FY2021 as the base year for
14 calculating these territories' Section 1108 allotments for
15 FY2022 and future years, and that uses FY2020 as the base
16 year for Puerto Rico. This interpretation of Section
17 1108(g) will raise the allotments to levels similar to
18 those in FY2020 and FY2021 plus the growth factor, in
19 perpetuity. However, there's some disagreement about
20 whether FY2020 should be used as the base year for Puerto
21 Rico.

22 In any case, none of this affects the

1 territories' FMAP, so without congressional intervention,
2 FMAPs will revert to 55 percent.
3 This table shows the Section 1108 allotment
4 starting with FY2020, FY2021, and then it shows the FY2022
5 allotments based on the initial interpretation, which I
6 think most people were expecting, and then it shows the
7 FY2022 allotments which CMS has notified the territories of
8 and will be using based on the revised interpretation. So,
9 you can really see the difference here.
10 So earlier this week, following these new
11 developments Congress included in the continuing resolution
12 two provisions related to the issue: first, a temporary
13 extension of the current FMAP levels, so 76 percent for
14 Puerto Rico and 83 percent for other territories during the
15 CR, so through December 3rd. They also included language
16 directing the U.S. Government Accountability Office to
17 review CMS' interpretation of Section 1108. The extension
18 of the FMAP combined with the higher FY2022 allotment means
19 that the immediate threat of a fiscal cliff for the
20 territories is off the table for the moment.
21 Now I'm going to turn to some of the decision
22 points and some of the discussions taking place for the

1 medium and longer term now that this fiscal cliff is off
2 the table for the moment. So, in the medium term, there
3 are some decision points -- first, the allotment levels.
4 The likelihood of Congress acting on this issue is still
5 unclear and may depend on the outcome of GAO's review. If
6 GAO agrees with CMS' interpretation allowing permanently
7 higher levels, Congress may accept those levels without
8 further action. If GAO does not agree with CMS'
9 interpretation, Congress may have more pressure to act and
10 may modify the allotments or act to clarify that the
11 increases are temporary. And, of course, Congress could
12 act to modify or make temporary the allotment levels or
13 both, as they see fit, regardless of what GAO decides.
14 Aside from the allotment issue is the FMAP issue
15 and whether to extend higher FMAP levels beyond the CR, at
16 which point the territories' FMAPs will revert to 55
17 percent. At a 55 percent FMAP level, some, if not all,
18 territories will struggle to draw down their full Section
19 1108 allotment due to limited local funds. This situation
20 could constrain resources just as much as a lack of federal
21 funds caused by a low Section 1108 allotment.
22 Additionally, there's the issue of program

1 improvement requirements and whether Congress would include
2 any of those, for example, as part of an FMAP solution or
3 change in allotment levels. For example, a requirement
4 that Puerto Rico implement an asset verification program
5 was part of the compromise bill providing temporary funding
6 to the territories, which passed the House Committee on
7 Energy and Commerce before CMS made this recent
8 announcement.
9 In the longer term, there are ongoing discussions
10 around a permanent change to the territories' financing
11 structure that would provide a transition to a more state-
12 like financing arrangement. A perennial issue in these
13 discussions is what kind of other reforms should accompany
14 changes in financing. These could range, for example, from
15 modest program improvements to a more broad expectation
16 that territory Medicaid programs become more aligned with
17 states. There are a number of considerations for lawmakers
18 contemplating such policies.
19 Several of these are related to the financing
20 structure. One is the Section 1108 allotment and whether
21 it should remain in place at the higher level and, if so,
22 how the appropriate level should be determined; or,

1 alternatively, if the Section 1108 allotment should be
2 removed entirely in favor of an open-ended financing
3 arrangement, which is what states have.
4 Another is the FMAP and whether it should remain
5 statutorily specified but perhaps set permanently at a
6 higher level or if it should be more removed from statute
7 and be determine based on the typical FMAP formula, and
8 then the timeline for any changes.
9 In terms of areas to align territory programs
10 with state programs, these could include requiring
11 territories to provide all mandatory benefits, cover all
12 mandatory eligibility groups, meet additional program
13 integrity requirements, and establish certain
14 administrative systems. Congress would need to consider
15 whether financing solutions and accompanying requirements
16 should be applied across all five territories or whether a
17 new policy should be customized to each territory based on
18 their unique circumstances.
19 Congress would also need to consider what
20 programmatic changes are desirable, appropriate, and
21 feasible for territories given factors such as territories'
22 health care infrastructure and delivery system, size of the

1 Medicaid program, and administrative capacity. For
2 example, although requiring territories to cover nursing
3 facilities along with all other mandatory Medicaid benefits
4 would be consistent with state Medicaid benefit packages,
5 doing so may not be feasible or desirable. These such
6 facilities exist in the territories, and building up
7 nursing facility infrastructure to provide these services
8 may be inconsistent with the policy goals to rebalance
9 delivery of long-term services and supports away from
10 institutions and towards home and community-based services.
11 The issue of whether to maintain American Samoa
12 and CNMI's 1902(j) waiver will also need to be weighed. If
13 it remains in place, any new requirements placed by
14 Congress would be superseded by the waiver unless
15 specifically carved out as exceptions.
16 Again, Congress would need to consider the
17 timeline for changes and new requirements and what type of
18 implementation periods are reasonable. New requirements or
19 program changes may be accompanied by incentives or
20 penalties. For example, Congress could provide enhanced
21 FMAPs for certain activities, or it could impose FMAP
22 penalties for failure to meet requirements. And, finally,

1 when considering new requirements, the timeline for
2 compliance and any penalties for not complying in
3 accordance with the timeline, Congress might wish to
4 consider what flexibility is appropriate if territories
5 experience extenuating circumstances.
6 So as our next steps, we will continue to monitor
7 CMS and congressional action in the short term regarding
8 financing for FY2022 and future years. We'll also monitor
9 discussions around longer-term changes to the financing
10 structure as well as programmatic and administrative
11 requirements. We welcome any feedback you have on how
12 MACPAC might be able to inform considerations of long-term
13 proposals, and I can answer any questions you have. So, I
14 will turn it over.
15 VICE CHAIR DAVIS: Thank you, Kacey, and thank
16 you for the updates. I think everybody is breathing a
17 little bit easier that that fiscal cliff has been pushed
18 out a little bit more. And you've given us a lot of
19 information here to kind of wrestle with and questions, and
20 I think it might be helpful to break them down into two
21 parts to think about those medium-term decisions and then
22 to think about, you know, the implications for state-like

1 financing.

2 So, let's start with the medium-term decisions
3 and maybe we can even go back to that slide. And if
4 there's any comments or questions, we can wrestle with that
5 a little bit. So, for the medium term. Heidi?

6 COMMISSIONER ALLEN: Sorry if you can hear my dog
7 in the background. I'm wondering if we've ever applied a
8 health equity lens to looking at the territories.

9 VICE CHAIR DAVIS: That's a great question. I
10 think we've talked before. Kacey, I'd love to hear, you
11 know, how we start to think about health equity issues in
12 the territories. It's much larger than, you know, we think
13 about kind of systemic or long-term disenfranchisement of
14 groups and how they're funded.

15 MS. BUDERI: That's definitely a great question
16 and something that, you know, will need to be considered as
17 these conversations go forward. I think as far as what
18 MACPAC has done so far, we talked a little bit about
19 disparities in our Puerto Rico chapter, which was in 2019.
20 But I think that's something we could maybe focus on again
21 for future work and, you know, obviously apply it to other
22 territories and not just Puerto Rico.

1 VICE CHAIR DAVIS: Thanks.
2 COMMISSIONER ALLEN: I think that that would be
3 really important for informing both Congress in the medium
4 and long term.
5 VICE CHAIR DAVIS: Thanks, Heidi. Brian?
6 [Pause.]
7 VICE CHAIR DAVIS: We can't hear you. You're not
8 muted on this end.
9 COMMISSIONER BURWELL: There we go. Sorry. I
10 thought I was still muted by organizer.
11 You know I've always been interested in the
12 relationship between Medicaid financing and Puerto Rico and
13 the overall financial situation of Puerto Rico. So, Puerto
14 Rico has been in bankruptcy for four years and has
15 defaulted on its municipal bond debt. And I'm wondering
16 how that has related -- I certainly don't expect you to
17 know the answer to this, but it's curious -- to Puerto
18 Rico's ability to provide the state match for the Medicaid
19 program and whether they have actually been able to come up
20 with a state match while it's been in bankruptcy over the
21 four years and what level of FMAP they are seeking in the
22 current negotiations. They got a temporary FMAP increase

1 to -- I don't remember the slide, but a fairly high one --
2 83 percent, is that right, Kacey?
3 MS. BUDERI: So, Puerto Rico's correct FMAP is 76
4 percent, plus the 6.2 percentage point bump that all states
5 and territories get.
6 So, they've had that for the last year, but I'll
7 note that for fiscal years 2018 through 2020, they had a
8 100 percent FMAP. So, they've had an enhanced FMAP for
9 some time now, and I think their ability to contribute the
10 local match at the 55 percent FMAP is still -- you know, I
11 don't know that we have information to predict their
12 ability to draw that down, but I think it's likely that
13 Puerto Rico along with other territories would struggle to
14 draw the allotments down at that FMAP.
15 COMMISSIONER BURWELL: Do we have any idea around
16 negotiations? Is Puerto Rico wanting 100 percent FMAP in
17 the current extension?
18 MS. BUDERI: I don't know what they are asking
19 for in their negotiations with Congress. I think the
20 conversation has mostly been around maintaining the levels
21 where they are now, 76 percent to Puerto Rico and 83
22 percent for the other territories.

1 COMMISSIONER BURWELL: Okay. I just think it's
2 important for us to be aware of what's going on with Puerto
3 Rico's overall financial situation as we research its
4 Medicaid financing. I guess that's just a comment.
5 VICE CHAIR DAVIS: Thank you, Brian.
6 Martha?
7 COMMISSIONER CARTER: I think we've had some of
8 this conversation before, but I'd like to reiterate that
9 from my perspective and I think from the Commission's
10 perspective, short-term financing like the territories have
11 is just no way to run a Medicaid program and certainly no
12 way to run a business. And so any of these medium-term
13 decisions, I think, should be an interim plan to get to the
14 point where those other considerations that Kacey brought
15 out can be hashed out and decided with a goal of some sort
16 of stability in funding the Medicaid programs in the
17 territories.
18 VICE CHAIR DAVIS: Thank you, Martha.
19 Verlon?
20 COMMISSIONER JOHNSON: Thanks.
21 So, this was great. I really appreciate you
22 really providing this information.

1 I have a question, though. If you can go back to
2 the slide where you do a comparison of the states and the
3 territories in terms of the financials. The question that
4 Heidi brought up and I think all of us are thinking about
5 in terms of equity really stands out, and I'm just curious.
6 Is there any way we can find out were there any improved
7 outcomes, or was the increased FMAP during this time frame
8 that got them up to at least a little bit better than where
9 they were before -- was there any improvements in the
10 health care outcomes from their perspective? Was it just
11 really a matter of getting them to a level of where we went
12 at the same place at this point? I'm just trying to figure
13 out from a financial standpoint if there's any data that we
14 can kind of support to show that this additional assistance
15 to really be helpful to the territories.
16 MS. BUDERI: Yeah. So, we don't have any, like,
17 quality outcomes that we could compare prior to when these
18 additional federal funds and higher FMAPs was available and
19 now, but we do have some information on program
20 improvements that the territories have made, in those fact
21 sheets, a little bit in the Puerto Rico chapter, that talk
22 about some of the improvements and additional benefits and

1 increased eligibility that territories have implemented
2 since receiving these additional funds. So, there is some
3 information on, I guess, program enhancements but not
4 necessarily data on quality.
5 COMMISSIONER JOHNSON: Okay. All right. Thank
6 you.
7 VICE CHAIR DAVIS: Thank you.
8 Bill and then Darin.
9 COMMISSIONER SCANLON: Yeah. Hi. I was going to
10 say kind of since we started to talk about the longer term,
11 but I think it relates in part to this comparison in this
12 figure as well as the longer term. And that to me is -- I
13 don't know how to interpret or understand this figure in
14 the sense that a dollar does not mean the same thing in
15 each of the territories versus to the states, and that --
16 and getting information about sort of differences in
17 outcomes or differences in structures of programs and
18 access, I mean, I think that gives you more reliable
19 measures of how these Medicaid programs in these areas may
20 vary.
21 For me, it also has an implication for the
22 question of the FMAP, and I think that moving from the

1 current statutory or FMAP to something different, it
2 certainly seems very reasonable. But the idea of saying
3 that we should do it using the FMAP formulate to me does
4 not make a lot of sense because a dollar of income in the
5 territories is not the same sort of as dollar of income in
6 the states, and since the current FMAP is built upon
7 relative income levels, I think that you end up with sort
8 of the wrong result.

9 It's much more appropriate, I believe, to look at
10 the territories, look at what their needs are, look at what
11 their ability is. And Brian brought this up. What's their
12 ability to do matching for a program that's going to meet
13 the needs of their citizens? And from the chapter or
14 materials, we know that the level of Medicaid is extremely
15 different in some of these territories than it is in an
16 average state. So, taking those factors into account, one
17 can maybe come up with an appropriate FMAP that can be in
18 statute, but it's in statute because it was well thought
19 out as opposed to what was a number that was picked at a
20 point in time and then left there for perpetuity.

21 So that's my reaction to this as well as comment
22 on the longer term.

1 VICE CHAIR DAVIS: Thanks, Bill.
2 Darin is up next, and I think we can also start
3 to transition into comments around the longer term.
4 COMMISSIONER GORDON: Yeah. Thank you for this,
5 Kacey. Always helpful.
6 I do want to tie this page a little bit back to
7 what we heard from Puerto Rico previously about -- from an
8 access perspective. You know, they were talking about
9 provider capacities diminishing, more and more providers
10 moving to the states, in which case then you also get in a
11 situation where members needing to access services are
12 getting care in the states at a higher price point. So, I
13 hear you, Bill, but I do think we need to recognize that to
14 the extent that they're not able to retain some of that
15 provider capacity on the island might default if they are
16 going to be paying something more closely to what the
17 states are paying because they're going to Florida to get
18 that care, so something about access needs to be
19 incorporated in all of this.
20 COMMISSIONER SCANLON: Darin, if I could just say
21 I would agree with you that we should be thinking of that
22 as one of the factors. It's just that the issue is think

1 about what the realities are in setting the FMAP as opposed
2 to using a formula that doesn't necessarily fit.
3 COMMISSIONER GORDON: My comment is more about
4 when we look at how this equates that we recognized in the
5 absence from what was shared in our prior meeting, that in
6 the absence of that, that by default, the numbers can
7 gravitate more to looking more like what the state range
8 looks like over there if they're not able to retain access
9 in care delivery on the island itself. So just -- it's
10 just access has got to be a component of all this and
11 understanding that's a dynamic we really don't have in the
12 states that we just need to be cognizant of.
13 VICE CHAIR DAVIS: I think if we can transition
14 now to the slides that have the design considerations for
15 considering state-like matching. So, you've put in a few
16 suggestions here around payment feasibility, financing
17 structure. Questions to the group? Thoughts that folks
18 have here?
19 COMMISSIONER HEAPHY: This is Dennis.
20 I'm wondering -- I'd like more data on the
21 disparities and the outcomes and access before I can even
22 imagine what the answer would be. It just seems that from

1 an equity perspective, we need a lot more information -- or
2 I do, to understand this to make a recommendation for an
3 outcome. What we have is just not viable, these are
4 Americans, and I think it's just important. Like, how do
5 we look at -- how would we -- what kind of data do we need
6 to better understand what's actually happening in the
7 territories from an equity perspective? Like, that for me
8 would be the immediate step.
9 VICE CHAIR DAVIS: Dennis -- and I open this up
10 to others too. You know, we kind of touched on this equity
11 issue in terms of the data, what it's like to see -- we
12 talked a little bit about kind of quality, but I think also
13 knowing, you know, who's -- access to providers, who's
14 being transported over, you know, what that looks like, it
15 would open it up here for folks to talk about what we would
16 really like to see from an equity standpoint.
17 COMMISSIONER HEAPHY: This is Dennis, and then
18 I'll shut up, but just diabetes, what's the percent of the
19 folks with diabetes, diabetes that's under control, folks
20 with amputations, the life expectancy of folks after
21 amputations? Like, select a couple of categories that we
22 can track and see -- or obesity, but I'll stop there.

1 VICE CHAIR DAVIS: Thanks.
2 Melanie and then Anne.
3 CHAIR BELLA: Yeah. I just have a question. I
4 mean, I guess for me, like the -- I'm thinking of equity in
5 terms of the access that people in the territories get
6 relative to the access that people in the states get and
7 the structural differences in the program. We don't make
8 decisions about whether -- I'll pick on my state --
9 Pennsylvania should get FMAP based on the number of people
10 in state with diabetes or other conditions. So, I'm
11 struggling a little bit with, I guess, the level at which
12 we're applying certain lenses.
13 And, Dennis, I think some of what you're asking
14 for, we probably have from past discussions and past
15 analyses, and it may just not have come back in this
16 context. For me, it's a much different order of question
17 before we start to look at sort of making decisions based
18 on is there chronic condition prevalence or are there
19 disparities bad enough that we would star to treat them
20 differently. That's where my head is, like, a little
21 unclear on what we would be looking for in that area.
22 VICE CHAIR DAVIS: Yeah. Anne and then Martha.

1 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. To follow on
2 with Melanie, I think the point being raised about what is
3 the status of health and what's the level of need in the
4 territories is obvious. It makes sense, but I don't think
5 that we have the data. I also think there's a first-order
6 question here about how much money do the territories can
7 access to actually address the level of need that's in
8 their territory.
9 The issue that Bill raised about standardizing
10 measures of spending based on income is potentially
11 something that we could do to create a more apples-to-
12 apples comparison, but my hunch is that we are still going
13 to see a large disparity in what is available to spend in
14 the territories, even if we adjust it for the fact that
15 incomes are relatively lower.
16 So, I think that staff can be clear with
17 Commissioners about what data exist to answer some of these
18 questions. Really the long-term issue for Congress is if
19 you're going to provide a permanent, more stable financing
20 structure for territories, what is the expectation for them
21 in terms of what their Medicaid programs should look like?
22 Presumably, you don't want to be making that based on a

1 bunch of sort of one-shot decisions, even though those
2 might be important.
3 VICE CHAIR DAVIS: Yeah. Martha?
4 COMMISSIONER CARTER: I think I'm repeating
5 myself to some extent, but the people in the territories
6 are American citizens. So, we don't ask all these
7 questions when we think about whether we're going to fund
8 Arkansas versus West Virginia.
9 Yes, there are some questions that have to be
10 addressed, and there are differences. And I think that's
11 the level that we need to be looking at, not whether they
12 deserve ongoing stable funding. I think that's a given, in
13 my mind, because of the equity issues.
14 VICE CHAIR DAVIS: Thanks, Martha.
15 Brian?
16 Stacey, did I see your hand?
17 [No response.]
18 COMMISSIONER BURWELL: I just remember when we
19 were talking about this in the spring that Sheldon raised,
20 went back and looked at it and found data that even though
21 physicians are leaving Puerto Rico in large numbers, that a
22 number of physician per capita in Puerto Rico is still

1 considerably higher than in the United States. And I just
2 looked it up, and that data are confirmed.
3 So, I guess I'm more in Bill's camp. It's really
4 hard to compare apples to apples in Puerto Rico and
5 elsewhere in terms of cost per capita or even workforce
6 supply. I guess my comment is I just think we need to be
7 careful in making judgments about what's going on down
8 there.
9 VICE CHAIR DAVIS: Thanks, Brian.
10 Stacey, was that a hand or passing?
11 COMMISSIONER LAMPKIN: Yes.
12 I have a question, Kacey, and I apologize if this
13 is something we've talked about before. Do we have a sense
14 of the funding opportunities that exist for infrastructure
15 rebuild and this stabilizing or addressing some of the
16 infrastructure challenges, workforce one of them but not
17 perhaps the only one? Because we're talking about here,
18 it's a financing for the service delivery itself, right?
19 MS. BUDERI: I can certainly see if we can
20 provide some more information on non-Medicaid funds that
21 are available for infrastructure or some things like that.
22 I don't know that we have information on how much of their

1 Medicaid dollars are going towards those types of
2 activities, but I can look in to see what information
3 that's available.
4 COMMISSIONER LAMPKIN: It's just to me it seems
5 like there's some linkages between the longer-term planning
6 of financing the services and what's happening through
7 other funding sources related to infrastructure rebuild and
8 service capacity.
9 VICE CHAIR DAVIS: Thanks, Stacey.
10 You know, Kacey, one of the questions that you
11 posed to us in the memo was being clear about -- and
12 thinking about it's really beyond our ability to say what
13 is the feasibility of a state to be of -- you know, a
14 territory to meet a certain level of, you know, readiness
15 or capacity, but that we can weigh in on saying that those
16 factors are important in recommending that who should --
17 you know, that Congress or CMS should take that into
18 account when we are really, you know, putting forth
19 recommendations. And I'm curious if folks have thoughts on
20 other things that could be included.
21 You know, it's not our job really to say, you
22 know, Puerto Rico can meet this threshold or not, but we

1 can say we think that that's an important factor to take
2 into account.
3 Yeah, Anne.
4 EXECUTIVE DIRECTOR SCHWARTZ: Well, I think I
5 just would like to add that the fact that the fiscal cliff
6 is not as imminent as we expected, the week before last,
7 maybe it buys us some more time to regroup on this and
8 think about what kind of analysis would be useful, because
9 we're looking at potentially a longer period of time to do
10 the work.
11 VICE CHAIR DAVIS: All right. I think we're
12 going to wrap up. Kacey, any of your questions for the
13 group?
14 MS. BUDERI: No. Thank you. Helpful feedback,
15 so thanks.
16 VICE CHAIR DAVIS: And I think what you're
17 hearing strong voice for is continuing to look at this
18 through an equity lens and also thinking about what are
19 those kind of requirements that we need to look in place,
20 and I think Bill's question of how we think about FMAP
21 plays into this as well.
22 All right. So, I think we can transition and

1 invite Joanne. Joanne?

2 We are about five minutes ahead, but I think

3 we'll just keep moving.

4 **### MEDICAID LEVERS TO ADDRESS CONCERNS ABOUT THE**

5 **PRIMARY AND SPECIALTY CARE WORKFORCE**

6 * MS. JEE: All right, Commissioners. Last session

7 of the day.

8 Okay. So, in this last session, we will focus on

9 Medicaid levers to address primary and specialty care

10 workforce concerns. This is an issue raised by

11 Commissioners over the past few years; for example, with

12 respect to behavioral health and substance use disorder and

13 oral health as well as primary care.

14 I wanted to be sure to mention that this session

15 will not focus on home- and community-based services or

16 nursing facility services, although workforce is, of

17 course, a very important concern for both.

18 MACPAC currently has separate projects underway

19 to examine workforce in those areas, and staff will be

20 sharing information from that work at future meetings.

21 I also wanted to acknowledge here that this is a

22 persistent issue, but it is not one that is unique or

1 limited to Medicaid, of course. But for purposes of today,
2 we really are just focusing on Medicaid's role in
3 addressing workforce and the levers there, and that role is
4 relatively limited compared to other federal programs.
5 So, during this session, I will quickly provide
6 some background information just for some context, then
7 review some of the ways in which Medicaid is responding to
8 concerns about workforce and then end with some next steps
9 for our work.
10 So, an inadequate or insufficient provider
11 workforce to serve Medicaid beneficiaries, as you know, can
12 create barriers to timely or culturally competent care.
13 Key factors affecting the Medicaid primary and specialty
14 care workforce include the supply distribution and
15 diversity of providers.
16 With respect to supply, the Health Resources and
17 Services Administration, or HRSA, projects the supply and
18 demand of different types of providers. They project that
19 there will be a shortage of providers such as primary care
20 physicians, OB/GYNs, and certain behavioral health
21 providers, but an oversupply of other provider types such
22 as nurse practitioners and certified nurse midwives by 2025

1 or 2030, depending on the provider type.

2 The next factor is distribution and

3 maldistribution of providers. Again, it's a persistent

4 problem, and HRSA identifies shortage areas by specialty,

5 populations, regions, and facilities. These are referred

6 to as the "health professional shortage areas," or the

7 HPSAs.

8 And last, a diverse workforce can help improve

9 access to care generally and in underserved areas. Greater

10 concordance between the race and ethnicity of providers and

11 patients has been correlated with better patient outcomes,

12 satisfaction, and communication. However, Black, Hispanic,

13 and Native American people are underrepresented in health

14 professions such as advanced practice nurses, dentists, and

15 physicians.

16 The states and the federal government play

17 different roles with respect to the health care workforce.

18 States are responsible for setting licensure rules and

19 requirements as well as establishing and enforcing scope of

20 practice rules. They also collect data and assess the

21 adequacy of their health care workforce and engage in

22 various recruitment and retention activities.

1 States also set the policies for the Medicaid
2 programs within federal rules. This includes, for example,
3 whether or how to use available Medicaid levers to address
4 the workforce concerns in their states.
5 Much of the federal responsibility for health
6 workforce activities lies within HRSA. These include, for
7 example, examining workforce supply and demand; in other
8 words, identifying the types of providers in shortage or
9 surplus, which I just mentioned, and designating the HPSAs.
10 The federal government also administers provider
11 recruitment and retention activities such as loan
12 repayments and scholarship programs. These are summarized
13 in your reading materials, and I won't review those during
14 this session. The federal government also provides funding
15 for provider training and education.
16 So, moving on to ways that policy levers can be
17 used in a Medicaid-focused way, the federal workforce
18 programs administered by HRSA affect Medicaid, given the
19 priority that they place on rural and underserved areas as
20 well as the priority that they place on providers such as
21 federally qualified health centers, or FQHCs, which serve
22 many Medicaid beneficiaries.

1 One of these programs, the Grants to States to
2 Support the Oral Health Workforce, includes an option for
3 grantees to target the Medicaid workforce specifically.
4 One option under this grant program provides for grants to
5 support oral health providers participating in Medicaid to
6 establish or expand practices in dental HPSAs, and they do
7 this by supporting the cost of equipment or in providing
8 for part of the overhead cost of these practices.
9 Two examples of states leveraging these grants in
10 this Medicaid-focused way include Washington and Wisconsin.
11 Washington is using these funds to help establish -- or use
12 these funds to help establish the state's first rural
13 health dental clinic, and the clinic's primary goal is to
14 serve Medicaid beneficiaries in the county in which the
15 clinic is located. So, through subgrants, the state
16 provided funding to a local provider for equipment as well
17 as to hire a staff person to help establish the rural
18 clinic.
19 Wisconsin is providing support to dental clinics
20 with the aim of increasing the number of dental clinics
21 serving Medicaid beneficiaries as well as increasing their
22 dental utilization rates.

1 Some Medicaid programs have incorporated a
2 workforce component into their delivery system reform
3 initiative payment programs, more commonly referred to as
4 the DSRIPs. As a reminder, DSRIPs are mechanisms for
5 providing Medicaid funding for delivery system
6 infrastructure and reform efforts. The workforce
7 components of DSRIPs are really intended to prepare
8 providers for working within the new delivery systems and
9 the new payment systems, but some states have also used
10 DSRIP funds, to some extent, to improve the adequacy of the
11 Medicaid provider workforce. However, the workforce
12 initiatives are relatively small components of the DSRIPs.
13 Another important reminder here is that CMS is no
14 longer approving new DSRIPs or renewing any of the existing
15 ones.
16 In Massachusetts, the DSRIP allocates about 6
17 percent of funds to strengthening the workforce. Examples
18 of the way in which Massachusetts is doing this include a
19 loan repayment program of up to $50,000 a year for primary
20 care for behavioral health providers practicing in
21 community-based settings, and the types of providers who
22 might be eligible for this include, for example, nurses and

1 care coordinators, psychiatrists, and primary care
2 physicians.
3 The community-based training and recruitment
4 program supports residency slots in family medicine and for
5 nurse practitioners at community health centers. The
6 workforce professional development grants support training
7 grants and training slots to improve the capacity of the
8 nonclinical workforce. These include, for example,
9 community health workers and peer specialists who work with
10 Medicaid beneficiaries with mental illness.
11 In New Hampshire, the DSRIP workforce program
12 focused on the behavioral health workforce as well. New
13 Hampshire's DSRIP required providers to form regional
14 coalitions to implement performance-based incentive payment
15 programs, and these coalitions, which are referred to as
16 integrated delivery networks, were required to engage in
17 workforce capacity development programs, and they were
18 permitted to use DSRIP funds to recruit, hire, train, and
19 retain behavioral health and substance use disorder
20 providers.
21 Finally, another Medicaid policy lever is the
22 Medicaid graduate medical education, or GME program. Here,

1 I'll just take a moment to note that while the total
2 Medicaid spend on GME in 2018 was about $5.6 billion, it is
3 relatively small compared to Medicare's $15 billion in
4 spending. So, the Medicaid spending was about a third that
5 of Medicare.
6 States are not required to make Medicaid GME
7 payments, but most do, and states have substantial
8 flexibility in how they design and implement their
9 programs.
10 While most states describe the objective of their
11 Medicaid GME programs as supporting the training of
12 physicians who will serve Medicaid beneficiaries, there is
13 very little data reporting required, and little is known
14 about the effects of Medicaid GME on workforce.
15 So, Commissioners, if you have feedback on other
16 ways that states are designing Medicaid-based approaches
17 for addressing the primary and specialty care workforce, I
18 would welcome it, and as far as next steps for this work
19 goes, staff could continue looking at these approaches that
20 I mentioned, including, for example, obtaining additional
21 information on the outcomes or state experiences using
22 those programs. And then we could prepare a brief that

1 would describe the findings from this work.

2 So that is all I have. I will turn it back to

3 you.

4 VICE CHAIR DAVIS: Thanks, Joanne.

5 I see Laura's hand -- oh, I'm getting feedback.

6 You know, one of the things that we hear a lot as

7 proposed as kind of a simple solution for provider

8 workforce issues that we recognize it's not nearly as

9 simple as what's out there is just pay providers more, and

10 we hear that a lot. And I wonder if you could just touch a

11 little bit on the complexities of that, the data that we

12 have that really talks about provider payment rates and how

13 that might relate to supply.

14 EXECUTIVE DIRECTOR SCHWARTZ: Do you want me to

15 jump in here, Joanne?

16 MS. JEE: Okay. Sorry. I am really having a

17 hard time with technology today. I apologize.

18 So, yeah. So, you're right. I mean, we do hear

19 a lot about, you know, pay the providers more. We didn't

20 really look at that for purposes of this work, but I think

21 that it is something that we hear about. We do know that

22 it is a major factor. I think that there was -- you know,

1 Martha presented some work several months ago about
2 provider acceptance of Medicaid, and that really sort of
3 underscored the importance of provider payment. If I'm
4 correct, we don't have a lot of data on sort of what the
5 provider payment is, particularly in managed care states.
6 So, I think that data is a little bit hard to get.
7 EXECUTIVE DIRECTOR SCHWARTZ: I guess I would
8 just add here that over time, the themes around provider
9 payment and particularly physician payment in Medicaid has
10 been consistent. Joanne is correct that we generally
11 collect fee-for-service data, and we have a general idea
12 that managed care plans may be paying somewhat more than
13 what fee-for-service is but definitely less than Medicare
14 and private payers, and that payment does affect
15 physicians' willingness to participate in Medicaid. But
16 there are other factors that also affect their willingness
17 that have to do with where their practices are located,
18 their accessibility to Medicaid beneficiaries, issues
19 around no-shows, and also some of these are the hassle
20 factor around getting paid by either the Medicaid program
21 itself or Medicaid MCOs.
22 VICE CHAIR DAVIS: Thanks, Anne and Joanne.

1 So, we have quite the list of folks here. Laura,
2 then Bill, Fred, Brian, Toby, Bob, Martha. If I missed
3 you, I'll get you after that, but let's go to Laura first.
4 COMMISSIONER HERRERA SCOTT: Thank you, Kisha.
5 Thank you, Joanne. This is a great overview.
6 So, I have several questions, you know, because
7 you presented work from -- through HRSA and then through
8 GME, but can you say anything about -- because I didn't see
9 any outcomes, and I know you left that hanging as potential
10 next steps, but anything around -- of those opportunities
11 that are provided, how many are left unfilled? So, people
12 are just choosing not to get loan repayment because they
13 don't want to then -- it's not -- they can make more money
14 someplace else and then pay off their student loans after?
15 So, if there's anything you can say about the number of
16 spots that are left open.
17 And then on the GME side, is there any data to
18 understand, of that $5 billion, how many of those are
19 funding primary care slots?
20 MS. JEE: Okay. So, I did not look at the HRSA
21 programs and sort of whether or not there are unfilled
22 slots in those programs. I could get back to you if

1 there's any information on that available.

2 I do know that in the Massachusetts -- through
3 the Massachusetts workforce program through the DSRIP that
4 they did fill pretty much all of their slots, but that
5 there was some -- and, you know, I think it's a pretty
6 modest program. But they were surprised in the first year
7 where there were not as many applicants in primary care,
8 and there were many more applicants in the behavioral
9 health space. So, in subsequent years, they were able to
10 sort of adjust the number of slots in the loan repayment
11 program.

12 Then, on the GME side, my understanding is that
13 there's very little data on the Medicaid side in terms of
14 how the GME payments are calculated, who they're funding,
15 and then there's no sort of data coming back to understand
16 sort of the, I guess, outcomes of that money.

17 VICE CHAIR DAVIS: Thanks, Joanne.

18 Bill, you're up next.

19 COMMISSIONER SCANLON: Okay. In part, Anne
20 touched on some of what I was going to say. I mean, we do
21 have sort of very strong evidence repeatedly that providers
22 do respond to financial incentives, but they don't

1 necessarily respond in the ways that we want in terms of
2 filling in needs that we think are important.
3 The HRSA shortage areas is a good example of that
4 because there are a lot of shortage areas across the
5 country, and there were not enough funding slots either in
6 terms of scholarship or loan repayment to fill all those
7 slots. And when you're given choices, which the
8 individuals enrolling in these programs are, they go to
9 places where there already are providers because those are
10 the better places -- there's more in those communities to
11 attract you; you have colleagues in those communities -- as
12 opposed to going out and being totally on your own working
13 in an incredibly remote area where there may be an extreme
14 need sort of for people.
15 This whole issue of graduate medical education is
16 very complicated because from 1997 until very recently, we
17 had a freeze on the number of Medicare residency slots, and
18 yet the number of residency slots was growing significantly
19 because hospitals were funded residency slots to expand
20 sort of the workforce that was going to benefit them.
21 If we start to think about what role does medical
22 education play in this, it gets complicated for us to sort

1 of examine because you have to go beyond both Medicare and
2 Medicaid and sort of ask sort of broader questions.
3 The last comment I would make is about the
4 projection that you show, Joanne, from HRSA saying that we
5 have a shortage of primary care physicians, but we have a
6 surplus of nurse practitioners. HRSA is going back -- I'm
7 not sure if they're going back and forth, but over the
8 years, things have changed in terms of their perspective of
9 how much nurse practitioners can substitute for a
10 physician, primary care physicians, and I guess I'm
11 wondering if we can think about how do we make better use
12 of that potential surplus of nurse practitioners to fill
13 essential needs.
14 Thank you.
15 VICE CHAIR DAVIS: Thank you, Bill.
16 You know, it's an important point that you bring
17 up around GME funding, and hospitals, as they continue to
18 fund residency slots, tended to fund them for the ones that
19 were also profitable for the hospital. And so do we think
20 about expanding those GME slots for primary care slots
21 first to help fill those shortage areas?
22 Next, we'll go to Fred.

1 CHAIR BELLA: I just want to jump in for one
2 second because Kisha is too nice and still getting used to
3 being a battle-ax chair, and so we have 15 minutes with a
4 lot of people that want to talk and also the need for
5 public comment. So, I'd just ask you guys to keep that in
6 the back of your mind as you make your final comments.
7 COMMISSIONER CERISE: Okay. I'll go quick.
8 So, the GME funding, I can tell you that it's not
9 tied to producing a particular type of person or having a
10 commitment after training. It's generally calculated based
11 on how many you have and what your percent of Medicaid is,
12 and it's a cost calculation which, frankly, to my point, I
13 think if we want to learn from the things -- you know, our
14 experiments, it looks like the Massachusetts DSRIP, it has
15 the right idea. And that is you put some concentrated
16 funding with some expectations and their idea that they
17 would support a psychiatrist or a nurse practitioner in
18 that area if they would commit to a panel with 40 percent
19 MassHealth members afterwards, I think, is more of the
20 right idea.
21 A lot of hospitals are funding positions, GME
22 positions above their Medicare-funded rate and certainly

1 above what Medicaid funds, and when you get more funded
2 positions, they're generally just backfilling those costs
3 that you've already absorbed. But you could tie new
4 positions specifically to commitments to 40 percent panel
5 of Medicaid or a practice in a particular area, and that
6 would be more likely to get the impact that you're looking
7 for as opposed to just funding new positions without those
8 sort of expectations. But you have to be much more
9 explicit.

10 VICE CHAIR DAVIS: Thank you, Fred.

11 We've got Brian, Toby, Bob, and then Martha.

12 [No response.]

13 VICE CHAIR DAVIS: Can't hear me?

14 [No response.]

15 VICE CHAIR DAVIS: Brian --

16 COMMISSIONER BURWELL: I'll say that I think we
17 should pay attention to supply and demand issues in terms
18 of what the market is telling us, because I just know that
19 a lot of physician practices, instead of hiring, kind of
20 recruit more physicians, are hiring nurse practitioners or
21 physician assistants to meet the lower-need patients. And
22 that's just a function of the market. I guess, you know,

1 financially, as a business model, that's a better decision.
2 Same in the mental health market. Most
3 psychiatrists to me now seem to be just medication
4 prescribers, and people who are getting psychotherapy are
5 generally going to other types of people, psychologists or
6 other kinds of therapists, to get ongoing therapy. And
7 psychiatrists are not providing that service anymore.
8 So, I just think we have to acknowledge what's
9 going on in the market in general, not just, you know, this
10 historic number of physicians per capita.
11 VICE CHAIR DAVIS: Thank you, Brian.
12 We've got Toby, then Bob, then Martha.
13 COMMISSIONER DOUGLAS: I'll just be brief.
14 On Bill's plan about projections and the growth
15 and physician assistants and NPs, I think it gets to other
16 ways. Some states have scope of practice constraints.
17 What's the role of Medicaid in incentivizing the use of
18 different types of providers?
19 VICE CHAIR DAVIS: Are you looking for an answer,
20 or is it rhetorical?
21 COMMISSIONER DOUGLAS: It's a rhetorical. Keep
22 it moving.

1 VICE CHAIR DAVIS: All right. Bob?

2 COMMISSIONER DUNCAN: All right. We talked a

3 little bit about the reimbursement from Medicaid and that

4 impact, and when you think about pediatrics and half the

5 population of pediatric covered by Medicaid, true impact on

6 pediatricians as well as pediatric subspecialists and

7 specialists, and then when you factor in the children's

8 hospital GME, it will be about 45 percent of GME of

9 Medicare in 2024, is there a way MACPAC or we can assess

10 and look and divide the population by Medicaid kids versus

11 adults to examine the physician shortage when it relates to

12 children?

13 VICE CHAIR DAVIS: Thanks, Bob.

14 I'm going to go to you, Martha.

15 And then, Dennis, are you trying to jump in here?

16 [No response.]

17 VICE CHAIR DAVIS: Okay. We'll go to you after

18 Martha.

19 COMMISSIONER CARTER: Thanks.

20 I have two comments. First, I don't think I can

21 let the passing comment about an oversupply of nurse

22 midwives go. There are two points in that. One is that,

1 unfortunately, the majority of nurse midwives in this
2 country are White, and so from an equity standpoint, we
3 actually need more midwives of color because we know that
4 there are better outcomes when the provider is congruent
5 with the population being served. So that's one point.
6 And the other is that if we don't change our
7 system to be more like some of the European countries where
8 the midwives do more, let's say -- maybe we reword that.
9 If we would consider changing our system in this country to
10 mirror the countries in Europe where the midwives attend
11 the majority of births and get much better outcomes, then
12 we do actually need more midwives. So, perpetuating the
13 current system, I can't really say whether we need more
14 midwives.
15 If we have the guts to change our system to
16 really work for better outcomes, then I think we do need
17 more midwives. So that's one point.
18 The other is following a little on Toby, what
19 Toby said, is what is the role of Medicaid in supporting
20 different types of providers. I think we also -- and it's
21 really a lever that Medicaid has in terms of credentialing
22 paying for some of these broader types of providers like

1 community health workers, doulas, peer-support counselors,
2 and making sure that the people that are trained and are
3 serving reflect the demographics of the populations that
4 they're serving. So, I think that is a Medicaid lever that
5 we can highlight.
6 VICE CHAIR DAVIS: Thank you, Martha.
7 I'll go to you, Dennis, for our last comment.
8 COMMISSIONER HEAPHY: Thanks.
9 I'm thinking that someone on Medicaid and
10 thinking that the approximate number which are served by
11 nurse practitioners and physician assistants with caseloads
12 of 20 to 30 people at most, and now it's over 100 folks.
13 And so, in terms of letting the market drive the need in
14 how we define the providers, I think, for me, just from a
15 user perspective, it's challenging because these folks who
16 are in that position ought to provide more time to folks
17 and be present to folks in ways that the doctors could not
18 be or primary care providers could not be. So, I'm
19 wondering how do we look at the market differently and what
20 kind of research do we need to do to understand how the
21 market has shifted and changed, even the roles of these
22 folks, to understand how -- whether or not this changing or

1 engagement with these different professionals is actually
2 saving money or reducing burden or increasing burden on
3 just a different set of providers.
4 And the other thing I would say is just I don't
5 think we really talked enough about having the primary care
6 providers, in particular, reflecting the populations that
7 they serve. I don't know if we have an answer to that or
8 can get an answer to that, but it's something I think we
9 need to at least say that it's radically important.
10 VICE CHAIR DAVIS: Thanks, Dennis.
11 You know, just as we wrap, I'll say, you know,
12 one, when you think about the oversupply and undersupply,
13 really thinking less about providers as widgets that we're
14 going to interchange and more thinking about primary care
15 teams and how they care for communities, and so, you know,
16 you may not need as many physicians if you have -- you
17 know, if you're thinking about serving a community as a
18 team of physicians and nurse practitioners that are working
19 together as opposed to this person is going to serve this
20 and they're going to have that many people, and so
21 expanding, I think, how we think about that, I think that
22 also brings in some of the diversity and equity issues and

1 how we look at the provider teams as opposed to this one
2 person serving an individual, and I think when we're
3 thinking about teams beyond just the physician or nurse
4 midwife or PA but also thinking about community health
5 workers and social workers and behavioral health and how
6 that kind of feeds in, which I've heard a lot of comments.
7 I saw Toby and Kathy and Heidi.
8 COMMISSIONER DOUGLAS: I can't help myself.
9 VICE CHAIR DAVIS: Actually, I think I'm going to
10 go to Heidi first and Kathy.
11 COMMISSIONER DOUGLAS: Actually, that's fair.
12 COMMISSIONER ALLEN: I'm glad you said that,
13 Kisha, about social workers because I think social workers
14 have had a hard time getting paid for in health care
15 settings, and that makes it -- them kind of a -- a part of
16 a team that's often left out of the team or is only funded
17 at clinics that can support the ability to pay a salary
18 without actually maybe first for care. So, I know social
19 workers care about this issue and would love to be part,
20 included in the payment.
21 VICE CHAIR DAVIS: Thanks, Heidi.
22 And then Kathy.

1 COMMISSIONER WENO: Yeah. I would just, to
2 follow Anne about oral health providers, a lot of those
3 HRSA oral health workforce grants funded a lot of thought
4 about different types of ways dental services could be
5 provided, whether they be by like a team approach, by
6 having physicians do preventive and risk assessment, as
7 well as developing midlevel providers. So, there's lots of
8 ways that oral health could be integrated into the broader
9 health care system.
10 VICE CHAIR DAVIS: Thank you.
11 Yeah, Toby.
12 COMMISSIONER DOUGLAS: Yeah. I can't help myself
13 but bring back up the intersection in terms of levers with
14 FQHC payment, and the way you describe kind of how when you
15 look at team-based care and the payment right now within
16 FQHCs per visit just prevents that ability to create more
17 supply and more efficiency, and so we've looked at this
18 before as a Commission, but I think it again comes to this
19 intersection here. If we're really going to create more
20 supply and more efficient way of care, we've got to get the
21 right incentives.
22 VICE CHAIR DAVIS: That's a great point, and when

1 we're thinking about value-based care, how are we really
2 incentivizing? If we're continuing to incentivize on a
3 fee-for-service-based model and incentivize the single
4 provider to see a single person, then it's not going to get
5 us to that more team-based, community-based model.
6 As we wrap up, I do just want to say on kind of
7 this idea about provider concordance that minority
8 providers serving minority communities -- and there is
9 definitely benefit to that. Minority providers also then
10 share the burden. They may not be coming. They tend to
11 have more loans and then are then working in a system where
12 they maybe reimbursed less, so continue to have that tax.
13 I will also say we can't get away with just
14 saying, well, all the minority providers are going to serve
15 the minority communities, right? You know, White providers
16 need to be culturally competent to serve whatever community
17 they are, and all of our providers do, right? My sister is
18 African American. She's serving an Alaska Native
19 population right now.
20 And, you know, when we think about DSRIP and
21 using funds to, you know, target education for providers
22 that are going into shortage areas, that's also what we

1 want to think about, that cultural competency piece.

2 So, you don't get a pass. You need to be

3 culturally competent to serve the community that you're

4 working with.

5 And I think, with that, we will wrap up. Joanne,

6 any other questions for us? Did you get what you needed?

7 I think you got a lot from us.

8 MS. JEE: Yeah. Lots of food for thought. Thank

9 you.

10 VICE CHAIR DAVIS: So, this will go nicely into

11 an issue brief, I think, where there's lots of meat here.

12 Melanie, I will turn it back to you for closing

13 and public comment.

14 CHAIR BELLA: Thank you. That's wonderful.

15 Thank you, Kisha.

16 We will now open it up for public comment. If we

17 have folks that would like to comment on the last sessions,

18 please use your hand indicator, and I would remind everyone

19 to please introduce yourself and your organization and to

20 limit your comments to no more than three minutes.

21 We'll see if we have any hands. It looks like we

22 have one person so far.

1 Ronnie Coleman, you have been unmuted. You can
2 unmute your line and make your comments.
3 ### PUBLIC COMMENT
4 * MR. COLEMAN: Hi. I'm Ronnie Coleman with
5 Benevis. We're a support organization for dental
6 practices, primarily Medicaid. We serve over 115 Medicaid
7 dental practices around the country.
8 I just wanted to point out to those of you who
9 have not seen it, the American Dental Association Health
10 Policy Institute put out an excellent presentation earlier
11 this month that looked at how COVID has impacted dentists
12 and the dental industry, and it's absolutely fantastic.
13 But one of the most relevant sets of points was
14 very applicable to your current conversation. They found
15 something that, I think, was 40 percent of the reason that
16 dentists feel that their patient population is not at the
17 volume that they would expect is because of shortages
18 within the workforce, and then they also looked at dental
19 assistants, hygienists, administrative staff, and dentists
20 to see over the past several years how challenging
21 recruitment has been. Well, the level of challenge for
22 recruiting in all of those spaces is up anywhere from 15 to

1 50 percent. It's absolutely brutal.

2 And so, to go back to your point about

3 reimbursement, reimbursement is critically important to

4 recruiting and retaining dental staff. In a number of the

5 states I'm responsible for, we have not seen rate increases

6 in 15-plus years. Virginia, a state that has significant

7 budget-positive -- I should say a significant sort of

8 budget surplus at this point, they haven't raised rates

9 since 2005. Maryland hasn't increased rates in 10-plus

10 years. That's the Deamonte Driver state.

11 So, I think that has to be a focus because I

12 think about just about any other profession. How would you

13 survive if you didn't have an increase in your pay for 10

14 to 15 years? So that's pretty much the crux of my

15 comments.

16 CHAIR BELLA: Thank you, Ronnie.

17 It looks like we have one more.

18 Hilary Daniel, you've been unmuted. If you could

19 unmute your lines.

20 MS. DANIEL: Good afternoon, Commissioners.

21 Thank you for the opportunity to provide comment today.

22 I'm Hilary Daniel. I'm with the Children's Hospital

1 Association, and I just want to reiterate a comment that
2 was made in the previous session regarding workforce and
3 relate this for the importance of looking at these issues,
4 particularly through the pediatric lens.
5 Children's needs or timely access to pediatric
6 primary, specialty, and subspecialty care providers is
7 vital, given their continuous growth in development, and
8 children's care is organized differently than adult care.
9 And the challenges and gaps in the workforce may look
10 different than those for the adult population. They may
11 face long wait times for care due to shortages in critical
12 specialties, and it's really vital that these differences
13 should be understood to be able to have -- to be able to
14 identify how best to address them.
15 A strong pediatric workforce is needed to create
16 sustainability across the spectrum of children's care and
17 address immediate and ongoing issues like the current surge
18 in mental and behavioral health challenges and the number
19 of children that either missed out or delayed health care
20 services during COVID like well-child visits, and
21 immunizations or generally for specialty care.
22 So thank you for the opportunity to provide

1 comments.

2 CHAIR BELLA: Thank you very much.

3 It looks like we don't have anyone else who wants

4 to make a comment. If someone has a comment down the road,

5 you're welcome to send it to comments@macpac.gov.

6 We are now done with the first day of our

7 meeting. We'll be back tomorrow kicking off at ten o'clock

8 with a discussion on monitoring access to care for Medicaid

9 beneficiaries.

10 So thank you all for joining us today. Thank

11 you, Commissioners. Thank you, Anne and staff. We'll see

12 you all tomorrow at 10:00 a.m. Eastern time. Have a great

13 evening.

14 * [Whereupon, at 4:47 p.m., the meeting was

15 recessed, to reconvene at 10:00 a.m. on Friday, September

16 24th, 2021].

PUBLIC MEETING

Via GoToMeeting

Friday, September 24, 2021
10:00 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 6: Monitoring access to care for Medicaid beneficiaries

Martha Heberlein, Principal Analyst and Research Advisor...162

Linn Jennings, Analyst.............................164

Session 7: Congressionally mandated study on Money Follows the Person demonstration program

Kristal Vardaman, Policy Director..................179

Public Comment..196

Recess..199

Session 8: Panel discussion: Health IT adoption and use by behavioral health providers to support care integration

Aaron Pervin, Senior Analyst.......................199

Jessica Kahn, McKinsey & Company...................201

Bebet Herminio Navia, Jr., New Jersey Medicaid

Enterprise Systems..............................209

Brooke Hammond, Integral Care.......................215

Public Comment..247

Session 9: Further Discussion by the Commission.........249

Recess..260

Session 10: Vaccines for adults enrolled in Medicaid:
access, coverage, and payment

Amy Zettle, Senior Analyst.........................261

Chris Park, Principal Analyst and Data
Analytics Advisor..............................266

Public Comment..294

Adjourn Day 2...296

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

2 [10:00 a.m.]

3 CHAIR BELLA: Okay. We are going to go ahead and
4 get started, because it's 10:00.

5 Good morning, everyone. Welcome to Day 2 of our
6 MACPAC September meeting. We are excited for what we have
7 to go over today and are going to jump right in. So, we
8 are starting off with monitoring access to care, and we
9 have Martha -- I see Martha -- and I believe Linn will be
10 joining as well. Yep, wonderful. Good morning, Linn.

11 All right. I'm going to kick it over to you guys
12 to get us started. Welcome.

13 **### MONITORING ACCESS TO CARE FOR MEDICAID**
14 **BENEFICIARIES**

15 * MS. HEBERLEIN: Well, good morning,
16 Commissioners, and a happy Friday. Today Linn and I are
17 going to kick off the Commission's work for this meeting
18 cycle on monitoring access to care among Medicaid
19 beneficiaries.

20 So next slide.

21 So I will start. I will offer some brief
22 background on the Commission's prior work on monitoring

1 access, before turning it over to Linn to discuss the
2 current requirements and challenges with monitoring access
3 as well as our proposed work for the next few months.
4 Next slide.
5 So, this presentation and the work to come
6 continues the Commission's earlier efforts related to
7 monitoring access to care. In the inaugural report in
8 March 2011, the Commission developed an initial framework
9 for examining access that has served as the basis for the
10 Commission's work in this area.
11 The framework includes three main elements:
12 enrollees and their unique characteristics, availability of
13 providers, and utilization. It also accounts for the
14 complex health needs and characteristics of the Medicaid
15 population as well as the program variability across
16 states. More recently, in the March 2017 report, MACPAC
17 examined the current regulatory framework for ensuring
18 access, noting that there is no single federally mandated
19 method for states to assess access to Medicaid-covered
20 services. The chapter also presented key challenges to
21 monitoring, including a discussion of the data limitations
22 and the constraints on state and federal administrative

1 capacity.

2 In addition to these chapters, the Commission has
3 also commented on several proposed rules to define
4 monitoring requirements. In these letters, the Commission
5 has consistently encouraged CMS to develop an effective and
6 efficient monitoring system that can both meaningful
7 capture access to care but also balances collecting and
8 reporting actionable information with limited state
9 administrative capacity.

10 Now I'm going to turn it over to Linn who will
11 talk about the current requirements and our path going
12 forward.

13 * MX. JENNINGS: Thank you so much, Martha.

14 All right. So, to begin I will talk about the
15 current requirements. So, the federal and state
16 governments are obligated to ensure access to care under
17 fee for service and managed care. So, in fee for service,
18 the Social Security Act requires Medicaid payment levels to
19 be sufficient enough to enlist enough providers so that the
20 care and services available are comparable to those of the
21 general population, and this requirement is commonly known
22 as the equal access provision.

1 Under managed care, the Social Security Act
2 ensures access to Medicaid services for enrollees by
3 requiring MCOs to demonstrate that they have the capacity
4 to serve the expected number of enrollees and have
5 procedures in place for monitoring and evaluating quality
6 and appropriateness of care.
7 There are also two rules that guide states in
8 complying with these requirements, and I'll cover them in
9 the next few slides.
10 So compliance with the equal access provision
11 requirement has primarily been assessed through the
12 adequacy of provider payment rates. However, on March 31,
13 2015, in the Armstrong v. Exception Child Center case, the
14 Supreme Court ruled that Medicaid providers and
15 beneficiaries don't have a private right of action to
16 contest state-determined Medicaid payment rates in federal
17 courts, and the Supreme Court decision underscores CMS's
18 primary role in ensuring access to care.
19 Partially in response to this case, on November
20 2, 2015, CMS published a final rule with comments
21 describing the requirements for states to monitor and
22 report on access to care under fee for service and provide

1 states with processes to review the effect of changes to
2 provider payment rates.
3 The goal of this final rule was to create a more
4 systematic and transparent approach to monitoring access
5 that would allow CMS to make informed and data-driven
6 decisions. It requires states to submit an access
7 monitoring review plan, an AMRP, every three years and that
8 an AMRP be submitted with any state plan amendment
9 proposing a reduction or restructuring payment rate that
10 could result in diminished access.
11 While states are required to monitor access for a
12 particular set of benefits, they do have the flexibility to
13 develop and define these measures, so there is substantial
14 variation in the processes and standards used by states.
15 For example, in MACPAC's review of the draft state AMRPs
16 published in the March 2017 report, states used data from a
17 variety of sources, such as utilization data from claims,
18 and self-reported access measures from beneficiary surveys
19 to report on required areas of access.
20 In response to this 2015 final rule with comment,
21 many states and stakeholders submitted in comments, and
22 many of these states, especially those with high managed

1 care enrollment, expressed concerns about the
2 administrative burden to monitor access and to analyze the
3 effect of making nominal payment rate changes. Other
4 stakeholders also had concerns about which services were
5 included in the core required services and about the
6 oversight of payment rate changes.
7 Now I'll talk about managed care. So, on May 16,
8 2016, CMS issued a comprehensive managed care rule. It was
9 the first to update the regulations on Medicaid and managed
10 care in over a decade. It established new requirements for
11 how states should assess network adequacy in MCOs,
12 including requiring states to develop and make publicly
13 available time and distance network adequacy standards for
14 specific provider types, and use their data to set baseline
15 standards to improve their managed care programs. MCOs are
16 also required to ensure covered service are available
17 within a reasonable time frame and in a manner that ensures
18 continuity of care and adequate primary care and
19 specialized service capacity.
20 In 2018, MACPAC reviewed Medicaid managed care
21 contracts and found that most states use multiple methods
22 to monitor access, and may also require MCOs to submit

1 additional information that could be used for access and
2 network adequacy monitoring, such as member and provider
3 grievances, member and provider surveys, and encounter
4 data.
5 In 2020, CMS issued a subsequent rule that
6 replaced the time and distance standards with state-
7 established quantitative standards to determine network
8 adequacy, and the remainder of the provider network
9 adequacy requirements in the final 2016 rule do remain in
10 place.
11 In both the final 2015 fee for service rule with
12 comment and the requests for information, CMS acknowledged
13 the need for a more unified approach that would align
14 methods and measures to analyze network adequacy under
15 managed care and access in fee for service.
16 In response to the comments in the final 2015
17 rule, the Trump administration proposed changes to the fee
18 for service monitoring rule that would have established
19 exemptions for certain states, and then later in the
20 administration CMS proposed rescinding the final fee for
21 service rule with the goal of them developing a more
22 comprehensive approach to monitoring access. Neither of

1 these rules were finalized.

2 Most recently, CMS is indicating that they are
3 revisiting the current approach to access monitoring, and
4 the forthcoming rule in January of 2022 would provide
5 support to monitor access to care across delivery systems,
6 including fee for service, managed care, and home and
7 community-based services programs.

8 As noted in the 2011 and 2017 MACPAC reports,
9 there are a number of challenges and tradeoffs that states
10 and CMS face in monitoring access. For example, monitoring
11 efforts are challenging due to the availability and quality
12 of data at the national, state, and population levels.
13 There are also tradeoffs that they have to consider with
14 the available data sources. For example, administrative
15 and claims data are useful for assessing utilization of
16 care, but there are also data quality and availability
17 concerns with some of these measures.

18 In terms of administrative capacity, Medicaid
19 agencies at both the state and federal level face staff
20 shortages and resource constraints, which can limit their
21 capacity to collect, analyze, and report on data.

22 States and the federal government may also have

1 different priorities for access monitoring. For example,
2 states were concerned that the resources required to
3 develop AMRPs and implement requisite monitoring activities
4 left few resources for state priorities such as monitoring
5 at the population level.

6 Given the interest from CMS in proposing a new
7 access rule, we will be assessing the existing approach and
8 potential changes that could be made to address current
9 gaps and limitations. This work will be informed by a
10 literature review, a review of stakeholder comments on
11 prior rulemaking, and key informant interviews with CMS,
12 states, plans, beneficiary advocates, and experts.

13 And in October we will focus on how current data
14 sources could be used to monitor access, identify the data
15 gaps and limitations of existing data, as well as
16 approaches to addressing these gaps. In December, we will
17 further discuss the considerations in designing and
18 implementing an approach to monitoring access.

19 And to help us focus our work, we are interested
20 in hearing from the Commission on key considerations and
21 priorities for monitoring access and areas for improvement
22 that the Commission would like to explore in greater

1 detail.

2 Thank you so much, and I look forward to your
3 discussion and suggestions for our work.

4 CHAIR BELLA: Thank you, Martha and Linn, for
5 taking us through that so efficiently. Commissioners, I'm
6 going to open it up. I see Martha to start.

7 COMMISSIONER CARTER: Thanks for this overview.
8 I think this is going to be an interesting area of inquiry.

9 I had a question about whether states are
10 required to, or if they are, factoring payments to FQHCs in
11 their access, what are they called, access monitoring
12 review plans? Areas to look at might be, you know, we know
13 that FQHCs are paid in a very unique way, but some states
14 pull some services into fee for service, and how does that
15 affect access? And then as we look at the value-based
16 payment models, how do changes in how the FQHCs are paid
17 affect access?

18 So, it's kind of a broad question, but I'd like
19 to know, you know, a little bit more in that area.

20 CHAIR BELLA: Martha, you're just wanting an
21 answer of what else we want to know, not an answer you're
22 looking for right now. Correct? You're getting it on

1 record.

2 COMMISSIONER CARTER: Right. Yeah. I want to
3 know a little bit more about it, how payments to FQHCs are
4 factored in and how that affects access.

5 CHAIR BELLA: Okay. Wonderful. Thank you.
6 Other Commissioners? Darin?

7 COMMISSIONER GORDON: This is helpful. I do
8 think it would be helpful, as we think about access, that
9 instead of just looking at time and distance what else
10 states are looking at with regards to access, for example,
11 looking at percent of licensed providers in that state that
12 are seeing Medicaid clients. You know, time and distance
13 doesn't seem to take into account what the supply is in the
14 state, and so I think that gives another lens through which
15 to look at it, and something that would be worth
16 understanding. There are probably other measures that
17 states have used that go beyond time and distance that may
18 be helpful in understanding.

19 MX. JENNINGS: Thank you. I will make note of
20 that as we continue to do stakeholder interviews.

21 CHAIR BELLA: Other Commissioners? Laura, then
22 Toby.

1 COMMISSIONER HERRERA SCOTT: Good morning. Just
2 building on what Darin said for consideration, not only
3 understanding what other states and measures but also
4 potentially wait times for those appointments, especially
5 for specialty care. So, time and distance but, you know,
6 60 days, 90 days, et cetera before they can get in to be
7 seen. And then if there's any breakdown by geography,
8 rural versus suburban, urban, et cetera.
9 CHAIR BELLA: Thank you, Laura. Toby?
10 COMMISSIONER DOUGLAS: Yeah. Just the other
11 piece is around how states are including in virtual care.
12 We're going to talk later today about, you know, within the
13 behavioral health, but just in general. I think some of
14 Laura's points around wait time would get at are there
15 other ways. But making sure we're not just talking about
16 providers in a geographic footprint, especially now and
17 using cross-state credentialing. So virtual is going to be
18 a big piece of the future in Medicaid.
19 CHAIR BELLA: Thanks, Toby. Denis, would you
20 like to make any comments?
21 COMMISSIONER HEAPHY: I --
22 CHAIR BELLA: All right. Other Commissioners?

1 Oh, sorry. Go ahead.

2 COMMISSIONER HEAPHY: It takes me a second. No,
3 I think it would be really helpful to understand what the
4 states are doing in terms of the contracting requirements
5 with MCOs beyond what's already been stated, particularly
6 around access to primary care providers, for folks
7 transitioning to 22 with disabilities, to see what kind of
8 provider capacity is actually out there for those
9 populations.

10 CHAIR BELLA: Thank you, Dennis. Heidi?

11 COMMISSIONER ALLEN: I'm particularly interested
12 in audit methodologies, where people actually call and use
13 standardized patient profiles to see how long and how hard
14 it is to get an appointment among network providers,
15 particularly in MCOs. And I'm also wondering if we've ever
16 asked MCOs to benchmark against their commercially insured
17 populations, for those that serve both Medicaid and
18 commercial populations.

19 CHAIR BELLA: Martha, can you remind me, in our
20 past work -- I mean, I have a bunch of thoughts in my head
21 about duals and access and Medicaid and Medicare and
22 challenges there, although it sort of goes outside of the

1 scope of this a bit. In our prior work have we looked
2 specifically at some of the issue around duals and lesser-
3 of and provider participation? It kind of doesn't fit
4 squarely here, but I can't help but ask.
5 MS. HEBERLEIN: We did do a lesser-of analysis a
6 long time ago, and I'm not going to remember the details of
7 it, but we can certainly share that with you. It has not
8 come up specifically in our comments on the letters that I
9 remember, or the comments on the rules that I remember, but
10 I think, you know, there are definitely issues that we
11 talked about, both in the most recent chapter as well as
12 the letters that have implications for duals, for like, for
13 example, we talk about like carved-out benefits, right, and
14 so how do you monitor benefits that may be provided in
15 multiple different systems. So, I think while we didn't
16 specifically name duals in much of that work, I think there
17 are a lot of things that we can take that are relevant to
18 the duals work. And I'm happy to dig up the lesser-of and
19 share it with you.
20 CHAIR BELLA: Okay. That would be wonderful. It
21 would be great to hear if we could get any of that in any
22 the panels too, if they indicate these are issues that come

1 up.

2 Fred, I think I saw your hand.

3 COMMISSIONER CERISE: Sure. So a couple of
4 things. On the primary care side there are outcome
5 measures that you could look at that are pretty readily
6 available that would seem to correlate well with access,
7 you know, annual visits and immunizations and things like
8 that, that it gets tougher on the specialty side, and as
9 Heidi just referred to, you know, if you've got these
10 third-party surveys, a lot of them out there that say how
11 tough it is to get appointments. And the primary care
12 providers will have some insight into that as well. And so
13 as you look at if there is some survey methodology, using
14 the primary care providers, because they know how easy or
15 hard it is to get specialty access to round out services.

16 CHAIR BELLA: Thank you, Fred. Other comments?
17 Heidi.

18 COMMISSIONER ALLEN: Sorry. I forgot to mention
19 that I really think patient voice is so important in this,
20 and I recognize that survey methodology as a limited
21 sample, but I just think it's essential to really, truly
22 understand what people's experiences are, to ask them. And

1 I'm curious the role of MCACs, the Medicaid advisory
2 committees in each state, if they actually do have
3 consumers on them and what they are doing to play a role in
4 monitoring access.
5 CHAIR BELLA: Great.
6 COMMISSIONER HEAPHY: This is Dennis. Just one
7 quick question, and that's about transportation. And would
8 that be included in this as something that we should be
9 looking into, into network adequacy?
10 MX. JENNINGS: So that has been one of the
11 questions we have been asking in our stakeholder
12 interviews, or that's come up, I guess, in a lot of our
13 stakeholder interviews. We try to take into account
14 transportation and other measures, really, of provider
15 availability and access. So, in October we will get a
16 chance to kind of go into a little bit more depth on those.
17 COMMISSIONER HEAPHY: Good.
18 COMMISSIONER JOHNSON: And then around that, too,
19 I mean, so just overall, have we done any thoughts around
20 other social determinants of health that could actually
21 limit some of these, make some of these challenges happen
22 as well? So, I just think we should keep that in the back

1 of the mind so it would be helpful for me.

2 CHAIR BELLA: Okay. Anyone -- oh, go ahead,

3 Linn. Sorry.

4 MX. JENNINGS: Oh, no. I was just going to say

5 that's also been something that's been coming up in

6 stakeholder interviews, so we'll make sure to highlight

7 that as well, in October.

8 CHAIR BELLA: So, remind us, who are you thinking

9 for the panel, what types of folks?

10 MX. JENNINGS: So, we're hoping to have a

11 research expert and -- well, so for October and December

12 kind of have a mix of researchers, and a beneficiary

13 advocate, and also someone from one of the states that

14 we've been interviewing, to get a mix of perspectives. But

15 then also in our interviews we have been interviewing

16 providers and managed care plans and other experts. So, it

17 will be people that we've talked to already.

18 CHAIR BELLA: Okay. Great.

19 Any other comment, considerations you'd like to

20 see as the work continues?

21 [No response.]

22 CHAIR BELLA: Okay. Linn and Martha, do you have

1 all that you need from us? Any additional questions?

2 Oh, Darin.

3 COMMISSIONER GORDON: I was just thinking, Linn,
4 as you were talking about the different folks we're talking
5 about hearing from, just for consideration, I wonder if it
6 would be helpful if there was some plan voice like from a
7 health plan that's also giving their perspective on access
8 and things that they look at, they monitor as well, maybe
9 even beyond what a state may ask for, but I think that
10 might be a perspective that might add something to the
11 discussion.

12 MX. JENNINGS: I'll make note of that and bring
13 it back to Martha and Ashley as we're planning.

14 CHAIR BELLA: Okay. I think we're set. We'll
15 look forward to the October panel. Thank you all very
16 much.

17 All right. We'll go ahead and move into the next
18 session on Money Follows the Person demonstration, and
19 Kristal is going to lead us through this session.

20 Good morning, Kristal. Welcome.

21 **### CONGRESSIONALLY MANDATED STUDY ON MONEY FOLLOWS**
22 **THE PERSON DEMONSTRATION PROGRAM**

1 * DR. VARDAMAN: Good morning. Thank you,
2 Commissioners, and good morning.
3 I'm here today to discuss our work plan for the
4 mandated study on the Money Follows the Person, or MFP
5 demonstration program.
6 As you know, in the Consolidated Appropriations
7 Act of 2021, Congress directed MACPAC to conduct a study
8 examining the settings available to MFP participants and
9 settings that qualify for home- and community-based
10 services or HCBS payment under the HCBS settings rule.
11 Today I'm going to describe our plan for that
12 fulfilling mandate, but since it's been a few years since
13 the Commission has engaged in discussion on either MFP or
14 the settings rule, we wanted to start the conversation.
15 I'll then go over the analyses that we have planned and the
16 plan for bringing you the results in the coming months.
17 So, first, I'll start with MFP. MFP is one of a
18 number of investments the federal government has made in
19 supporting state efforts to rebalance, which is what we
20 call the "shifts in long-term services and supports," or
21 LTSS, from a reliance on institutional services to serving
22 more individuals in the community with an associated shift

1 in Medicaid dollars.

2 MFP was first authorized by the Deficit Reduction
3 Act of 2005, and it's subsequently been reauthorized for
4 both very short and longer-term periods of time, most
5 recently in the CAA, which provided MFP funding through
6 fiscal year 2023.

7 Over the course of the demonstration, 44 states
8 and the District of Columbia have been provided flexibility
9 and enhanced funding to support transitioning MFP
10 participants from institutions back into the community. In
11 recent years, the number of states participating in MFP
12 dropped due to an anticipated sunsetting of the program,
13 which was subsequently extended.

14 In September 2020, 33 states were still
15 participating, but we heard that some states are restarting
16 their program now that funds are available for additional
17 years.

18 In total, MFP has transitioned over 100,000
19 participants back to the community.

20 Specifically, MFP assists beneficiaries who
21 resided in an institution for at least 60 days. This is
22 done with the help of coordinators from states, a

1 contractor, or managed care plan. They provide
2 beneficiaries with the supports needed to identify and move
3 into community residence, so this could include things like
4 identifying accessible and affordable housing or making
5 home modifications.
6 MFP includes participants who have intellectual
7 or developmental disabilities, individuals age 65 or older,
8 individuals with physical disabilities, and individuals
9 with mental health conditions.
10 In addition to help moving back into the
11 community, MFP participants receive demonstration services
12 beyond what's delivered in the state typically under their
13 existing waivers and state plan options. This could
14 include things like assisted technologies or 24-hour
15 personal care. These services are available to
16 participants for a one-year period after they leave the
17 institution.
18 After that, people who are transitioned through
19 MFP will continue to receive the typical HCBS services
20 provided under the existing state plan options and waivers
21 in their state.
22 The current MFP state specifies that

1 beneficiaries receiving services funded under the program
2 must be transitioned into a qualified residence. This
3 includes a home owned by or leased by the beneficiary or
4 their family member, an apartment with an individual lease,
5 or a community-based setting in which no more than four
6 unrelated individuals reside. We'll come back to this
7 definition later as we discuss the mandate.
8 States participating in MFP receive an increase
9 in their federal match for HCBS provided to participants.
10 States must then invest the amount above the regular match
11 and into their HCBS infrastructure. Those are called
12 rebalancing funds. State uses of those funds vary widely,
13 but some examples include using them to reduce HCBS waiver
14 waiting lists or to provide transition support to
15 beneficiaries who would not qualify for MFP transition. So
16 that might include, for example, beneficiaries who have
17 resided in an institution for less than 60 days who
18 wouldn't be eligible to participate in the program.
19 Next, I'll turn to the settings rule. The
20 settings rule was published in 2014, and it's intended to
21 ensure that HCBS settings are different from institutions
22 and that individuals receiving HCBS have the same ability

1 to participate in community life and control over their own
2 lives as others in the community. It applies to HCBS
3 provided under the broad range of authorities states use
4 including waivers and state plan options.
5 Here are standards that are included in the rule.
6 For example, it affirms individuals' ability to select
7 settings, services, and providers, and it governs both day
8 services like supported employment and residential
9 settings. The residential standards includes requirements
10 around leases, choice of roommates, lockable units, things
11 like that.
12 Each state has been required to submit a
13 statewide transition plan to CMS describing how they will
14 assess HCBS settings and how noncompliant settings will be
15 brought into compliance. CMS has extended the full
16 implementation deadline multiple times, most recently to
17 March 17, 2023, due to the complexity of the undertaking
18 and competing state priorities, including responding to the
19 COVID-19 pandemic. Settings that have characteristics that
20 isolate beneficiaries to receive Medicaid-covered HCBS from
21 the broader community will be ineligible for HCBS payment
22 unless those characteristics are sufficiently mitigated by

1 other factors.

2 States can demonstrate that these settings should
3 remain eligible for HCBS payment through a process called
4 heightened scrutiny, in which they justify what kinds of
5 characteristics and policies and procedures mitigate those
6 isolating factors, and that's something that CMS will be
7 reviewing states' evidence packages that will include those
8 justifications.

9 The MFP resident criteria predates the HCBS
10 settings rule by about nine years, and the standards
11 differ. And we've heard so far that some states in their
12 process of implementing the settings rules have used the
13 MFP criteria as a guide, but that was not a requirement.

14 So, in general, more settings are allowed under
15 the settings rule than the qualified residence criteria for
16 MFP. For example, the MFP criteria had a strict four-
17 person limit, while under the settings rule, a group home
18 of six or eight would be allowed, assuming that those
19 settings would need to meet all of the requirements under
20 the rule.

21 I will note here that there's been some
22 uncertainty about certain settings like assisted living.

1 CMS has put out additional guidance for assisted living.
2 In terms of how they fare under the MFP criteria can vary
3 by state because there is some variation in that model of
4 service across states. So that variation is going to have
5 some implications for how assisted living is considered.
6 We'll have more to discuss on that when we bring you the
7 results of our interviews with states and stakeholders.
8 So, the CAA directs MACPAC to conduct a study to
9 identify the settings and services that are available to
10 MFP participants and to settings that are in compliance
11 with the settings rule. It doesn't require the Commission
12 to make any recommendations, but if deemed appropriate, the
13 Commission could do so.
14 Staff has begun work on this project over the
15 summer. So far, we've surveyed state MFP program directors
16 for their perspectives on the residence criteria. We're
17 currently interviewing stakeholders, including state and
18 federal officials, beneficiary advocates, providers, and
19 researchers to understand the advantages and disadvantage
20 of the current criteria and implications of making any
21 changes to those criteria. We've also been assessing the
22 availability of data, and we'll be reviewing CMS guidance

1 and evaluation reports.

2 The scope of the mandated report is pretty

3 narrow. As we conducted our stakeholder interviews, we

4 heard some additional insights on the successes and

5 challenges of MFP, including how states are dealing with

6 the uncertainty of MFP funding. So, as we focus on the

7 mandated report, we will certainly provide some of that

8 information to you all as context for how the MFP program

9 is operating.

10 Next month, we'll present the results of our

11 survey and some interview themes from our work. If

12 Commissioners are interested, we can then develop policy

13 options for draft recommendations. The Commission again

14 could also decide to write a primarily descriptive report.

15 Either way, we anticipate our work will be completed this

16 winter, and we can fulfill the mandate in the 2022 report

17 cycle.

18 So, with that, I'll turn it back to you all for

19 your discussion, and we appreciate any feedback you have on

20 the work plan or any other issues you'd like us to consider

21 as we conduct this work. Thank you.

22 CHAIR BELLA: Thank you, Kristal.

1 Let me first start with just any questions or
2 clarifications for Kristal on the scope, on the question
3 we're trying to answer, and what we've been asked to do.
4 Is everybody pretty clear on that?
5 I see some nodding heads. Great.
6 All right. Then let's start then with comments
7 or feedback on the work plan or on how we want to --
8 anything we want to see as Kristal and team approach the
9 work to satisfy this requirement.
10 Brian.
11 [No response.]
12 CHAIR BELLA: I believe you're on mute, Brian.
13 COMMISSIONER BURWELL: I do have some clarifying
14 questions for you, Kristal.
15 So, my presumption is that people who have been
16 transitioned to the community under MFP are -- where they
17 live, their settings are governed by MFP but also by the
18 settings rule. Am I correct on that? I mean, the MFP
19 requirements are a subset of the settings rule.
20 DR. VARDAMAN: Right, right. Yes. So, all MFP
21 settings will have to meet the settings rule requirements,
22 but all settings that qualify under the settings rule would

1 not necessarily qualify for MFP participants.

2 COMMISSIONER BURWELL: Thank you for that.

3 My follow-up question, are there some
4 requirements in the settings rule that are considered more
5 rigid or difficult for persons in MFP to meet? For
6 example, you discussed isolation as one of the criteria.
7 If MFP recipients are in an isolated setting that still
8 meets all the other MFP settings, requirements, might they
9 still be subject to noncompliance with the settings rule if
10 they're considered to be an isolated setting?

11 DR. VARDAMAN: So, to the extent that setting
12 hasn't yet -- any settings, HCBS setting, hasn't yet, you
13 know, come into compliance with the rule, states are
14 working with settings to do so. So, any MFP setting that
15 may have factors that would be isolating would be required
16 to meet those requirements under the same timeline. You
17 know, given the criteria of the MFP qualified recommended
18 settings, they tend to be things like individual apartments
19 or individual homes -- are probably less likely to be in
20 those groups of settings that would have isolating factors
21 because they're not necessarily in places that would be
22 flagged for review like settings on the same campus as an

1 institution, for example, is something that would likely be
2 flagged for review, which would probably be less likely for
3 a setting that would be eligible under MFP.
4 COMMISSIONER BURWELL: So, I am gaining the
5 assumption that the main difference between the two
6 settings requirements between MFP and the settings rule is
7 the four-person limit on the MFP settings requirement, and
8 that bringing them into alignment, the primary change would
9 be allowing the MFP beneficiaries to live in residential
10 settings of more than four people. Am I correct or
11 incorrect on that?
12 DR. VARDAMAN: Yes. So far, the implications of
13 expanding the MFP criteria would be mainly -- from our
14 understanding so far would be mainly to open it up to
15 larger congregate settings.
16 The only other issue we've heard is they're
17 around sort of where some assisted living settings fit into
18 that, which, you know, in some cases, they may still
19 qualify under the MFP criteria, and some cases, they don't,
20 depending on sort of the model of the community. And so
21 those are things that we plan to bring you some more
22 details on, but you are correct that primarily the results

1 of expanding the criteria would be to open MFP up to larger
2 congregate settings.
3 COMMISSIONER BURWELL: And I am then -- I'm sorry
4 to keep asking all the questions. I feel I'm taking up the
5 time.
6 One rationale for bringing those two requirements
7 into alignment is that then states have one set of criteria
8 by which to survey and evaluate settings in which people
9 receiving HCBS services are living. It would simplify the
10 regulatory oversight.
11 DR. VARDAMAN: Yeah. That is one of the
12 questions we've been probing about in our interviews in
13 terms of the advantages and disadvantages. So, some
14 administrative simplicity might be some of the things that
15 would occur if they were aligned. We're also hearing
16 comments on the other side that MFP is a higher bar for
17 transitions and is a bit more of an aspirational bar in
18 terms of where settings should be going to the future, but
19 we'll be bringing you the results of some stakeholder
20 comments on both sides of the issue next month.
21 COMMISSIONER BURWELL: Thank you. Those answers
22 have all been very helpful.

1 CHAIR BELLA: Toby and then Tricia.
2 Oh, Tricia, did you not raise your hand?
3 Toby.
4 COMMISSIONER DOUGLAS: Yeah. So, two quick --
5 one, I think the plan looks really good. Great job, first
6 of all.
7 And, secondly, is there any -- as you look at the
8 question around flexibilities and future flexibilities and
9 all the funding that's coming through -- I always forget --
10 the American Rescue Plan Act HCBS funding, so there's going
11 to be so many new initiatives. How are you going to -- are
12 you going to be looking at that interaction?
13 DR. VARDAMAN: Some comments that have come up,
14 primarily some of what we're hearing are a lot of the ways
15 that states are using the rebalancing funds, which might be
16 things that states could turn to, to expand additional HCBS
17 funding.
18 COMMISSIONER DOUGLAS: Okay. Great. I think
19 it's definitely something we should track if they're going
20 to be investing in similar places, what works and should
21 actually fit into this.
22 Thanks.

1 CHAIR BELLA: So, Kristal, I agree it's a very
2 solid work plan, and it seems very focused for what we have
3 to answer. In the interviews you've done so far,
4 particularly with any of the beneficiary advocates, are you
5 expecting that we're going to get a group of people that
6 say it's not a problem, a group of people that say it is a
7 problem, and then we're going to debate whether we think we
8 should sort of make those things -- whether there's a
9 problem to solve, or are you sending that there is
10 definitely something for us to call attention to? I'm just
11 trying to figure how to tease out of what you're hearing so
12 far so that we can be thinking about where we have the most
13 value, and if it's too premature, we can wait until next
14 month.
15 DR. VARDAMAN: Sure. Well, I think so far, you
16 know, we're definitely hearing a lot of comments,
17 particularly from the advocacy community, about how MFP
18 sets a higher standard than the settings rule, particularly
19 around that four-person limit, and it's a more integrated
20 option for people, and that some of the settings,
21 particularly concerns around, I would say, things like
22 settings that are on the campuses of institutions and how

1 much flexibility the settings rule provides for those
2 settings to continue to receive HCBS payment versus MFP
3 that sets a more strict definition.
4 Some of those things that we are hearing from
5 folks, we will definitely try to tease out some of the pros
6 and cons. I think we're hearing similar pros and cons from
7 different groups in terms of whether it be states or
8 advocates, so depending on where they sit, the composition
9 of the HCBS settings and whatnot. So, we'll definitely
10 have lots to talk about that next month.
11 CHAIR BELLA: Brian?
12 COMMISSIONER BURWELL: So, a more specific
13 question around that same issue. My understanding is that
14 it is often difficult to place people in the community out
15 of institutions under MFP largely because the transition
16 coordinators cannot find an appropriate place to have them
17 live. So, are you also getting feedback that the higher
18 bar that is used in the MFP program is a barrier to
19 actually placing people and that people are waiting, wait
20 for a longer period of time because of that bar?
21 DR. VARDAMAN: So that's something that we did
22 ask about in our survey. I would say that where people

1 have identified MFP as a barrier for transitions, we're
2 trying to probe a bit on for what populations and to the
3 extent that has been a barrier, and that's where we've
4 heard concerns specifically about things such as assisted
5 living, and as we're talking to states, we're hearing some
6 descriptions of why that is, like why is it true in a state
7 for assisted living and not for another? So those are some
8 of the kind of nuances that we're trying to tease out in
9 our interview.

10 COMMISSIONER BURWELL: Thank you.

11 CHAIR BELLA: Other Commissioners, comments or
12 questions?

13 [No response.]

14 CHAIR BELLA: Kristal, I think we're going to let
15 you off the hook very early in this session because you
16 explained it so well and it's so well designed. If there
17 aren't -- do you have what you need from us?

18 DR. VARDAMAN: Yes, these comments were really
19 helpful and will help us, you know, pull together the
20 themes that will be of interest to the Commission. So
21 we'll be back next month with those results. Thank you.

22 CHAIR BELLA: Well, I'm really excited to hear

1 those results, so thank you for doing this work. And we
2 are ahead of schedule. Anne, since our next session is a
3 panel, I assume we need to wait, right? So we could take a
4 short break?
5 EXECUTIVE DIRECTOR SCHWARTZ: Yeah, I think you
6 wanted to take some public comment. We can do that as
7 well.
8 CHAIR BELLA: Yeah, let's do that. Let's take
9 public comment on the last two sessions that we just had,
10 so access monitoring and the MFP report. If anyone in the
11 public would like to comment, please do so by using your
12 hand signal in GoToWebinar function, and then please state
13 your name, organization, and I'll remind folks that we have
14 a request that you keep your comments to three minutes or
15 less.
16 **### PUBLIC COMMENT**
17 * MS. HUGHES: Noah Haines, you've been unmuted.
18 You can unmute your line and make your comment.
19 [No response.]
20 MS. HUGHES: Noah, there's a little microphone
21 icon under the orange arrow in the upper right side of your
22 screen.

1 [Pause.]

2 MS. HUGHES: He doesn't appear to be unmuting his
3 line.

4 CHAIR BELLA: Okay. So he is muted. We can't --
5 there's no muting on our end, correct?

6 MS. HUGHES: No. That's correct.

7 CHAIR BELLA: Okay. Well, why don't we go ahead
8 with Nataki, and hopefully Noah can unmute, and then we can
9 hear from those two.

10 MS. MacMURRAY: Good morning, Commission. This
11 is Nataki MacMurray from the Office of National Drug
12 Control Policy. I actually had a question. I know this
13 current study that's being discussed is specific to LTSS
14 population. Do you foresee that they may be able to
15 replicate or expand this study to apply to other
16 populations? For instance, I'm always thinking about a
17 population of folks that are in long-term care for
18 substance use disorder, and so do you foresee that this may
19 be something applicable at a future time for a different
20 study for that population? Thank you.

21 CHAIR BELLA: Anne, do you want to answer that
22 one? Just because --

1 EXECUTIVE DIRECTOR SCHWARTZ: Sure. This is a
2 statutory direction to the Commission to look specifically
3 at Money Follows the Person and how the settings under that
4 program relate to those under the home and community-based
5 settings rule. Congress could ask us to do additional
6 studies, but right now we're focused on answering the
7 question that Congress put to us.
8 CHAIR BELLA: Thank you.
9 All right. Let's try Noah one more time. And I
10 would also remind folks that you're always welcome to make
11 comments. Just address it to comments@macpac.gov.
12 MS. HUGHES: Noah, just a reminder. You are
13 self-muted and you need to click the little red microphone
14 icon under the orange arrow.
15 [Pause.]
16 CHAIR BELLA: Okay. I'm going to ask for now
17 that -- Noah, you are welcome to make a comment later in
18 the session, or you're welcome to send to
19 comments@macpac.gov. We'll take a short break and be back
20 at a couple minutes before 11:00 so we can start right on
21 time with our panel. So that gives you all, I don't know,
22 12 minutes or so. So we'll see you back here shortly.

1 Thank you very much.

2 * [Recess.]

3 CHAIR BELLA: Okay. Let's go ahead and get
4 started. Welcome back, everyone. Aaron, nice to see you,
5 and welcome to our panelists.

6 Aaron, I'm going to turn it over to you for
7 introductory remarks, introduce the panelists, and then
8 we'll be off and running. So thank you all for being here
9 today.

10 ### **PANEL DISCUSSION: HEALTH IT ADOPTION AND USE BY**
11 **BEHAVIORAL HEALTH PROVIDERS TO SUPPORT CARE**
12 **INTEGRATION**

13 * MR. PERVIN: Excellent. Thanks, Melanie.

14 Good morning, Commissioners. This year we will
15 be investigating ways to improve clinical integration of
16 services by focusing on health IT adoption among behavioral
17 health providers. In prior meetings, we discussed low
18 rates of behavioral health IT adoption for Medicaid
19 providers, and Commissioners highlighted the need to talk
20 with stakeholders about how electronic health record
21 platforms could strengthen quality of care for
22 beneficiaries. I'm excited to introduce three panelists

1 today to talk with the Commission about all of this.

2 First up is Jessica Kahn. Ms. Kahn is the former
3 director of data and systems at the Center for Medicaid and
4 CHIP Services and a current partner at McKinsey. Ms. Kahn
5 will provide an overview of Medicaid efforts to date to
6 strengthen health IT adoption within the provider community
7 under the Promoting Interoperability Program and the
8 ramifications of leaving behavioral health mostly out of
9 these efforts.

10 Second, you will hear from Bebet Navia. Mr.
11 Navia is the program director for New Jersey Medicaid
12 Enterprise Systems, and he will discuss New Jersey's
13 Substance Use Disorder Promoting Interoperability Program,
14 which is completely funded with State dollars and pays
15 substance use disorder providers to adopt EHRs.

16 Third, you will hear from Brooke Hammond. Ms.
17 Hammond is the director of operations at Integral Care in
18 Austin, Texas. Integral Care is a behavioral health
19 provider that participates in Texas' Comprehensive
20 Community Behavioral Health Clinic Initiative. Ms. Hammond
21 will present on Integral Care's ongoing efforts to optimize
22 its EHR platform and how EHRs have strengthened quality of

1 care for its patients.

2 With that, I will hand it over to Ms. Kahn.

3 * MS. KAHN: Thanks, Aaron, and thanks for having

4 me. Can I get like a thumbs up that you guys can hear me?

5 Okay. And can I also just take a moment to say it's

6 wonderful to see so many friendly faces of brilliant

7 colleagues. I miss you all and wish we could be in person.

8 So, yes, as Aaron mentioned, I'm going to try and

9 set a stage here and then turn to Bebet and to Brooke to

10 provide some more specificity on New Jersey and on the

11 clinical practice element as well. And, Aaron, thank you

12 in advance for advancing the slides for me as we go

13 through. Then we can have some questions. So let's jump

14 in.

15 MR. PERVIN: Yeah, let me just make sure that I

16 have control of the slides.

17 MS. KAHN: Always a good thing.

18 MR. PERVIN: There we go.

19 MS. KAHN: There we go. Great.

20 So looking back, actually we're coming up --

21 let's see. Today's September 24th. Six more days of

22 HITECH, you guys. Six more days. Can you believe it has

1 been a decade of HITECH, for Medicaid at least? So,
2 clearly, we have the ability to look back and understand
3 the significance of the investment; $35 billion was set
4 aside for the incentive programs to encourage hospitals and
5 providers to adopt EHRs and, dare I say it, to use them
6 meaningfully. And we saw from the inception of the
7 incentive programs EHR adoption increased 53 percent among
8 the non-federal acute care hospitals right away. So just
9 using hospitals as a benchmark there, within a quick four
10 years we saw a dramatic uptick in adoption and use.
11 And yet we also see broadly that it has been
12 fairly limited in the behavioral health space. As you
13 know, behavioral health providers, writ large, were not
14 included in the EHR Incentive Program. And even those
15 where it was a psychiatrist who may have or a psychiatric
16 hospital, and we still see a general lag in EHR adoption.
17 So psychiatric hospitals lag behind other specialty
18 hospitals in using what we call "certified electronic
19 health record technology." Those are electronic health
20 records that have been certified and blessed, so to speak,
21 that they meet ONC's criteria. And, similarly, office-
22 based physicians practicing psychiatry lag behind specialty

1 physicians in EHR adoption. Still progress at 61 percent
2 compared to what we would have seen prior to HITECH, but
3 still a significant lag.
4 Again, those are two who arguably could have been
5 part of the incentive program although there are many
6 barriers, which we'll talk about in a moment. So
7 definitely seeing the disparity.
8 Let's go to the next slide, Aaron.
9 So, let's talk about why we still see that lower
10 adoption rate for BH providers. For the first part, we
11 thought of the incentive program not as a way to offset the
12 total cost of adopting election health records, but to
13 really help providers make that risk-reward decision to
14 lean in and to do the adoption, because it was more than
15 just paying for the software, right? It was also the
16 training and the work flow redesign and the transition of
17 practices and processes from paper to electronic. So, the
18 incentives really helped not just those initial providers
19 who received them, but at a practice level it helped them
20 make that transition from paper to electronic. So not
21 having others within the practice to support BH be part of
22 the incentive program created some of those barriers there,

1 so psychologists, social workers, other kinds of therapists
2 were ineligible.
3 And then behavioral health providers have less
4 incentive to adopt EHRs because they're typically not
5 included in health information exchanges, which, again,
6 sometimes serve as a catalyst for EHR adoption among other
7 providers. If you are part of an exchange and there's a
8 demand and an expectation for data coming from your
9 practice to the exchange with other practices, you look for
10 the means to be able to do that and to facilitate that kind
11 of exchange in an easier and more automated way. And so BH
12 providers, for reasons related largely to Part 2 barriers
13 or perception of Part 2 barriers have not been as highly
14 involved in health information exchange and, therefore, are
15 not grabbing for the EHRs that would enable that.
16 And then they're often unable to invest in the
17 hardware, software, and training. You know, these are low
18 operating margins in general, and looking back, with the
19 hindsight of ten years, perhaps we even underestimated the
20 costs for this transition, again, going way beyond software
21 but also the connectivity, the work flows, making it
22 configurable to your site and to your providers and your

1 need, as well as the ongoing training so that it didn't
2 bottleneck the healthier work flows within a practice. You
3 know, it's quite costly over time, and if you're starting
4 off with a low operating margin, that's a high cost to put
5 out without any sort of incentive or financial
6 reimbursement.
7 And then the last one I sort of alluded to
8 already, which is BH providers are subject to the data-
9 sharing regulations that go beyond what the certified EHR
10 technology requirements these programs require, and so they
11 have challenges perhaps in implementing what we would call
12 compliant systems.
13 There are a number of interoperable health
14 solutions that could bridge the gap. There are a growing
15 number of companies that are offering solutions designed
16 for interoperability with these provider types. I was
17 digging around before this conversation, and I saw on
18 Capterra there are 226 BH EHR products listed there. Two
19 hundred and twenty-six. This is the site that the American
20 Psychiatric Association points to, right? Guess how many
21 are actually on the site that lists all the certified EHR
22 products? Two. So, there's 226 out there in the market,

1 and I'm sure that's not even an inclusive list, right, or
2 exclusive list. But because there's not an expectation
3 that they be certified in order to meet these requirements
4 and to facilitate access to incentive payments, they
5 haven't gone through this same sort of compliance steps to
6 show that they could be certified to the extent that other
7 EHRs have, and, you know, perhaps there is, as I said, also
8 additional barriers on top of that.

9 So, this is just a small subset of the kind of
10 tools that are out there, but they're certainly still
11 outside of this margin of where the rest of the integrated
12 health world or the physical health world is looking for
13 the Good Housekeeping Seal of Approval for an EHR.

14 Let's go to our next slide.

15 So, let's talk for a moment here about, you know,
16 why this matters and why increasing adoption of certified
17 EHR technology for BH providers could have wide-reaching
18 benefits. I think this is what you're most interested in,
19 right? Like, what's the outcome that would come from this?

20 So I think we have seen and acknowledge the
21 clinical integration that could come from electronic health
22 record use to improve coordinated care, to improve data

1 sharing, to improve clinical decision support, and other
2 kinds of tools that improve population health and health
3 care value, which also can help drive cost reductions, so
4 not having repeated screenings, being able to share
5 screenings that were done at one site for another, reducing
6 administrative duplication, among others. So, all of the
7 benefits we see on the physical health side hold true here
8 on the behavioral health side as well for that category.
9 The other one to flag is value-based payment.
10 There is a lot that has to happen on the back end in order
11 for providers to effectively participate in value-based
12 payment. There's the data that helps pull together all of
13 the inputs for clinical quality measures and for the
14 reports that need to demonstrate that they are actually
15 creating the value. There's attribution, sort of which
16 patients belong to which providers. All of that is
17 facilitated better through technology than, say, you know,
18 Excel spreadsheets, right? So, in order for them to really
19 participate in value-based payment models, particularly if
20 you're thinking about states and programs that are trying
21 to do it in an integrated behavioral and physical health
22 way, this really hamstrings their ability to come to the

1 table the way that the physical health colleagues can and
2 really participate fully in value-based payment scenarios.
3 And then another one would be improving the
4 quality of health reporting. You know, just thinking about
5 the data that we've been struggling to pull out of this
6 system over the past 18 months to see where behavioral
7 health utilization has gone and what's the quality of care
8 and what does it look like when it's more telehealth
9 provided versus in-person provided and, you know, never
10 mind what we're going to do when 988 rolls out next year
11 and there's going to be an increased demand to understand
12 the quality of crisis response being delivered by states.
13 The ability for these providers to provide high-quality,
14 consistent, standards-based data to support health
15 reporting and, therefore, participate and ease the burden
16 of that reporting to state agencies, to Medicaid, to
17 Medicaid plans is really better done through technology
18 than through chart extraction, manual chart extraction.
19 So, I think while none of these is exclusive to
20 BH providers, the reality is we're moving more and more
21 towards a more integrated model in the first place, and we
22 see an increased demand for BH services. Not having access

1 to certified EHR technology is an impediment to their
2 ability to fully participate in the realized outcomes that
3 we've described here.
4 Let's go to our next one.
5 All right. With that, I think I've set the stage
6 for my friend Bebet to talk about some of the exciting work
7 that they're doing in New Jersey, and then we'll open it up
8 for questions after Brooke describes what she's doing in
9 Texas as well. Thanks.
10 * MR. NAVIA: Thanks, Jess. I'm just checking if
11 everyone can hear me.
12 MS. KAHN: Yes.
13 MR. NAVIA: Okay, thanks.
14 My presentation is going to occur without any
15 slides. I saw Jess' slides, I'm a little bit jealous about
16 that. But, anyway, nevertheless, slides -- or without
17 slides I hope that I'm fairly compelling in telling the New
18 Jersey story.
19 So, on behalf of New Jersey Medicaid, we thank
20 the Commission for inviting New Jersey to present our
21 Substance Use Disorder Promoting Interoperability Program,
22 or SUD PIP. In order to leverage the limited amount of

1 time we were provided to present here, I would like to
2 elaborate on the well-known benefits of integrating
3 physical and behavioral health and clinical care using
4 electronic health records. I believe Jess has discussed
5 this, and it is also exceptionally explained in detail in
6 Chapter 4 of the recently released June 2021 Report to
7 Congress by MACPAC. There was a very good article in that.
8 I hope to be able to share the efforts made by
9 New Jersey to establish and implement our SUD PIP by
10 discussing its background, the strategy on how the program
11 was implemented, and the current status related to
12 participation and attestation by SUD facilities.
13 So, way back in 2018, which seems like a very
14 long time from now, Governor Murphy's administration
15 advanced $100 million commitment to tackle New Jersey's
16 opiate crisis, $6 million of which was carved out to focus
17 on health information technology. Also around the same
18 time, New Jersey Medicaid's 1115 demonstration waiver was
19 approved with an additional substance use disorder waiver.
20 It was approved by CMS around the same time. And then a
21 collaborative effort was established between New Jersey
22 Department of Health and the New Jersey Department of Human

1 Services, which Medicaid is a part of, to form a Substance
2 Use Disorder Health Information Technology Work Group. One
3 of this work group's main tasks was to develop policies and
4 make decisions on how to effectively invest or utilize the
5 governor's HIT upgrade funds. In addition, we also
6 discussed policies in meeting the requirements of the SUD
7 waiver in the Medicaid 1115 demonstration.
8 Also, lastly, around the same time, as the HITECH
9 program is sunsetting, as Jess mentioned earlier,
10 discussions were starting within the state and also across
11 different states on how to leverage the state's -- we call
12 it the "state-level repository," which is the attestation
13 system utilized by providers and hospitals to attest to the
14 HITECH EHR incentive payments.
15 So, in a sense, we were saying at the time that
16 it seems like the stars aligned for this program with the
17 SUD waiver, the availability to reuse the HITECH system,
18 attestation system, and, of course, the all-important
19 funding which led to the establishment of the New Jersey
20 Substance Use Disorder Promoting Interoperability Program,
21 or as we call it SUD PIP.
22 So the question that we focused on when we

1 started this, how can it really make a difference? Because
2 unlike HITECH, we don't have ten years for the program, and
3 we have relatively limited funding, $6 million. So, one of
4 the initial steps we took was to conduct an HIT survey on
5 all the SUD facilities in the state. We partnered with the
6 New Jersey Association of Mental Health and Addiction
7 Agencies, NJAMHAA, which represents all of the behavioral
8 health providers in the state.
9 We found out -- obviously, there's a lot of
10 details and analysis in the survey, but we found out that
11 most of these facilities were not eligible for the HITECH
12 program and was not able to take advantage of the EHR
13 incentive payments. So based on this survey and analysis,
14 the SUD PIP was established as a milestone-based EHR
15 incentive program. "Milestone-based" is a critical term
16 and a crucial decision because with the limited time frame
17 and fund, it would have been challenging to release funding
18 to the facilities and then monitor them: Are they meeting
19 the criteria? Are they achieving the program criteria? By
20 making it milestone-based, the SUD facilities will only
21 receive the incentive payments each time they achieve the
22 requirements of a milestone.

1 Currently, there are five different milestones
2 which are focused on EHR adoption, upgrade, and
3 interoperability. So, if the SUD facilities adopt an EHR,
4 that's a milestone. If they connect to the New Jersey
5 Health Information Exchange, that is a milestone. If they
6 connect to the Prescription Monitoring Program, another
7 milestone. And, lastly, if they connect to the New Jersey
8 Substance Abuse Monitoring System. And facilities
9 attesting to the milestones can receive up to $42,500 in
10 incentive payments if they are able to accomplish all those
11 milestones.
12 So, in order to assist the SUD facilities in
13 meeting the requirements, the state also has partnered with
14 New Jersey Innovation Institute. This was formerly the New
15 Jersey Regional Extension Center. If folks recall the
16 RECs, it was established by the state university, New
17 Jersey Institute of Technology. With their former Regional
18 Extension Center experience, we knew that they had the
19 tools, the resources, and the expertise to get the program
20 off to a running start.
21 And with them functioning as -- also functioning
22 as administrator of the New Jersey Health Information

1 Exchange they are able to readily assist facilities in the
2 interoperability of integration work.
3 So, two years ago, the program, since then, we
4 have received a total of 204 total facility application
5 requests. There are actually 230 substance use disorder
6 facilities in New Jersey. There were 74 facility active
7 participation with 145 attestations so far in milestone
8 payments. We have issued a total of $1.3 million in
9 payments.
10 The public health emergency slowed down
11 attestations in 2020, but we have observed that activity
12 has started to pick up.
13 Since this program is supported by state-only
14 funds, New Jersey has been exploring the potential for
15 federal matching funds through the 1115 waiver, HCBS
16 funding, but that is another conversation.
17 But in closing, the SUD Promoting
18 Interoperability Program provided much-needed financial
19 incentive to these groups of providers who, for the most
20 part, were unable to participate in the HITECH incentive
21 program. The state was also able to support some of the
22 sustainability funding for the Regional Extension Center

1 and also provided a pathway of the HITECH program and
2 leverage and reuse HIP systems and initiative CMS funding
3 to HITECH.
4 We had also some anecdotal comments from some SUD
5 facilities that the program actually supported their
6 financial solvency, but the ultimate beneficiaries of this
7 program are the substance use and disorder clients, who, in
8 some form or manner, we hope they are able to assist in
9 their way to recovery.
10 Thank you so much, and I will pass it on to
11 Brooke.
12 * MS. HAMMOND: Good morning. I first want to
13 thank the MACPAC Commissioners and staff for this
14 opportunity to participate in this panel, and give a
15 virtual nod, if you will, to my fellow panelists for really
16 setting the stage well for my comments.
17 So, what I bring to this discussion is the
18 provider-level perspective, and I'll do that by focusing on
19 three main areas. One, how having an EHR has really helped
20 us provide targeted intervention to get people the care
21 that they really need, and also having an EHR has
22 facilitated our efforts to address health disparities and

1 promote health equity in everything that we do. And then
2 lastly, how having an EHR has really helped support our
3 overall sustainability efforts as we move forward in an
4 ever-growing value-based care environment.
5 So, when Integral Care received word they would
6 finally be getting COVID vaccines for its client
7 population, we quickly put together a list of clients,
8 stratified by health risk and vulnerability if they were to
9 actually contract the COVID virus. So that, paired with
10 most up-to-date contact information that we have for them,
11 we put together a team of staff to directly start calling
12 individuals, starting with those, you know, at the top of
13 that health stratification.
14 At the same time, we embedded a screening form
15 and put it into our EHR to really help guide those calls,
16 gauge vaccination -- if they had received it already or
17 they were interested in getting the vaccine -- and really
18 to drive appointment setting.
19 So, one such individual that we called on that
20 list -- we'll call him Carlos for purposes of this panel --
21 a little bit about Carlos. He is a 59-year-old Hispanic
22 male. He has a sixth-grade education and a history of

1 childhood trauma. He is diagnosed with schizoaffective
2 disorder, hypothyroidism, hypertension, and chronic
3 obstructive pulmonary disease, COPD. He is considered
4 clinically obese with a BMI of 36.1.
5 He had a history of many psychiatric
6 hospitalizations, approximately 15 in the last 13 years.
7 He is financially dependent on Social Security disability
8 insurance, so SSDI, and he is enrolled in Medicaid managed
9 care.
10 We called Carlos on a Friday, and on Monday he
11 was in one of our clinics getting his first vaccine dose,
12 and he was the 11th client of Integral Care to get his
13 vaccine through us.
14 So, I described Carlos because he's not unique in
15 his situation in terms of having a psychiatric diagnosis
16 along with comorbid medical conditions. Integral Care
17 serves approximately 30,000 individuals every year, and 35
18 percent of them have these comorbid medical conditions.
19 So without an electronic health record that can
20 check whole health information -- so not just the
21 psychiatric but the medical -- as well as with the social
22 determinants of health, and an EHR that can make it really

1 easy on staff to keep that up-to-date contact information
2 in the EHR, as well has having an EHR that either has
3 business intelligence tools built into it or have its data
4 easily accessible to external business intelligence tools,
5 without all of those things in combination such a swift
6 response like the one I described would not have been
7 possible.
8 Another example of how we are using our EHR to
9 better serve people in the community is how we can really
10 quickly look at diagnostic patterns, all the way down to
11 the individual physician level. So, we wanted to start
12 addressing diagnostic disparities, and specifically start
13 by looking at the disparity in diagnosis of schizophrenia
14 in a male population within the African American male
15 population. So, we looked at some data before and after we
16 added some specialized questions to the physician area of
17 our EHR, and those questions were basically to get the
18 physicians to pause, re-look at the symptomology to see if
19 they might want to consider an alternative diagnosis.
20 So preliminary analysis of the data that we were
21 looking at has shown a 19.3 percentage decline in the
22 disparity of this diagnosis within this demographic, really

1 demonstrating how a pretty easy customization of our EHR,
2 along with some targeted outreach to our physician group,
3 could really make an impactful change not just in how we
4 diagnose but provide subsequent treatment that is
5 appropriate to the appropriate diagnosis.

6 Can you collect the kind of data that I described
7 in these two examples without an EHR? Yes, technically,
8 sure, you could. But by the time that you got to the data
9 point that you needed they could very well be outdated, and
10 you will have wasted many staff hours that you could have
11 used doing other things, like either doing, you know,
12 targeted outreach to perhaps people in the community that
13 aren't enrolled in services yet, or taking your current
14 programs and really refining them even further, to make
15 sure you are providing top-notice quality care.

16 It would be highly irresponsible of me to suggest
17 that any behavioral health career organization can just,
18 you know, one day decide they want an EHR, go out and find
19 one, purchase it, and then put it into place in such a way
20 to make such impactful changes. Having a fully
21 functioning, sophisticated EHR that helps drive decision-
22 making both at the clinical and the administrative levels

1 is not an easy or inexpensive feat. It takes a
2 considerable amount of resources, both financial and
3 personal.
4 So, we have staff that work tirelessly, really
5 setting up a diverse set of funding streams. Given the
6 disparity in reimbursement for behavioral health care
7 services, such a diversity in funding streams becomes
8 critical, not just to provide basic services but to afford
9 organizations like ours to go out there and get modern
10 tools, like EHRs, to support our clinical work.
11 As a certified community behavioral health
12 clinic, a CCBHC, we were able to apply for, and were
13 awarded a SAMHSA grant. So, having the EHR was really
14 important so that we could monitor and report out on
15 meeting the nine quality care measures that come with being
16 a CCBHC.
17 So, we also participate in the Delivery System
18 Reform Incentive Payment Program, DSRIP, also a wonderful
19 yet also time-limited funding opportunity. So, our
20 involvement with DSRIP actually requires Integral Care to
21 monitor and report out on 21 quality care measures, many of
22 which actually address some of the comorbid medical

1 conditions I mentioned at the start of my presentation.
2 Having these funding opportunities and the EHR
3 really demonstrates a circular dependency, if you will.
4 You know, we needed the funding, for example, like through
5 the SAMHSA grant, to be able to afford an EHR, but having
6 an EHR then becomes absolutely necessary to be able to pull
7 data to report out on our performance on the quality care
8 measures in order to sustain that funding.
9 Having an EHR, and the staff that can pull data
10 from it, and the clinical services that all tie that
11 together really helps open up the doors for other potential
12 funding opportunities. For example, a Medicaid managed
13 care organization, MCO, that Integral Care contracts with,
14 they were looking for a set of characteristics in a
15 provider and collaborator for a health home pilot it wanted
16 to get off the ground. One such characteristic included
17 intentionality towards health equity and addressing social
18 determinants of health. And then another characteristic
19 they were looking for was a performance improvement culture
20 that leverages actionable practice trend data.
21 So, with our EHR and our staff and the clinical
22 services that we were able to provide, we've actually

1 implemented a successful health home model with this MCO.
2 And through this collaborative work between us, the
3 provider, and the payer, the MCO, we are really striving to
4 improve care coordination, care integration, demonstrate
5 cost savings for the system of care, and ultimately improve
6 those clinical outcomes.

7 So, I mentioned staffing a couple of times, and I
8 would be remiss not to mention the staff and the team that
9 it really takes to make the most of our electronic health
10 record. We have an individual whose role it is to focus on
11 just population health, looking at community data, our
12 internal data, and analyzing that, and really giving us
13 some really important and informative reports.

14 We have a dedicated team whose job it is solely
15 on upkeep and optimization of our electronic health record.
16 And we have a whole separate team, that we call OneData,
17 that does just that. They work within the EHR and outside
18 the EHR, creating reports and tools and dashboards that are
19 used all the way from our direct care clinical operations
20 all the way up to our executive management team.

21 So, having those individuals and those teams in
22 place, and not just the EHR, having those people in place

1 really supports many aspects of Integral Care's work, but
2 mostly, and most importantly, the care that our clinical
3 teams are providing.
4 To wrap up, I'm often reminded, in the work that
5 I do, that individuals diagnosed with severe mental illness
6 die, on average, 25 years earlier than those in the general
7 population -- 25 years earlier. This needs to change. And
8 it is possible by recognizing the importance and value of
9 fully integrated care. Truly weaving behavioral health
10 care into the larger health care landscape and adequately
11 supporting behavioral health organizations of all sizes in
12 the work that they do, via realistic and sustained funding
13 mechanisms, and ensuring they have the necessary tools,
14 like electronic health records, so that they can do their
15 work efficiently.
16 Thank you.
17 CHAIR BELLA: Anne, I am just going to jump in
18 with questions, unless you want to do any. Okay.
19 All right. Many thanks to all three of you.
20 Let's open it up to Commissioners for questions and
21 comments. Fred, take us away, followed by Darin.
22 COMMISSIONER CERISE: Those are all great

1 presentations. Thanks to you guys for being here and the
2 information.
3 A quick question. What is your EHR, and what's
4 your experience coordinating with the other providers, the
5 physical health providers, the bigger system HIEs, whatever
6 it is in Austin that you coordinate care with?
7 MS. HAMMOND: Sure. Well, first of all, for EHR
8 we use Netsmart's solution, NX, which is the most recent
9 update to their myAvatar solution. And in terms of
10 communication with other providers, we do participate in an
11 HIE. And then we do have the functionality with our EHR to
12 do things like share back and forth CCDs, those clinical
13 care documentation. And then we are heavily in the process
14 of working out all the tweaks to be able to readily
15 exchange more like real-time data.
16 So we have a functionality. The pandemic
17 certainly kind of slowed down some of our optimization
18 efforts, but it's out there. And so our applications
19 support team is working on making that happen.
20 And we've done some tests with some other
21 providers. I know with the state hospital that's here in
22 Austin we've been able to successfully send information

1 back and forth, kind of test scenarios, so hoping to get
2 that more in place regularly.
3 COMMISSIONER CERISE: Can I follow up real quick?
4 I really am impressed with how you're using data
5 internally. Has the Part 2 issue been a problem to you in
6 exchanging with other providers?
7 MS. HAMMOND: Yes, very much so. In fact, the
8 HIE that we participate in, you know, we send data into
9 that. However, right now for any consumer that is
10 currently, or in the past, has been enrolled in any one of
11 our substance use programs that fall under Part 2, we don't
12 share any of their data, which is really limiting, because,
13 you know, some of them have crises in behavioral health
14 diagnoses that would be irrelevant to other providers. But
15 because they have those services in those SU programs,
16 currently we're not sharing any of that information, which
17 is unfortunate for those individuals that we don't have
18 that kind of total open communication of their data.
19 COMMISSIONER CERISE: Thank you.
20 CHAIR BELLA: Thank you. Darin.
21 COMMISSIONER GORDON: Thank you all. This is
22 very helpful. You know, it really forces me to think about

1 this in a different lens than just, you know, getting the
2 technology within the practices. But also thinking about
3 how, in the absence of it, it inhibits progress in a lot of
4 the areas that we've been focused on, whether it's physical
5 health and behavior health integration, whether it's value-
6 based purchasing, whether it's improvements in equity.
7 Progress in any of those three areas are just not going to
8 be achievable if there's a practice that's not able to move
9 in this direction. So thank you. I think you all
10 highlighted that very, very well.
11 And I was very impressed with what you all were
12 able to do in New Jersey with very little funding. Very
13 surprising how many people engaged on that. I would not
14 have anticipated that at that level of funding, but that's
15 kudos to you all for designing a system that really tapped
16 into what the need was for those providers.
17 This is a question for the group, and, Brooke,
18 you brought it up, and Jess, you highlighted it. Here's a
19 couple of reasons why it's challenging for this provider
20 class. Brooke, you talked about staffing, and there was
21 like support of it but there was also like how to leverage
22 it broadly within the organization in running the business,

1 which, you know, I consider this, the second, really,
2 really important, and I always get excited about that. But
3 the first is really kind of like you have to have.
4 So, you know, staffing was one that just wasn't
5 on your list, but what would you say, you know, for this
6 particular provider group, what are some of the other
7 practical barriers? You know, we did talk about Part 2,
8 you know, being an issue in exchange, but I don't consider
9 that, again, like what are some of the practical barriers
10 for a practice to actually go down this path, beyond some
11 of those higher-level categories, Jess, that you described
12 in your presentation?
13 MS. KAHN: Well, I mean, I think we talked about
14 it a little bit, and Bebet noted the provision of REC-type
15 services, right. Practically, having support for
16 integrating the EHR into your workflow and actually
17 supporting that as a transformation is no small feat, and
18 it probably is the difference between successful EHR
19 adoption or not, in any type of practice.
20 And so even if you have -- let me say this
21 differently -- a large hospital system might not need that
22 because they might have those people in house. But a

1 smaller practice, be they BH or otherwise, really needs
2 that hand-holding and that pattern recognition. We have
3 seen clinics of your size, or arrangements like yours, and
4 these are the workflows that work for them and this is the
5 level of staffing that should be doing these parts of the
6 input within the workflows, and, you know, bringing that to
7 the table for them. It's not something that needs to be
8 sustained forever. It helps with that integration, unless
9 there's new updates or whatnot.
10 But I think the other part that I thought was
11 really interesting about what Brooke was saying is also
12 having the staff that are going to take advantage of the
13 system, right? You actually want people then who can pull
14 the data out and look at it and examine your practice and
15 examine the quality of care and examine what's happening.
16 So, it's people who are going to use the technology, not
17 just support and the adoption of it, that I think is
18 another practical point.
19 And there sometimes we're seeing -- and again,
20 this is true of physical as well as behavioral health --
21 partnering between facilities. So, you know, the way that
22 FQHCs do such a good job grouping themselves together to be

1 able to share resources across multiple sites. So that's
2 one of the ways that some of these more practical
3 impediments can be addressed, instead of each particular
4 practice feeling like they have to solve for it one by one
5 by one. Sometimes there are roles that can be shared and
6 facilitated across, but better Brooke to add as well, other
7 practical barriers.

8 MS. HAMMOND: Yeah. In terms of staffing,
9 probably one of the big things that I didn't mention was
10 just the training required. You know, we have an
11 organization of a thousand staff, the majority of those
12 being clinical staff. So anytime you introduce any sort of
13 new technology, you'll have various levels of abilities
14 across staff, and so you really have to dedicate a good
15 time to making sure everyone feels comfortable with the
16 technology so that they're using it to the fullest and not
17 just initial training, but, I mean, training and support
18 for us is constant. And it takes a lot of people for sure.

19 COMMISSIONER GORDON: Yeah. That's helpful.

20 We had a discussion yesterday about just provider
21 capacity, and just based on some of the discussion here, it
22 seems again like another enabler to actually help practices

1 to be more efficient. I was thinking of Brooke's example
2 of "Could you do it all without an EMR?" Yes. But, yes,
3 that sounded incredibly painful and time consuming and not
4 focusing on the things that people should be focusing on
5 like particularly the clinicians with the patients. That's
6 another enabler.
7 So, this is very helpful. Thank you. Thank you
8 all. Appreciate it.
9 MS. KAHN: And one of the other institutes we see
10 stepping in a little bit here, though it certainly varies
11 across the country, are health information exchanges, like,
12 for example, Health Current in Arizona who is now
13 Contexture because they merged with Colorado. Part of what
14 their HIE does is actually help providers on board and use
15 their EHR and take advantage of the connectivity that comes
16 with the HIE.
17 So, I just wanted to note that in different
18 places, you could look to the resources, be they
19 internally, be they from the vendor themselves, or from
20 some REC-type organization and HIE. There's a long list of
21 actors.
22 COMMISSIONER GORDON: One last question, Melanie.

1 You had Fred ask a question about changing
2 information with like all providers. Are there certified
3 systems out there that are integrated already for physical
4 health and behavioral providers for those practices that
5 want to integrate at the clinical level?
6 MS. KAHN: There are. There are a number of
7 physical health EHRs that have a behavioral health module,
8 right? So, they started off, you know, like NextGen. You
9 know, they have an EHR that's meant to be broad, broadly
10 across multiple disciplines, and then they have a BH module
11 in specific. So, it's -- that's the more common trend.
12 MR. NAVIA: So, if I may as well, I'd like to
13 discuss how New Jersey is handling 42 CFR Part 2
14 information. As always, we have implemented or we're
15 currently deploying behavioral health consent management.
16 This is actually funded by HITECH as well, which is ending
17 in six days.
18 But what this program is, it allows SUD
19 beneficiaries or clients to provide consent to which
20 providers and which information that provider carried for
21 them can share with other providers. So, it's not
22 necessarily attached to an EHR or within EHR, but it's a

1 separate consent mechanism.

2 And our intent was -- it's not part of our
3 milestone program right now, but hopefully, if we receive
4 additional funding from the feds which -- that the MACPAC
5 influence -- and I'm sorry, but if we do get additional
6 funding, we were angling to include it as a milestone for
7 the providers in our programs. So, if they participate in
8 the behavioral health consent management, they will receive
9 additional funding.

10 So, the milestone to connect their systems into
11 HIEs are actually right now one direction. It's a
12 direction where they only received data because they cannot
13 share their data. So, they receive notice of discharge
14 transfers, and they receive clinical summaries when their
15 patients or their clients may get discharged or transferred
16 to another facility. So, the behavioral consent
17 management, we are hoping would address this issue.

18 CHAIR BELLA: Thank you.

19 Verlon?

20 COMMISSIONER JOHNSON: Thank you.

21 This has been a really great conversation, and I
22 really appreciated hearing your successes in your areas and

1 what you're doing around it and definitely appreciate the
2 last round of conversation around the training and the
3 staffing and all of that because that was definitely on the
4 top of my mind.
5 But that just again, I think we've already echoed
6 just amazing work that you all have done in New Jersey and
7 just continued success there. I always have in the back of
8 my mind, though, of like what the things were that didn't
9 work, and so even though I know it was a very small
10 population, that number, what, 26 providers who have not
11 jumped on the bandwagon kind of just has me kind of
12 thinking like what are some of the challenges that are
13 still there.
14 Similarities around the reasons why they haven't
15 jumped on the bandwagon are other things you may have heard
16 that may be helpful to ask as we kind of think about ways
17 to assist states and others in getting -- in moving the
18 needle further on this issue.
19 MR. NAVIA: One of the things that -- you know,
20 one of our lessons learned is when we established the
21 program, we had -- like I said, there were 230 SUD
22 facilities in the state, and they have limited funding.

1 So, it was a first-come-first-serve basis, and so we
2 established an eligibility criteria that we felt was maybe
3 could be too onerous to achieve for some providers. For
4 example, we did say that we only wanted programs that are
5 able to prove that they have at least 50 clients that
6 they're serving. So, there are a number of SUD facilities
7 that are fairly new, that just got their license approved.
8 So, there were several of them that did not meet that
9 requirement.
10 So, what we did is they're actually -- the work
11 group that we established actually regrouped, and we are
12 starting to increase the flexibility for eligibility, for
13 example, lowering the number of admissions that we require
14 for them to participate and potentially expanding it to
15 some of the facilities that do not have a contract with
16 their mental health and patient services division. So
17 those are some of the eligibility criteria that we are
18 expanding right now.
19 COMMISSIONER JOHNSON: All right. Thank you.
20 And I think -- was it -- I think, Brooke, maybe
21 you mentioned too the idea of our -- and maybe it was Jess
22 as well -- in terms of kind of partnering for these smaller

1 practices. Would that be something that could potentially
2 be in play in this kind of case as well? Just curious in
3 terms of what you're looking at, the smaller numbers in
4 trying to make sure they're able to capture or be a part of
5 this particular process.
6 MS. HAMMOND: Yeah. I mean, absolutely. We'll
7 coordinate with anybody within the technical security specs
8 for sure. Yeah.
9 COMMISSIONER JOHNSON: All right. Thank you.
10 CHAIR BELLA: Toby?
11 MR. NAVIA: And I think what -- oh, I'm sorry.
12 CHAIR BELLA: Go ahead.
13 MR. NAVIA: I'm sorry.
14 So, one of the things that also we observed was,
15 like you said, staffing is an issue for some of these
16 providers. Some of them are just one-practice facilities
17 and some are more, but those smaller practices, what we've
18 done is in partnership with New Jersey assessment on
19 addictions agencies is that we -- they've created
20 consortiums of providers so they can help with
21 implementation and adoption of EHR in groups, so they are
22 able to negotiate contracts with particular EHR vendors

1 because there are a number of them that will sign a
2 contract, so not only with financing but also with
3 implementation of the systems, the establishment of
4 consortiums. So that actually also helped improve our
5 attestation numbers and participation numbers.
6 MS. HAMMOND: Yeah. And here in Texas, we have a
7 handful of Senators that have all adopted the same
8 electronic health record within the span of a few years,
9 and so we talk regularly and meet every couple of months to
10 kind of walk through what things are you doing, are you
11 discovering, what hiccups are you experiencing. So, it
12 really takes coordination across organizations using the
13 same EHR to be able to fully use all of its potential.
14 CHAIR BELLA: Thank you.
15 Toby and then Martha.
16 COMMISSIONER DOUGLAS: First, just thank you so
17 much for wonderful presentations and just the human impact
18 you guys are all having on the work you do, so thank you.
19 The question I have, first, when I think of the
20 enormity of what you've laid out in terms of really the
21 people, the process, and the technology, so the huge
22 investment in technology and keeping an investment on

1 people and then process redesign.

2 So, first question is really when you think of
3 that -- and that's a huge price tag and a starting point.
4 What are areas that we as MACPAC can lean in where we can
5 be -- you know, that are areas that we could actually
6 input? Jess, you mentioned the HITECH Act. I don't think
7 with everything else on the plate that Congress said that -
8 - something that big. So, what are measurable steps that
9 we could be focusing on in this area?

10 MS. KAHN: I can take a first step here. I do
11 think helping states understand what flexibility they have
12 under their current funding authorities that mentioned
13 looking for funding as sustainable funding now that HITECH
14 funding is sunsetting, so understanding that is and is not
15 permissible within the federal funding is always a good
16 point of clarification, and where there are additional
17 sources of funding that are coming available, HCBS or
18 otherwise, making sure there's clarity so they understand
19 what's available.

20 I think the other theme that I've heard come up
21 is also where states could be braiding funding, be it
22 SAMHSA plus CMS plus CDC. That's quite tricky, and you're

1 also talking about sitting and straddling across multiple
2 organizations within the state often, right? So, to the
3 extent that MACPAC has suggestions on how their federal
4 partners could present the menu of options to states, like
5 for states who are receiving these different buckets of
6 funding from our different agencies, here's ways that they
7 complement each other and could be put together to help
8 achieve some of these goals is always helpful.
9 States have, as you know, so much on their plate
10 at any given time. So sometimes just presenting the
11 available options to them with some sort of confidence that
12 those are going to be well received when they go to those
13 respective federal agencies can be really helpful.
14 I invite Bebet to add in since he's doing the
15 dance on a daily basis now.
16 MR. NAVIA: Yeah. Yeah, sure. Like I mentioned
17 earlier, we are exploring ways to increase the funding
18 availability for our program, and one of the things that we
19 looked at is potential federal match to what the state has
20 invested. This would tremendously help not only in
21 assisting the number of SUD facilities that are in our
22 state but also being able to start expanding the program to

1 all behavioral health facilities, because there's -- we're
2 focusing on the SUD facilities right now, but there's
3 really a whole subset of this category of providers that we
4 can truly assist, you know, using the same qualities and
5 the attestation systems that are already existing. So
6 those are the things we're looking at now.
7 MS. HAMMOND: Yeah. I think I always try to
8 remind folks that managed care costs associated with
9 helping providers is often used -- like health information
10 technology is below the line for the medical loss ratio,
11 right? So sometimes it's also understanding where states
12 are leveraging their MCO partners and contracts.
13 I don't think it's any one set of funding or any
14 one initiative. It's, again, helping create or stitch
15 together a network of what are your waivers, what are your
16 variety of different grants and funding streams, who are
17 your MCO partners, do you have health information exchange
18 that you've made investments in, where do they bring it to
19 bear, are some of these providers also serving Medicare or
20 other payers and therefore there could be a multi-payer
21 effort to try and improve the capabilities that benefit,
22 especially when you're doing broader value-based payment

1 efforts that are multi-payers. So, again, I think it's
2 creating a set of tools and ideas that states could then
3 take as a -- and pick what's the right play for them in
4 their current environment.
5 MS. KAHN: Yeah. I can appreciate how -- just to
6 mention, you know, helping folks identify and realize if
7 there's some flexibility in funding out there. It's not
8 common that such a large grant would be available that has
9 a significant amount of funds that can be used for
10 something like an EHR. So we were really excited about
11 that.
12 And then I mentioned how we're a CCBHC. However,
13 as probably most of you know, Texas was not one of the
14 states selected for the pilot. So, there is opportunities
15 out there for alternative payment programs that just
16 perhaps need to be expanded further so that more can take
17 advantage of that.
18 COMMISSIONER DOUGLAS: I have a couple of follow-
19 ups. Is it okay if I ask more questions, Melanie?
20 CHAIR BELLA: Yep.
21 COMMISSIONER DOUGLAS: You mentioned SAMHSA, and
22 can you talk a little bit more about their investments? Is

1 that anywhere we should be both -- given Medicaid
2 expansion, obviously not for Brooke in Texas, but in most
3 states, are there changes in kind of how SAMHSA investment
4 could be being used, and is that anything that we should be
5 examining?
6 MS. KAHN: I can't speak for what their current
7 priorities are, but I think what would be really intriguing
8 would be to think about who has which abilities and which
9 authorities, though Bebet mentioned this unified consent,
10 the BH consent sort of tool. That's certainly a multi-
11 payer kind of investment and works broadly. So, are there
12 things where SAMHSA as a partner could help create some
13 investments or some federally hosted solutions or things
14 that would be able to be leveraged by states in ways that
15 CMS funding has prohibitions or constraints? But I think
16 it's definitely an important conversation to have with
17 them. I imagine they're quite focused on the ability to
18 quantify, measure, and monitor the access to a quality of
19 behavioral health services right now and not the least of
20 which is looking ahead towards the 988 rollout as well.
21 COMMISSIONER DOUGLAS: The final thing, Melanie,
22 and then it will be -- it's just around the duals and given

1 so many of this population are duals around the innovation
2 center, you know, back to other areas too that -- and I'll
3 just leave it more as something that we should be
4 exploring.
5 CHAIR BELLA: Thank you, Toby.
6 Martha?
7 COMMISSIONER CARTER: So just a bit of
8 background, I was the CEO of a community health center that
9 has had medical services, integrated behavioral health,
10 integrated substance use disorder services using a
11 certified EHR, and I first thank you for bringing out the
12 realities of implementing an EHR and the complexities of
13 exchanging information. And I want to focus just a little
14 bit more in on Part 2 challenges.
15 In the EHR that we were using, which is a
16 certified EHR, we could block. We could decide who could
17 share visit information and, you know, sequester blocks,
18 and we had trouble sequestering psychotherapy notes. But
19 what we couldn't block was the inflow of prescription data,
20 and so you've got the person's antibiotic prescription as
21 well as their Suboxone prescription, and that was a problem
22 with Part 2 and sharing.

1 So, I want to look at what are the practical
2 recommendations that you all might have because you've been
3 out there working with this. How do we comply? How do we
4 fit within the parameters of Part 2 and still figure out
5 how to share data in a way that, first of all, preserves
6 patient safety? Because if you don't know that somebody is
7 on some of these drugs, there's a safety issue. So patient
8 safety is primary.
9 So, preserving patient safety but also then
10 figuring out how to improve care and integrate care. So
11 should Part 2 change? Should the EHRs change? Should we
12 make a recommendation that the EHRs have to have this
13 system like Bebet described where there has to be that
14 integrated consent? What's your recommendation?
15 CHAIR BELLA: Well, can I stop there for just one
16 second? That's a monster of a question, and it's a great
17 question.
18 COMMISSIONER CARTER: I know.
19 CHAIR BELLA: But we have one minute left, and if
20 the panelists have a hard stop, this is not your only
21 opportunity to dialogue with us, and so if you'd like to
22 take a minute and come back to us with your thoughts or any

1 other things, we're always willing to have you do that.
2 And so I just want to be respectful of your time. If you
3 have time and each of you want to give your parting
4 thoughts with the option to come back, please feel free,
5 but if you have to drop off, we understand.
6 MS. HAMMOND: I have time, and it is a huge and
7 very complex -- could be a complex response. But I would
8 just very quickly say, you know, we have an EHR that has,
9 you know, sequestering and blocking capabilities, but as
10 Martha described it's like, yeah, but kind of like that
11 other information kind of creeps in there, in terms of
12 like, you know, medications and things like that, that if
13 someone is paying attention they can figure out, like oh,
14 this person is in substance use treatment.
15 So, I think it really then becomes like, okay,
16 how do you really break down those barriers, while still
17 ensuring safety of clients, but really, you know, just
18 relooking at how we're treating that data so that you don't
19 take a super-conservative approach so as to avoid maybe
20 some of those data intrusions that hint at substance use
21 treatment. Much easier said than done, but I think it's
22 just the whole system that needs to relook at the need to

1 share that data across different providers, because really,
2 ultimately, it's in the best interest of individuals
3 getting treatment, in various places, for all their
4 treatment providers to have that full picture.
5 CHAIR BELLA: Jess or Bebet, do you want to weigh
6 in on this, as your parting comments?
7 MR. NAVIA: So, the approach we took with
8 regards for this eval Part 2 is, because as everyone knows,
9 it's a humongous and challenging effort to have all these
10 EHRs being able to abide by technology. There's technology
11 out there called data segmentation where you can actually
12 separate out the information that you want to share or
13 keep. So, we focus on the member on the consent
14 management. At least, at that point, the member can define
15 which providers their information can be shared with. That
16 may not be shared electronically at that point in time, but
17 at least whatever information that they try to produce can
18 be shared to a particular provider that they choose to.
19 But that's the goal of the first iteration of our consent
20 management is what the patients wants, what the new clients
21 wants.
22 CHAIR BELLA: Thank you.

1 MS. KAHN: I just would say thanks again for
2 having us. I think Brooke and Bebet answered the question
3 best. I think it's helpful to identify where, within this
4 journey, is the easiest problem to solve for and what's the
5 more complex. I don't know that we're all going to be able
6 to fix Part 2 or fix the ability to segment the data, as
7 the data is nuanced and what's a BH drug and what's not.
8 The consent at the top of the journey is a really important
9 piece, and it's definitely something I see around the
10 country that a lot of folks are focusing on, because it can
11 really obfuscate the need for all of the rest that flows
12 from that. But that said, it's a pressure. The systems
13 want to be compliant, and yet, at the same time, as Martha,
14 you mentioned, the providers really want to make sure that
15 they help improve care at the patient level.
16 So very complex. Thank you guys for inviting us
17 and for bringing this topic to the table.
18 CHAIR BELLA: Well, thank you again, all three of
19 you, and honestly, the door is always open for your ongoing
20 thoughts and input and expertise. I really can't thank you
21 enough for what you shared with us today. You've given us
22 a lot to chew on, for sure.

1 MS. HAMMOND: Thank you for having us.

2 MR. NAVIA: Thank you so much.

3 CHAIR BELLA: Okay. We have a little bit of time
4 for discussion amongst ourselves. I actually am going to
5 open it up to public comment first, just to see if there's
6 anything we hear from public that we might want to include
7 in our discussion, and then we'll come back to the
8 Commissioners and then wrap things up.

9 So, I'm going to give the folks in the audience a
10 minute to use your hand indicator if you would like to make
11 a comment. And I'll remind you if you do, please introduce
12 yourself and your organization, and we ask that you keep
13 your comments to three minutes or less.

14 [Pause.]

15 CHAIR BELLA: Just give this a minute.

16 **### PUBLIC COMMENT**

17 * MR. GUIDA: Yes. I don't know, Melanie, whether
18 you can hear me. My name is Al Guida. I'm with Guide
19 Consulting Services. I represent both the Behavioral
20 Health Information Technology Coalition as well as
21 Netsmart, one of the vendors that were highlighted in the
22 presentation.

1 Let me make two quick points. The first point,
2 with respect to the complexity of the patient population
3 that Brooke described is very, very common in the mental
4 health and addiction treatment world, as you probably know.
5 So, the incidence rate for comorbid medical-surgical kind
6 of diseases among individuals with serious mental illnesses
7 and addiction treatment disorders hovers between 35 to 50
8 percent, and that explains why there is such a high
9 mortality rate among these patient populations, that Brooke
10 also referenced.
11 Secondly, with respect to the -- I found the
12 financing discussion fascinating. There is -- and prior
13 MACPAC slides have noted -- a Center for Medicare and
14 Medicaid Innovation, CMMI, demonstration program that
15 authorized by Congress in the SUPPORT Act, that would
16 provide demonstration financing specifically for electronic
17 health records, for the behavioral health providers that
18 were referenced in the discussion today. CMMI has told us
19 that they don't have the money to finance it, and so we are
20 obviously working with Congress to see if we can't provide
21 CMMI with some resources to provide EHR incentives of a
22 size and type that Bebet indicated during his outstanding

1 presentation.

2 Thank you so much for the opportunity to speak.

3 CHAIR BELLA: Thank you very much.

4 All right. It looks like we don't have anyone

5 else who would like to make a comment at this time. I will

6 remind folks you can always make comments at MACPAC.gov.

7 **### FURTHER DISCUSSION BY THE COMMISSION**

8 * CHAIR BELLA: I will open it back up to

9 Commissioners to have some wrap-up discussion and to share

10 any input with Aaron on this work as we go forward.

11 Brian.

12 COMMISSIONER BURWELL: So, I think people heard a

13 couple of times, and I think it was Jess who mentioned HCBS

14 as a way to finance behavioral health IT systems with

15 providers. And we talked earlier about doing something

16 perhaps around the ARPA HCBS funding initiative. And from

17 reading the spending prelims by states, one of the

18 interesting aspects of the legislation is that the

19 legislation defines community-based HCBS services as

20 eligible for the 10 percent FMAP, for example, services

21 provided under the state plan rehab option.

22 So, there's definitely an expansion of kind of

1 the concept of HCBS under this initiative, and states have
2 opposed to do significant expansions in terms of mental
3 health services in their spending plans, including IT
4 development.
5 So, another component of this imitative is that
6 states are -- and this has been provided with CMS guidance
7 -- can use the 10 percent FMAP money that they've saved for
8 the 10 percent match on new IT systems development. It's
9 getting fairly technical here, I understand, but there was
10 a lot of interest in kind of the future of financing, both,
11 you know, EHRs and the behavioral health provider community
12 and interoperability between behavioral health EHRs and,
13 for example, administrative data.
14 If we wanted to, this is an area of the ARPA HCBS
15 initiative that we could, I think, make a contribution in.
16 A fairly small area, you know, slicing it up, but I think
17 an interesting policy, important area.
18 CHAIR BELLA: Thank you, Brian. Other
19 Commissioners? Fred.
20 COMMISSIONER CERISE: Thanks, Melanie. Yes, I
21 heard two big themes. One is funding and the other one is
22 sharing information and integration. And, you know, on the

1 sharing information side there's this tension, right,
2 between integrating care and segregating data that we just
3 keep struggling with, that's going to be an ongoing
4 struggle. And I'll give you an example of some of the work
5 that we've done looking at this.
6 We know we share about two-thirds of the patients
7 with our local mental health authority, and we also know
8 that only about 40 percent of those patients in our system
9 carry a behavioral health diagnosis. And so there is a
10 significant drop-off there in information that gets shared,
11 and as Martha said, sometimes that's really important
12 information.
13 So, work around that, I think, is going to
14 continue to be important. We heard, I thought, some
15 interesting things and ideas from Bebet, for instance, that
16 eConsent management. And as we look at funding mechanisms
17 to get these systems in place, being able to take care of
18 that piece, the segregated data piece, is going to be
19 critically important. When I talk to our local mental
20 health authority it's a big, frustrating issue for them in
21 terms of being able to participate in the local HIE because
22 of the requirements to segregate data.

1 And then I heard, at the tail end, Brooke talk
2 about the CCBHC, essentially the Coordinating Center for
3 Behavioral Health and the potential to use that. That
4 sounds like an interesting place to go, not only for
5 funding but because they've got the comprehensive services,
6 the ability to actually use the data, like she talked about
7 using. You know, all of this requires some infrastructure
8 and scale, and, you know, that Health Home for behavioral
9 health patients is an interesting approach that would seem
10 like could provide not only the funding needed but also the
11 staff and other services to be able to use the information
12 you get from the EHR.
13 So, anyway, just a couple of thoughts.
14 CHAIR BELLA: Thank you, Fred.
15 COMMISSIONER HEAPHY: This is Dennis. I think
16 it's great, the whole concept of EHR and integration of
17 information. But I think it would be really helpful to
18 hear directly from clients, from folks with SUD or mental
19 health diagnoses about what they perceive the barriers to
20 sharing that information, so we have a better understanding
21 of what the challenges are and why. There may be a high
22 percentage of folks who don't want some information shared.

1 And so as we're looking at managing utilization and sharing
2 of information that's from an informed place. So, I would
3 like to see a lot more information directly from folks in
4 the community.
5 CHAIR BELLA: Thank you, Dennis. Martha.
6 COMMISSIONER CARTER: Dennis, we actually did
7 have some panels, but it's been several years ago now,
8 around Part 2, and included, I'm pretty sure, users of the
9 services. But it might be something to think about
10 revisiting.
11 I'd really like the Commission to wrestle with
12 this whole issue of patient privacy and ability to share
13 data in the most useful way. And I don't know what the
14 recommendation would be or how it would come down, but I
15 think that we're not going to get to a point that there's
16 good integration of behavioral health and medical
17 information through electronic systems until that issue is
18 resolved. So, I think we just need to, you know, bite the
19 bullet, wrestle with it, and come up with at least our best
20 recommendation.
21 CHAIR BELLA: Thank you, Martha. Other comments?
22 COMMISSIONER HEAPHY: This is Dennis. I guess I

1 should have just been clear and say there's so much stigma
2 and bias against folks in the population that, building on
3 what Martha just said, that we've got an obligation to
4 really wrestle with that as a Commission, with the folks
5 who are to be most impacted by bias and discrimination, if,
6 in fact, that's what folks are experiencing, or can
7 potentially have exacerbated through integrated health
8 records.

9 COMMISSIONER CARTER: Can I respond to that? One
10 of the things that we've talked about in the past is, are
11 there other ways to protect data sharing, prohibit use of
12 data in ways that would increase stigma or cause somebody
13 to be disadvantaged, you know, discriminated against? Are
14 there other regulations that can be put in place that
15 protect the patient, the user, in a more open data-sharing
16 environment? That's just a question. I don't know the
17 answer, but I think that's one way that things could go,
18 rather than just saying we can't share because there's
19 stigma. You know, where can we go? Anne?

20 CHAIR BELLA: Go ahead, Anne.

21 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just
22 wanted to share, particularly for the new folks, and it has

1 been a while even for the folks who have been around, we
2 did do a roundtable as part of our initial work on Part 2
3 that brought in a variety of perspectives. And also, our
4 recommendations regarding clarification of the regulations
5 in part were focused on a lack of understanding about what
6 could be done with the beneficiary's consent to facilitate
7 information sharing. The more conservative approach being
8 taken on the part of providers was just like, "Oh, we don't
9 want to get in trouble. It's just easier not to do
10 anything." And so that was one of the things we called out
11 in our recommendations on clarification. Always putting
12 the patient at the center of it, but clarifying so that
13 providers can have that sense of comfort, that this is what
14 we can do with the patient’s consent. The patient is the
15 driver, but if given that opportunity to give that consent,
16 and to give the consent, these are the possibilities for
17 integration that are created.
18 COMMISSIONER CARTER: But the EHRs don't have
19 that capability, a lot of them, so that's something that I
20 think we could weigh in on.
21 EXECUTIVE DIRECTOR SCHWARTZ: But that's a
22 separate issue. It's not actually a policy issue. It's

1 more like a technical and market issue. Correct, Aaron?
2 MR. PERVIN: Yeah. I would say that's the sense
3 we've received too, is that there are EHR vendors that have
4 created consent management tools within their EHR. It's
5 just these consent management tools and data segmentation
6 requirements are not mandated to be part of the
7 certification program. So, it's more of a technical and
8 regulatory issue. These are permissions that can be built.
9 It's just they're not mandated as part of OMB's
10 certification requirements.
11 COMMISSIONER CARTER: So, to me that sounds like
12 a policy issue. It's whether there's a mandate to include
13 those provisions. So, it's technologically possible. It's
14 not mandated so it doesn't happen. There aren't financial
15 systems to support behavioral health providers so there's
16 not a lot of market drive to make it happen. So, it's sort
17 of a circular problem.
18 CHAIR BELLA: Toby, and then Heidi, and we're
19 getting ready to wrap this one up, guys.
20 COMMISSIONER DOUGLAS: Yeah, I just wanted to
21 reiterate it again. I hope we can focus on some more --
22 like just things that I think are feasible, because of the

1 enormity of the costs of some of this, and what Jess
2 mentioned around is there guidance or work that could be
3 done on best practices that's going on in states or what
4 managed care plans are doing in terms of incentives for
5 driving this. And then the SAMHSA as well as, I would say,
6 is there an intersection here with the duals.
7 But as much as I want to see us, you know, get
8 investment, the costs are just -- you know, I don't think
9 putting a recommendation out there, or in areas that are
10 outside of our purview, I don't know what that's going to
11 solve.
12 CHAIR BELLA: Heidi? Thank you, Toby.
13 COMMISSIONER ALLEN: Following up on Martha's
14 comment, I would just add that systems in place to revoke
15 consent, or the ability to easily revoke consent if you
16 feel like it's impacting the care that you're receiving to
17 have more providers know your mental health conditions.
18 Because in qualitative work that I've done with Medicaid
19 recipients they really do talk about how if a provider
20 thinks that you are drug seeking, if they think that you
21 have a substance history, how it really changes your access
22 to pain care. And also, if they think that you have a

1 psychiatric diagnosis that they might dismiss your physical
2 complaints as being psychosomatic.
3 And so, some mechanism for patient engagement in
4 this seems really, really critical from a policy
5 perspective.
6 CHAIR BELLA: I'm struggling a bit with sort of
7 where our line is with the policy and authority that we
8 have. It was part of the conversation. I know, Aaron,
9 you're going to help us map that out. Fred, I like
10 thinking about it in terms of funding and sharing
11 information and integration in those buckets, and we
12 certainly heard a lot from the panel, but I do want to make
13 sure that we're not sending you off with any concerns about
14 if we're trying to take on things outside of our policy or
15 authority.
16 So, is there anything else from us you would like
17 to talk about, or Anne, anything else you would like to
18 raise to get final Commissioner input or clarity?
19 MR. PERVIN: No. I think, yeah, I think this is
20 helpful. Staff can kind of -- we can talk about what
21 potential next steps might be. But what I'm hearing is --
22 and please correct me if I'm wrong -- what I'm hearing what

1 the Commission is interested in looking at is maybe not a
2 HITECH 2.0, because of cost implications with that, but
3 maybe looking at what the rules are about federal financial
4 participation and how that can be used to maybe promote
5 more interoperability among behavioral health providers.
6 What I'm also hearing is are there things that
7 managed care plans can do, maybe through some kind of
8 directed payments, to promote more EHR adoption among
9 behavioral health providers. And then I'm also hearing
10 are there things that the Commission could suggest around
11 certification requirements to have better consent
12 management tools within the EHR platforms.
13 Is that approximately what I'm hearing, and if
14 so, I think we can work with that.
15 CHAIR BELLA: Yes. You did a very nice job of
16 bringing that all together. Does anybody want to make any
17 final comment? I feel like that summary was wonderful.
18 Any other Commissioners who feel like there's any nuance
19 you want to add there?
20 EXECUTIVE DIRECTOR SCHWARTZ: We're going to have
21 multiple more opportunities for nuance. We'll be back at
22 this issue several times before we're done.

1 CHAIR BELLA: We certainly will.
2 Okay. Aaron, I don't have to ask if you have
3 what you need, because you just nailed it, so thank you.
4 Any final comments from Commissioners?
5 [No response.]
6 CHAIR BELLA: It was a wonderful panel. Thanks
7 for getting that group together. We'll close out on this
8 session. We will take a break. We will come back at 1:30,
9 and we'll have our final session on adult vaccines, that
10 Kisha is going to lead, and then we'll wrap up for our
11 September meeting.
12 So, I would ask you all to be back in a little
13 over an hour, at 1:30 Eastern time. Thank you.
14 * [Whereupon, at 12:23 p.m., the meeting was
15 recessed, to reconvene at 1:30 p.m., this same day.]
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1 AFTERNOON SESSION

2 [1:30 p.m.]

3 CHAIR BELLA: Welcome back, everyone. Hope you
4 all had a nice break.

5 Kisha, I will turn it over to you to take us
6 through the last session of the day.

7 VICE CHAIR DAVIS: Thanks. The clock strikes at
8 the bottom of the hour. So, we are going to jump in to
9 talking about vaccines for adults in Medicaid, and I will
10 turn it over to Chris and Amy to kick us off.

11 **### VACCINES FOR ADULTS ENROLLED IN MEDICAID: ACCESS,**
12 **COVERAGE, AND PAYMENT**

13 * MS. ZETTLE: Great. Thank you.

14 So today, for our last session, we are going to
15 be returning to our work on vaccine coverage and access for
16 adults enrolled in Medicaid.

17 We first presented on this topic last September
18 and then later turned our attention to focus more
19 specifically on COVID-19 vaccines and federal actions to
20 support access in that area. The COVID-19 pandemic has
21 brought attention to the issue of vaccines and vaccine-
22 preventable diseases.

1 The Commission has expressed an interest in
2 examining vaccines more generally and explore how federal
3 policies might improve access to recommended vaccines for
4 adults enrolled in Medicaid.
5 Next slide.
6 So, I'm going to begin with a brief background on
7 Medicaid coverage for adults and highlight some barriers to
8 access. Then I'll lay out our work plan for the cycle, and
9 then Chris Park will present our recent analysis of adult
10 vaccination rates by insurance coverage and will also
11 introduce our framework for assessing potential policy
12 options. Lastly, we'll share our next steps.
13 Next slide.
14 So, as we presented last September, vaccine
15 coverage is not mandatory for all adults enrolled in
16 Medicaid. Vaccine coverage varies by state and eligibility
17 pathway. For individuals in the new adult group,
18 preventive services are covered without cost sharing. This
19 includes all vaccines recommended by the Advisory Committee
20 on Immunization Practices, or ACIP.
21 All other adults are not subject to essential
22 health benefits, and therefore, states can decide whether

1 to cover recommended vaccines and whether to apply cost
2 sharing. This group includes individuals with
3 disabilities, pregnant women, and parents, they account for
4 about 40 percent of Medicaid enrollees. And while this
5 presentation is a focus on adults, just a reminder that
6 children enrolled in Medicaid receive all recommended
7 vaccines without cost sharing through the Vaccines for
8 Children program, or VFC.
9 Next slide.
10 Coverage of vaccines varies by state. A CDC
11 study looked at Medicaid policies in 2018 and 2019 and
12 found that 49 states offered some coverage for adults on
13 Medicaid, but only about half, 24 out of 49 states
14 surveyed, covered all ACIP-recommended vaccines.
15 The Affordable Care Act does provide a financial
16 incentive for states to cover all preventive services
17 without cost sharing. States receive a 1 percentage point
18 FMAP increase on all spending for preventive services,
19 including the cost of the vaccine and provider
20 administration. According to the CDC researchers, only 12
21 out of 44 states surveyed implemented this option.
22 Next slide.

1 There are a wide range of barriers that prevent
2 vaccinations in adults, and today we're going to focus on
3 barriers that relate to Medicaid policies specifically.
4 First and perhaps the most fundamental barrier is coverage.
5 If a state is not providing coverage of a vaccine, an
6 enrollee's ability to gain access is limited. The enrollee
7 could pay out of pocket, which may be prohibitive, or they
8 could navigate potential other programs to gain access.
9 As we noted, about half of states are not
10 covering all recommended vaccines. So, for example, 16
11 states are not covering the shingles vaccine.
12 Cost-sharing requirements can create barriers,
13 even when a service is covered. One study showed that for
14 each additional co-payment dollar on vaccinations decrease
15 the flu vaccination rate by 1 to 6 percentage points. The
16 CDC showed that 15 states have cost-sharing requirements
17 for vaccines.
18 And, lastly, we turn to provider payments.
19 Recent studies have shown that some states may not be fully
20 covering the cost to providers of acquiring and
21 administering vaccines. A recent survey reported that 55
22 percent of general internal medicine physicians surveyed

1 reported that they lost money administering vaccines to
2 Medicaid beneficiaries. So, payment policies could be
3 resulting in Medicaid providers not purchasing or
4 administering vaccines.
5 So, next, I'll turn to the project work plan for
6 this cycle. Our work plan this cycle centered around some
7 key policy questions, many of which were raised by the
8 Commission when we discussed this topic last year. We'll
9 conduct three different research projects to help answer
10 these questions.
11 First, we want to know more about the vaccination
12 rates for Medicaid enrollees and how they compare the
13 vaccination rates of individuals with other forms of
14 coverage. We also want to understand how those rates may
15 differ by race and ethnicity.
16 Today Chris will present findings on this topic
17 using survey data.
18 Next, we want to understand how state policies
19 might be affecting vaccination rates. For this, we'll use
20 Medicaid claims data to estimate state vaccination rates
21 and see if rates are associated with differences in
22 coverage or payment policies. We'll also look at these

1 estimated rates to see if we can better understand which
2 state policies have resulted in improved vaccination rates.
3 We hope to bring you this analysis later this fall.
4 And then, lastly, we're going to be conducting
5 some semi-structured interviews with Medicaid officials in
6 five states and also federal officials, Medicare managed
7 care plans, providers, vaccine manufacturers, experts, and
8 beneficiary groups. They're going to help us better
9 understand the barriers to vaccine access for adults but
10 also help us explore the set of questions that focus on
11 federal policy options and help us understand the different
12 tradeoffs between the federal policy options.
13 We also want to use these interviews to help us
14 better understand how COVID-19 vaccination policy might be
15 affecting vaccines more generally for adults, and of
16 course, we'll be turning to the literature to help us
17 explore these questions as well.
18 So now I will turn it over to Chris.
19 * MR. PARK: Thanks, Amy.
20 I'm trying to get the slide to advance. There we
21 go.
22 So, working with the State Health Access Data

1 Assistance Center, we analyzed National Health Interview
2 Survey data to estimate vaccination rates for eight ACIP-
3 recommended vaccines. To increase sample size, we combined
4 data from 2015 to 2018.

5 First, we examined vaccination rates for Medicaid
6 enrollees compared to those enrolled in private insurance
7 and those without insurance. We did look at Medicare but
8 did not display the results due to large differences in age
9 composition compared to the other payers.

10 Second, we examined how vaccination rates
11 differed by demographic characteristics and some access-to-
12 care measures. Today's presentation, we'll just focus on
13 the difference in vaccination rates by race and ethnicity,
14 but the other breakouts were included in your background
15 materials.

16 Here, we summarized some of the key findings. I
17 won't spend too much time here as we'll go through the
18 results in greater detail in subsequent slides. So, just
19 to summarize, adult vaccine rates in Medicaid were
20 generally lower than private insurance but higher than the
21 uninsured. Racial and ethnic disparities appear to be
22 smaller in Medicaid compared to private insurance, and

1 pregnant women enrolled in Medicaid received recommended
2 vaccines at lower rates than those with private insurance.
3 This slide shows the proportion of adults
4 receiving each vaccine by the primary source of coverage.
5 Shown here are Medicaid or CHIP, private insurance, and the
6 uninsured. The highest vaccination rate for each vaccine
7 is circled in red. As you can see, privately insured
8 adults had the highest vaccination rate for all vaccines
9 except for the pneumococcal vaccine, where Medicaid had the
10 highest rate. Uninsured adults had the lowest rate across
11 all vaccines.
12 Within Medicaid, difference across racial and
13 ethnic groups was mixed. This table shows where there was
14 a statistically significant difference in the vaccination
15 rate between each racial and ethnic group compared to the
16 White, non-Hispanic adults in Medicaid. People of color in
17 Medicaid generally had lower vaccination rates for tetanus,
18 Tdap, and pneumococcal vaccines than White, non-Hispanic
19 enrollees, but they actually had a higher vaccination rate
20 for influenza. There were few statistically significant
21 differences for shingles, hepatitis A, hepatitis B, or HPV.
22 This table shows whether there is a statistically

1 significant difference in the vaccination rate between
2 Medicaid and private insurance for each racial and ethnic
3 group and vaccine. Vaccination rates were more similar
4 between people of color enrolled in Medicaid and private
5 insurance than they were for White, non-Hispanic adults.
6 Within the White, non-Hispanic group, Medicaid enrollees
7 had a lower vaccination rate than privately insured adults
8 for six of the eight vaccines.
9 For Black, non-Hispanic, and Hispanic
10 individuals, Medicaid enrollees had a lower vaccination
11 rate than privately insured adults for four out of the
12 eight vaccines, and for Asian, non-Hispanic, Medicaid was
13 lower for only three vaccines. The difference within the
14 White, non-Hispanic population appears to be a key driver
15 in the overall lower vaccination rates in Medicaid compared
16 to private insurance.
17 These next couple of slides just provide specific
18 examples on the differences in racial and ethnic groups
19 that I just discussed. This table shows the vaccination
20 rates for Tdap by race and ethnicity and payer. As you can
21 see circled in red, privately-insured adults had higher
22 vaccination rates than Medicaid-enrolled adults across

1 almost all races and ethnicities. Encircled in blue within
2 Medicaid, the vaccination rate for White, non-Hispanic
3 Medicaid-enrolled adults was higher than Black, non-
4 Hispanic, Hispanic, and Asian, non-Hispanic enrollees by a
5 statistically significant margin.
6 This table shows the vaccination rates for
7 influenza, and you'll see it's almost the opposite picture
8 of the Tdap results. Privately insured adults had a much
9 higher vaccination rate than Medicaid-enrolled adults for
10 the White, non-Hispanic individuals, and that's circled in
11 red. However, the vaccination rates for most people of
12 color enrolled in Medicaid were not different from those
13 privately insured by a statistically significant margin.
14 Encircled in blue, the vaccination rates for
15 Hispanic, Asian, and American Indian or Alaska Native was
16 higher than White, non-Hispanic enrollees within Medicaid.
17 While children under 19-year-olds are not a focus
18 of our current work, we did want to see if children would
19 have a higher vaccination rate than adults relative to
20 private insurance. The thinking here is that since all
21 Medicaid-enrolled children had vaccine coverage without
22 cost sharing to the VFC program, we could see a smaller

1 difference between Medicaid and private insurance than we
2 do for adults because Medicaid-enrolled adults are not
3 guaranteed coverage without cost sharing.
4 This survey only had vaccine information for
5 influenza for children, which is showed in this table, and
6 while the difference is statistically significant, the gap
7 was smaller for children than it was for adults. For
8 children, the difference between Medicaid and private
9 insurance was 2.6 percentage points versus 8 percentage
10 points among adults.
11 And for pregnant women, we also took the
12 opportunity to look at vaccination rates of pregnant women
13 receiving the recommended influenza and Tdap vaccines. The
14 influenza rate was about 20 percentage points lower for
15 pregnant women enrolled in Medicaid than it was for those
16 in private insurance, and for Tdap, it was about 12
17 percentage points lower.
18 When we presented on this topic last September,
19 we included some potential policy options to address the
20 gaps seen in vaccine coverage for some adults. The
21 Commission has expressed interest in the options and asked
22 that staff come back with more information.

1 So, as we move forward with this topic over the
2 next few meetings, we have identified a few primary goals
3 for the Commission to consider in thinking about how to
4 increase vaccination rates. The first is to expand
5 coverage. This could be done by either making vaccination
6 coverage a mandatory benefit or creating financial
7 incentives to cover such as increased federal match.
8 Another decision is whether to only target
9 certain populations such as individuals eligible on the
10 basis of disability or only cover certain vaccines. The
11 second goal is to improve access. As we have seen with the
12 COVID vaccine, it is important to make access to vaccines
13 convenient to beneficiaries. Policies could try to
14 increase providers' willingness to offer vaccines by
15 reducing the acquisition cost of the vaccine or increasing
16 payment for administration.
17 Commissioners will also need to consider how each
18 policy option affects state and federal spending, and some
19 options could increase spending, while others may shift
20 cost from states to the federal government. Additionally,
21 the policy options will vary in how hard it would be to
22 implement both for states and providers.

1 To help the Commission think about each of the
2 options, we developed a framework to guide our work on this
3 topic. As a quick refresher, the policy options we
4 discussed last year are mandatory coverage of adult
5 vaccines. This would make ACIP-recommended vaccines a
6 mandatory benefit for Medicaid enrollees.
7 Adding vaccines to the Medicaid drug rebate
8 program, this would essentially make vaccine coverage
9 mandatory if the state chooses to offer prescription drugs.
10 Medicaid would receive the statutory rebates to help reduce
11 spending.
12 Additional federal funding, this could take
13 several forms. Some examples are the 1 percentage point
14 increase on preventive services, including vaccines, if a
15 state offers coverage without cost sharing. Another
16 example is the 100 percent match on vaccine cost and
17 administration for the covered vaccine offered under the
18 American Rescue Plan Act.
19 The last option was federal purchasing program or
20 price negotiation. Again, this option can take several
21 forms. The policy could create a federal purchasing and
22 distribution program for adult vaccine, similar to the VFC

1 program, or it could allow a state and providers to
2 purchase vaccines for a discounted price based on the CDC-
3 contracted price.
4 As we consider each of these options, we have
5 highlighted a few design considerations and assessment
6 criteria reflecting the goals and considerations mentioned
7 earlier. For consideration, the inclusion criteria, what
8 vaccines are included, how will the price be set and if it
9 will change the net cost of the vaccine, whether or not it
10 will change beneficiary cost-sharing requirements, will the
11 policy change provider payment or participation, and will
12 the policy have an effect on the current supply chain.
13 Also, we'll try to assess how a policy would
14 affect vaccination rates, racial disparities, state and
15 federal spending, and how operationally complex it is to
16 implement the policy.
17 As Amy presented earlier, our work plan includes
18 interviews with a variety of stakeholders and a claims
19 analysis using T-MSIS data. We will present these findings
20 over the next couple of meetings.
21 Staff would appreciate any feedback you have on
22 this presentation, particularly on the work plan and the

1 policy framework, so that we can incorporate your comments
2 as we proceed with the work on this issue.
3 Thank you, and I'll turn it back over to the
4 Commission.
5 VICE CHAIR DAVIS: Thanks, Chris and Amy.
6 So, lots of good work here. Thank you for this
7 really robust report, and I think I want to start with if
8 there's any questions around the data piece of it and then
9 dive into the work plan.
10 One of the things that I wanted to highlight here
11 -- and I really do appreciate the effort of showing the
12 racial disparity piece and kind of how that breaks out
13 along insurance lines -- I do want to make sure that we're
14 mindful of what the goal vaccination rate is or should be.
15 So, at the end of the day, we want the Medicaid rates to
16 compare, be comparable to what private insurance folks are
17 getting, but when we look at the just base rate, we're not
18 looking for 100 percent coverage in most of these, right?
19 And that nuance doesn't necessarily come out in the report.
20 Tdap is something that should happen across the
21 board. Influenza is something that should happen across
22 the board. But many of those vaccines are very much

1 dependent on age or health status, and it's hard to know if
2 there are differences in health status that might be also
3 contributing to the difference in vaccination rate that we
4 see in private insurance versus Medicaid.
5 So, you do call that out specifically for the
6 pneumococcal vaccine where there may be more folks in
7 Medicaid who are recommended to get the pneumococcal
8 vaccine, and hence, that may be why that is higher.
9 I think the other thing is comparing that. You
10 didn't include the rates for Medicare, but for some of the
11 vaccines, like shingles, where that's a 50-and-over vaccine
12 or pneumococcal which is typically a 65-and-over vaccine,
13 unless you have a health condition, it can be hard to just
14 kind of compare base rates on that. So, I just wanted to
15 highlight that.
16 Any other questions that folks have on the data
17 piece before we move to look a little bit more deeply at
18 the work plan?
19 Yeah. Fred and Darin.
20 COMMISSIONER CERISE: You referenced the fact
21 that many of the providers say the cost of acquiring or
22 administering the immunization doesn't cover their cost.

1 Do you have data to show what the acquisition cost is
2 compared to what the Medicaid reimbursement is?
3 I know it's going to vary by provider, but, you
4 know, in those cases where the providers are reporting they
5 lose money administering the vaccine, do we actually have
6 any comparable data to say this is what Medicaid
7 reimburses, this is what it actually -- the ingredient cost
8 is to the practice?
9 MR. PARK: Yeah. So, we are doing some analysis
10 on the T-MSIS data. We will look at kind of what they paid
11 for the vaccine code, which should reimburse for the
12 acquisition cost, and we can compare that. While we don't
13 necessarily know the acquisition cost, the CDC does publish
14 kind of like a list of retail prices and also their
15 contracted prices for vaccines. So, we can certainly try
16 to compare to that retail price list to basically kind of
17 use that as a benchmark for maybe what the acquisition cost
18 would be.
19 But I think what we've heard in prior interviews
20 and also from the study, the administrative fee, providers
21 feel is particularly low, and so that is where -- you know,
22 for example, for COVID, CMS, the American Rescue Plan Act,

1 the federal government is paying 100 percent match on
2 vaccine administration cost. So, most states are paying
3 what Medicare is paying for the COVID vaccine
4 administration. So that's, I think, where we've been
5 hearing some comments about where it would be helpful to
6 try to increase provider rates in particular.
7 VICE CHAIR DAVIS: Thanks.
8 Darin and then Laura.
9 COMMISSIONER GORDON: Thank you both for this.
10 Very helpful.
11 One data point that I think would be helpful as
12 we consider the policy options would be a better
13 understanding of whether so few states took up the
14 additional match for the preventative services because I'd
15 be curious if there were things -- you know, I vaguely
16 remember all this. I just don't remember the analysis of
17 what the background says. In other words, I'm trying to
18 find out if there were things other than vaccines that were
19 a hurdle for the state or was it the vaccines. I'm just
20 curious because it really helps us understand whether or
21 not an incentive-type approach versus a mandatory approach
22 could be effective if tailored specifically around

1 vaccines. That may be something that could be added to the
2 interview process.
3 MR. PARK: You know, we've been talking to a few
4 states, and when we asked one state in particular, because
5 they did offer vaccine coverage, coverage of all vaccines
6 without cost sharing, they had mentioned that they're in
7 the process of doing it, but based on all their other
8 priorities, trying to get their system set up to actually
9 separate out those costs, they claimed the additional FMAP
10 wasn't necessarily high on their list.
11 So, I think we're definitely seeing a handful of
12 states where they do seem like they might meet the
13 requirement based on vaccine coverage and cost sharing to
14 get that percentage point, but we're not sure if they're
15 doing that for all preventive services, so --
16 COMMISSIONER GORDON: Gotcha. So, they may not
17 have checked the box for everything, but with regards to
18 vaccines and what you saw, they were.
19 MR. PARK: Right.
20 COMMISSIONER GORDON: Okay. That's helpful, very
21 helpful. Thank you.
22 CHAIR BELLA: Thanks.

1 Laura?

2 COMMISSIONER HERRERA SCOTT: I have a few
3 questions. One, is there any way to look at utilization of
4 the delivery system related to vaccine-preventable
5 diseases? So, as you think about expanding coverage for
6 certain vaccines, could whatever spend on the vaccine-
7 preventable disease have offset that coverage for the
8 expansion? So that's one.

9 Two, thinking about the co-pay or the cost share,
10 is there any way on the Medicaid side to see if there were
11 differences in states where there was cost share versus no
12 cost share, and in those states where there was no cost
13 share, did they look more like their commercial
14 counterpart, so instead of aggregating but differentiating
15 between cost share and no cost share and what the
16 vaccination rates were for the different states?

17 MR. PARK: With the survey data, we don't have
18 enough sample size to look state by state, and so that's
19 why it's aggregated, and so we wouldn't necessarily be able
20 to compare the results to commercial payers.

21 We are trying to take a look at that as we go
22 through the claims analysis with the T-MSIS data. I can

1 say that the early findings at least don't show a lot of
2 co-pays being reported on the claims, but we will try to
3 take a look at states that report, you know, that they do
4 report that they do require some cost sharing and try to
5 compare the vaccination rates there to states that don't to
6 see if there's any discernable difference.
7 VICE CHAIR DAVIS: Thanks.
8 We'll go to Martha, and then after Martha, if
9 there's nothing on the data, if we can start talking about
10 some of the policy options and probably go back to Slide 20
11 at that point, but, Martha, I'll turn it to you.
12 COMMISSIONER CARTER: Kisha, mine may be sort of
13 between both.
14 Always when I look at data like this, I wonder
15 about the FQHCs because -- well, a couple points. One is
16 the FQHCs get the administration cost of a flu vaccine
17 reimbursed for Medicare patients, but of course, when a
18 health center does a flu vaccine campaign, they're not
19 going to just focus on Medicare patients. They're going to
20 vaccinate their whole population. So that may explain some
21 of the somewhat higher rates of flu vaccine in some of the
22 populations that we saw.

1 And then to sort of get to policy, overall adult
2 vaccines for the health centers is kind of a mess. It's
3 challenging from the provider's standpoint. They often
4 feel like they can't get their patients covered. Since
5 it's Medicaid, it varies by state, and so the cost of the
6 actual vaccine and the administration of the vaccine is
7 often rolled into their rate, their PPS rate, and so each
8 organization has to make a decision about whether they're
9 going to use those funds to buy the vaccine or whether
10 they're going to send their patients out to the health
11 department.
12 So, it's a complicated mix, and how that whole
13 system works does affect the rates for patients that access
14 services a community health centers, FQHCs.
15 So, I don't know whether it would help us to look
16 at FQHC adult vaccination rates separately. Maybe not, but
17 I wanted to throw that out there as sort of a confounder, I
18 think, in some of these data.
19 VICE CHAIR DAVIS: Thank you, Martha.
20 As we kind of switch gears a little bit and think
21 about the policy option frameworks, Chris and Amy have
22 really laid out these different options, and if we can talk

1 about them as a group in terms of thinking about mandatory
2 coverage, coverage through the Medicaid drug rebate
3 program, additional federal funding, and purchasing
4 programs, you know, in terms of one plus minuses or, for
5 each of these options and other things to consider and also
6 what information we think we'll need as we start to work
7 towards a chapter and recommendation, recognizing we're
8 going to have a lot of additional bites at this apple over
9 the next few months.
10 [Pause.]
11 VICE CHAIR DAVIS: Everybody is quiet this
12 afternoon.
13 Go ahead, Fred.
14 COMMISSIONER CERISE: Give me a second to get off
15 mute.
16 Yeah. I guess I would -- well, you know, as ACIP
17 looks at this, if we're going to follow the ACIP, I wonder
18 to what extent cost effectiveness is considered in their
19 evaluation. I know it's a factor that they consider.
20 I get a little nervous about recommending
21 requirements when there's going to be great variation in
22 terms of the cost effectiveness of some of these vaccines.

1 We did some stuff on drugs not long ago, and we're
2 struggling with this same thing, at least how do you deal
3 with these very high drug costs. While some vaccines, it's
4 really straight forward, we've got widespread diseases,
5 common diseases, and low-cost vaccines, but when you start
6 getting into rare diseases and expensive vaccines, I think
7 we have to acknowledge that at some point cost is an issue.
8 Without having a better understanding of how ACIP is
9 considering that in their recommendations, I'd be hesitant
10 to make broad recommendations that states should be
11 required to cover all vaccines. I think that's a little
12 broader than I'm comfortable with right now without more
13 information on how the ACIP is -- what they're recommending
14 and how they're -- you know, what categories of
15 recommendations they might make, like this is maybe prudent
16 or maybe we recommend it or -- you know, if you take --
17 something could be recommended for a very rare condition
18 that's costly, but to do that on a population basis has
19 implications much broader than an individual patient
20 recommendation in terms of a risk-benefit analysis.
21 I think there's some real cost implications that
22 we've got to be concerned about before making a statement

1 of -- a suggestion that states require it for every
2 approved vaccine.
3 VICE CHAIR DAVIS: I guess, Fred, that kind of
4 gets back to this point of who's actually supposed to get
5 the vaccine. For ACIP-covered vaccines, many of those are
6 based -- are dependent on health status or age. So, to say
7 we're going to cover the shingles vaccine or everybody,
8 well, we're not going to cover it for somebody who is 22,
9 right? That wouldn't be consistent with what the
10 recommendation is, and so just how we think about that in
11 terms of the cost analysis -- and so, if you're looking at
12 the vaccination rate for shingles for the entire adult
13 Medicaid population, but a small portion of that is over 50
14 who would actually be eligible, I think that's a type of
15 nuance we need to be able to better assess kind of what
16 that cost analysis would be, what's the impact.
17 Yeah, Melanie.
18 CHAIR BELLA: I guess I feel like that this
19 framework is going to help us work through all of those
20 issues.
21 So, for example, Fred, like the lens of what's
22 included, that's going to drive sort of the magnitude of

1 the potential additional spending. That feels like
2 decisions like ACIP or someone else should make versus us
3 about what's include or not a little bit, because we're
4 struggling a bit, but I really like this framework. And I
5 think if we're able to kind of fill it out and use it to
6 make tradeoffs and decisions about how we can make the
7 biggest impacts responsibly, that feels like a really --
8 that we're on a really good path for that.
9 VICE CHAIR DAVIS: Yeah. Heidi?
10 COMMISSIONER ALLEN: This just kind of brings to
11 mind for me Oregon’s prioritized list methodology that
12 they've been using for 30 years to assess what they pay for
13 and what they don't, and it's a pretty nuanced instrument
14 that includes things like vulnerability in a population,
15 the size of the population, the efficacy of the treatments,
16 and the quality of life gained from having something
17 prevented. I think they have other characteristics that
18 they look at as well, but I think that that's a framework
19 that somebody could look at to see if it helps on a
20 vaccine-by-vaccine basis to kind of see which ones rise to
21 the top versus those that don't.
22 VICE CHAIR DAVIS: Thanks, Heidi, and thanks,

1 Melanie, for your framing. And I agree. I think this is a
2 good way, a good approach, a good way to think about it.
3 Do folks have other thoughts as we look at panels
4 or additional information that we'll need as we start to
5 approach this work?
6 Brian.
7 COMMISSIONER BURWELL: I have a question. Is
8 there any rationale why vaccines are excluded from the drug
9 rebate program?
10 MR. PARK: I think they've been excluded since
11 the beginning of the drug rebate program, and we have tried
12 to ask some staffers who worked on the program, you know,
13 worked on the legislation way back then. I think their
14 recollection is that some of the vaccine manufacturers
15 argued that it should be excluded because it would affect
16 their willingness to develop and produce these vaccines.
17 But we don't know for sure exactly why they were excluded.
18 Another possibility of why they're excluded is
19 that the VFC program does exist, and so that is a separate
20 purchasing program for the Vaccines for Children, and
21 that's a large part of the vaccinations that the Medicaid
22 program would be responsible for. So, I think that

1 combination is probably why vaccines are excluded
2 currently.
3 COMMISSIONER BURWELL: But tell me if I'm wrong.
4 If there was legislation, one of our recommendations would
5 be to make them part of the drug rebate program, but then
6 states would be required to cover those drugs in all the
7 states. So that would address a coverage issue.
8 MR. PARK: Yes. That's the second option we have
9 here on the chart, and as you mentioned, if states offer
10 drug coverage and vaccines are in the rebate program, then
11 they would have to cover vaccines as well.
12 MS. ZETTLE: I might just add there, we are -- as
13 I mentioned, we're doing the interviews right now. We have
14 included vaccine manufacturers in those interviews. So,
15 when we come back to you with those findings, we'll be able
16 to talk a little bit about the views of the various
17 stakeholders on sort of some of these policy options.
18 COMMISSIONER HEAPHY: This is Dennis.
19 I'm pondering, what are the barriers for folks
20 wanting to get the vaccines? As we see with COVID, there
21 are similar things happening with other vaccines as well.
22 They don't necessarily see their value.

1 And then in terms of state policy, is it possible
2 to incentivize states that have low rates in cycles, and if
3 states achieve a certain level of vaccination rates, they
4 get bonus payments or something? I'm just trying to figure
5 out how to get the vaccination rates up, and I think it's
6 multi-factorial. There are so many other factors besides
7 just the payment thing, looking at all the tables that were
8 in the -- in what you guys put together. Across the board,
9 there seems to be, at least from what I saw, an issue with
10 vaccination rates.
11 VICE CHAIR DAVIS: Yeah. Martha?
12 COMMISSIONER CARTER: I'm really glad, Brian,
13 that you brought up the point about the drug rebate program
14 because that was something I thought of and I forgot to
15 say. I think that's a really important point.
16 I also had another question, and I don't know if
17 this is relevant. But does it matter how the vaccine is
18 covered? I know sometimes it's covered through a pharmacy
19 benefit, and sometimes it's covered through, I guess, the
20 regular primary care benefit. Does that matter?
21 MS. ZETTLE: I can just say --
22 COMMISSIONER CARTER: I don't even know if it's a

1 question that's important, but I know that there are
2 differences in how the states cover the vaccines, some of
3 the vaccines. So, is that important?
4 MS. ZETTLE: Yeah. And I will just say we have
5 looked at studies that have cataloged where -- which
6 settings where it's allowable either through a pharmacy
7 versus the medical benefit. So, there is definitely
8 variation across the states, and that is a topic that has
9 come up quite a bit in our interviews. So, we can
10 certainly provide more detail on that when we come back.
11 VICE CHAIR DAVIS: Thanks.
12 Darin, did I see your hand up?
13 COMMISSIONER GORDON: Yeah. I think I was
14 thinking about Martha's question.
15 Martha, were you wondering if that would impact
16 the rebate situation as well? Is that part of that
17 question?
18 COMMISSIONER CARTER: I think that's one of the
19 parts and just how it gets reimbursed.
20 COMMISSIONER GORDON: Yeah.
21 COMMISSIONER CARTER: And, of course, where
22 there's an access problem, if you go to your primary care

1 provider and you can get the vaccine when you're there in
2 the office, say, is that easier for people, to Dennis'
3 point, than having to traipse off to the pharmacy to get
4 it? So, I don't know. I just had enough to ask the
5 question.
6 COMMISSIONER GORDON: I would say that states can
7 claim for rebates, even if it's physician-administered
8 drugs. They just have to have the information. That
9 shouldn't be an issue for that potential policy.
10 COMMISSIONER DAVIS: It is, I think, that a
11 consideration, as we are thinking about design, about ease
12 of access for patients, and whether that's, you know, are
13 they forced into a pharmacy to get it, and they get it at
14 their primary care provider, you know, are they forced into
15 a silo of one versus the other and how those access issues
16 might play out in their ability to get the vaccine. So
17 that's one thing that I don't necessarily see here is
18 thinking about an ease for the beneficiary.
19 COMMISSIONER CERISE: And one more comment. On
20 the purchasing program and price negotiation, Chris, I
21 don't know if you looked at the program on hep C that
22 Rebekah Gee came and talked to us about a few years ago.

1 You know, I mean, is prescription pricing one of the
2 considerations there? Is there a different way to look at
3 some of these that you might want widespread utilization?
4 Is there a different pricing practice?
5 MR. PARK: Yeah, so we can certainly think about
6 different price negotiation strategies. Certainly, you
7 know, the federal government could do something similar to
8 what Louisiana is doing, negotiation on the benefit of all,
9 all Medicaid programs. And we are talking to a few states
10 that it does appear that they do a universal purchasing
11 program in the state for vaccines, or for some vaccines, so
12 we're going to talk to them and we'll have some more
13 findings when we come back with those results.
14 COMMISSIONER DAVIS: And Brian, I think we will
15 make this the last comment.
16 COMMISSIONER BURWELL: Give it to someone else.
17 I've had my opportunity, if someone else wants to --
18 I was just curious. We didn't get data on
19 Medicare vaccination rates, but I assume that Medicare has
20 coverage also for duals. And I just wondered how that
21 relates to Medicaid.
22 MR. PARK: Sure. Medicare did have higher

1 vaccination rates, but one reason why we didn't display
2 those is that, you know, the population is largely 65 and
3 older, and, it's hard to compare overall vaccination rates
4 when there are some pretty significant age differences in
5 vaccination rates across the age groups.
6 COMMISSIONER BURWELL: Does Medicare generally
7 cover vaccines without cost sharing?
8 MR. PARK: Yes. Well, certain vaccines, I don't
9 remember off the top of my head which ones, are covered in
10 Part B, but then the rest of the vaccines are covered
11 through Part D. So, it's a little bit of a split in terms
12 of coverage, but generally speaking Medicare should be
13 covering all ACIP-recommended vaccines.
14 COMMISSIONER DAVIS: Any other last questions on
15 vaccines before we wrap this session up?
16 Chris and Amy, do you guys have what you need,
17 direction-wise?
18 MS. ZETTLE: Yeah. Thank you. This was really
19 helpful. I appreciated the feedback.
20 COMMISSIONER DAVIS: All right. Thank you,
21 Melanie. I will turn it back to you for closing comments
22 and any comments from the crowd.

1 CHAIR BELLA: Thank you, Kisha, and thank you,
2 Amy and Chris. Great framework.
3 We'll turn it open to public comment now. If
4 anyone in the audience would like to make a comment please
5 indicate. And just as a reminder, we ask that you
6 introduce yourself and your organization, and we ask that
7 you keep all comments to three minutes or less. We will go
8 ahead and open it up now.
9 It looks like we have one person waiting so far.
10 Can we can go ahead and recognize Nataki please.
11 **### PUBLIC COMMENT**
12 * MS. HUGHES: Nataki, you are now unmuted.
13 MS. MacMURRAY: Great. Good afternoon again,
14 Commissioners. Nataki MacMurray from the Office of
15 National Drug Control Policy. I just wanted to know, and I
16 didn't see this in the data, of course, because you were
17 looking at vaccination, but do we know whether or not the
18 same pattern corresponds to the COVID testing? I just
19 wanted to see whether or not folks are doing better at
20 getting tested than they are at getting vaccinated, and
21 whether or not the payment or coverage of the services
22 makes a difference, coverage versus testing, because it

1 seems to be more prevalent where people to get testing but
2 less prevalent for where people can get vaccinated. So, I
3 just wondered whether or not there was any indication or
4 correlation between testing versus actual vaccination.
5 CHAIR BELLA: I think --
6 MS. MacMURRAY: -- a study, but, you know, I just
7 wanted to know whether or not there was any correlation.
8 CHAIR BELLA: Yeah, we actually -- Amy and Chris
9 left, I realize.
10 MR. PARK: I'm still here, but the data we've
11 been looking at is historical, so up to like 2018, 2019.
12 So, we won't have information on COVID right now.
13 CHAIR BELLA: Thank you, Chris. Sorry. My
14 squares are bouncing around. Thank you, Nataki.
15 Anyone else who would like to make public
16 comment?
17 [No response.]
18 CHAIR BELLA: Okay. Amy and Chris, thank you.
19 We really are done now with our session. I appreciate it.
20 I want to thank Anne and Jim and the rest of the
21 MACPAC staff for once again providing us with a really rich
22 meeting, virtually, which I know is becoming the norm but

1 it's still challenging, and so thank you very much. Thank
2 you to all the Commissioners.
3 Just to let everyone know, our next meeting is
4 October 28th and 29th. We look forward to having you join
5 us again at that time. And with that we are closed for our
6 meeting today. Thank you all very much. Have a wonderful
7 weekend.
8 * [Whereupon, at 2:14 p.m., the meeting was
9 adjourned.]
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