PUBLIC MEETING

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-and-

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P R O C E D I N G S

[10:00 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to the April MACPAC meeting. It is a pleasure to see the Commissioners in the room and we appreciate everyone who is joining us remotely to participate in the April meeting.

So we are going to get started with talking about access monitoring. This is a culmination of quite a bit of work we've done in this area, leading to a chapter in the June report, including some recommendations. We will follow this with a discussion about our response to the RFI from CMS.

So I am going to turn it over to Martha, Ashley, and Linn to get us started.

ACCESS MONITORING: REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR JUNE REPORT

* MS. SEMANSKEE: Thank you, Melanie, and good morning, Commissioners. It's nice to see everyone in person today. Today Linn and I will be reviewing our draft report chapter on a new access monitoring system for Medicaid, including a package of policy recommendations the Commission will be voting on tomorrow.

The chapter is a culmination of --

CHAIR BELLA: Excuse me. Can you speak up a little bit? There's like air blowing around people's heads.

MS. SEMANSKEE: Is that better? Can you hear me?

CHAIR BELLA: Maybe just a little bit louder.

MS. SEMANSKEE: Okay. Today Linn and I will be reviewing a report chapter on a new access monitoring system for Medicaid, including a package of policy recommendations the Commission will be voting on tomorrow.

This chapter is the culmination of the Commission's work during this past cycle on improving access monitoring in Medicaid. In September, the Commission discussed the current approach to monitoring and in October and December we heard from experts on data availability and design and implementation considerations for a new monitoring system.

In January, the Commission discussed potential recommendations for a new system. The recommendations the Commission will vote on tomorrow are the same that we discussed in January, although we have consolidated the first few recommendations into one in order to simplify the

text. Otherwise, the recommendations are unchanged.

This chapter provides background on the current approach to access monitoring and its limitations. It also discusses the goals and key elements of a new access monitoring system. The chapter ends with the Commission's recommendations for a new system, rationale, and implications.

As we discuss in the chapter, there are separate statutory requirements for describing how states and managed care plans must ensure access to care and the current monitoring approach is not uniform across delivery systems or states. This lack of consistency limits the ability to make meaningful comparisons, assess the effects of policy choices, and identify priorities for improvement.

Further, the existing system does not capture all the domains of access, most notably, beneficiary experiences and perceptions of their care. Additionally, the current system does not monitor access to some services that are important to Medicaid beneficiaries and states, such as long-term services and supports.

And finally, available data produced limited actionable information. For example, there are concerns

with the completeness and accuracy of administrative data and there is a lack of reliable beneficiary demographic data, which limits the ability to identify disparities in access.

As the Commission has previous discussed, a new access monitoring system should prioritize seven goals: It should allow for actionable and meaningful comparisons across states and delivery systems; it should prioritize methods that are efficient, timely, and adaptable, and this includes building on existing data and collection, wherever possible, in order to minimize administrative burden and allow for updating over time.

Finally, the monitoring system should be focused on equity. This includes collecting and analyzing data by race and ethnicity, primary language, disability, sexual orientation, and gender identity.

This chapter also describes the key elements that need to be included in designing a new monitoring system. First, stakeholder engagement with states, beneficiaries, consumer groups, plans, providers, researchers, and policy experts is critical during the design and implementation process. A new system should also include a core set of

access measures that allow for comparison across states and delivery systems and are stratified by key demographic characteristics. These access measures should capture the three domains of access that we have discussed, including provider availability, beneficiary utilization of services, and beneficiary perceptions and experiences.

A new system will also need to clearly define the roles of CMS, states, and plans in the data collection and analysis, including how to set benchmarks for adequate access.

Public reporting and oversight is also important. CMS should publicly release the methods, data, and monitoring results in order to promote transparency, accountability, and ensure results are actually used to identify and address access problems.

Finally, given that changing Medicaid's approach to access monitoring would be a significant task, a state's implementation of the new system is needed to allow for sufficient time to engage stakeholders and provide states and plans enough time to set up any new processes.

Now I am going to turn it over to Linn who will go through our policy recommendations and rationale.

* MX. JENNINGS: Great. Thank you, Ashley.

Before we jump into the recommendations, I just want to remind you, as Ashley said, that this first recommendation combines the three recommendations we presented January, so it reflects all three of those. And then regarding our recommendation implementations, we asked CBO about the cost estimates and we were told that they wouldn't have a direct effect on spending. So instead, the implications reflect the consequences of these recommendations rather than a cost.

As shown on this slide, the first recommendation in the package recommends that CMS should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems, and CMS should issue public reports and data at the state and national level in a consumer-friendly format at regular intervals.

Our rationale for this recommendation is that states and the federal government have statutory obligations to ensure sufficient access but there is insufficient information to assess whether the program is

meeting this obligation. And a core set of standardized access measures would allow for comparable assessment of care across states and delivery systems, while also accounting for differences in state policies, populations, and geography and how they affect access.

A monitoring system should also assess the full experience of Medicaid beneficiaries in accessing care, including the availability of services, use of services, and experience with care. The measures should be constructed to meet the goals of a new monitoring system and capture these range of services and prioritize the services for which Medicaid plays an outsized role and where there are known disparities or access concerns.

Finally, the new system should also prioritize data transparency and public reporting, and these are critical in ensuring accountability, identifying problems, and guiding program improvement.

The federal implications of this would be increased data collection, standardization, and reporting could increase federal costs. For states, the costs could be minimized if the new system builds on existing data collection and reporting. And for beneficiaries, a new

system may identify barriers and actually result in changes to improve access to services. For plans and providers, a new system may capitalize on existing data measures which could minimize reporting burden.

All right. And as seen on this slide, we have a second recommendation, and we recommend that CMS should actively solicit stakeholders in the development and future modifications of a new system, and this process for establishing a new access monitoring system should be public and transparent.

And CMS should take a primary role in developing a new access monitoring system but stakeholders should be involved throughout the process, and engagements should go beyond required public notice and comment periods in formal rulemaking. To ensure that the system is both meaningful and feasible, CMS should actively solicit input from states, beneficiaries, plans, providers, and other key stakeholders through multiple avenues such as requests for information, roundtables, and workgroups throughout the process to secure their support.

And including stakeholders from multiple perspectives, including those who benefit from services,

can facilitate stakeholder understanding of the standards and processes being used to monitor access.

Federal implications of this recommendation are that the cost to CMS may increase if additional staff time is necessary to ensure that the process is meaningful for beneficiaries, states, and other stakeholders. and for states, beneficiaries, plans, and providers, the development of a new access monitoring system may provide other avenues and opportunities for engagement.

And here we have our third recommendation, and we recommend that CMS should field a periodic and ongoing federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care.

And our rationale for this recommendation is that beneficiary perceptions and experiences are important components of monitoring access, and these types of data are lacking in the current monitoring system. These data cannot be captured with administrative data, and grievances and appeals information, which often aren't aggregated, transparent, or representative of general experiences.

Conducting a federal Medicaid beneficiary survey would be an important tool to measure beneficiary

perceptions and experiences with care and to address gaps in the other domains of access. It should be designed to allow for state and subpopulation comparisons and to gather information on service use, unmet need, and more complete demographic information. It should also not duplicate existing state efforts, and CMS should work with states to ensure that the data meet their needs. For example, CMS could consider state customization approaches that don't affect the ability to compare data across states and delivery systems.

The survey data collection and reporting processes should also be designed to promote beneficiary usability and public transparency, so there should be multiple survey modes such as in person, by mail, online, or by telephone in order to increase response rates. And the survey data should also have a timely release and be publicly available to facilitate broader analyses.

And the federal implications of this recommendation are that CMS may need additional funds to field such a survey and the federal costs would increase in the amounts provided by Congress. For states, they could be asked to assist in the design and fielding of a federal

beneficiary survey. And for beneficiaries, this new information on the beneficiary experience could be used to identify specific barriers and result in increased access.

And then our fourth recommendation, we recommend that CMS should further standardize and improve the T-MSIS data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity.

And our rationale for this recommendation is that T-MSIS is the only federal Medicaid data source for person-level information on eligibility, demographics, service use, and spending, and there are quality concerns and inconsistencies that make state- and population-level comparison difficult.

Improving the access and completeness of T-MSIS data would make the data more useful for access monitoring, and in particular, it would be important to focus on standardizing definitions of service and provider categories, which are important for monitoring utilization and provider availability.

Additionally, CMS and states should prioritize

improvements in the collection of encounter data for managed care plans, consistent accounting of telehealth services, and beneficiary-provided race and ethnicity data.

And the federal and state implications of this recommendation may be minimized by aligning improvements to T-MSIS with existing work. For beneficiaries, a new system may identify access barriers, and once again result in improved access to services, and for plans and providers, they may need to update or change how they report particular data to the state to improve standardization.

And in our final recommendation we recommend that CMS should provide states with analytical and technical assistance.

And the rationale for this recommendation is that there are several areas where Commissioners, panelists, and stakeholders noted the need for technical assistance. States may have limited administrative capacity to collect and analyze additional data, and they will likely need technical assistance and tools such as templates and data dictionaries to improve the quality of data reported to CMS, to collect and analyze additional access measures that are comparable across states, and to report on new

requirements. States may also require technical assistance from CMS to address access issues identified through monitoring.

And the federal implications of this recommendation might be minimized if the technical assistance is provided as part of the existing efforts, and for states the additional technical and analytical support from CMS could help them meet the obligation of collecting and reporting data to assess adequate access. And for beneficiaries, they may, once again, experience improved access to services.

All right. So I am going to leave this last slide up to provide as a summary of our package of recommendations, but we can always move back to specific slides for language changes. And I will turn it back to the Chair for discussion.

CHAIR BELLA: Thank you very much. Just to remind ourselves and the public, we will be discussing all of these things. We won't be taking any votes on the recommendation until tomorrow, where we will take votes typically as a package for most of these.

Thank you for this work. It is meaningful, it is

important, and I am especially excited to see that we might actually ask Medicaid people how their experience is, and we might actually like have something like Medicare has had for years.

So let's open it up for discussion. Questions, comments? We have generally already been down the path of getting to this point in this recommendation, but if there are refinements that folks want to make, now would be a good time to hear those.

Tricia and then Heidi.

COMMISSIONER BROOKS: Thank you. I have a couple of comments here but also a recommendation for one language change, and I just lost my file. So on 1.2, could you go back to that? It will be easier to see it here. Thank you. All the way back to the language.

In January, we discussed this, and I went back and looked at the transcript, and one of the suggestions I had made, I know we broadened the key stakeholders, but sometimes you look at a list and you go, check, check, I need to include those, and you miss that including but not limited to. So I would really like to see consumer groups added to this language, so researchers, consumer groups,

and other policy experts.

Linn, I noted in your comments -- and sorry I didn't mention this earlier in Executive Session -- you did actually say "timely reporting." And when I look at the recommendations, I think it is 1.1, it talks about regular intervals. But, you know, posting data three and four years after the fact is just not very actionable, and I'm wondering if we can weave "timely" in that in some way.

And then the last thing I will comment on, which is not specific to suggestions on the recommendations but just wanted to get on the record, on March 31st, CMS issued an information bulletin that is delaying the access monitoring review plans for another two years. You know, quite frankly, at this point they should just scrap that reporting. It wasn't very effective. We have got reports from 2019 that have never been made public, and I think that's because they were sort of all over the place. And if we're going to develop a new monitoring system, we should scrap that old system and proceed with getting something new in place. Thank you.

CHAIR BELLA: Thank you, Tricia. Does anyone have a concern with adding consumer groups to the

recommendation?

Heads nodding no. Are there any head nods yes? Are we good on that? Okay. And maybe you guys can think about the "timely" piece and bring something back to us if you feel like that needs to be highlighted.

Okay. Heidi.

COMMISSIONER ALLEN: First I want to say thank you for this report and thank you for letting me read in advance and make comments. And I felt like my comments were really incorporated so I appreciate that.

I have a couple of minor, maybe not so minor, points to make. In R1.1, I feel like we're missing the opportunity to tie that making the data available and useful to researchers. In our chapter we have a great text box that talks about the role of health services research and monitoring access, and yet in this recommendation it doesn't say anything about researchers. And I think a real simple addition would be where it says, "CMS should issue public reports and data at the state and national level," in a consumer- and researcher-friendly format at regular intervals. I think that making that addition would kind of bring it full circle.

The major recommendation that I hope we can consider changing here is that I would like us to request that it be an annual survey. And I have a lot of reasons for this, but I just wanted to give three top reasons why I think it's critical.

Having an annual survey allows researchers to basically take multiple years of data to create an adequate sample to look at subgroup analysis in populations at a lower rate. This is particularly important in racial and ethnic minorities in examining health disparities because in any one year you may not have a sample of a subgroup to do an analysis, but if you pulled three years of data you could.

And so for both looking at specific populations and looking for conditions that are lower rate, you know, even just trying to look at diabetic use of emergency departments, it may take a couple of years of data to pool, particularly if you want to look at state variation and examine how state policies can impact some of these access issues, you really do need more samples.

So that annual survey can allow a lot richer, more nuanced understanding of issues, and especially

because Medicaid is an innovation lab. We want to be able to look at baseline data, implementation year data, and post-implementation year data, and longer-term outcomes, which having annual surveys allows you to do. So even if you are just looking at one state and something that one state is doing, by having that longitudinal analysis you can do a much stronger empirical assessment of what's happening.

And then, three, to align with Medicare because Medicare has an annual survey. Medicare has fewer people. We should have one too. So that's my main point.

And then the last thing -- and I don't know if this is in our purview, but would it be possible for us to recommend that NIH consider Medicaid as a priority population for any research as we're asking for access research, 1.5 to assist states in collecting, analyzing access measures, Medicare, Medicaid should provide additional support and technical assistance. You know, would it be possible to add anything there about other -- the agencies that fund research could prioritize Medicaid as a population that should be studied more?

That's it.

CHAIR BELLA: Thank you. Let's take each of those.

The first one on the 1.2 -- right? -- I think that you guys -- that if the Commissioners agree, I'll ask the team to go back and sort of incorporate research ready, which I think is consistent with some of the other work, Anne? Anybody --

EXECUTIVE DIRECTOR SCHWARTZ: 1.1.

CHAIR BELLA: 1.1. Anybody have any concerns with that?

[No response.]

CHAIR BELLA: Okay. Then they can bring that back to us tomorrow morning.

Let's talk about the periodic versus annual. How do folks feel about that?

Toby?

COMMISSIONER DOUGLAS: I mean, I think it's the overall tension with -- so, you know, just stepping back on this body of work, first of all, I just think it's such a great step forward, when I think back to when I was at the state and having to make decisions on access and not having this framework, so huge steps and huge support for states.

But then we've got to balance that with additional -- how much burden are we putting on, and I'm just afraid everything annual, all these things, how much is there, the resources, both at the state and have CMS to do this, to insert at this point annual. We might let them work, you know, through a process of putting the periodic. It doesn't preclude annual, but I think all these pieces, we just need to think through how much additional burden, while this whole framework is such a huge step forward.

CHAIR BELLA: How much lift do we think would be required of the states?

Heidi?

COMMISSIONER ALLEN: So if it's administered like the CAHPS survey, which is what we recommended, it would be no burden to the states, right? But they would have the opportunity to add questions, which they often like to do.

I work with multiple states. I find them to be enthusiastic about collecting information about their state, particularly when they're not the ones responsible for collecting it.

And this is a survey that is done every single year for the Medicare program. There's vendors that do

this. It's not very expensive relative to the value added of understanding, you know, how things you do in your program impact the populations you serve, and it does bring in beneficiary voice, which is the only actionable thing in our entire portfolio here that brings in beneficiary voice.

CHAIR BELLA: Darin and then Tricia.

COMMISSIONER GORDON: Can you expound on your comment about CAHPS?

COMMISSIONER ALLEN: Yeah. So CAHPS is administered by the federal government through a vendor, which is different, and this is, I think, the framework that we put forward as opposed to PRAMS, which is a state-run survey. PRAMS is a lot of work for states to do, and they have a hard time sometimes getting enough response rate to actually make that data releasable. So many states, it's kind of like you almost get there, but you didn't get over the line because the data is collected, but nobody can use it.

But CAHPS is very successful. They do it for Medicare. They do it for Marketplace. They do it for home- and community-based services, and they did it for Medicare -- Medicaid before. They've only done one.

EXECUTIVE DIRECTOR SCHWARTZ: This is not the CAHPS that you're thinking about in terms of the health plan survey. It was unfortunate in their naming of that survey that they did once that they used basically the same --

COMMISSIONER GORDON: The same, okay.

COMMISSIONER ALLEN: -- the same name, but it's --

COMMISSIONER GORDON: Thank you. I was getting really confused there because it was like --

COMMISSIONER ALLEN: Yeah.

COMMISSIONER GORDON: -- we did CAHPS in -- okay. Thank you. Yeah, unfortunate naming.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: Just very quickly, I would be in favor of going annual.

I have to remind us, these are recommendations. These are not mandated, and we want to put language in that gets us to the ideal situation. So I could support annual.

CHAIR BELLA: Brian.

COMMISSIONER BURWELL: So I'm more in Toby's camp. I think to mount an annual survey of all Medicaid

beneficiaries that produces state-level estimates by also the cuts that we're talking about in this will be a very large lift. A lot of the CAHPS survey are national in level, and to develop state-level estimates is, I think, a very expensive proposition, and I also have that concern.

I think this is great work. It provides a great framework, but I have serious concerns about the feasibility of actually having an access monitoring system like this within any type of realistic time frame. This could be another T-MSIS is my concern.

CHAIR BELLA: Can someone clarify the cost? I was actually thinking -- well, I had in my head this would actually be less expensive, for example, than what we do in Medicare today.

MS. HEBERLEIN: Yeah. So we looked at the CAHPS, but the NAM CAHPS, the survey, and it cost about $10 million for one year, and that included -- that didn't include the CMS staff, but it included the contractor and the fielding and the data cleanup and analysis.

The Medicare current beneficiary survey is about 25.4, and actually, the $10 million was over four years for that contract.

And then to get to the point about state burden, so the sampling frame was pulled from MSIS at that point in time. So it's quite possible that the sampling fame could be pulled from T-MSIS, and states, most states chose to pick -- they had an option of how they participated in the sampling frame. And most states chose basically having the contractor pull the sampling frame and then providing the beneficiary contact information, and they reported it took about nine hours to complete that.

So I think, you know, as Heidi pointed out, if they build on sort of what they did with the NAM CAHPS and sort of, you know, took some of those lessons, then I think, you know, the cost and the burden on states might -- could be minimized.

COMMISSIONER ALLEN: Can I ask a follow-up question? So, to Brian's point, my understanding is that the beneficiary survey for Medicare is quite large. The sample that they get every year is actually adequate for state individual and could allow a lot of subpopulation analysis and a lot of really good analysis.

If for some populations -- let's say gender minorities -- you would need to pool several years of

sample to be able to get at that, but that's the only way you can get at it, right? Like, if you don't do it annually, you can't get at it. But, if you do it annually, you can take two years of data or three years of data and pull enough sample to do that kind of analysis.

How many? 289,000?

MS. HEBERLEIN: It was a sampling frame of 270 -- okay, sorry -- 270,000 adult enrollees, which was about 5,800 adult Medicaid enrollees from each state, and the way they did their sampling frame is they tried to get -- they had four stratum is what they called them. So it had a managed care component, a fee-for-service component, component for individuals with disabilities, and a duals component. So it looked -- it oversampled among those populations so that they could specifically look and make comparisons across those populations.

COMMISSIONER ALLEN: That's a huge sample. That is a huge sample. You could do a lot of very high-quality health services research on access using a sample like that, and the Medicaid program could do the same thing. They could oversample populations of interest for subgroup analysis.

But, regardless of that, that would allow you to look at state variation and policies that could impact access and care and cost. So I think it's really valuable.

CHAIR BELLA: Verlon, did you have a comment, or were you just winking at me?

[Laughter.]

COMMISSIONER JOHNSON: I was kind of winking at you.

So it was really about the periodic versus annual, and I wanted to get at exactly, I think, what, Heidi, you said about how meaningful it would be to have more annual in the reporting, because when I think about periodic, my kid always says, "Oh, I'll clean my room periodically," and that never happens. So I just really wanted to -- I think it really shapes the parameter a little bit more.

So I'm just coming back to the cost again. For a Medicaid capsule, how much is that again?

CHAIR BELLA: Can we go to the slide actually that has this recommendation on it, please?

MS. HEBERLEIN: Yeah.

So the cost of the NAM CAHPS was $10.8 million

over four years.

COMMISSIONER JOHNSON: Okay, gotcha.

MS. HEBERLEIN: And so I think, you know, that's -- they would have to design the survey and figure out sort of what they wanted. If they built the survey instrument on the CAHPS, so not to be more confusing, but there may be additional questions they want to ask. There may be other things they want to do. They may want to, you know, work with states to make sure that there's questions that are of interest to states. They may want to target certain populations. So I think, you know, that's --

COMMISSIONER JOHNSON: Okay.

MS. HEBERLEIN: -- a guesstimate of sort of here's what it costs for them to do this once, and if they wanted to -- depending on how they built it --

COMMISSIONER JOHNSON: Okay, good. Okay. Thank you. Thanks.

CHAIR BELLA: Darin, and then, Dennis, I'm going to see if you have comment.

COMMISSIONER GORDON: So, conceptually, the annual thing doesn't scare me. The thing I'm trying to reconcile -- I mean, I go back to like alignment with some

of what states are doing now to actually actively, you know, use this information to manage to make sure that individuals have access. And I'm trying to figure this out, and the reason I'm getting a little stuck, I don't have a good sense of if every state -- well, I'd venture to guess not every state does this.

But we had been doing a beneficiary survey every year since 1993, and it's 5,000 families. What I'm trying to figure out in my own mind is like so when you come in and you do this, does it basically break that longitudinal value that we have over 20-some-odd years because the state says we've got this other survey that's being done at the national level? I'm just trying to reconcile those things because there was a lot of thought put in that. The longitudinal aspect of it is invaluable, to your point, so you could evaluate how different policy decisions happen.

And I'm trying to figure out if we do this, to what degree can you accommodate some of those things? Because I think it's got its limits. Let's say there's 30 states that do something like this. I don't think CMS can accommodate some of those unique questions that may be in some of those other surveys that some states are doing.

So the annual comment makes total sense to me. That's where I'm getting stuck.

CHAIR BELLA: Is that something we could reflect in the chapter, just so we would want to take care to make sure that this is thought of in the context of what states may already be doing?

COMMISSIONER GORDON: You know, I think a lot of the discussion we've just had, I think we need to be a little bit more specific, like talking about some of the prior things that were done, the unfortunate-named CAHPS, thing that they did, and trying to sync up with what states are needing, because this alignment need to what a state -- because there's one thing to doing the retrospective review of it, looking at the research and all that, but a state is like day in and day out, using various tools to try to manage access, and you got to make sure that this is complementary and not creating conflict with some of the things that they are going, and they feel they need to do to actually make sure this is happening on the ground.

CHAIR BELLA: Okay. Heidi? And then Dennis. Is it on this point?

COMMISSIONER ALLEN: Yeah. I was just going to

say that I am a survey researcher. I field surveys, and there's not a lot of variation. We have a set group of questions that we use. We all draw from the same instruments. My guess is that there would be a lot of overlap between what states do and what would be designed for a survey like this. We have kind of set ways that we ask about, you know, was there a time that you needed care that you weren't able to get it? That's -- you know, these are things that we do.

But the probability that two people would be sampled for the same survey is very low, and so if a state felt like, oh, this longitudinal thing that we've been doing with our beneficiary surveys -- which I actually don't think that that many states have regular, you know, annual beneficiary surveys. So I don't know that there would be that many states in this situation.

But for those that are, they could look at the survey and say, you know, "This still has value for us. We're still going to do it," and I don't think it would impact their ability to do their survey if they still felt like it was worth doing for that longitudinal purpose.

COMMISSIONER GORDON: Yeah, yeah. I wasn't

thinking the overlap, that it's hitting the same survey. It's that latter point. Will a state then like say, "I'm not going to do what I have been doing now that we have this federal thing"? Which that's what I'm trying to think through myself, and yes, it will be a state decision, whether they still see value in it or not, but that's what I'm trying to figure out in my own mind.

COMMISSIONER ALLEN: It's kind of hard for me to imagine what they have on their survey that would not be on a regular survey. Like running through my mind, all of the kind of things that we put on a beneficiary survey, and I really can't think of like a specific measure that a state might have that they're like, "We love this measure. This tells us so much about our population," and it's not available in a regular survey.

COMMISSIONER GORDON: I'll be quick.

I'll just give you an example of what we learned over many, many years. Asking an individual in Tennessee whether or not, you know, about their feelings about Medicaid, you get almost like crickets because they don't think of our program as Medicaid. It is TennCare. And they won't even say TennCare. It's not relevant. You need

to ask about Blue Care Tennessee, Amerigroup Tennessee, or United. Things we learn that over time that the consumer relates to the program differently at that state level, so that's just an example.

COMMISSIONER ALLEN: But just to respond directly to that, all surveys insert the language of the state on that question. So it would say, "Do you have Oregon Health Plan or the Oregon Healthy Kids Program?" Yeah. There's like it's just the states provide the name of their program. It's put into every individual survey. That is just very common 101 survey practice.

CHAIR BELLA: I'm going to suggest you two sit next to each other at lunch, and I'm going to go to Dennis for comments.

COMMISSIONER HEAPHY: Thanks. I was wondering, is it possible to do a baseline analysis of state surveys to date, if that would be helpful?

MS. HEBERLEIN: So I'm not going to get the number right, but we can go back and check. It's not clear to me how many states actually do them. There's a number of states that do broader health surveys of their populations that aren't necessarily Medicaid-specific.

This question was asked at a panel, the October panel, and the researcher -- we didn't get -- I don't think anybody knows how many states are currently doing it. So we can do a bit more digging, but I don't know off the top of my head. And it wasn't something we came across in our research.

COMMISSIONER HEAPHY: So I was wondering if that could be part of the recommendation. That's why I asked the question.

MS. HEBERLEIN: I think it can be part of the chapter about how we might accommodate the states that are already doing something and would ask that we include that or reinforce that.

COMMISSIONER HEAPHY: That's great.

And then in the recommendation on dissemination to consumers, I think it said that consumers apparently -- it might have been 1.1. No, it wasn't 1.1. But I think it would be helpful in terms of the dissemination information that somewhere in the chapter, it says -- I just spaced the word -- that the information be provided in a plain text format, because a lot of organizations are doing that now. They're providing two levels of information, one that's

higher and one that's literally at the fourth or fifth grade level, and that standard language is really helpful and accessible to people, really dense information.

And the other is for the chapter, and it's great to talk a lot about disability access, but I think if you were to add the Americans With Disabilities Act somewhere in the chapter, it would be appreciated.

And then also, I know we talked about this, the definition of services. That's something we grapple with is how is services being defined. I know that's part of the conversation, but it's a really big issue. What is care coordination? What is a touchpoint? These are concerns that we have, and from a consumer perspective, what does that really look like? Does that make sense?

CHAIR BELLA: It does, and I see heads nodding that we can take this feedback into account for the chapter.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: I'm going to --

COMMISSIONER HEAPHY: And the last thing --

COMMISSIONER CARTER: Oh, sorry, Dennis. Go

ahead.

COMMISSIONER HEAPHY: I'm sorry. The last thing I wanted to say was there's so many different types of size of CBOs that I think it's important to put in the chapter that they include consumer groups that whose leadership and composition include folks who are served by that, that are served by the organization, because we often see CBOs, larger CBOs that represent populations but don't necessarily -- the CBO itself is not reflective of the populations that they serve.

CHAIR BELLA: Thank you, Dennis. Martha?

COMMISSIONER CARTER: I'm going to go back to something I think Tricia said, and I think we sort of need to thread the needle in terms of our recommendation. I'm not saying that we would disregard the cost of something, but I think our role is to distinguish what we think is the best practice. And I'm basically coming in support of what Tricia said.

I think this comes up in lots of areas of Medicaid and balancing federal and state responsibilities and funding. And I don't know that we can, as a Commission, sort all that out. We'll address this again

when we start looking at mandating services later on. But I think that our role is to make the recommendation that we think is best for the whole picture, but most important the people that are served by the program.

So I would support the annual surveys from that perspective, not disregarding that it's costly, that it's a burden, but it comes down to sort of a moral, ethical question about what we want this program to look like.

CHAIR BELLA: I too would support annual. I understand it's not -- the current language doesn't preclude annual, but I'm sort of tired of Medicaid -- it kind of feels like an afterthought sometimes, and I feel like if we're going to do it, we should do it, and we should make the statement that it's important. It's done every year for Medicare. If we're going to do this for Medicaid, why wouldn't we seek to have it done every year?

So that is my feeling. It's only my feeling. But I would like to know how others feel so that the staff knows what to bring back to us tomorrow. Who has -- let's see, should I do this positive or negative? -- who has concerns with moving to annual in the recommendation?

EXECUTIVE DIRECTOR SCHWARTZ: None.

CHAIR BELLA: No one. Or no one wants to say anything. Okay. Darin's taken your lunch card. Unrelated. Okay. If you could bring back to us tomorrow, just shift that language to the annual, that would be great. Darin?

COMMISSIONER GORDON: Just one other thing that I didn't see in the chapter that I think would be appropriate context to include is around telehealth and the role that it plays. Because we talk a lot about kind of the world as it was versus kind of the new reality, so somehow, we have to incorporate that, I think, to recognize that that changes the game somewhat. Thank you.

CHAIR BELLA: Could you flip to the last slide that has all five up, please? Thank you. We have all five in front of us. Are there any comments anyone wants to make on any of the five before we conclude this session? And just to let folks in the public know, oftentimes we might veer from the agenda as to when we take public comment. For this meeting we won't. We will take public comment when it's stated on the agenda. So we will take public comment on this, I believe, right before lunch.

Okay. Commissioners, anything else on any of

these five? Heidi, you did raise another point. I feel like we haven't talked about that, and so it would be hard to bring it in at this point. But this doesn't mean we are done with this body of work, but I would encourage that we save that for the next time we take this work on.

Okay.

COMMISSIONER GORDON: One clarification. You had brought up something about the aligning with states. Somebody had brought that up. I didn't know how we solved for that.

CHAIR BELLA: We're going to handle that in the chapter.

COMMISSIONER GORDON: Okay.

CHAIR BELLA: Is that okay?

COMMISSIONER GORDON: Sure.

CHAIR BELLA: Okay. Last call on any of these five. Anything you want to see different for tomorrow?

All right. So what's going to come back to us tomorrow, we're going to have the research element reflected in one of the recommendations, we're going to change "periodic" to "annual," and consumer groups, and then we have some refinements, additions, enhancements in

the chapter. Okay.

Dennis, any last comments from you before we move on?

COMMISSIONER HEAPHY: No, I really appreciate Darin's point about the telemedicine.

CHAIR BELLA: Okay. Darin, you're good? Okay. Heidi, you're good?

All right. Thank you very much. Exciting discussion.

CHAIR BELLA: We are going to move into a very related discussion which is an opportunity to comment on the RFI that CMS has released on access to coverage. And so we will turn it back over to you guys. Actually, Martha. Everyone is leaving you. That's okay.

MS. HEBERLEIN: I'm abandoned.

CHAIR BELLA: I know.

MS. HEBERLEIN: It was a group effort for this, so, you know, I just stand up here.

REVIEW OF CENTERS FOR MEDICARE & MEDICAID SERVICES REQUEST FOR INFORMATION ON ACCESS TO CARE AND COVERAGE IN MEDICAID AND CHIP

* MS. HEBERLEIN: Okay. So thank you. As Melanie

noted we are going to spend the next session discussing the Commission's response to a request for information, or RFI.

CMS released an RFI on February 17th. It's fairly broad in its request, seeking feedback on a wide range of access-related topics, including enrolling in and maintaining coverage, accessing services, and ensuring adequate payment rates.

As you heard during the panel discussion in December, CMS is looking to develop a comprehensive Medicaid and CHIP access strategy, and this RFI is one of the first steps the agency is taking. The RFI notes other examples of additional activities that may come, which include interviews with subject matter experts and stakeholder roundtables.

Comments on the RFI are due April 18th, through Medicaid.gov.

The memo in your materials walks through our possible responses, which draw on our body of work, which predates many of you, as well as some of us staff, as well as some of the more recent work, including some of the recommendations that are going to be presented at this meeting.

In the RFI, CMS has identified five objectives and is seeking comments and strategies in the areas listed here on this slide. I am going to go through each of these objectives and possible areas for comment, in turn.

Starting with Objective 1, CMS is interested in identifying strategies to ensure that individuals are able to apply, enroll in, and be determined eligible in a streamlined fashion. CMS seeks specific ways to support states in making timely eligibility determinations and asks what additional capabilities, such as systems, staffing, and data sharing needs, that states may have.

Some possible areas for comment. The Commission can point to our prior research, showing that efforts at simplification including using electronic data sources and automating processes can lead to administrative savings and streamline procedures for both states and beneficiaries. However, in-person assistance is still necessary, especially for certain populations, such as families with mixed coverage and communities with lower computer literacy.

Additionally, there are some longstanding issues that predate implementation of the ACA that still remain as

barriers. For example, logistical concerns regarding delivery of notices and receiving responses from beneficiaries is a process that's often hampered by inaccurate contact information. So strategies for addressing some of this would include more up-to-date contact information, providing multiple methods of communication, and providing additional time for beneficiaries to respond.

Under Objective 2, CMS is interested in strategies to ensure beneficiaries are not inappropriately disenrolled and minimize gaps in coverage due to transitions between coverage programs. In our comments, the Commission may want to draw on the agency's attention to areas of known concern. Foremost on many people's mind is the upcoming unwinding of the continuous coverage provisions at the end of the public health emergency, or PHE. Panel discussions at the January 2022 and October 2020 meetings identified strategies to facilitate these transitions, including spreading out renewals over the full period available to states and updating beneficiary contact information, including working with managed care plans to do so.

Improving continuity in coverage transition extends beyond the unwinding, and especially for individual who may be more likely to experience a change in circumstances that makes them ineligible for Medicaid. For example, our recent work found that one of the populations with the highest rates of churn were children enrolled in separate CHIP programs. And while most of these children enrolled in Medicaid without a gap in coverage, these results may indicate that particular attention should be paid to the redetermination and transition process for children.

CMS can also continue encouraging states to use available options such as 12-month continuous eligibility and express-lane eligibility, both of which the Commission has previous noted as successful.

Finally, without clear communications about requirements and procedures, coverage may be inappropriately terminated and some individuals will remain uninsured even though they are eligible. Focus groups we conducted with beneficiaries last year found that while communication preferences and ability to access technology vary, providing multiple avenues to connect with the

program helps to ensure that individuals complete processes in a way that best meets their needs.

Under Objective 3, CMS is interested in feedback on how to establish minimum standards for timely and equitable access across delivery systems, provider types, geography, and other areas. CMS also asks how the agency should consider concepts related to whole-person care and care coordination, as well as ways to support states in diversifying the pool of available providers.

For this response, the Commission can draw heavily from the chapter on access monitoring that we just presented. While the recommendations do not identify specific measures for collection, the Commission agrees that CMS should establish consistent and comparable measures across delivery systems that reflect the three key domains of access included in the RFI, which are the same as ours.

The Commission also notes the importance of having the measures reflect the priorities of multiple stakeholders, including beneficiaries, and focus on identifying disparities in access among historically marginalized populations.

MACPAC's forthcoming chapter on a new access monitoring system also discusses a number of approaches that CMS could take to establish standards or benchmarks for access to care.

Regarding whole-person care, Medicaid beneficiaries often have complex physical health, behavioral health, and long-term care needs, as well as experience social risk factors associated with poor health. Understanding the needs of beneficiaries and how their unique characteristics may affect access to care can provide CMS and states with a more complete picture of access.

To inform the agency's thinking in this area the Commission can pull from its prior work on integrating physical and behavioral health, including our forthcoming work on electronic health records and incentive payments, that will be presented later today. We can also draw on our work looking at integration for dually eligible individuals, and more details are provided in your memo.

Finally, the availability of providers is a key factor affecting access to Medicaid enrollees. Telehealth has the potential to mitigate barriers such as insufficient

supply of proprietors, inadequate transportation, and long distances to providers. The recent increase in the use of telehealth during COVID presents an opportunity for CMS and states to gain an understanding of the effects of telehealth on access to care, an area which has been historically under-researched.

CMS may also want to examine the success of existing state efforts as it considers ways to increase the pool of home and community-based service providers. MACPAC recently examined state efforts to address workforce shortages in HCBS, and we can point to that in our response.

Under Objective 4, CMS is interested in feedback on new and existing data sources that can be used to monitor and encourage equitable access. CMS also asks where the agency can provide technical and other assistance to support states in standardizing monitoring and reporting.

So in response to this objective we can also draw on our forthcoming chapter on the new access monitoring system, discussing the limitations of the current system and highlighting the recommendations you will make on

improving T-MSIS and fielding an annual Medicaid beneficiary survey as key opportunities to address these gaps.

There are also unique challenges to measuring access to long-term services and supports in home and community-based services. These services are particularly important given the predominant role of Medicaid in funding them, and are also highlighted as an area of interest in the RFI.

As noted in our chapter, there are several beneficiary surveys that can be used to address some of the limitations of relying on claims data alone to assess access to HCBS.

The Commission can also point to its recommendation on providing states technical assistance. This recommendation will be made with the recognition that states will need help to improve the quality of the data reported in T-MSIS, as well as to collect and analyze additional access measures.

Under the last objective, CMS asks for opportunities and priorities to align approaches and establish minimum standards for payment regulation and in

compliance across delivery systems. CMS also asks for comments on how to assess the effect of state payment policies and contracting arrangements that are unique to Medicaid.

Assessments of payment adequacy require having data on all types of Medicaid payments and examining how capitation rate-setting incorporates considerations of access. MACPAC's forthcoming chapter on directed payments will include recommendations on increasing transparency for directed payments as well as to clarify the roles and responsibilities in the review of directed payments in managed care capitation rates.

CMS may also want to consider establishing minimum payment standards for particular services and an approach to improving access. Should the Commission adopt it, staff can also reference the recommendation that CMS implement payment regulations for vaccines that are similar to those already in place for outpatient prescription drugs.

The Commission could also provide comments related to payment approaches and services unique to Medicaid as well as point to our prior work on program

integrity, which are described in more detail in your memo.

The RFI also provides an opportunity to submit comments in areas not specifically addressed in the five objectives CMS identified. Two areas for possible comment could include incorporating equity and ensuring transparency. MACPAC is committed to examining how it can best contribute to addressing racial disparities by embedding a health equity lens across our work. Similarly, CMS has made a commitment to these efforts, noting specifically that the RFI is part of the administration's broader work to advance health equity. So as such, the Commission could note that the agency should honor this commitment by maintaining an equity focus as it examines and seeks to improve access to care and be specific about the steps it tends to take to address disparities.

The Commission has also repeatedly raised the importance of transparency, both in releasing data and in ensuring a public and transparent process to rulemaking. However, as the request for information was released on Medicaid’s website rather than through regulations.gov, it is unclear whether the submitted comments will be available for review by individuals outside the agency. In addition,

given the option for individuals to submit written comments through the portal, options that are typically available through the formal rulemaking process, such as email and mail, do not appear to be available.

In the forthcoming chapter that we just walked through, the Commission will recommend CMS actively engage stakeholders in a transparent process to implement a new access monitoring system, and the Commission could reiterate that recommendation here.

So building on all this prior work and what you discussed today, staff will pull together a comment letter in response, which again is due on April 18th. As a note, the RFI is designed as a fillable online form, but we are going to consolidate the responses into a formal comment letter to submit to the agency and post on our website.

At this point I welcome any comments and areas for emphasis or things we may not have addressed.

CHAIR BELLA: Thank you, Martha. I am consistently amazed by how much you can pull from current work, prior work, as you said, all of this stuff that predates any of us probably.

I'm going to open it up for comments. Clearly

there is a lot here. You have already put a lot in front of us. I think there are a lot of heads nodding, so I think the answer is probably yes to the majority of things you suggest, but why don't I open it up for specific comments.

Heidi? Oh, sorry. I looked right at -- Laura, then Heidi. Yes.

COMMISSIONER HERRERA SCOTT: So just on the behavioral health and physical health, just mentioning the states that have carved out behavioral health and the barriers that that creates to integrating.

CHAIR BELLA: Thank you. Heidi?

COMMISSIONER ALLEN: So I have a question about strategy, because I'm new to the Commission. Is it better to say this is every thought we've had about access to care and coverage, or is it better to say here's the top five things we think you need to do?

EXECUTIVE DIRECTOR SCHWARTZ: Given that they are going to get, I guess, thousands of comments on this, and they have a lot to do, and they have asked for a lot of things, I think it's worth it to remind them of work that might not be top of mind for them or that might be tenth on

our series of priorities. Personally, given that it's a kitchen sink request, I think we can follow suit with a kitchen sink response.

Now what we would say in the first part of the letter might signal what we think is most important right now, and then we can go into our long litany of items.

COMMISSIONER ALLEN: So and a follow-up. My preference would be to take that approach and say, "We have done a lot of work in this area. We have a lot of thoughts. But if we were to prioritize five things, this is what we would prioritize, simply to signal to them the things that we think are the most urgent or salient in this opportunity and not miss this chance. We are not like every other stakeholder. We are an important stakeholder that very systematically assembles a collective group of people who have expertise and has done all this work. And we probably all can think of the things that we think are the most critical right now. And that way we would do both, right, get at what you're talking about, signal all this other work, but kind of have some oomph.

CHAIR BELLA: Tricia.

COMMISSIONER ALLEN: I'm curious how you spell

oomph in the transcript. I'm going to have to look that up later.

CHAIR BELLA: Tricia, then Verlon.

COMMISSIONER BROOKS: Heidi, I get your point completely. I think with 11 days left in the comment period it would be very difficult for the Commission to agree on what those top five things are. But I do have a couple of other comments.

Great work, Martha. When I went through the list of the things we could comment on I looked. We've been working at the Georgetown Center for Children and Families on our own responses. I mean, we could write the whole kitchen sink up and send it in, and I think we sort of have to do that.

One thing I thought was missing, and this is one of my soapboxes, is that the performance indicator data was not mentioned within the draft that you sent, or the memo that you sent, and I think that's really important. Those performance indicators have been on the books since 2014. We've seen only a few given the light of day. And recently CMS put out the data reporting requirements on the unwinding of the continuous coverage protection, and in

that template is data, only data that is not in the performance indicators.

So I think we should be pushing CMS to report all of those data. There was always this plan to go to a Phase 2 of those performance indicators. I think the data reporting template for the end of the PHE is a good start on that. I think also you talk a lot about standardizing some of the data so it's comparable within T-MSIS. I think we need to add disenrollment codes that give us an idea of why people are losing coverage for procedural reasons, because that's where we really should focus our efforts on promoting continuity of coverage.

And one last point, and that is that the current scorecard that CMS devised, I just don't think it does an adequate job of allowing us to monitor both access and performance. I think there's a growing interest in seeing states develop dashboards that are consumer friendly, that would have a lot of the information that we need to really evaluate how well we're doing on both access and other performance measures.

So I'm wondering if we can weave in something like that into the final comments. And I'd be happy to

review comments and react to them when you develop a draft. So thank you.

CHAIR BELLA: Verlon?

COMMISSIONER JOHNSON: Okay. I've got to just say I have to applaud you. That was really impressive, and some of the things I remember when I was at CMS, it was nice to remember. It jogged my memory, of course, some of these items.

The only thing I have to say, though, is that I love how at the end, you talk about incorporating equity and ensuring transparency as an other, but I would suggest that we bring that up to each of those different areas because I think it's important that if this is where we've said as a Commission that we really want to focus on equity throughout everything that we do, I think it's important that each of these different areas, that we kind of line it up as well.

Great work. Thank you.

CHAIR BELLA: Thank you.

Dennis, do you have comments?

COMMISSIONER HEAPHY: Thank you, and thanks for this part. It looks really good.

I was wondering, though. We talk about integration of BH and medical, but I think it would be helpful to highlight BH and LTSS and HCBS because that's a really big issue right now and a lot of disparities there.

And then also, I think it's page 11. It talks about actuarial soundness, and that sentence really just jumped out at me and sort of sits in the middle of the report. I'm wondering when you do the overview at the top, there's something about oversight or plans or something could be up there, because to me, that's a big area of concern is the actuarial soundness of the payments.

CHAIR BELLA: Thank you, Dennis.

Other comments? Bob.

COMMISSIONER DUNCAN: Thank you again for the report. I was just wondering if we could recommend language ensuring that CMS looks at vulnerable populations, and my bias would be particularly kids. We tend to, when we look at metrics, use Medicare or adult metrics that don't always apply, and I'd like to be able to have Heidi be able to feather out in her research, access and things like that for kids.

CHAIR BELLA: Thanks, Bob.

I'm looking over here because it's like the hidden corner. Do you guys have any comments? No? Okay.

COMMISSIONER DOUGLAS: I mean, I --

CHAIR BELLA: Toby?

COMMISSIONER DOUGLAS: -- have a little nit on the communication. I mean, one thing that is becoming more and more prevalent, especially as we see on the PHE, is for texting and this intersection with TCPA and just calling out. There needs to be more just help on how to navigate and provide states, plans, the ability, the protections to be able to engage but comply with TCPA.

CHAIR BELLA: Thanks, Toby.

Heidi?

This actually may already be here. Tricia, I'm going to look at you because I think you might know.

You mentioned the disenrollment codes. Do we know why people are denied when they try to enroll?

COMMISSIONER BROOKS: No. So I think you can use the same codes for denials and disenrollments. I always sort of focus on the disenrollment, but things like the mail got returned or they didn't provide documentation, I think there was a body of work done by Mathematica and

NASHP in the Maximizing Enrollment Project a number of years ago, and they came up with a coding scheme that I think would really work. So I don't think there's a lot of work to go into that that would then standardize that and require that kind of tracking of reasons.

COMMISSIONER ALLEN: When you say disenrollment code, could we add enrollment and disenrollment codes, just modify that slightly to also understand why when people try to enroll, they can't and then why when they try to reenroll, they're disenrolled?

COMMISSIONER BROOKS: Yeah. And I think appropriately would be denial and disenrollment codes, so you're being denied at application.

CHAIR BELLA: Okay. Other comments?

COMMISSIONER HEAPHY: This is Dennis.

For me, I appreciate the social determinants of health section, but if you could put in there how disability status can actually complicate access to SDOH housing, it needs to be accessible or if the person has a mental health diagnosis, it can make it harder to get housing, so just putting something in there, a quick phrase, would be great.

COMMISSIONER BROOKS: So Toby's comment on texting, it jogged my memory. We still don't have every state providing all four modes of communications for applying or whatever. I think that's something we can do.

We have very few states that are reporting CHIP outreach expenditures, even though outreach is required. We haven't looked at out-stationing. We haven't required states to have certified application counselor programs. There's a whole lot of work that could be done on consumer assistance that I think also should show up in our comments.

And I could go on, but I'll stop.

CHAIR BELLA: Other comments? CHAIR BELLA: Other comments?

[No response.]

CHAIR BELLA: Well, I would echo what Verlon said about pulling up the transparency and the equity. I also really appreciated the opportunity to talk again about the importance of the redeterminations as we come out of the PHE.

I think in this case, I see the kitchen sink as a positive thing. I appreciate CMS asking for all of this

information, and I don't envy the people that are going to be reviewing all of these comments and turning them into policy action. But I think it's also kudos to CMS for doing this and giving us all the opportunity to comment.

Should we take wagers on how many comments we think they'll get?

EXECUTIVE DIRECTOR SCHWARTZ: Or whether we'll know.

CHAIR BELLA: Way to make it negative --

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: Making it fun.

CHAIR BELLA: Several, several thousand, I'm going to say.

Okay. And, Martha, do you need anything else from us?

MS. HEBERLEIN: Nope. Thank you.

EXECUTIVE DIRECTOR SCHWARTZ: I just want to mention to folks that this will be a very quick turnaround because it's due a week from Monday. So, if we ask you to review, if you can return it promptly, or if it doesn't fall at a good time for you, just let us know so that we won't be counting on you if you're on vacation or you're

grading exams or having a Joint Commission review or something like that.

CHAIR BELLA: All right. Martha, thank you very much.

Kisha, I'll turn it over to you.

VICE CHAIR DAVIS: All right. As Audrey comes up, we're really, I think, enthusiastic about our next session around health equity, which is something that we've been talking about not just this year but last year as well, and so I'm excited for Audrey to review the chapter that we have in the June report and reviewing the work that we've done and what we have lined up for the future.

So I'll turn it to you, Audrey.

MEDICAID'S ROLE IN ADVANCING HEALTH EQUITY: REVIEW OF DRAFT CHAPTER FOR JUNE REPORT

* MS. NUAMAH: Hi. Good morning, everyone.

As Kisha mentioned, during today's session, I'm going to walk through the health equity chapter. We discussed the general framework for the chapter during the March session, and given your feedback, the fully fleshed-out chapter does not stray far from this framework.

While MACPAC is working to embed a health equity

lens across all of our work, this is the first time that MACPAC has a dedicated focus specifically on promoting health equity and addressing disparities in our report to Congress.

The purpose of this chapter is to express your views. I'm looking forward to hearing all your feedback today, and if you do have any specific line edits, please feel free to share with me via email.

I'll provide an overview of the key themes that are presented in the chapter, and they're all listed here on this slide. Then I'll close out with some next steps for this health equity chapter and ask you to provide any feedback for these key themes.

The chapter begins by defining key concepts that are foundational in the health equity space and discusses the nuances of certain terms such as the difference between health equity and health equality.

As we've discussed, health equity more broadly focuses on beneficiaries who have been historically marginalized due to their race, ethnicity, age, geography, disability, sexual orientation, and gender identity, as well as the intersection of these identities.

Due to our country's history of structural racism, Medicaid beneficiaries of color have worse outcomes compared to white beneficiaries, and this disparity is amplified when you examine other intersectional identities. This is why the chapter focuses on Medicaid on the basis of race and ethnicity.

The chapter includes a breakdown of the racial and ethnic composition of Medicaid and CHIP beneficiaries. As you can see, more than half of the adults and two-thirds of children enrolled in Medicaid and CHIP are individuals of color. As you can also see from the graphs, compared to the racial and ethnic composition of the total United States, a disproportionate number of Medicaid beneficiaries identify as Black or Hispanic.

In the chapter, we highlight what is known about the disparities in access and outcomes for these groups, such as higher rates of maternal mortality or the fact that Black and Hispanic Medicaid beneficiaries are less likely than white beneficiaries to receive primary care. We know that there's a lot of ground to cover when it comes to applying a health equity lens to the Medicaid program, and while Medicaid alone cannot remedy societal health

inequities or their causes, there are efforts and policy levers that can eliminate disparities and access to care and health outcomes among beneficiaries.

The chapter begins by summarizing some of the historical and current efforts by HHS and CMS to address health equity. The chapter describes recent CMS actions to do so within the Medicaid program specifically. For example, CMS recently released a funding opportunity for outreach and enrollment grants that focus on strategies that reduce racial and demographic coverage disparities. CMS has also signaled that there will be further guidance to come around Section 1115 waivers that focus on SDOH.

We state that the Commission is encouraged by the commitment of CMS to prioritize health equity and that the Commission looks forward to learning more about specific actions.

There are also multiple opportunities for state Medicaid programs to advance health equity. The following sections highlight some current state activities and points at opportunities for other work.

The first opportunity is around data collection and reporting. As we know, having robust data is

foundational to how health equity works. Last week, staff released a brief about the availability of race and ethnicity data for Medicaid beneficiaries, and in the chapter, we draw on this brief and highlight the key findings about the strengths and limitations of various data sources. The chapter also describes the considerations and challenges for collecting and reporting race and ethnicity data.

Although the gold standard for collecting race and ethnicity data is self-reporting by individuals, the chapter describes why beneficiaries don't always provide this data.

The chapter also highlights how inconsistent data collection methods can exacerbate these problems. We reiterate the point that the Commission has made in the past that the absence of complete race and ethnicity data should not prevent our health equity work from progressing. Staff are also currently kicking off work to dig deeper into potential solutions for data improvement while ensuring that the beneficiary experience of reporting this data is centered. We hope to bring findings to the Commission this fall.

The next opportunity examines the importance of having commitments from state-level state leaders to ensure that programmatic policy changes for advancing health equity actually have staying power. The chapter discusses the challenges states face, given they also have to balance these efforts with other state commitments. The chapter describes how some states have established infrastructure to support their health equity work such as designating a health equity advisor to lead efforts and creating health equity plans.

We also mention how some state Medicaid agencies are doing the work internally by facilitating anti-racist trainings for staff and hiring staff who are representative of the populations they serve.

The Commission has spoken several times about the importance of beneficiary engagement. The chapter outlines how this is specifically important from a health equity perspective. Structural racism has resulted in the lack of trust in the system, which may discourage use of health services and ultimately lead to poor health outcomes. We describe opportunities to engage beneficiaries of color at multiple points during the policy and program development,

such as the use of medical care advisory committees(MCACs) and how states are going beyond these federally mandated MCACs to have member-only advisory committees.

The chapter also describes barriers to beneficiary engagement; for example, the lack of compensation for their time and expertise as well as logistical issues. The chapter shares strategies some states are using to overcome these challenges.

As we just discussed in the prior session, we are also aware of high Commissioner interest about the restart of regular redeterminations when the COVID-19 public health emergency ends. While this is an area of concern for all Medicaid beneficiaries, the chapter lays out concerns of the likely disproportionate effects on Medicaid beneficiaries of color. And thinking beyond the beneficiaries, the chapter describes what some states are doing to reduce systemic barriers in application and renewal processes to help beneficiaries gain and maintain Medicaid coverage, such as making renewal materials more easily accessible electronically or partnering with navigators.

Next, the chapter describes how states are using

delivery system levers such as contracting, payment, and quality performance strategies to advance health equity goals and address disparities in care and outcomes. The chapter describes how states are leveraging their MCO contracts to embed health equity and reduce disparities among Medicaid beneficiaries, such as requiring MCOs to have their own equity plans and requiring MCOs to address the social determinants of health.

The chapter provides an overview of the way some states are beginning to use payment policy to incentivize improved MCO performance and hold them accountable for improving disparities and advancing health equity. These strategies include alternative payment models, capitation withholds to incentivize reduction in racial disparities, and value-based payment arrangements that require MCOs to set performance targets for reducing disparities.

We acknowledge efforts must be taken to ensure these strategies do not perpetuate inequities. The chapter discusses how states are building health equity into managed care quality strategies and their expectations for MCOs. These include state quality strategies, external quality review, quality measurement, MCO quality assessment

and improvement projects, and accreditation.

Finally, we address culturally competent workforce. We understand that a workforce that is representative of the beneficiaries they serve and that provides care with cultural competence, regardless of identity, can drive improvements in equity for Medicaid beneficiaries. The chapter details the importance of culturally congruent care for Medicaid beneficiaries and the challenges to achieving this. The chapter also touches on how states are using a non-clinical workforce, such as community health works, peer support specialists, and doulas to connect beneficiaries to services and advocate for their needs in a culturally competent way. Finally, the chapter discusses how states have implemented modest programs using Medicaid policy levers.

Commissioners, as we look toward next steps on MACPAC's health equity work, staff welcome any thoughts on the chapter. We will take this feedback and incorporate it into the final draft of the chapter.

Thank you, and I'll turn it back to you all for discussion.

VICE CHAIR DAVIS: Thank you, Audrey. This was a

very comprehensive chapter summarizing a lot of work, and I really appreciated how you were able to pull in the federal, the state, and the challenge of balancing all of that but still keeping the beneficiary as the center and the focus.

So I will open it up to comments, if there's anything that folks want to highlight or additionally elevate in the work.

Laura.

COMMISSIONER HERRERA SCOTT: So it's more of a question. I thought the chapter was outstanding, but thinking about the cultural-competent workforce, is there any way to braid funding for graduate medical education and thinking about culturally competency at training that then translates into the ultimate workforce that serve Medicaid beneficiaries? Can we bring in other sources of funding from the federal government to tie this in?

VICE CHAIR DAVIS: I think that's a great point. Any comments on that, or, Audrey, any response there?

MS. NUAMAH: Yeah. We looked at that a little bit to see what some states are doing. I think one of the challenging parts is how the state Medicaid program can

fund graduate medical education or even doing other activities, such as loan forgiveness. Some states are going at it in creative ways but not many. So we will take a look to see if there's something more we can talk about in terms of braiding or doing this training, but it seems that most cultural competency training happens afterwards. But you're right that we should get them earlier.

COMMISSIONER HERRERA SCOTT: Even thinking the spots that CMS funds.

COMMISSIONER CERISE: TO this point, I mean, I think it's a great point, and I know Medicaid does support some of that work but does not tie the funding of that to a particular outcome. And I think you'd want to try to get some commitment from those GME slots that you support to then practice in a particular area or with a particular population, and that's the part that doesn't follow with the GME funding today.

VICE CHAIR DAVIS: Thank you, Laura.

Tricia?

COMMISSIONER BROOKS: So one comment and one question. The comment is that you have some language on page 2, the last paragraph, that explains why we're

focusing on race and ethnicity in this particular chapter. I think if you pulled that to the front that that would be helpful because the lead-in, you know, you go, "Wait a minute. This is about race, or is this about health equity?" So I think it would just help explain why there's the focus there.

But I'm confused a little bit, in particular, about Table 6.1 and how we've clustered race and ethnicity together to come up with the notion that 70 percent of beneficiaries are of color because Hispanics can be White. Typically, when we've looked at race and ethnicity, it's been done separately. I know that analysis that we've done on kids is that still 57 percent of kids in Medicaid are White. So I'm a little confused about how we approached those data because the numbers were really different than I've seen in other cuts of the data.

MS. NUAMAH: Thank you. I appreciate the point about bringing why we're focusing on race and ethnicity up. I totally hear that.

And then about this table, this is what Tricia is referring to here. I pulled it in a different way here from what is in the draft chapter, so you could see a

little bit more of the breakdown of the difference between the overall total U.S. population versus Medicaid and CHIP beneficiaries.

But to your point, Tricia, about why we decided to loop the race and ethnicity together versus having it more broken out is that this is just pulled form some of our MACStats analysis that we pulled from the NHIS data, and I was just trying to show the overall people of color in this group. But I hear you that putting ethnicity with race makes it a little bit more confusing. So we could think of ways to better show this data without overstating.

VICE CHAIR DAVIS: Thank you.

Heidi, and then, Dennis, I've got you in line.

COMMISSIONER ALLEN: So I thought this was really wonderful, and there's so much here.

I feel a little weird that we're focusing on ethnicity and there's not much about language access. There's a couple of parts of sentences where it's mentioned, like the language concordance or availability of interpretive services, but since the Latinx or Hispanic population is so great, it seems like really bring out how important language access and interpretation services are

would be nice.

MS. NUAMAH: Great. Yes. That's something that we can definitely add, and we are exploring a project on limited English proficiency. We can also mention that in the chapter that more is to come.

VICE CHAIR DAVIS: Thank you, Heidi.

Dennis?

COMMISSIONER HEAPHY: Thanks. This was a really good chapter. I think more is actually needed, and so I guess I was hoping that maybe you might explicitly state or include the six questions from CMS on disability status to better understand the intersection of race and disability in this chapter, if that would be possible, because I think it's really important to understand that intersection.

And then at the end where it says next steps, to me, I think it's really important that there actually be chapters on disability, sexual orientation, and the other categories, age, et cetera, but, again, in doing that to cross-cut it with race, because I think this chapter looks great. There's such a broad overview that we really need a chapter that talks explicitly about that intersection of race and other identities so people really understand the

impact of racism and other social determinants of health.

MS. NUAMAH: Thank you.

VICE CHAIR DAVIS: Thank you, Dennis.

Any other comments?

Yeah, Fred.

COMMISSIONER CERISE: I'm struggling with this one because it's Medicaid and it's not Medicaid.

You make the point that you still have a large chunk of the population in non-expansion states, and when you look at inequities, so much still exists there. And it's a difficult issue. Obviously, for Medicaid, these are state decisions, but if you want to make an impact, there are huge populations that remain uninsured, and are there ways that CMS or other agencies like CMMI can work with states and some of those major provider systems in there.

I can tell you in Texas, there are about six systems that do a third of the uncompensated care in Texas. That's a lot of uncompensated care. Our place alone, we deliver more babies than 10 individual states in one system, and we made the unilateral decision to cover those moms for a year after childbirth within one system. So you can make an impact, but it's a tough -- I realize how

difficult that is because CMS works with states, not providers.

But through agencies like CMMI -- and we can talk some about this at another time perhaps, but are there populations that get left out? I'll tell you, there's one, the dialysis population, emergency dialysis. Different states handle that differently. Some states cover that outpatient dialysis as an emergency service. In those states, that makes a huge impact, and states that don't do that, you've got large populations that get intermittent dialysis through the emergency rooms because outpatient dialysis is not covered in that way.

The number needed to treat to prevent one death in that population is 17--17. You're hard-pressed to find an intervention with an NNT like that.

So I don't know. Again, I struggle to bring it up because I know it's an uninsured issue and not a Medicaid issue, but it's a huge area for opportunity. I don't know if there's thinking among states, some states that have programs like coverage of emergency dialysis through outpatient, where other states don't, where we can point to those potential programs or interventions, to

target, to put some targeted effort in those states that are not expansion states, because the people in those states generally want to be expansion states, and you've got a lot of uninsured people who are going without services.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. I was going to say maybe the way to deal with this in this chapter is to talk a little bit more about the limitations of Medicaid generally as a health insurance coverage program. I mean, it does things that other payers don't do, but it is a coverage program, and maybe sort of building out that point. In addition, states have made policy choices, that there's work that's not being done or tackled that would also be promoting equity. I think it's problematic for CMS in the sense that their primary goal, I would say, for this administration is to get everybody a baseline of coverage. But I think we could raise it in that context about the limitations of Medicaid.

VICE CHAIR DAVIS: Thank you, Fred.

Other comments?

Toby.

COMMISSIONER DOUGLAS: I'm not sure how to weave

it in, maybe into the next steps, but the point about state leadership, Audrey, that you lay out really well, gets to just how are we going to assess. If so, much of this starts with a state and the leadership and then building it into contractual, how they are building out their teams, the training, but that gets to resources as well as what's the role of CMS in laying out, requiring that balance. Is this just going to be a state-by-state? Is this part of the overall framework of Medicaid? And then how do those resources get embedded for state leadership and down to the staff to execute on whatever the plan is? So I don't know if there will be ongoing assessment of looking at capacity and needs within that area.

VICE CHAIR DAVIS: All right. Thank you.

Just closing comments as we wrap this up -- and I think it speaks to the strength of the chapter -- I do want to highlight, again, back to what Fred brought up on there's only so much Medicaid can do if that person is not a part of Medicaid and doesn't have insurance. The inequities that exist by having coverage and not having coverage and I think pulling that out a little bit more. I think in our future kind of analyses and as we bring health

equity into all that we do, getting really specific into the programs, into the measures that we want to look at beyond just, you know, health equity is more than just social determinants of health. That's a big part of it.

I don't know that we think of access to dialysis as a social determinant of health. You know, it is and it isn't, but whether that's available in the state has a big impact on the racial disparity that exists and kidney disease. So how we think about bringing in health equity into everything that we do when we're thinking about access monitoring, when we're thinking about vaccines, when we're thinking about redeterminations, how health equity embeds into our work, and I think the staff and us as a Commission have done a better job more recently in being able to do that and highlight that in our work.

So it's great to have a chapter on health equity. It's even more important to make sure that health equity is weaved into every chapter that we write, and so being very intentional about how we do that.

Tricia?

COMMISSIONER BROOKS: Yeah. Sorry. I meant to make this comment earlier. I was in the Core Set annual

review workgroup the past two days, and there were proposed drivers of health measures that were under consideration, although they didn't meet the minimum requirements.

But one thing that became apparent when we had a conversation -- Dan Tsai was there, and then there were a lot of public comments on drivers of health. There's actually some recent research that suggests instead of calling it "social determinants of health," that "drivers of health" resonates more with people, that these drivers drive health in one direction or another, but they don't necessarily determine health. And "social" is limiting. We know that there are economic factors, other factors that imply.

So I just wanted to put that out there on the record. I really like that concept of referring to “social determinants of health” as “drivers of health”, and I think it might help us overcome some of the resistance to doing SDOH, so thank you.

VICE CHAIR DAVIS: Thank you, Tricia.

Martha?

COMMISSIONER CARTER: I agree with you, Tricia, also because I've seen some of that work as well.

I'd like to see us really highlight the intersectionalities. There's a little paragraph on rural, on how communities of color in rural areas do so much worse -- and disability, and I think there are other areas that we could really focus on as special work.

VICE CHAIR DAVIS: Thank you, Martha.

Audrey, any other questions, or do you have what you need from the Commissioners?

MS. NUAMAH: Thank you all so much.

VICE CHAIR DAVIS: Thank you. Thank you for this work.

Great. I will turn it back to Melanie.

CHAIR BELLA: Thank you, Audrey.

We are going to now take public comment on this session or the two access monitoring sessions that we had to start our meeting.

So I assume this works the same way as before. The folks who would like to make a comment, please use your hand icon, and I'll remind you to please introduce yourself and who you are representing. We ask that you keep your comments to three minutes or less, please.

We will see if we have any takers. I know you're

all anxiously awaiting. I don't see any hands yet.

All right. We do have a hand.

PUBLIC COMMENT

* MS. HUGHES: All right. Mandar, you can go ahead and unmute yourself and make your comment.

MR. JADHAV: Hi. Good morning. Thanks for letting me ask a question.

I was looking at some of the data-related recommendations that you all are considering, and what I was wondering is, in terms of making that data accessible to researchers, if there is a cost component that you would like to comment on as a Commission.

CHAIR BELLA: Can you introduce the organization you represent, please, just so we have some context?

MR. JADHAV: Oh, sorry. Yes. I represent most directly right now the Office of Senator Bill Cassidy, but we're not taking the political position on this. It's just a technical question.

CHAIR BELLA: Okay. Well, we appreciate you joining us. Thank you.

If this is a long technical answer, Anne, we can offer to follow up offline.

EXECUTIVE DIRECTOR SCHWARTZ: Well, I'm not actually totally sure what the question is. Is the question whether in the recommendation, in the text of the chapter, we talk about the cost of making the access monitoring results available to researchers and at what cost? Is that the question?

MR. JADHAV: Yes, because I have been thinking about all of the discussion today on equity and also thinking from the perspective of researchers who may lack resources to analyze the data that CMS pulls together, so just thinking from that perspective if there is a value on making the data cost-accessible to certain researchers who may benefit from it.

EXECUTIVE DIRECTOR SCHWARTZ: We do talk a little bit in the text of the chapter about that.

CHAIR BELLA: Okay. Thank you for the comment. As you know, you're always welcome to follow up with the MACPAC staff on anything in particular.

Are there other folks who would like to make a comment? Okay. Can we open up one of the lines, please?

MS. HUGHES: Monica, you've been unmuted. So you can make your comment.

MS. TREVINO: Hi, everyone. I apologize for the background noise. I just want to make sure you can hear me.

CHAIR BELLA: Yes.

MS. TREVINO: Okay. I just wanted to make a comment.

CHAIR BELLA: I'm sorry. Monica, can you introduce yourself and the organization you represent, please?

MS. TREVINO: Oh, sure. Of course. My name is Monica Trevino. I'm the director of the Center for Social Enterprise at the Michigan Public Health Institute. We partner with the Department of Health and Human Services in a number of program support roles, including Medicaid.

Michigan has been tracking Medicaid quality by race and ethnicity for about 10 years, and the way Michigan and other states break down the racial and ethnic categories is actually how you've got them broken down here. So I just wanted to draw your attention to how there is existing reporting in Medicaid for quality by race and ethnicity already.

And I appreciate the way you've laid the

categories out here, and if you're considering changes to that presentation, just try to be informative about how state agencies are currently reporting data that they have by race and ethnicity, and try to align those or at least recognize that there are different ways to categorize those.

Thank you.

CHAIR BELLA: Thank you, Monica, and we actually didn't hear any background nose. But thank you for the comment.

May we have another commenter, please?

MS. HUGHES: Maria-Cecilia, you've been unmuted.

MS. COLOMA: Hello, everybody. My name is Maria-Cecilia Coloma. I work for iRhythm Technologies. It's on the provider side regarding technologies particularly in the EKG monitoring, long-term care -- long-term cardiac monitoring.

My question is whether in the -- whether is there any way to include access to technology for Medicaid patients in that race and ethnicity lens. So, particularly, as we go into, you know, beyond telehealth, I'm looking specifically at there may be, you know, a lot

of high-quality technology that's not available to Medicaid patients due to reimbursement issues. We all know that they're lacking behind that. So is there any way to include that type of information where we see technology and how accessible it is to Medicaid patients?

CHAIR BELLA: Thank you for that comment. It is something that we can certainly take into account, and we appreciate your raising it.

Okay. It looks like that might be it for public comments on these sessions. So we are going to take a break for lunch. We will convene, reconvene at 1:15 for our session on vaccine. So I would encourage you all to please rejoin us at that time. Thank you very much.

* [Whereupon, at 11:14 a.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION

[1:15 p.m.]

CHAIR BELLA: So a quick reminder for everyone to please make sure you're logged back in.

[Pause.]

CHAIR BELLA: Okay. Can everyone please take their seat? Okay. Ready to go? All right. We are ready to roll. We welcome Kisha. I'll turn it over to you.

VICE CHAIR DAVIS: All right. Thank you, Melanie. Thanks, and welcome to everybody back from lunch for our session on vaccines. We welcome Amy and Chris to give us the overview.

ACTING TO IMPROVE VACCINE ACCESS FOR ADULTS ENROLLED IN MEDICAID: REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR JUNE REPORT

* MS. ZETTLE: Thank you, Kisha, and good afternoon, Commissioners.

So today we're bringing to a close this year's work on vaccine access and coverage for adults enrolled in Medicaid.

As you all know, we started this work back in 2020 at the start of the pandemic, and since that time, we

have reviewed the available literature, estimated vaccination rates for recommended vaccines, and we've interviewed states, stakeholders, and experts to better understand why adults enrolled in Medicaid have lower vaccination rates than those with private insurance coverage and how policy changes could improve access and increase vaccine uptake for Medicaid enrollees.

Today we'll start with a brief overview of our draft chapter for June, and we're going to spend the majority of our time discussing five draft recommendations, their rationale, and their implications, and then we'll discuss next steps.

The March report to Congress really laid the foundation for this upcoming June report. The March chapter described the important role that vaccines play in promoting public health, preventing the spread of illness, preventing hospitalizations, and reducing death, and it described how Medicaid has a more limited coverage policy for recommended vaccines than the private health insurance market.

The report detailed vaccination rates and showed that Medicaid enrollees have lower vaccination rates for

nearly all recommended vaccines.

In this chapter, the Commission also stated that mandatory coverage of recommended vaccines is necessary to ensure access for Medicaid enrolled adults. Now, this June chapter, which you all have in your briefing materials, further describes the barriers to vaccine access for Medicaid enrollees. The chapter focuses on four major barriers.

First, the most fundamental barrier is that vaccine coverage is only guaranteed for some adults enrolled in Medicaid, which creates limited and unequal coverage within the Medicaid program.

Second, inadequate provider payment for vaccines can create access barriers for beneficiaries. If providers' costs are not being covered to purchase, store, and administer vaccines, providers may choose to simply not offer vaccines to patients, and access will be limited.

Third, limited provider networks can be a particular barrier for adults who are less likely to have a medical home and are more likely to receive care from specialists or emergency rooms.

And, lastly, the experts that we spoke with had a

strong concern about vaccine hesitancy, which seems to be growing. Limited beneficiary support and education may be hindering vaccine uptake.

The report chapter concludes with the Commissioners' recommendations, their rationales and implications, and it lastly discussed the next steps. And the chapter notes that we will be monitoring the situation, and specifically, we will watch concerns that over the course of the pandemic, routine vaccinations have decreased among adults and children.

So you all have seen this table before. We shared it last month, and it summarizes the five draft recommendations and shows how each recommendation attempts to address specific barriers to access. The majority of the conversation during last month's presentation focused around Recommendations 1 and 2 regarding the mandatory vaccine benefit and provider payment. There seemed to be general support, however, for the remaining three recommendations which focused on broadening provider networks, improving beneficiary support and education, and improving immunization information systems.

So we'll start with the first recommendation,

which aims to improve Medicaid coverage of vaccines for adults. It reads that "Congress should amend Section 1902(a)(10)(A) of the Social Security Act to make coverage of vaccines recommended by the Advisory Committee on Immunization Practices a mandatory benefit and amend Sections 1916 and 1916A to eliminate cost sharing on vaccines and their administration."

So, currently, not all Medicaid beneficiaries have coverage of recommended vaccines, which creates unequal and limited access.

Vaccine coverage is optional for almost two out of every five Medicaid-enrolled adults. Health equity has been a strong focus of the Commission, as we heard earlier today, and several Commissioners have shared concerns about the health equity issues that this policy creates within Medicaid.

We took a look to further examine this issue, and we found that enrollees with optional coverage do tend to have lower incomes and are more likely to be people of color. This means that for enrollees of color, they are more likely to have limited coverage because of current Medicaid policies.

In addition, these enrollees who have optional coverage of vaccines may be particularly vulnerable to vaccine-preventable diseases, specifically pregnant women and those who qualify for eligibility on the basis of disability.

This recommendation would basically equalize coverage across all Medicaid-enrolled adults and ensure that all beneficiaries within Medicaid would have coverage of vaccines that are recommended for them.

And it would also remove any confusion for beneficiaries and providers who may be uncertain about what vaccines Medicaid covers.

This recommendation would also ensure that all Medicaid beneficiaries have coverage to COVID-19 vaccines and any other future vaccines that are recommended. This is worth noting because currently, mandatory coverage of COVID-19 vaccines are tied to the public health emergency.

So for adults who are not enrolled in the new adult group, coverage of COVID-19 vaccines will become optional about a year following the end of the public health emergency.

So, next, we looked at implications to this first

recommendation. CBO, the Congressional Budget Office, is estimating that this recommendation would cost the federal government between 250- to $750 million in the first year and somewhere between 1- to $5 billion over five years.

We expect that states would see an increase in spending. We don't expect that increase to be substantial since most states do already offer some coverage of vaccines for adults, and almost all cover the vast majority of recommended vaccines.

About half of the states would need to add somewhere between one to three vaccines, and 15 states would be required to remove their cost-sharing requirements.

Under this recommendation, beneficiaries would stand to gain. They would gain coverage of recommended vaccines that are currently not available to them if they are not in the new adult group, and the most common vaccines that are not covered are HPV, Hib, and the singles vaccine.

Under this recommendation, plans would be required to offer coverage, and this would then be reflected in the capitation rates. For providers, this

would remove confusion around Medicaid coverage policies.

So now moving to Recommendation 2, Recommendation 2 aims to improve access by ensuring that provider payments cover provider costs for purchasing and administering vaccines. The recommendation reads "The Centers for Medicare and Medicaid Services should implement payment regulations for vaccines and their administration. Payment for vaccines should be established at actual acquisition cost and a professional fee for administration, similar to the payment requirements established for outpatient prescription drugs under 42 CFR 447.512(b) and 447.518(a)(2)."

Throughout this project, we heard that payment adequacy was a major barrier for vaccinations within Medicaid. Low payment rates may discourage some providers from administering vaccines and, thus, reducing access.

Although states generally have flexibility in setting rates and determining whether these rates are sufficient to access, there have been cases where CMS has implemented payment regulations for certain services, specifically outpatient prescription drugs. So, for outpatient prescription drugs, CMS requires that states pay

based on actual acquisition cost.

Vaccines are similar to prescription drugs in that providers have to purchase the vaccines in order to administer them, and they purchase them from wholesalers or manufacturers and have little or no control over the price that they have to pay.

This recommendation would align payment to providers with a market price so that providers will not be over- or underpaid for vaccines that they purchase.

By ensuring providers are paid adequately to cover their costs, it could increase provider willingness to offer vaccines and in turn, improve access.

Next, we'll look at the implications. CBO did not score this recommendation because this can currently be done under existing law, but we do expect that it would result in an increase in federal and state spending since the literature does suggest that some states do not appear to be covering acquisition cost and administrative cost for providers.

The administrative burden for states may also increase since states would need to conduct surveys to determine actual acquisition cost and administration cost

for providers.

But by improving payment adequacy, more Medicaid-enrolled providers may choose to store and administer vaccines for Medicaid enrollees, and as a result, beneficiaries may have greater access to recommended vaccines.

Similar to the regulations for outpatient drugs, health plans would not be required to use this payment methodology described under the federal rules, and this recommendation would provide greater certainty for providers that their costs to purchase and administer vaccines would be covered.

So now to go over the final three recommendations, I'll turn it over to Chris.

* MR. PARK: Thanks, Amy.

Recommendation 3 deals with expanding provider networks. It reads "The Centers for Medicare & Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in administering adult vaccinations."

Adults are less likely than children to have medical homes and are more likely to access the health care

system in settings other than primary care or physician offices. Vaccine access could be improved by making vaccines available in more settings and from more providers.

While many states allow pharmacies and providers other than physicians to administer vaccines, this is not universal. A recent CDC survey found that 31 state Medicaid programs paid pharmacists to administer vaccines, 29 states paid nurse practitioners, and 4 states paid midwives to administer adult vaccines.

States can use existing authority to expand the types of providers eligible to administer and bill for vaccinations, but federal guidance could encourage additional states to adopt or expand these policies.

The implications will depend on state action and response to this guidance. For states taking action, federal spending could increase, depending on how vaccination rates increase. CBO did not score this recommendation since it can be done under existing authority.

State spending could also increase as vaccinations increase. States could also incur some

administrative burden if they need to submit state plan amendments or enroll new providers into the program.

Beneficiaries' access to vaccinations could improve if new providers begin to administer vaccinations. This recommendation could address racial disparities if the expanded provider network serves a greater share of people of color or underserved geographic areas.

State action could also allow health plans to expand their provider networks, and some providers may be able to expand the scope of their services to include vaccinations.

Recommendation 4 looks to expand beneficiary support and education. It reads "The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort with the Centers for Medicare & Medicaid Services (CMS), the Office of the Assistant Secretary for Health, and the Centers for Disease Control and Prevention to provide guidance and technical assistance to improve vaccine outreach and education to Medicaid and CHIP beneficiaries. Additionally, CMS should release guidance on how to use existing flexibilities and funding under Medicaid and CHIP to improve vaccine uptake."

Increasing beneficiary support and education could help address vaccine hesitancy and low vaccine uptake. Because this messaging could be directed by different federal agencies, the Secretary should coordinate efforts to avoid duplication and identify ways for states to target outreach to Medicaid and CHIP beneficiaries.

Coordinated federal guidance and technical assistance across HHS agencies could help states identify the options that could be used to improve beneficiary education and support and the various federal funding streams that may be available.

Again, since this is guidance, implications will depend on whether or not states take action. CBO did not score this recommendation because it can be done under existing authority, but federal spending could increase, depending on how vaccinations increase.

Guidance could help states identify and tailor vaccination education and outreach programs and help prevent state Medicaid officials from duplicating efforts of other agencies. State spending could increase, particularly if the state increases utilization of ancillary services, such as nonemergency transportation,

but states may be able to offset some of that spending by getting federal match on some activities that were funded by state-only dollars.

Additional outreach and education could result in more beneficiaries receiving recommended vaccines. These efforts could address racial disparities if the state focuses additional resources on barriers that disproportionately affect people of color. States could also partner with plans and providers to better engage beneficiaries.

Recommendation 5 looks to improve immunization information systems. It reads "Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department of Health and Human Services to coordinate efforts across relevant agencies within the Department to release federal guidance and implement standards to improve IIS data collection and interoperability with electronic health records and state Medicaid management information systems (MMIS). The Centers for Medicare and Medicaid Services should also provide guidance on matching rates available and ways to

integrate IIS and MMIS to be eligible for the 90 percent match for the design, development, installation, or enhancement of MMIS and the 75 percent match for the ongoing operation of MMIS."

One of the major challenges with IIS is that they do not capture many adult immunizations. In 2019, only 63 percent of jurisdictions reported actively and routinely capturing adult vaccination data. IIS improvements will be needed for these systems to support vaccination efforts for adults. This includes both financial investments to help states and localities make system changes as well as guidance and standards to improve interoperability across providers and states.

States have implemented different functional standards based on their specific priorities, and many have not achieved functional standardization.

In a recent survey, not all IIS exchanged data with Medicaid programs, and only about 20 percent exchanged data with other states or regions.

IIS support broad public health functions. As such, federal funding for IIS improvements would benefit all payers, not just Medicaid.

Coordinating federal guidance and technical assistance across HHS agencies would help states and localities identify ways to strengthen their IIS and improve interoperability with other state systems and EHRs. Furthermore, CMS could provide guidance and technical assistance to help states understand what types of activities may be eligible for the higher MMIS-related matching rates and ways to make improvements to integrate MMIS in IIS systems.

Federal spending would increase by the amount allocated by Congress. Federal Medicaid spending could increase for some states if they make changes to MMIS and IIS that allow them to access the higher matching rate. This recommendation could help states improve their IIS and take advantage of additional federal funding. It could increase state spending if states need to make system changes but could reduce some state spending if the state can claim the 75 percent match for ongoing maintenance instead of the 50 percent match.

An improved IIS would provide a more complete and accurate record of beneficiaries' immunization history which can facilitate targeted outreach and reminders and

could help ensure that beneficiaries receive recommended vaccines.

Plans could benefit if states make IIS improvements that allow or improve exchange of information with their providers, and IIS improvements would make it easier for providers to identify which vaccines are needed for their patients, to target messaging to their patients, and to enter vaccination records into the IIS.

For next steps, we would appreciate any feedback you have on the draft chapter. As a reminder, you will vote on the recommendations tomorrow morning. So we need you to finalize the recommendations you will bring forward for a vote, and if you have any tweaks to the recommendation language, please let us know so that we can make those changes and have them ready for tomorrow's voting session.

With that, I'll turn it back over to the Commission. I'll leave it here on this slide that shows Recommendations 1 and 2, but if you want to move forward to the other ones, I will advance the slides.

VICE CHAIR DAVIS: Thank you, Chris and Amy.

We have visited vaccines several times throughout

the year, and I think most of the conversation will probably focus on Recommendations 1 and 2, but I did want to open it up if anybody has any comments on the chapter or on Recommendations 3, 4, and 5 before we transition.

Yeah, Martha.

[No response.]

VICE CHAIR DAVIS: The mic.

COMMISSIONER CARTER: Yes. Let me find my notes. Thank you. I got to take a second to turn everything on here.

I had emailed Chris and Amy some questions that I had about language that we might include in the chapter and not in the body of the recommendation but perhaps in the rationale. Can I do that?

Okay. In the first recommendation, we -- well, what I really want to get to is this not talking about cost effectiveness and the CBO cost analysis that was done, and I think they referenced a -- they did a pretty good job in the overview of the chapter talking about how vaccines are cost effective. But I would like to maybe put that again in the rationale for Recommendation 1, I think.

I know you've had time to think about that. Are

you okay with that, and does the rest of the Commission need to weigh in on that?

MS. ZETTLE: So the question would be adding it into the narrative around -- yeah. I think in the rationale, we could pull some of the language from the March chapter where we talk about the literature around cost effectiveness.

COMMISSIONER CARTER: That would be great. Thanks.

Then my second point, I think it goes to Recommendation 3.3. Just somehow putting in the chapter that we urge states to work with the FQHCs to develop a strategy that brings them to some sort of payment adequacy so that they can feel comfortable increasing the vaccines that they administer. It would be currently calculated into their rate, whatever they're doing now, but if they're going to ramp up, for example, and do a big push on adult vaccines, that's not necessarily going to be covered. So, instead of trying to figure that nuance out, because it's very complicated, just urge the states to work with their FQHCs to come to some resolution on payment adequacy.

VICE CHAIR DAVIS: Amy or Chris, any further

question or clarification on that point for 3.3?

MR. PARK: No. We can add a little bit into the narrative surrounding the recommendation on that.

COMMISSIONER CARTER: Thanks.

CHAIR BELLA: Thanks.

Yeah, Fred.

COMMISSIONER CERISE: I had a point just for clarification. In the chapter on page 5, the paragraph that starts at line 8, we're talking about the vast majority of states cover at least one vaccine for influenza in addition to Tdap, MMR. Can you clarify? Is that 48 states covered that first -- those vaccines in that sentence, or they cover one of those?

And then I guess my next question is, of the ones that when you say fewer states cover HPV and zoster, is there any sense from those states that don't cover it, the rationale for that? Did you get into any of that when you looked at states? I mean, is it a cost thing? It is making a statement about HPV and covering kids? Is there any sense to that?

MS. ZETTLE: Yes. So the first question, we can make this a little bit clearer. Those 48 states, we're

saying that they cover -- beneficiaries have access to at least one type of flu vaccine, and in addition to Tdap and MMR, pneumococcal, so basically the core set of vaccines, 48 states cover those.

COMMISSIONER CERISE: Cover that.

MS. ZETTLE: So, really, when you think about what we're talking about here is we're looking at half of the states that maybe don't cover one to three vaccines and making sure that those vaccines would be covered similar to the new adult group.

COMMISSIONER CERISE: Thanks.

MS. ZETTLE: Then to answer your second question, we did talk to a couple states that do not cover all vaccines, and yeah, I think it was a cost issue in one state and working with managed care plans to provide coverage of most vaccines. So, yeah, I would say cost is the consideration there.

MR. PARK: Yeah. I think cost is a consideration, but for some of these, like the HPV vaccine, a large portion of the population who would get it are children, and it would be covered in the VFC program. So I think that might come into consideration there, and that

might be something for shingles as well, like 50 and older. It's only a small portion of their adult population.

VICE CHAIR DAVIS: Thank you.

Yes, Toby.

COMMISSIONER DOUGLAS: Clarifying question. On this intersection between the fact that the expansion group has a different benefit because of the ACA, are there other examples of that inconsistency, or is this the one?

MS. ZETTLE: That's a good question. I, off the top of my head, can't think of --

MR. PARK: Yeah. It's hard for us to think about exactly what all the essential health benefits entail and how that might interact.

COMMISSIONER DOUGLAS: I'm just trying to understand if this was one of the few, if this was amiss or --

COMMISSIONER LAMPKIN: Well, isn't it the case that the new adult Medicaid population can operate under an alternative benefit plan, and as long as it includes the essential benefits, it can be a customized coverage package versus traditional Medicaid populations?

COMMISSIONER DOUGLAS: Yeah.

COMMISSIONER LAMPKIN: Not every state operates it that way, but statutorily, they have the option to do an alternative benefit plan.

COMMISSIONER DOUGLAS: But I'm not sure I'm following, though, what you're saying, Stacey, on that. How would that change?

COMMISSIONER LAMPKIN: I just thought that was an example of how the benefit package for the adult -- the new adult population can be customized versus state plan Medicaid traditional benefit package.

COMMISSIONER DOUGLAS: Got it, got it, got it.

COMMISSIONER LAMPKIN: States don't have to operate under an alternative benefit package, but statutorily, they can.

COMMISSIONER DOUGLAS: That's helpful.

VICE CHAIR DAVIS: I think also now kind of focusing in on Recommendations 1 and 2, Recommendation 1 being around mandating coverage and Recommendation 2 around payment regulations around that, and so if folks have comments on this -- we talked about this a lot at our last meeting, and I think we've come to a middle ground but want to continue to refine that today.

So, Fred?

COMMISSIONER CERISE: Can you -- maybe once again, but can you explain the operational complexity of the federally contracted rates and why that becomes difficult and what the advantage that would bring if that were tied to this?

MS. ZETTLE: I can start, and then if you want to jump in.

So, when we first sort of started pursuing this path, we came up with a lot of different policy options that we talked through with all the interviewees that we spoke with and got feedback from you all, and one of those options, it was like you said, just leveraging that CDC-negotiated price, what that would do would potentially, you know, make it more accessible for the provider. So the provider would have a lower payment that they -- or a lower price that they would have to pay for the vaccine, right?

So, when we talked to interviewees, I guess the major feedback that we got is that that would be particularly complex to implement without a certain benefit. So it's easier to address the payment side, so paying the provider the appropriate amount for what they

acquired rather than trying to leverage what CDC negotiated. Again, that's not a fixed price. So down the road, that dynamic could change in the negotiation between the CDC and the manufacturer.

The operational complexities seem to not merit the uncertain benefit was the feedback that we had heard from interviewees and from several folks on the Commission, but, Chris, feel free to add.

MR. PARK: Yeah. And just to jump in there, so currently, that negotiated price is used for the VFC program. The difference is that the federal government controls distribution. So they purchase the vaccines and distribute them to providers. So it's a little bit easier to manage because, you know, one entity is purchasing it and distributing it. If each individual provider is trying to purchase at that price, then there probably needs to be some kind of chargeback system or other way for them because they would probably purchase it from a wholesaler at a market price, but then you would have to do something to get that discount, or it would have to be more like a rebate model where the discount went to the state after they paid the provider at kind of the market price. So

that's where it becomes a little bit more complicated than what currently happens under VFC.

MS. ZETTLE: Chris, I might just add, I think there are -- when we did do interviews, there were a couple states that were considering doing this on their own and have the authority to do it. The way they were sort of able to manage that or negotiate that is because they were trying to pull in the uninsured as well or covered, and so it gave them some ability to --

MR. PARK: Right. Yeah. Rhode Island has a state pool that they purchase all adult vaccines under, even for Medicaid, and so they're using that process and negotiating, basically using the CDC price with manufacturers, but that's statewide.

VICE CHAIR DAVIS: I think it's definitely something worth highlighting in the chapter. Is that something that we haven't tackled with these recommendations of the potential cost implications? And that that, you know, may be on a future agenda.

MR. PARK: Yeah. And, certainly, nothing in this recommendation would prevent the state from trying to negotiate their own discounts with the manufacturer.

VICE CHAIR DAVIS: Thanks.

Others on Recommendations 1 and 2?

COMMISSIONER GORDON: I mean, I'm just reiterating -- and I'll do it briefly -- some of what I had mentioned before. I obviously see a lot of value in vaccinations, see a lot of benefit, but I've been consistent with regards to mandating that a state do something without funding what we're mandating them to do. So I still have concern there on No. 1.

Then No. 2, pricing is typically -- you know, there's an exception I can think of, and it's discussed in the chapter. Typically, price, setting price is at the state level, and this just feels like we're moving -- we'd be taking another step moving away from that which I don't particularly care for.

So those are my two initial comments, but I do have a question for you all as well. Help me think through the acquisition costs. What limits or prevents the market raising basically what the wholesalers sell the vaccines for in that situation?

MR. PARK: I would say similar to other prescription drugs, it's just market pressure. You know,

the acquisition cost would reflect the price to the wholesaler so that it would not only affect Medicaid. It would be commercial payers and Medicare as well.

So I think similar to the way prescription drugs are priced now, you know, it's just the manufacturer's own decisions, and similar to right now even without any pricing mechanisms, there's no limits as to why a manufacture may change their price, either raise it or lower it, besides kind of market dynamics.

COMMISSIONER GORDON: Where there's multiple manufacturers.

MR. PARK: Exactly.

COMMISSIONER GORDON: Thank you.

VICE CHAIR DAVIS: Thank you, Darin.

Stacey.

COMMISSIONER LAMPKIN: Yeah. With respect to Recommendation 1, when we last talked last month, I guess, I was one of the Commissioners who was expressing some discomfort with this recommendation, and I thought about it quite a bit since that meeting, maybe even an inordinately amount since that meeting, and find that I'm still uncomfortable. And so I want to explain that for me, this

is more about principle than content.

It's not that vaccine coverage is not a value. It's not that public health is not important. For me, this is more about maybe similar to what Darin has said too. This is a federal-state partnership where the states have financial skin in the game, and they have decisions to make. We've heard that most of the states have decided to cover these -- or 20-some-odd have covered them all, and then other big chunks of states have decided to cover most of them. So they weighed these same pros that we've talked about here, cost effectiveness, value to the beneficiary, and within the context of their other competing priorities, they've made decisions about what to cover.

So we're looking at this in a silo, focusing exclusively on the value of adult vaccines, and we're saying, yes, there's value here, go, go, go, and yet we're not looking at the other range of priorities and decisions that the states have to make. We're in a silo. If we were to pick up another operational benefit, like adult dental, for example, and dive into that and look at all the benefits of covering dental services for adults -- Kathy can speak more to this than I can, but I think heart

disease and some other things are affected by oral care. And so we'd probably come down on the side of saying, hey, Congress, tell states they need to cover this.

But the idea is that states are weighing these things in the context of very complicated priorities, and they're making decisions. For me, that's why I hesitate as the Commission to come in and say, "Congress, tell states to take this choice and this flexibility and this ability to prioritize away." So that's why I'm still uncomfortable about this.

VICE CHAIR DAVIS: Thank you, Stacey.

Heidi and then Toby.

COMMISSIONER ALLEN: So I'm totally comfortable with this because I feel like our voice should be primarily for the beneficiary, and without these being covered, they are not accessible to the beneficiary.

When we know –they are sensitive to even small amounts of cost sharing, but when you're saying you have to pay for the whole thing, it just seems like an insurmountable barrier, and even though we know that most states are covering many of these, this puts a structure in place. So, when new vaccines come out and new public

health emergencies, that they're immediately available once they're recommended by the body that makes these recommendations.

So I think that that is a safety mechanism that's really, really beneficial, especially because states have to balance a budget, and sometimes they may not know what to do or they may be slow on the draw of getting these things covered.

I also like conceptually find it a little strange that because we inject this, that it's not covered, but if it were a pill, it would be covered. Like, that just seems so weird to me. Medicaid has a principle that they cover effective treatments, and yet because a doctor puts a needle in your arm and you get it through that mechanism, we can say no, you don't need to have it covered. But if you, you know -- I don't know. It just seems to me kind of strange, and that the principle of Medicaid is to provide coverage to benefits that we believe should be essential, which the Affordable Care Act lists this as an essential benefit, and therefore, it's available to some members of Medicaid.

And we don't want to see inequality among the

most vulnerable, and this is a way that we can take an actionable step towards addressing that.

VICE CHAIR DAVIS: Thank you, Heidi.

Toby?

COMMISSIONER DOUGLAS: So I'm still really on the fence trying to assess this, where to land. Stacey and Darin really articulated a lot of one side. I do not like the idea of us continually taking away the controls, policy levers, away from the states, given how challenging. We just don't know in the future, thinking again back to how we would have to think about where we cut expenditures and there are tradeoffs, as much as we want to keep on spending.

Also, a lot of these recommendations are just putting a lot more spending on the states. We don't have any offsets on the table, which I know we have in the past. I know that's not required, but I wish we were doing that.

That being said, the last point Heidi said, fundamentally, Congress took an action with the essential benefits, with the Medicaid expansion. Really, I just find it hard to reconcile that you have in some states Medicaid expansion, TANF populations that are not getting these, and

then a little bit higher income adults are getting them, and to reconcile that. In certain ways, I see this as Congress needing a fix rather than being that the essential benefit should have been for all is one way to look at this rather than it being an optional. Changing something to mandatory gets to the same place.

On Recommendation 2, I know last time, I was very concerned, like Darin. I thought the analysis was well articulated around explaining how this fits into similar to what we do with outpatient drugs. That being said, I still -- you know, this issue of how much more continue to mandate on states and spending is still a concern.

So I know we're not taking recommendations today. So I'm still on the fence.

VICE CHAIR DAVIS: You still have the night to ponder.

We'll go to Melanie and then Bob. Go ahead, Bob.

COMMISSIONER DUNCAN: Thank you.

I appreciate my colleagues' comments. I'm like Heidi. I feel like we have a moral obligation to those that we serve, and then to the financial aspect of it, again, I think weighing the cost of what Medicaid spends

when they're not vaccinated from a hospitalization and those costs versus the investment it takes in the prevention of long-term hospitalization, I think you'd see the states balance out on the better end of the cost standpoint.

VICE CHAIR DAVIS: Thank you, Bob.

COMMISSIONER WENO: I want to thank Stacey for mentioning adult dental.

[Laughter.]

COMMISSIONER WENO: You know, both vaccines and oral health are two things that are deemed essential for children that somehow when you become an adult you no longer need to have oral health care, and so for one of those reasons, I'm going to fall on the other side. And I feel like these things are -- both of them are essential. I don't think we're right now in the mode to approve mandatory adult dental, although I'd love to talk about it.

But I do think something that's evidence-based and cost effective should be covered in the Medicaid program, and I just can't not support that.

VICE CHAIR DAVIS: Thank you, Kathy.

We'll go to Martha, then Verlon, then Laura.

COMMISSIONER CARTER: Like I said earlier, I think our responsibility is to state what we think is the right thing to do for the population served.

I also want to bring this down to a more personal level. Talking to clinician friends in Southern West Virginia where we do have expanded Medicaid, to say to this person who is in the expansion population -- in our case, they would have to go to the pharmacy, get their shot, bring it back to the clinic, and get it injected. But, anyhow, so you, you can have this shot, and you, you can't, because you have more money, you're in the expansion population, and you, who make less money, don't get this benefit.

So, of course, it's a huge equity issue, and it's also very frustrating for the clinicians. I mean, they don't know the difference when the patient is standing in front of them.

As we talk about clinician burnout and frustration, I think these kind of equity issues weigh at people, and I've heard my friends talk about that.

VICE CHAIR DAVIS: Thank you, Martha.

Verlon and then Laura.

COMMISSIONER JOHNSON: Yes. I'm not going to repeat what I think I've heard. I'm in support of it. So I will echo those who are in support.

I guess when we first came up with these recommendations and I looked at it, I looked at it as a package, honestly, and I really felt that together, these really worked to move a needle and to get more people vaccinated.

I feel like taking out the first two; we're not going to get as far as we can. The other two, the other ones are primarily guidance. The last one, No. 5, to me will go somewhere, but it won't move far enough. I really feel like making sure that we have this mandatory will really move that needle a little bit better as well as looking at the payment. So I'm very much in support of it.

VICE CHAIR DAVIS: Thanks, Verlon.

Laura?

COMMISSIONER HERRERA SCOTT: Just to piggyback on everyone else's -- or at least those that recommend vaccination, you know, just as a reminder, these are infectious diseases, certainly HPV, and then I also want to remind everyone about cancer prevention.

So there's been a significant reduction in cervical cancer just with HPV vaccination. I think it's upwards of 40 percent, but don't quote me on that number.

I can't imagine anyone who if they thought they could prevent a case of cancer that would say on to something, and so to your point around, the cost savings or cost avoidance by having these evidence-based vaccinations, for me, it's something that we would want to support.

VICE CHAIR DAVIS: Thank you, Laura.

Melanie?

CHAIR BELLA: Yeah. I'll just say I think a couple things. One is people who are not supporting this recommendation, I think we have to realize does not mean they do not support the value of vaccines, and people who are supporting the recommendation, it doesn't mean that we don't also feel very troubled about saying, "States, go do this." So both of those things can be true, and I think both of those things are true, despite which side you fall down.

If we are thinking about if we are charged with ensuring access, we are charged with making sure we're looking at things that provide value to beneficiaries,

potential cost reduction, harm reduction, all of those things, this checks that box.

I understand there are other things that could check that box, but Congress actually checked this box for a group of higher-income Medicaid folks. So it's also a way to sort of put in front of them, should they choose to take it, an opportunity to remedy that.

I do want to comment that we understand that people -- the very legitimate concerns. When I sat in the Medicaid director seat, I'm sure I wouldn't have wanted to have another thing added to my budget. So we can both -- I think it's important that we all understand that we all care about not passing on unfunded mandates to states, and we call care about vaccines and people's public health. And we also can have a vote where every person doesn't vote yes.

So this is a healthy part of our process, and I just don't want anyone to feel like this is not how this should be unfolding.

VICE CHAIR DAVIS: Thank you for that, Melanie. I think that's a great way to wrap up. To recognize --

COMMISSIONER HEAPHY: Excuse me.

VICE CHAIR DAVIS: Oh. Go ahead, Dennis.

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

I think, again, to the equity perspective, that if African Americans are 40 percent more likely to have asthma than White folks and 24 percent of folks hospitalized for flu in 2020 had asthma, then we need to look at this from a race and equity perspective as well, and I think some folks have said that. But for me, this is really a way of making a statement about that as well.

VICE CHAIR DAVIS: Thank you, Dennis, for highlighting that.

I think as wrap up this session and have a healthy debate, which I think is good for the Commission to really wrestle with this and understanding where each of us brings our own perspective from the seat in which we sit and being able to understand the relative perspectives of the different Commissioners and really appreciate that we can bring this to this table in a respectful way.

Amy and Chris, any other questions, comments, or further clarifications that you need from the Commissioners?

MS. ZETTLE: No. This was helpful. Thank you.

MR. PARK: Yeah.

VICE CHAIR DAVIS: Thank you, everyone.

CHAIR BELLA: All right. Moving right along, thank you, Chris and Amy. Thank you, Kisha.

We are heading into -- Rob is joining us, and we're going to talk about directed payments and our recommendations for the June report. Welcome.

OVERSIGHT OF MANAGED CARE DIRECT PAYMENTS: REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR JUNE REPORT

* MR. NELB: Yes. Thanks so much. Great to see all in person.

So I'm going to present our work, our draft chapter on directed payments and managed care and talk about some of our proposed recommendations.

Since we talked about this at last month's meeting, I'm going to mostly focus my remarks today on some of the changes that we made in response to some of your comments.

The chapter itself begins with some background about directed payments and then talks about some of our findings about how they're currently used by states and how

they're currently overseen by CMS.

Then the chapter walks through five proposed recommendations and related to improving the transparency and oversight of these payments.

Finally, the chapter concludes with a discussion about potential considerations for setting an upper limit on directed payments. We're not recommending any change in this policy at this time, but we highlight some of the additional data and information that would be needed to help inform future discussion of this issue.

So, first, some background. As we've discussed at previous meetings, directed payments are a new option for states that was created in the 2016 Medicaid managed care rule. In the chapter, we provide some more of the regulatory history, noting that in 2016, CMS also phased out the use of pass-through payments, which states were previously using to indirectly increase payments to providers.

We also talk about CMS's stated intent in creating this new option, which was to help advance quality and access goals, and we talk a little bit more about some of the ways states are using directed payments to help

achieve those objectives.

We then discuss our findings about how the use and spending on directed payments has grown rapidly in recent years, from 65 unique arrangements in August of 2018 to more than 200 when we looked at it as of December 2020.

We don't have great spending information on directed payments, but for about half of approved arrangements, we found that projected spending was more than $25 billion, which for context is larger than DSH or UPL supplemental payments.

And moreover, because there's currently no limit on directed payment amounts, we do expect spending on directed payments to grow in the future.

So, in our review, we categorized directed payments based on the categories that CMS currently uses in its application form, and we found that the vast majority of the number of directed payments adjust base rates by establishing a minimum fee schedule typically tied to the state plan rate. However, most directed payment spending is attributed to what are called "uniform rate increases."

At our last meeting, Commissioners discussed the fact that some of these categories used by CMS don't quite

capture the full range of different types of payments, and there are some of these payments we've identified that sort of don't fit neatly into some of those categories.

So, in the chapter, we tried to provide some more descriptive information about the small subset of arrangements that appear to make very large additional payments to providers, focusing on the ones that increase payments by more than $100 million a year.

Here, we found that this subset of just 35 arrangements accounted for over 90 percent of projected directed payment spending.

Most of these are in the category of uniform rate increases, but it's important to note that they're a lot different from other types of rate increases that we see that are making incremental adjustments to base rates that providers pay.

We also saw some that were value-based, classified as a value-based payment arrangement and typically making a large pay-for-performance incentive, similar to a DSRIP incentive under 1115 demonstration. Again, these types of value-based payments are a bit different from other ones such as ones promoting shared

savings or other alternative payment models that are again making adjustments to sort of the base rate that providers are paid.

Finally, again, looking at the subject of the very large directed payments, we found that most were targeted to hospitals or hospital systems, and they're financed by hospitals through IGTs or provider taxes. Then we found that most were paying hospitals above the Medicare rate, which is what the limit is for payments in fee-for-service.

To provide some more specific examples, the chapter highlights some examples that we identified in our interviews about how states are using directed payments to achieve various goals.

Again, the vast majority of directed payments are focused on adjusting base rates. Some examples we found at our interview include Florida requiring MCOs to pay nursing facilities no less than the fee-for-service rate, and in Massachusetts, they made some temporary increases to HCBS providers during the COVID pandemic, about like a 10 percent rate increase.

However, during our interviews, we also

identified this other set of directed payments that appeared to make increases in payments to providers that are more similar to supplemental payments and fee-for-service.

Some of these, when we talked to states, we learned that they were preserving prior payments that the state was making. So, in Utah, they have a large directed payment that preserves a prior pass-through payment to hospitals. In California, we learned about how they've been transitioning their DSRIP program from their 1115 demonstration into a directed payment when the DSRIP program expired in 2019.

In our review, we also identified some states that are using this new option to make new additional payments to providers. For example, Florida recently approved to make $1.8 billion in new payments to hospitals, which for context is larger than the state's DSH allotment and larger than the uncompensated care pool that's authorized under the state's Section 1115 demonstration. Another example we found was in Ohio making new payments to hospital-based physicians, and a portion of the payment, about 10 percent, was tied to achievement of quality goals.

So, of course, in Medicaid, each state is unique, and there's a variety of state-specific factors that play in each of these examples, but the hope is that by highlighting some more specific examples, it can give a flavor for all the different ways states are using directed payments.

So, finally, looking at directed payment oversight, the draft chapter discusses some of the steps that are involved with CMS's review of directed payment applications, which are known as pre-prints, the process for incorporating directed payments into capitation rates, and finally, the process for assessing whether directed payments are achieving their objectives.

CMS did recently make some revisions to its directed payment pre-print, which was appreciated by many of the stakeholders that we spoke with. However, there's still no written guidance about who's responsible for reviewing directed payment amounts or information about written guidance about how states should evaluate their programs.

Based on these findings, we identified several recommendations that could be an important first step to

improving transparency and oversight of these payments.

The first recommendation focuses on improving the transparency of the data that CMS already collects. I won't read the full recommendation text, since it's the same as what we discussed last month.

Overall, the rationale for this recommendation is based on the fact that directed payments are such a large and growing portion of Medicaid spending. CMS already makes approval documents for other types of arrangements available on its website, and so it doesn't seem like it would be that much of a lift to make these directed payment approvals available as well.

In the recommendation, we highlight the importance of information about managed care rate certifications because they help to complement the approval documents and provide some more information about the spending amounts under these arrangements.

Finally, evaluation plans and, more importantly, the results are obviously important for understand whether directed payments are achieving their objectives.

The second recommendation would require CMS to collect new provider-level data on directed payment amounts

in a standard format that enables analysis. We didn't make any changes to the recommendation text, but based on Commissioner feedback at the last meeting, we did add some additional discussion about some of the design considerations for how CMS could do this in a way that reduces administrative burden for all involved.

Overall, this recommendation builds off of the Commission's prior recommendations for more transparency about all the payments that providers receive, especially supplemental payments.

States currently report provider-level data on DSH, and they've just begun reporting provider-level data on UPL payments, but we don't have comparable information on directed payments which, as I mentioned, now appear to be larger than DSH or UPL.

In order to reduce the administrative burden on states and providers, the chapter discusses the fact that T-MSIS could potentially be used to help track especially many of the smaller directed payments that make small adjustments to base payment rates.

In our preliminary review of T-MSIS, it seems like most states are reporting some sort of base payments,

but it doesn't appear that some of those larger sort of lump-sum payments are currently being reported, and so for that subset of arrangements, it may be better for CMS to collect that information through a separate process, perhaps similar to what it's doing now on the UPL front.

So our third recommendation relates to clarity of directed payment goals and calls for the Secretary of HHS to require states to quantify how directed payment amounts compare to prior supplemental payments and to clarify whether these payments are necessary for health plans to meet network adequacy requirements or other existing access standards.

The rationale for this recommendation is really based on our finding that that link between directed payments and access goals is often unclear, and that there's sort of this wide variation in different types of directed payments, and so more understanding about the goals will help us understand what they're being used for.

Currently, managed care rates are required to be sufficient to ensure access, but it isn't always clear when we looked at the approval documents to know kind of what additional improvements in access states are buying when

they are using directed payments to make large additional payments to providers on top of rates that were previously certified as actuarially sound.

In the rationale, we discussed how states and CMS can use external benchmarks to help clarify the payment goals. One piece of information that would be helpful that CMS doesn't currently collect is information on how the directed payment compares to prior supplemental payments or pass-through payments that it might be replacing.

Another benchmark that could be used is comparing payment rates to Medicare or another benchmark, which we discussed about at the last meeting.

CMS's revised pre-print does actually include some questions related to this so we didn't call it out specifically in the recommendation text, but obviously, it's another benchmark that could be used to understand the effects of the directed payment.

Finally, the rationale for this recommendation concludes just by noting some of the benefits of additional clarity about directed payment goals and how it could potentially help inform future policy development, including how directed payments are evaluated and how they

are incorporated into the managed care capitation rates.

Our fourth recommendation relates to improving guidance for evaluation plans. One change from last month is that we changed the text to note that we're particularly interested in stronger evaluations for that subset of directed payments that are substantially increasing provider payment rates above the rates described in the state plan and hope that any administrative burden with additional evaluations would be more commensurate with the level of federal investment involved in these arrangements.

Overall, this recommendation is intended to address some of the concerns with the evaluations that we found in our review, including the fact that many directed payment arrangements didn't have any evaluation results, and that in our review, it was sort of unclear how those evaluations are being used in the review of the directed payments. In some cases, performance was getting worse, but the arrangement was still getting approved without any changes.

Because of data lag involved with calculating baseline measures needed to evaluate performance, the recommendation calls for multi-year evaluations, which

would hopefully be more meaningful than the current annual evaluations.

Finally, as I noted before, the recommendation calls out that subset of directed payment arrangements that are substantially increasing payments as ones that require a more rigorous review.

Last but not least, our fifth recommendation is intended to help clarify roles and responsibilities for all the different stakeholders involved in the review of directed payments and managed care capitation rates.

During our interviews, we heard conflicting views about the extent to which actuaries should be involved in assessing directed payments, and so, hopefully, better guidance would help clarify this.

The recommendation rationale calls out three particular areas where guidance would be most helpful: first, clarifying who, if anyone, is responsible for reviewing those directed payment amounts; second, providing more guidance about whether capitation rates should be sufficient to comply with access standards before or after accounting for directed payments; and finally, clarifying what additional review is needed after CMS approves the

directed payment pre-print.

Finally, the chapter just talks about potential next steps for our work in this area, including potential areas for future work looking at establishing an upper limit on directed payments.

The chapter discusses two potential benchmarks that could be used; first, an external benchmark such as Medicare payment rates, which is currently used for UPL. It also talks about potentially using historic spending, which is what was used to establish DSH allotments.

Also, based on our discussion last month, we added some additional discussion about the potential interaction between limits on spending and managed care interaction with the current limits for spending and managed care authorized under Section 1115 demonstrations or Section 1915(b) waivers.

Finally, the chapter concludes by discussing some additional data that would be needed to help inform these limits. Obviously, implementing our transparency recommendations would help, but we also are hopeful that the new pre-print that CMS is using will at least provide a little more information about directed payment spending at

the state level that we can hopefully use in future analyses.

So that concludes my presentation for today. The current plan is for the Commission to vote on these as a single package tomorrow and for the chapter to be included in the June report.

I welcome any feedback you have about the chapter or about the recommendations. To help guide your discussion today, here is a summary of the five recommendations that I talked about.

Thanks.

CHAIR BELLA: Thank you, Rob.

I don't know if anyone is noticing, but there is a theme of five here. We had five access monitoring and five vaccine. I'm going to say duals and integrated care got the short end of the stick. We did not have five of those for the record.

[Laughter.]

EXECUTIVE DIRECTOR SCHWARTZ: But it's Chapter 5.

CHAIR BELLA: Oh, all right. Well, okay.

Thank you, Rob. Let's talk about the recommendations, and then let's talk about the upper

payment. So who has comments on the recommendations, please?

Bob.

COMMISSIONER DUNCAN: Thank you.

First of all, I'd like to acknowledge I work for a pediatric hospital, and I'd also like to acknowledge the pediatric hospital I work for receives no supplemental payments other than DSH, but I want that to be on record.

First of all, I applaud the work that's been done, particularly around the transparency issue, because I think that's what we have to really get into to understand. The reading provided a lot of great information around some of the examples that we all kind of question, but my caution is not to paint a broad brush that everywhere that this is happening is something negative, and so I think we have to be careful because I think it ties to our other discussion around the actuarial soundness of some of the rate-setting process.

So that would just be my caution is I think we're headed in the right direction, but I think we've got to be careful not to paint a broad brush of all supplemental directed payments are negative.

CHAIR BELLA: Thank you, Bob.

Anything specific on the recommendations?

COMMISSIONER DUNCAN: I'm good.

CHAIR BELLA: Thank you.

Stacey?

COMMISSIONER LAMPKIN: Yeah. Thank you.

Thanks, Rob. Great chapter.

I agree with Bob on kind of the nuance here. I'm in support of all the recommendations as they're worded right now.

I think one of the things that came up at our last discussion here was that nuance and the fact that we have a whole set of directed payments that are pretty transparent, and we can see in T-MSIS, and we have the information that we need, and then yet we have another set where they may or may not be worthwhile expenditures of money. We don't know. We don't know because we don't know enough about them. There is no transparency there.

Taxpayers and policymakers really need to understand what they're getting for their money, and so that's why the push for transparency.

The layout of all of these recommendations make

perfect sense before we move to something more substantive like an upper payment limit. Let's get our arms around what's actually happening and why and what it means first, and that's what these recommendations do.

With respect to the chapter, I just want to say how much I appreciate the "how we got here" part of the chapter. I think that will really help people understand how we've gotten to this point, and that's great nuance.

Oh, one other -- I think for the most part, the way you flowed through the rationales about this kind of directed payment versus that kind of directed payment was very good. The one place where I thought maybe there could be a little bit more nuance drawn is in that very first place. So, when we talk about the growth of directed payments, for example, how many of them existed prior to the 2016 rule and became a directed payment when the rule was published and promulgated? Is that part of the growth? I think the example from the chapter of the Florida nursing facility payments is a good one. That was in place before the rule was published. You know, it's pretty transparent, but it may be captured in that growth of directed payments, so just a little more nuance there if you can figure out

how to get it in that first section.

Thank you.

CHAIR BELLA: Thanks, Stacey.

Fred, then Martha, then Brian.

COMMISSIONER CERISE: I have a couple questions on the recommendation. First off, I support the recommendations. I think it's a great chapter, and as usual, Rob, you explain complex stuff in ways we can understand.

We're going to come back to the last part, so don't leave that alone for now?

CHAIR BELLA: You can go ahead.

COMMISSIONER CERISE: All right. Well, I'll start with the recommendations.

First, I agree with you guys. There's some legitimate things that are happening here with transition of some supplementals that have gone away, but I think what is also clear is that states are relying more and more on financing Medicaid through provider taxes and other forms, whether it's to keep up or to supplant state funds, rely more and more on that, and with that comes less clarity in terms of what policies are we tracking or prioritizing or

principles are we advocating for, and then where's the money coming and going? I do think this is an important topic that needs a lot of attention.

A couple of questions. One, on the provider level data, would you be able to also include in that, Medicaid -- and I would throw in uninsured activity there as well -- for a relative understanding of what's happening there with those payments? That's one.

Let me stop there and let you react to that.

MR. NELB: Sure. So we certainly would -- the recommendation just focuses on the payment data itself, but part of that recommendation says data that will enable analysis. And I think as we think about this, especially with hospitals, it's getting it in a format that we can link to the information that we already have from DSH or cost reports about what's the payer mix, what's the level of uncompensated care and things, without trying to duplicate information that's being collected, but hopefully, it would be in a format that we could look at and sort of look at some of these questions about whether it's begin targeted appropriately.

COMMISSIONER CERISE: How much can you track

prior payments that have been replaced? Some of it may be clear. It may be a DSRIP payment that now is becoming a directed payment, and then are states going to replace other payments like DSH, for instance, as DSH goes down? Are we going to increase directed payments? You can say that's a substitution. How difficult would that be as one of the recommendations to kind of track that?

MR. NELB: Yeah, it's a challenge, and I think we talked about it last month. This probably would be more of a one-time thing when you're making that transition to --

COMMISSIONER CERISE: Right.

MR. NELB: -- at least have a record. I think especially the pass-through payments because there was no data on that before. It's harder to know what is being replaced.

But when we talked to the states during the interviews, it was very clear, and they could kind of trace for us what was happening. So that's, I think, a piece. It's obviously one piece of the puzzle, and I think as you note, there's been -- ultimately, we do really want to understand the totality of payments that providers are receiving, and so, in some cases, yes, there may be these

new supplemental payments. But the states are cutting the base rates. You probably do want to really understand the whole picture.

COMMISSIONER CERISE: My last comment is just around putting limits on things and what you base that on. We've grappled with a benchmark for DSH that's based on history, which every year we say there's no connection to uninsured and Medicaid business. I vote against having that as the benchmark. I think Medicare is probably something more standard you can point to.

CHAIR BELLA: Thank you, Fred.

Martha, then Brian.

COMMISSIONER CARTER: First, I want to say I'm in favor of these recommendations. Transparency, though, sometimes painful, I think is always ultimately good and helpful.

I have a curiosity question that either you know or Stacey knows. FQHCs get paid a prospective payment system rate, and they're either paid the fee-for-service rate and then there's a wraparound that comes later, or they're paid usually by the MCO their full rate. Does that come into this whole picture anywhere?

MR. NELB: You know, when we looked at it, there are very few directed payments that are targeted at FQHCs, but you're right that, in part, the MCOs are required to pay the PPS rate. So states operate that in different ways. I guess it's one thing to think about as the way that these payments sort of interact, but yeah, there's been few directed payments that we've seen that have been targeted to FQHCs, and perhaps that's related to the other rules that exist about the way that they're paid.

COMMISSIONER CARTER: So that wraparound would come from the state level, but do we know about that either? I mean, I'm looking for transparency across the board, really. Where does that all happen?

MR. NELB: I can look into that and follow up with you. Yeah.

COMMISSIONER CARTER: Okay. It may not be part of this conversation.

MR. NELB: It's incorporated in the rates in different ways, but yeah.

COMMISSIONER CARTER: But it's an interesting question: How does all that payment happen? Because it's so different than other providers.

MR. NELB: Yeah. I think those wraparound payments aren't classified as a directed payment here, but it's obviously another type of additional payment that states may make through the MCOs to certain providers.

COMMISSIONER CARTER: Well, thank you.

MR. NELB: Yeah.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: So I just want to say I support all the recommendations, but I also want to talk a little bigger picture in that this being my last meeting, I think one of the greatest accomplishments of MACPAC over my six years has been Rob's work on trying to explain all the different ways the hospitals particularly are financed now, including DSH supplementary payments and direct payments.

It was an area, I don't think anybody had any clue what all these things meant, and it's really been a great contribution, I think, to Medicaid policy.

But, at some point, I mean, you could see all these recommendations are still about better data, more transparency, so we can figure out what's going on, and the more we figure out what's going on, the more kind of ridiculous the whole scheme things.

Rob is very measured in his presentations. He's laughing now, but I see his head nodding, and even Fred says I get 50 percent of my revenues are cash -- are checks. They're not related to any services we provide. At some point, I would like MACPAC in my absence to take up some kind of fixes on the way Medicaid pays hospitals. It's not all bad. It's very different reasons why we do this, but it just seems totally ridiculous to me that Medicaid has ended up with this kind of financing mechanism for hospitals, particularly safety net hospitals.

I think there's some obvious fixes around provider taxes where you tax a provider, you get a federal match, and then you pay the provider back. I mean, we've done other work that just shows how these schemes increase FMAP for states. You might say they're necessary. States have very difficult times raising their share of the revenue, but I think that there is a huge need an opportunity to remedy some of the things that are going on in these financing schemes.

CHAIR BELLA: Any takers on that one?

[Laughter.]

COMMISSIONER DOUGLAS: Well, for the Commission

and since I'm on it too, I do have to say -- and being a former state official, I respect what you're saying, Brian, but I also think we have to remember these are federal rules. They're not -- schemes is a little -- these are all within the federal structure and construct that states are following.

Medicaid is not straightforward, and Medicaid financing is clearly very complicated and has created many different unintended consequences. To unwind that is extremely complicated back to just this federal-state relationship and the financing and the different levers, and we can -- you all -- both you and I will be gone, but the Commission can continue to explore how best to do that without creating other unintended consequences that impact beneficiary access and the stability of really, really important safety net providers.

That being said, I really want to make sure we don't on the record thing of these as anything more than federally allowable payment mechanisms or provider taxes, and that's what they are.

CHAIR BELLA: I'm going to suggest we continue this discussion at dinner, but, Fred, if you have a comment

-- and I'm also going to offer to the three folks who are departing us, you may give us your wish list in the morning of the five things you really wish we could do in your absence, and you can put this on yours, Brian.

Fred, a brief comment on this. Then let's circle back. It sounds like everybody supports the recommendations. Let's see if anybody else wants to say anything about a cap, and then let's close out this session.

COMMISSIONER CERISE: Well, just to make it even more complicated, implicit in here is coverage for the uninsured as well. I mean, it's not stated. It's based on your Medicaid activity, but if it's replacing UC -- and states will use it to replace DSH -- and DSRIP, we've always said, although based on Medicaid, it's got money that ends up subsidizing uninsured. So, as you look at the cap, my plea for just sort of an explanation around what's actually in there is why I sort of throw the uninsured in on the activity side as well because there always has been, you know, uninsured mixed in with some of these Medicaid payments, particularly waiver and DSH, right?

CHAIR BELLA: Darin.

Thank you, Fred.

COMMISSIONER GORDON: Just to your comment before you went back to Fred about the cap, I agree with what Stacey brought up. I think it's hard to have that conversation until we get all this information. So I would stay away from cap until we know more, and I think Toby's point is a good one in understanding unintended consequences. You can start thinking about that, but that's for a later day.

The other thing I do want to point out, sometimes -- and this is a personal thing for me. We talk about lack of transparency, and sometimes I think about because we had to report all those payments to CMS. So it isn't that states are -- there isn't something that they're doing to hide information, and sometimes I think it can come across that way. There's been things in the past where CMS didn't ask for something, it doesn't mean it's not being done or that there's not information out there, or in some of the things that we classify in directed payments are things that go through the public legislative process. That's where the legislature weighs in.

I just think I will just state it and not saying

anyone has got any -- let's understand that it isn't that, you know, there is no transparency. The challenge, I think, we're trying to address is where that's bubbling up in a more uniform way so that it can be looked at easier than it maybe is today, because it does require a great deal of effort.

The other thing I will say, this goes back to an earlier discussion. I was trying to think about it, and I should have just asked you because you would give me the answer. When you end up having the DSH audits, they look at every stream of funding that goes to that hospital from the Medicaid agency in order to ensure it doesn't exceed the limit. I don't know -- I was trying to think in my mind. Are those just in discrete reports, or does CMS get those in some kind of uniform way that they have it rolled up somewhere? Because I would think that would answer a pretty decent amount of the questions that are coming up here.

MR. NELB: Sure. To your first point, we do want to clarify that. I think states are collecting and tracking the provider-level payments for a lot of this, and we found during the interviews, states are willing to share

that with us. But it's one of these things where CMS isn't asking for it or it's not being made at the federal level, which is important for understanding how it all fits together.

In terms of your question about DSH, there is a standard provider-level data just for those hospitals that receive DSH. So we don't have information on the hospitals that don't receive DSH. So that's one issue.

Then the other piece is that DSH information is just for inpatient and outpatient hospital services, and so there is this sort of new category where a lot of hospital systems are getting payment for physicians affiliated with their hospital, and it supports the overall health system. But that type of information is not on a DSH audit.

COMMISSIONER GORDON: That's helpful. Thank you.

CHAIR BELLA: Okay. So, Dennis, let me see if you have comment; otherwise, I'm going to wrap this up and move us to public comment.

COMMISSIONER HEAPHY: Thank you for all the work you did.

I keep looking at the actuarial soundness of the data, and I just think we need a lot more transparency

there but also uniformity and definition of what that actually means.

I appreciate everything you laid out. I don't know if you have any comments on that, Rob.

MR. NELB: Yeah. I think it is certainly a piece, and hopefully, our Recommendations 3 and 5 will help get at that, if just providing more guidance and expectations for what the actuary should be looking at. There's this sort of general statement that the rates need to be sufficient to meet the network adequacy requirements, but implementing that in practice is a challenge. Perhaps more guidance will help clarify what that means.

For example, one question to think about is understand whether the directed payment is needed to meet those network adequacy requirements, and if for some reason, you didn't have the directed payment, would the rate otherwise have to be increased to ensure access? So some of those sorts of questions can hopefully be clarified in future guidance.

CHAIR BELLA: Okay. So it sounds like everyone is in agreement on the recommendations, also in agreement with how you've done the cap, which is let's tee it up and

say it's there, but we need to get more information as we'll be getting through these recommendations.

I'm going to turn now to public comment. If anyone would like to make a comment on the vaccine session or on this session, please use your hand icon. Please remember to introduce yourself and your organization and to limit your comments to three minutes.

It looks like we have some takers.

PUBLIC COMMENT

* MS. HUGHES: Benjamin, you've been unmuted. You can make your comment. Benjamin, you need to click the mute icon yourself.

MR. FINDER: Can you hear me?

CHAIR BELLA: Yes.

MS. HUGHES: Yep.

MR. FINDER: Great. Hi, Commissioners and Commission staff. My name is Ben Finder, and I'm a director for Policy Research and Analysis at the American Hospital Association. On behalf of our nearly 5,000 member hospitals, health systems, and other health care organizations, we appreciate the opportunity to provide public comment here today.

We commend the Commission for taking action to better understand Medicaid payments and how they support program objectives. We appreciate that you understand the complexity of the relationship between base payments, supplemental payments, and Medicaid financing.

For example, in the March report, you noted that base payments are often set below the cost of providing care to Medicaid beneficiaries, and according to our data from the AHA annual survey, Medicaid shortfall was around $25 billion in 2020, and that's after we account for DSH and non-DSH supplemental payments that hospitals receive, including directed payments.

So, in other words, while these supplemental payments are critical to health care system financing, they're still insufficient to cover providers' costs.

We appreciate the robust conversation that the Commissioners engage in around directed payments. In particular, we appreciate that many Commissioners have expressed a more deliberative process that seeks to better understand how states are using these payments and what the policy goals are and how these payment programs achieve their intended goals before considering any regulatory

changes.

For example, Commissioner Duncan expressed the desire not to paint these payments with a broad brush, and I think I heard a lot of agreement consensus today.

At the March meeting, also, Commissioner Gordon framed this analysis as a better way to understand directed payments and appreciate them for the role they play in each state's program.

We also think that Commissioner Duncan's comments capture the same sentiment in emphasizing the importance of a transparency-first approach that reflects the complexity of directed payments and the relatively short existence to date and the relationship to other Medicaid payments and the financing structures that often differ by state.

A few Commissioners, including Commissioners Duncan and Lampkin, also expressed concern about adding new and additional administrative requirements on states and CMS at a time when states are likely to turn their attention to redeterminations as the PHE ends. We appreciate Commissioner Lampkin's comments at previous meetings around balancing the need for transparency with a potential for new and additional administrative

requirements on states, including her suggestions to consider the extent to which T-MSIS and existing resources can be leveraged to increase transparency without new reporting.

So, in closing, the AHA supports the goal of increasing the transparency of prior payments, and in your deliberation regarding today's recommendations as well as future policy approaches, we encourage careful consideration of the complex ways that states are using directed payments to support Medicaid providers as well as support for efforts to ensure continued state flexibility to use these payment mechanisms in ways that align with state program and policy goals.

Thanks very much.

CHAIR BELLA: Thank you for your comments.

MS. HUGHES: Lisa, you have been unmuted by the organizer. So you can unmute your own line.

MS. FOSTER: Good afternoon. My name is Lisa Foster, and I am pleased to offer support for the vaccine chapter that has been presented to the Commission. I'm here on behalf of the Adult Vaccine Access Coalition. We're a coalition of 70 organizational leaders in health

and public health that are committed to addressing the barriers to adult immunization and raising awareness of the importance of adult immunization.

AVAC works towards common legislative and regulatory solutions that will help strengthen and enhance adult immunization across the health care system.

We've appreciated the robust discussion on behalf of the Commissioners here today and appreciate the understanding that immunizations are a highly cost-effective form of providing medicine to help save lives by protecting the health and well-being of individuals, families, and communities nationwide.

We've seen a lot of advancements over the past couple of years in vaccine technology and policy and infrastructure as a result of the COVID-19 pandemic, and we've seen some drastic changes, improvements in the immunization landscape, in particular, around adult populations.

Vaccines have always been one of our greatest public health achievements, but especially during the pandemic where we've seen overlap between those populations who have been vulnerable to the adverse health effects of

COVID-19 as well as other chronic and vaccine-preventable illnesses.

We greatly appreciate the robust discussion that's taken place today and strongly support the set of recommendations that's been put forward for the Commission's consideration.

I just want to highlight a few key points. We really support the fact that the vaccine chapter and the recommendations included in the chapter would help close disparities that have been longstanding in coverage for vaccines under Medicaid across the different populations. As the Commissioners have discussed today, it's unfortunate that today your coverage can drastically vary, depending on what state you live in or even within a state depending on what population group you fall under, under Medicaid.

I think one of the things that we've really seen with the COVID-19 pandemic is the disparate coverage and reimbursement rates have really been challenging for a long time but have been exposed as a result of COVID. There's a lot of disparities across minority population groups, people with disabilities, those living in rural areas, and those that live in extreme poverty. We believe the

recommendations being put forward today would help to significantly address those health equity issues not only for COVID but for all vaccines that are recommended to a person across their life.

Childhood vaccines have long been supported by Medicaid and CHIP as a mandatory benefit, and we believe that vaccines across a life, of course, play an important role in preventing illness and death, reducing caregiving demands and avoiding unnecessary health care spending, as well as improving health equity and setting a foundation for healthy aging.

We really appreciate the opportunity to offer our perspective today. Thank you.

CHAIR BELLA: Thank you for your comments.

MS. HUGHES: Julie, you've been unmuted to make your comment.

MS. KOZMINSKI: Hi. I'm Julie Kozminski, senior policy analyst at America's Essential Hospitals. On behalf of America's Essential Hospitals, I want to thank the Commission for the opportunity to comment and for your work on directed payments.

Medicaid supplemental payments are critical to

essential hospitals and other Medicaid providers. In the absence of adequate Medicaid-based payment rates, states increasingly rely on various types of supplemental payments to support providers and ensure Medicaid beneficiaries access to care.

Directed payments under managed care drive value-based payments and equity objectives, financing payments to certain classes of providers. They are regularly reviewed, all payments, whether rate increases or explicit value-based or performance improvement payments, are expected to advance quality and require to have an evaluation plan, and they have been incorporated into actuarial reviews of MCO rates, which are subject to CMS review.

Regarding the question of whether to establish upper limits on directed payment amounts, America's Essential Hospitals believes that CMS's current policy of payments equal to commercial rates should be maintained.

For too long, Medicaid rates have been well below rates paid for care to patients who have private coverage. Low Medicaid rates have been a significant contributor to disparities in care. Now is not the time for MACPAC or CMS to adopt an explicit policy that prohibits states from

establishing rates equal to those paid for commercially insured patients. After all, the equal access provision of the Medicaid statute requires payment rates to be sufficient to ensure access to care at least to the extent available to the general population.

Prohibiting payment rates that are available to the general population undermine states' attempts to ensure equal access and equitable care to Medicaid patients.

We welcome the opportunity to work with the Commission as you continue to work on directed payments and prepare your recommendations for Congress in the coming months.

Thank you.

CHAIR BELLA: Thank you for your comments.

It looks like we don't have any additional comments at this time.

We do have a technical announcement.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. It turns out that we're having a technical problem where the public can't see the Commissioners speaking, even though they can hear everything. So we're going to ask everybody, public included, to leave the GoToWebinar while we're on break,

and when you come back, restart it, and hopefully, it will be fixed at that point, so thank you.

CHAIR BELLA: We are not making funny faces or doing anything else interesting, but please do try to hang up and come back in, and we'll come back at 3:05 to give people time to take care of that and anything else. We'll come back at 3:05. Kisha will kick us off. So please be back promptly. Thank you.

* [Recess.]

CHAIR BELLA: Okay. Just a reminder to Commissioners to please dial back in because I don't see most of your faces on here.

Actually, no one on this side of the room is compliant. Let's get going, guys.

Okay. We're going to kick back off. We have two sessions left. I know the time is flying. Kisha, turn it to you.

VICE CHAIR DAVIS: All right. We are jumping back into health IT and behavioral health. This is another one that we've spent quite a bit of time on this year, and we'll turn it over to Aaron.

ENCOURAGING HEALTH IT ADOPTION IN BEHAVIORAL

HEALTH: REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR JUNE REPORT

* MR. PERVIN: Thank you.

Good afternoon, Commissioners. Today I will be presenting draft recommendations on encouraging health IT adoption within behavioral health, which as you are probably aware is a culmination of our work on behavioral health, IT, and also integration.

In 2021, in our past report, we documented low IT adoption rates within behavioral health providers and the effects this has on Medicaid beneficiaries and care integration.

In September, you heard from an expert panel on the value of IT and promoting care integration efforts among behavioral health providers. In March and December, you heard policy options.

In our last meeting, Commissioners reviewed our draft recommendations on how Medicaid can finance EHR adoption within behavioral health and how ONC and SAMHSA could improve the quality of behavioral health IT.

This session presents a draft chapter that provides the rationale and evidence base for the

Commission's recommendations. As part of this session, we are expecting you all to provide any feedback on the specific recommendation language, and any changes to the recommendation language will be incorporated in our presentation on Friday.

To start off, this presentation is fairly similar to last presentation we gave in March. We updated a bit of the rationale for the recommendations. Specifically, we added more information on behavioral health and EHR use in integrated primary care settings, but the recommendation language is the same as what was presented last time.

I plan on starting with a brief bit of background reminding us on where we have been. Then I will provide an overview of the chapter before moving on to specific recommendation language and discussing next steps.

As the Commission is aware, Medicaid and behavioral health agencies serve similar populations but are treated by different providers and different care settings using different funding streams, which can cause fragmented care. Because of this, behavioral health treatment is not coordinated or integrated with treatment for physical health conditions.

Furthermore, the Medicaid population itself has higher rates of co-occurring substance use disorders, serious mental illnesses, and chronic conditions compared to their privately insured peers, indicating that integration is integral for this population.

There is also a growing body of evidence that health IT is a key pillar of care integration, but behavioral health providers were left out of previous efforts to incentivize EHR adoption, limiting state progress.

So I am now going to present an outline and summary of the June report to Congress in our draft chapter.

The first section of the chapter outlines the benefits that health IT has on patient quality. Certified IT can foster integration through real-time data sharing, care coordination, and referrals across the continuum of care. One example of how health IT supports care quality is it lowers the likelihood that a patient will receive conflicting treatments and receive medications that have deadly interactions.

As discussed in last year's report, certified

health IT also supports other priorities of interest to the Commission. First, it supports participation in value-based payment arrangements. Without IT capturing, tracking, and reporting different clinical quality measures, VBP programs can often be cost prohibitive for the provider.

Second, it facilitates easier access to state health information exchanges, which is a mechanism that can support data alerts for other members of a patient care team.

Third, certified health IT supports provider data submissions that are necessary to calculate many of the quality measures under the adult and child core set that require behavioral health data. State reporting of the adult and child core set will be mandatory starting in 2024. However, low adoption has limited these benefits to outside of behavioral health.

The chapter then discusses the principal barriers to IT adoption. First, the first major barrier is cost. The second primary barrier is that behavioral health providers often don't know what kind of product to buy, and the Commission has discussed at length the challenges with

segmenting subject use disorder information and how EHRs generally do not have standardized mental health data and clinical tools.

Something we have discussed less but should also be mentioned is that since EHRs may not include behavioral health functions or standardized data structures, this is implications for physicians that work in integrated care settings. Many state agencies encourage behavioral health services to be provided in these care settings. However, primary care practices or community health centers may not have an EHR that adequately supports fully integrated care. Not having a way to store behavioral health data in a standardized format makes it challenging for these providers to share data both within and outside of their practice.

The chapter then provides an overview of CMS guidance on health IT. In our review of CMS guidance, we found multiple mechanisms that states can use to encourage EHRs, but states lack guidance from CMS on how to deploy these authorities appropriately. We discussed previously 1115s. We discussed previously directed payments, and we have also discussed CMMI's SUPPORT Act authority, how they

can be used to support EHR incentives if they are in service of larger quality goals, but that states lack deal on how to do this.

All three of these mechanisms can be used to offset IT costs at the provider level. To incentivize sharing behavioral health data across health information exchanges, MITA offers an enhanced federal match, but guidance has not been updated for this in almost 15 years.

Our findings suggest that while Medicaid can pay for the technology itself, it may not be able to pay for IT trainings and consultants that support vendor selection and also help to incorporate EHRs into provider workflows. Other resources might be necessary here.

The chapter then level-sets on behavioral health IT guidance. The first is that ONC creates voluntary standards for practice setting-specific IT systems that are built on top of certification requirements. A good example of this is within pediatric care, which has similar data segmentation needs.

The second is that SUD consent management systems have been developed by both ONC and SAMHSA, but these consent management systems require further refinements

before they can be brought to scale.

Finally, stakeholders have asked ONC and SAMHSA to provide information that can help standardized data fields that are used in integrated care settings. For example, within many EHRs, there aren't standard data elements for social determinants or a family's behavioral health history. Guidance on this would help with information sharing and interoperability efforts which would further support integration goals.

Now we're going to discuss the two recommendations.

The first recommendation is on guidance to states on using Medicaid authorities for EHR adoption. This is outlined as "The Secretary of HHS should direct CMS, SAMHSA, and ONC to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability."

The rationale for this, again, pretty similar to what was in the last presentation, but it is that states currently have no playbook for incentivizing EHR adoption for providers that were ineligible for incentive payments

under the meaningful use program.

Our findings indicate that there are few authorities that can be used to purchase EHR technology and promote information sharing.

A component of this recommendation also provides detail on how other federal resources might be necessary for EHR training and vendor selection.

Providers typically need assistance around selecting, training, and estimating cost for an EHR product.

Under previous incentive payment programs, this assistance was done through ONC's Community Health IT grants to community health IT assisters, which was known as the Regional Extension Center program.

The implications of this recommendation is as follows for federal spending. CBO did not estimate this. So this recommendation did not estimate this because it would be under current guidance, and so it would not have a direct effect on federal spending. But, depending on how states respond to guidance by providing additional health IT incentive payments or encouraging greater behavioral health use of HIEs and other general connections of state

IT systems, cost to the federal government could be affected, although the extent to which spending would increase or decrease is difficult to predict.

For states, this recommendation would give states the option to advance clinical integration goals through greater uptake of behavioral health IT. Providing guidance to state agencies on these different authorities would help remove technological barriers to clinical integration for patients with behavioral health needs.

For these states, greater behavioral health IT funding would have other positive implications for other uses as well. This includes greater state capacity to collect data related to the adult and child core set and encouraging behavioral health participation in value-based payment programs.

For beneficiaries, to the degree that additional federal guidance supports state's ability to encourage greater use of behavioral health IT, it could enhance integration of services by strengthening care coordination and data sharing. Greater information sharing is correlated with better patient health outcomes, such as lower risk of medication discrepancies.

For plans and providers, providers would benefit from greater funding for EHR adoption and more funding for broader data-sharing integration efforts through health information exchanges. Providers would have improved capabilities to integrate care for patients with behavioral health needs, and plans would benefit from guidance that encouraged EHR adoption by directed payments because they could receive data from their behavioral health providers.

Moving on to our second recommendation. So our second recommendation is around improving quality of behavioral health IT, and it reads "The Secretary should direct SAMHSA and ONC to jointly develop voluntary standards for behavioral health IT."

The reason for this, again, is that there is no industry standard for behavioral health IT. This recommendation would replicate the pediatric health IT standards development process. MACPAC would recommend that ONC and SAMHSA engage in a collaborative process with stakeholders to develop technical specifications for an EHR that conforms with both Part 2 and is built on top of ONC certification requirements.

A voluntary standard would provide a non-

financial incentive for adoption among physicians working in integrated care settings, such as a community health center. This is because specifications could include many functions that are critical to behavioral health and using integrated care settings which includes Part 2 segmentation and other clinical support tools.

Furthermore, once these EHR functions have been market tested, they could be eventually incorporated and made mandatory, incorporated in the certification and be made mandatory under conditions of participation in Medicaid for the long term.

This recommendation also would have no direct effect on federal spending, though SAMHSA and ONC would incur costs associated with standards development.

For states, a few of them have already started an EHR incentive payment program for behavioral health providers. A voluntary standard would allow them to point to a federal standard that meets the needs for the provider community that they are targeting.

For beneficiaries, a voluntary standard that allows the EHR to tag specific SUD information would give beneficiaries greater control over what kind of data they

share. This would help beneficiaries share their entire record while withholding specific SUD information.

In the near term, behavioral health providers and primary care providers that work in integrated settings would have access to tech specs for clinical and privacy behavioral health IT functions. While these would be voluntary in the short term, in the long term, these functions could be made mandatory, which would further support integration efforts.

I now turn it over to you, Commissioners, for your feedback and input on both the draft chapter and the recommendation language. Any changes to the recommendation language could be incorporated in the presentation tomorrow, and I'm looking forward to hearing your feedback on the draft chapter.

VICE CHAIR DAVIS: Thank you, Aaron.

Can you go back so we have the recommendations on the screen?

MR. PERVIN: Sure.

VICE CHAIR DAVIS: They're not all together, but that's okay. He's getting off easy with just two.

Any comments on the general chapter first? Then

we can go to Recommendations 1 and 2.

Yeah, Martha.

COMMISSIONER CARTER: Aaron, I'm delighted with this chapter. I've given you a lot of grief, I think, over this, adding nuance and substance to it over the last couple meetings, and I think you've really done a great job capturing the issues, and I'm fully in support of the recommendations.

VICE CHAIR DAVIS: Thank you, Martha.

Aaron, I think you're seeing a lot of support for a log of hard work over this. We've brought this back several times. I think we've had lots of conversations to it. We found a good middle ground with that voluntary standard. That potentially could be a stepping stone to something more in the future as we pursue it. So I'm not hearing any other comments from Commissioners. Are there any questions you have for us or anything else that you need?

MR. PERVIN: No. Thank you very much. This has been very easy.

[Laughter.]

VICE CHAIR DAVIS: Go ahead, Fred.

COMMISSIONER CERISE: It's a great chapter.

The issue of disconnected information is so real, I mean, the amount of people who go back and forth between behavioral health providers and other providers, and so I just think it's an important contribution. It's on a really very relevant issue, and so just affirmation and thanks for a great report.

COMMISSIONER BROOKS: If you've satisfied Martha, I am satisfied.

[Laughter.]

COMMISSIONER CARTER: So I want to put a pin in a conversation I think we still need to have. This is great, and accepting that we've got Part 2 the way it is, this works with that.

I think we still need to think about whether Part 2, which requires sequestration of SUD data, in fact, contributes to stigma and othering people who are struggling with substance use disorder, because we make it something that can't be shared, because we make it so sensitive. It's sort of a circular process, I think.

There's no easy answer to this, and I'm not sure the Commission is going to tackle that. But I just want to

say that there are conversations that need to happen around stigma and treatment of substance use disorder.

These kind of regulations -- what's the word I'm looking for? -- sort of build in that othering of people who are struggling in recovery.

VICE CHAIR DAVIS: Thank you, Martha. That's an excellent point that we want to constantly be thinking about how we are being inclusive and not further stigmatizing people who already have diagnosis that has put them outside of the norm, for whatever reason, and not creating barriers with health IT that makes it difficult to care for these patients and in an integrated, coordinated way, and really finding ways to bring them into this system. And I think this is a really good step to do that.

Thank you, Aaron.

MR. PERVIN: Thank you.

CHAIR BELLA: All right. Thank you, Aaron. You did the heavy lift last time, so thank you.

All right.

Rob and Linn, please join us.

Welcome back. We are going to end the day talking about churn, which is like remarkably exciting to

all of us. So I'll turn it over to you.

UPDATED ANALYSES OF CHURN AND COVERAGE TRANSITIONS

* MX. JENNINGS: Great. Well, good afternoon. Today Rob and I will present our updated analyses of churn and covered transitions.

So, in September, we presented analyses on rates of churn using pre-pandemic T-MSIS data, and the Commission was interested in continuing this work and suggested additional analyses that would be helpful in furthering our understanding of churn and how health outcomes may change after experiencing a gap in coverage.

So I'll start today by presenting some background information on churn, and then I'll give an overview of our findings from our prior analyses last fall, and then I'll present our results on analyses on the effects of churn on health service use. Then Rob will present the results on our analyses on transitions between public health coverages and the policy implications and next steps.

Churn is defined in our analyses as when beneficiaries disenroll and subsequently reenroll in Medicaid within 12 months. Churn can occur for many

reasons, including administrative reasons or income fluctuations that make beneficiaries temporarily ineligible for Medicaid. Churn can also result in unnecessary administrative cost for states, and gaps in coverage can delay care for beneficiaries.

In addition to churn, we'll be presenting results related to gaps in coverage, which is when beneficiaries experience -- they can experience it when churning but also when moving between insurance types.

There are new policies in place that are intended to make these transitions between coverage types smoother and to reduce coverage gaps, but there hasn't been much research about how these policies are working. So our analyses help demonstrate how they work in practice.

Last fall, we worked with Mathematica to analyze 2017 through 2019 T-MSIS enrollment data. We found that about 8 percent of beneficiaries churned, and the rates of churn were higher for Black, Hispanic, and American Indian and Alaska Native beneficiaries.

We also found that certain state policies were associated with lower rates of churn, and these policies include 12-month continuous eligibility, elimination of

midyear data checks for changes in circumstances, and increased use of automated renewals or ex parte renewals, which is when states use other data sources to help streamline the renewal process.

After presenting our results last fall, the Commission expressed interest in understanding the health effects associated with churn and an understanding where beneficiaries transition to after disenrolling from Medicaid and CHIP. In our updated analyses, we look at both of these things. We examined health service use, and we measured rates of inpatient admissions and ED visits related to four ambulatory care-sensitive conditions, before and after an episode of churn, and these conditions were short-term complications related to diabetes, heart failure, asthma among young beneficiaries, so those 18 to 39, and COPD or asthma among older beneficiaries, so 40 to 64.

We chose these four measures because they're prevention quality indicators, or PQIs, which are included in the Adult Core Set, and these measures have long been used to assess health risk, and prior research shows that hospitalizations related to these conditions could be

potentially avoided if they were managed or treated properly in primary care settings.

For our second analysis, we focused on coverage transitions. We linked T-MSIS data with enrollment data from the federal exchange so we could identify whether those who disenrolled churned back to Medicaid or CHIP, which we were looking at in T-MSIS, or if they successfully enrolled in another public coverage program.

Our analyses were limited to states that used the federally facilitated marketplace or have state-based partnerships with the federal exchange.

Both of these analyses excluded states where there were T-MSIS data quality concerns, and we excluded beneficiaries who were dually eligible for Medicare and Medicaid. This is because for our health service use, we looked at hospitalizations, which are covered by Medicare, and we were using T-MSIS data. For the coverage transitions, we were looking at federal exchange plans, which they aren't eligible for.

Before we jump into our results, we also want to highlight some of our high-level results on churn. In this table here, we've shown four eligibility groups and the

number of beneficiaries included in the analyses, and these are lower than in our prior analyses, and this is because we've used a different subgroup of states, as I mentioned, and we have some different methodological -- or we had different methodologies for these. So it's just a smaller sample.

But, even with that, we see a similar rate of disenrollment and churn. What we do also see is that adults under age 65 and Separate CHIP still have the highest rate of disenrollment, and also, in the third column, this includes only those who disenrolled and that we couldn't identify where they moved to or that they churned. So we've excluded those who either moved from CHIP to Medicaid or Medicaid to CHIP and those who moved to the exchange.

Then, in the final column, we show the share of beneficiary who churned. I also want to highlight that for separate CHIP in our prior analyses, we saw a slightly higher rate of disenrollment and a higher rate of churn, but those have now decreased now that we account for some of these other transitions.

In our first set of analyses, we examine the

effects of churn on ED visits and inpatient admissions related to the four ambulatory care-sensitive conditions, and we found that after an episode of churn, beneficiaries were more than twice as likely to be hospitalized or have an ED visit compared to the baseline rates, six months prior to disenrollment, and this was the case for all four conditions.

We also stratified these measures by the length in coverage gap between disenrollment and reenrollment and by race and ethnicity, and what we found is that for some measures, beneficiaries with a longer gap in coverage experienced a larger percent increase in the rates of ED visits and inpatient admissions related to these conditions than beneficiaries with short gaps in coverage. For example, beneficiaries with a gap in coverage of more than six months were 65 percent more likely to be hospitalized for heart failure as beneficiaries with a gap in coverage of less than 30 days.

We also observed differences in rates of hospital use by race and ethnicity, and they varied by measure. For example, Black and Hispanic beneficiaries experienced a higher increase in the rates of hospitalizations related to

asthma in younger adults than White beneficiaries, and American Indian and Alaska Native beneficiaries experienced a larger increase in the rate of hospitalizations related to diabetes than White beneficiaries.

These differences by race and ethnicity are also supported by prior research. A prior study in California that looked at hospitalization risk over a five-year period found that Black and Hispanic Medicaid beneficiaries were three times as likely as White beneficiaries to experience hospitalization related to ACSCs after an episode of churn.

To help visualize some of these changes in hospitalization, this figure here shows hospitalizations for 100,000 member months, which is the rate used in the Adult Core Set Measures, and we look at this rate in hospitalization at three time periods. One is at baseline, so that's the six months prior to disenrollment, and you see that the rate is lowest at that point. Then one month after reenrollment, the rate in hospitalizations has more than doubled for all four conditions. This could suggest that hospitalization was a reason for reenrollment. Then at three months, although the rate has decreased, it is still higher than at baseline. We also saw the same trend

across ED visits.

I am going to pass it on to Rob to present the results on coverage transitions.

* MR. NELB: Thanks, Linn.

Now looking at those transitions between public coverage programs, which we're talking about Medicaid, separate CHIP, and the exchange.

First, when we looked at where people went after leaving Medicaid or CHIP, we found that very few, less than 4 percent, ended up in exchange coverage. This was much lower than some prior estimates that have been out there, which were largely based on income data surveys, sort of estimating what income range someone might be after leaving Medicaid or CHIP.

There are a couple things that may be going on. First is that some people may be eligible for exchange coverage but not enrolling, perhaps because of premiums or other factors, and then also there may be some people who are maybe income eligible for the exchange but aren't eligible for subsidies because they're considered to have an affordable offer of ESI. Some of those people may have enrolled in private coverage.

Second, when we looked at that subset of people who did successful move from one program to another, we found a wide variation in how seamless this transition was. Overall, more than two-thirds of beneficiaries moving from Medicaid to exchange coverage had a gap in coverage. On average, this was about three months. However, it was longer on average for Black, Hispanic, and AI/AN beneficiaries.

Transitions the other way around from exchange to Medicaid were a bit more seamless. Some of that may be due to the retroactive eligibility provisions in Medicaid. We're not exactly sure how that shows up in the T-MSIS data.

One interesting point here, though, we found that there are several beneficiaries who actually seem to have an overlap in coverage of more than one month, which suggests that potentially they may be paying exchange premiums when they didn't have to.

Finally, looking between Medicaid and separate CHIP, we found that the transitions were very common, but they were relatively smooth, which was a bright point in the data.

Finally, just a caveat here throughout all of this is just recognizing that we don't have data on beneficiaries who are eligible for a program but don't enroll. There may be some people that we're missing in this analysis.

This figure helps visualize that next source of coverage for beneficiaries who disenrolled in 2018. In dark blue, you can see that very few beneficiaries moved from Medicaid or CHIP to exchange coverage, and dark green, you can see that a much higher share of people who lost coverage ended up returning to Medicaid or CHIP within a year without any coverage in between. That is the phenomenon that we refer to as churn.

Finally, you can see in light green that there is a high share of beneficiaries who disenroll and don't appear to transition to other sources of coverage. Again, it's possible that some of these people may have moved to private coverage. We don't have data on that, but it's also likely that many became uninsured. Then, as I mentioned before, some of those people who became uninsured may have actually been eligible for exchange coverage or other sources but didn't enroll.

This next figure illustrates that variation in gaps in coverage that we observed for people who made those transitions between Medicaid, CHIP, and exchange coverage. Again, you can see that more than two-thirds of beneficiaries moving from Medicaid or CHIP to the exchange had a gap; whereas, it was much lower especially between Medicaid and separate CHIP.

We welcome Commissioner feedback on how these findings can help inform our future work in this area. We know that you all are very interested in the unwinding of the public health emergency and that there are a lot of similar questions there. For example, many people who lose Medicaid coverage are expected to potentially transition to the exchange. However, it's important to note that the data in this presentation is pre-pandemic and that we won't have access to real-time data to monitor some of those Medicaid and exchange transitions during the unwinding.

However, if there is Commission interest, we could in the next cycle start exploring some longer-term policy options to help address some of these issues of churn and coverage transitions. These could include statutory or regulatory changes. On the regulatory front,

it's important to note that CMS, currently, on its regulatory agenda has plans to issue a proposed rule on eligibility and enrollment, potentially later this summer.

To help guide your discussion today, here are just some potential policy options we could explore further. First, in terms of reducing churn, as Linn mentioned, we found in the past several of these policies listed here are associated with reduced rates of churn. So we could explore ways to increase use of these options.

Second, in terms of transitions between public coverage programs, we can look more into different policies here. Thinking of the Medicaid to exchange transition, it may require some changes on the exchange side, but there may be some changes to Medicaid policies that could help make that transition a bit smoother; for example, better coordinating notices between the programs.

Finally, we can explore whether there's ways to improve the monitoring of eligibility and enrollment processes, perhaps using some of the T-MSIS stuff that we've used in our analysis or other data sources, and this could help supplement some of the performance indicators that CMS currently collects to monitor eligibility and

enrollment.

With that, I welcome any questions you have about our analysis and thoughts about our future work.

CHAIR BELLA: Thank you.

I'm going to guess there's interest from the Commission in doing something. I saw Laura first and then Tricia.

COMMISSIONER HERRERA SCOTT: This is a question for future work. Do you have any cost data, so thinking about the price of the inpatient admission that could have been avoided had they stayed in Medicaid and comparison of staying versus not being eligible?

MR. NELB: Yes. I forgot to mention that. In your materials, you have some back-of-the-envelope calculations that we did, suggesting -- we certainly know that the cost of hospitalization for an individual is much more expensive than the cost of keeping that individual covered. However, at the same time, hospitalization is a relatively rare event. When you apply that across this whole population, there will be cost savings from reducing hospitalizations but still probably some increased costs on that for keeping people covered.

COMMISSIONER HERRERA SCOTT: Not in the ambulatory case-sensitive conditions that you describe. So, even thinking of the churn of the people that had a condition that would -- could lead to versus no, you know -- I mean, is there any way to break the population down versus some comorbidity versus none and then of those with the diagnosis, admission or no admission?

MR. NELB: Yeah. I suppose we could look at whether we identified people who had these conditions at baseline and some of the issues there.

CHAIR BELLA: Tricia, then Brian.

COMMISSIONER BROOKS: Well, as you can imagine, I loved this and just can't get enough of it.

When we did the first report, I asked if it was possible to get that out in the public domain. I think this is equally important, particularly considering that reconciliation is back on the table in Congress, and we don't know what's going to happen with the potential mandate for a 12-month continuous coverage for children. So I hope that we can consider that and get it out in the public really quickly.

I also thought it was really helpful to look at

the transitions and see how the churn rate in CHIP dropped because now we're looking back both, you know, at Medicaid.

In Figure 2, I just want to clarify for folks. It's noted in your note, but if people aren't perfectly aware of how all of this works, MACPAC has previously estimated that about 58 percent of children that are funded through CHIP are actually in Medicaid, and so for the purposes of your analysis, those children are treated as enrolled in Medicaid, correct?

MR. NELB: Yes, yes. Medicaid, yeah. Yes. The separate CHIP is the only piece that's in that right column. Children covered under Medicaid CHIP are in the Medicaid.

COMMISSIONER BROOKS: Right. So, when I look at Figure 2 and I see that 45 percent of children covered by Medicaid transitioned to no other identified insurance source in M-CHIP states, the states that cover all their kids in Medicaid, they don't have a separate CHIP program to go to, and that might explain why that is somewhat higher.

I don't know if you can do this with the states that you're working with, but it would be interesting to

actually look at the transition separately for M-CHIP states versus separate CHIP states. So, for future work, I think that would be really informative.

Then I would also love to see the kind of analysis of what happens with use of services and -- or avoidable services during gaps in coverage for children as well with some of those top conditions. That would be really helpful as well.

And thank you for this work. It's really great.

CHAIR BELLA: Thank you, Tricia.

Brian?

COMMISSIONER BURWELL: It just seems to me that when the PHE ends and people are reassessed for Medicaid eligibility after the PHE that that creates a good opportunity to identify reasons for disenrollment and whether they reenroll. Do you have ideas? Are there fields in T-MSIS that identify reasons for disenrollment?

MX. JENNINGS: Yeah. So Mathematica did look at that for us. There is a field in T-MSIS. Right now, there's too much missingness in that variable for us to use it and look across states, but hopefully, in the future --

COMMISSIONER BURWELL: It is missingness because

states don't capture that data when they do their enrollment in their eligibility systems?

MR. NELB: We don't know, but I think that could be an important area for future work, and I think it fits into the third option here about thinking are there ways to improve the data that we do have to know about, you know, monitoring coverage, transitions. It's a gap in the data we have now, and we can explore what can be done to improve that. But, yeah, it's unclear for us right now, but we can look into it further.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: I want you to know this is the first place I've ever heard the term "missingness" as a word.

I think the policy options are pretty high level and sort of hands off. I'd like to also think about the places where we can help beneficiaries, and one place that I keep hearing in various work that I've done and in personal experience, I have a daughter who skirts the line between Medicaid and the exchange because she has a seizure disorder. She has a catering business and works part-time, and so she kind of skirts that. What helps her the most

and in some other work I've done is that a real person who can help sort of wade through the data, the documentation that needs to be submitted, how to determine whether they're covered by Medicaid or the exchange. So I think we should put that in there as an additional approach to support people to stay covered.

CHAIR BELLA: Thank you, Martha.

Well, I have a comment and a question. My question, were you surprised by the number for the movement to the exchange? It seems so low.

MR. NELB: Yes, it was surprising. Some of the previous estimates suggested that maybe a quarter of people were moving, and so we found it was a lot lower.

Again, I think some of it is maybe that people are having trouble making that transition. Another piece is remembering in our data that we're capturing a lot of people who are maybe losing Medicaid coverage, who are still eligible for Medicaid, and they fell off for procedural reasons. Maybe if you subtract those out and look at the people who truly lost Medicaid coverage due to maybe a higher income, in that subset, I suppose a greater share did make it to the exchange. It was surprising.

COMMISSIONER CARTER: There's not much difference. A couple dollars can make a difference between Medicaid and the exchange, and so once you get to the exchange, that means there's some additional copays or all your medications aren't covered fully. I don't know all the different plans. But it's not surprising to me at all because, if you look at the whole group of people who might be eligible for the exchange, maybe, but if you're looking at that borderline, it makes perfect sense that if you fall off Medicaid, you can't afford the exchange.

CHAIR BELLA: Laura, then Fred, then Tricia, all on this point.

COMMISSIONER HERRERA SCOTT: I landed where you did, and I guess my question was more of a data issue and if there's -- I don't know if they're using like a master patient index or something to map people across the exchange. Was there any data integrity that contributed to the low number?

MX. JENNINGS: So they were matched by Social Security number.

COMMISSIONER HERRERA SCOTT: Oh.

MSX JENNINGS: But it could also be we don't

include state-based exchanges. So we are missing, I guess, 11 of the states.

CHAIR BELLA: Fred and then Tricia. It's not on this point? Okay. You're on this point? Tricia and then Heidi on this point.

COMMISSIONER BROOKS: Well, I think there's also the 60-day special enrollment period, and that's why when we look at this in the future and go back and look at this year -- well, of course, people aren't losing Medicaid this year, but where we've increased subsidies and we have eliminated fundamentally -- or given open enrollment to everyone under 150 percent of poverty, I think those are really key policies in the future that could make a difference in those transitions.

CHAIR BELLA: Thank you.

Heidi.

COMMISSIONER ALLEN: I was just going to say that we published a paper in JAMA Health Forum this year looking at Colorado marketplace and Medicaid data and found that there was just a precipitous drop in enrollment right at the 138 percent of federal poverty level. In fact, enrollment was 81.3 percent lower in 2014 and 88.6 percent

lower in 2015.

I think that your point is well taken that it's not just the premium, but you have to effectuate coverage too. You have to actually pay the premium to be enrolled. There's money, and there's the administrative hurdle. And if you don't do that, then you lose your coverage.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: I'm looking at Figure 1 and wondering, is there any subset or anywhere where you can look at those, state unenrolled, and saw their experiences? There are regional hospital areas that have all payers in admissions. I know, in our region, you can track admissions regardless of payer, including uninsured. So I'm just wondering if there's any samples of where you can look at -- because it would certainly be a stronger picture if you had something to say about that group.

MX. JENNINGS: Well, it's not something we were able to look at with these data, but something we certainly talked about is a limitation that we --

COMMISSIONER CERISE: Yeah.

MX. JENNINGS: -- don't know if those who didn't return are different from those who did return and what

their risks are.

MR. NELB: But there certainly is prior data using other sources showing that uninsured are more likely to have some of these different conditions. So we can think about how to incorporate that.

COMMISSIONER CERISE: I mean, to your earlier point, are you catching people who reenrolled because they had an admission? Is that --

COMMISSIONER ALLEN: I was going to say any hospital claims dataset, even if it has the uninsured, it's going to have that phenomenon because that's where people get reenrolled in Medicaid like through presumptive eligibility policies. It's always had to capture the uninsured. It's just really such a challenge, and that they may not be using care that they should be getting care. So there's also, you know, even if you can look at it and say this is how you compare their utilization, you have that foregone care issues that you can't capture analytically, which is tough.

MX. JENNINGS: Actually, I just wanted to add as well, another thing that we noticed was that we brought up a little bit was that those who had longer gaps in coverage

generally had lower rates of hospitalization and ED visits to begin with and then continued to have lower rates, and they had a longer gap. That's, I guess, as close as we get to a comparison.

CHAIR BELLA: All right. Then I did have a comment which is -- wait for it -- duals. I know that duals are excluded, but I'm going to put a plug in that it's really important to look at churn, particularly if we're promoting policies to increase eligibility in integrated programs like aligned enrollment. If they administratively or for some other reason lose Medicaid eligibility, all of those other things don't matter because they pop out of the integrated program. If they come back in, it's even more difficult to get them back into kind of the alignment in the integrated program. I think people assume that duals don't lose coverage. They do, and I think ASPE may have done kind of an eye-opening report not too long ago. I think people were shocked to see the amount of churn. I could be wrong on that. So I'll check, and maybe if you guys have something that --

EXECUTIVE DIRECTOR SCHWARTZ: We have something in the duals data book that shows -- it's just a couple

statistics that shows people losing their Medicaid coverage over the course of the year. Kirstin is nodding.

CHAIR BELLA: So I understand there might be reasons why for this we have to exclude them, but I would just say it is our ability to make the other integrated care work that we're doing matter also is impacted by their churn.

And on one other question, you know, for duals, for D-SNPS, CMS allows deeming. So the plan can -- well, the state has to approve it, and then if someone loses their Medicaid eligibility, the D-SNP has the option to keep them for three or six months, believing the person is going to come back. If they don't come back -- I'm oversimplifying this, but if they don't come back, the plan is out that money. But often they do come back, and so the plan believes it's more cost effective to be able to keep them and not see that churn. So deeming might be something we think about. We'd have to think about how that would apply in the Medicaid population, but there is precedent for recognizing that if people are going to come back on a plan in a managed care environment might have an interest in sort of going at risk for that eligibility potential.

Brian?

COMMISSIONER BURWELL: Just to build on what Melanie says, does T-MSIS identify partial duals from full duals? Do you know?

MR. NELB: Yes. Yeah, we can identify that.

COMMISSIONER BURWELL: Because they would be different, have very different patterns.

MR. NELB: Yeah, exactly. For the brief we did in October, it does have some data on duals, and we can look into that more between the partial and full benefits.

COMMISSIONER HEAPHY: This is Dennis. Is it possible to link it with ACOs, folks on Medicaid, to get the ACOs that data in advance of people churning off so they can actually actively engage folks on Medicaid and reduce the level of churn before they drop off?

We tried that in Massachusetts with the duals. It's going to be a huge problem, but why not with ACOs and folks on straight Medicaid?

MR. NELB: Yes. I think you're asking what can plans or providers do to help beneficiaries avoid churn, and I think in terms of policy approaches, that's certainly something we can look at.

COMMISSIONER HEAPHY: What mechanisms can state use, what can they leverage.

CHAIR BELLA: Thank you, Dennis.

Tricia?

COMMISSIONER BROOKS: Yes. Brian made comment about this being important until for the end of the PHE. What we know -- and this was important that you only looked at FFM states in this analysis is that the account transferred to the FFM just simply doesn't work. The idea that people can go in and find their application and not have to complete a whole new application just is a myth. It doesn't work. CMS acknowledges that, I think, in many ways; whereas, the account transfer in the other direction works much better, even though most states are determination states where they go ahead and treat it like a new application.

So it would be interesting if you can get any state-level -- state-based exchange data to show how account transfers actually can work when they are working. It's sort of redundant. Are you able to access any state-based exchange data? Because that might be another area, even just looking at a couple of them.

MR. NELB: Yeah. We don't currently have state-based exchange data. We'd have to set up an arrangement with the state.

But I guess to your point about the account transfer, maybe one thing to not and perhaps one of the reasons for the smoother transfers between Medicaid and separate CHIP is that we've seen that a lot of states have -- even though they have separate programs, they have an integrated eligibility system between the two. We can at least point to some other data suggesting that better integrating those systems helps people have a smoother handoff.

CHAIR BELLA: Any other comments, questions?

[No response.]

CHAIR BELLA: Please bring this back. I think we're hungry for some of this data and some of this work. Do you need anything from us at this time? We'll go to public comment after this.

MR. NELB: I think this is fine, and we can certainly look at the data, and just as we continue this work, we'll welcome your thoughts in terms of policy approaches. So thinking about, you know, recognizing the

limits of the data that we do have, whether you think you can come to conclusions on any of these policy approaches as we move forward in the next cycle.

I really appreciate the great discussion today.

CHAIR BELLA: Thank you for the work.

We will open it up to public comment. We can take comment on the churn and transition analysis or on the behavioral health IT, actually pretty much on anything for the day, but the only two we haven't had comment on so far. So, if you would like to make a comment, please raise your hand icon and tell us who you are and who you're with, and please limit your remarks to three minutes.

We have one. Yep.

PUBLIC COMMENT

* MS. HUGHES: Mandar, you've been unmuted to make your comment.

MR. JADHAV: Thank you. Yeah. So I'm again with Senator Cassidy's office. I'm not presenting any office positions. Just a question about the EHR incentive or EHR uptake recommendations, whether MACPAC has been including developments with Health and Human Services' proposed rule on the 42 CFR Part 2, which is the substance use disorder

confidentiality and privacy regulation in formulating these recommendations and in writing this chapter.

EXECUTIVE DIRECTOR SCHWARTZ: We're waiting on a proposed rule aligning HIPAA and 42 CFR Part 2. Is there another rule that you're referring to?

MR. JADHAV: No, it's not really a rule. The reason I ask is because the statutory direction to HHS has been around for a little while. So, granted, the rule is still in development, but the principle behind it has been made available. So I was just wondering how MACPAC has been thinking about this anticipated development when developing this chapter, creating the recommendation specific to behavioral health IT update.

EXECUTIVE DIRECTOR SCHWARTZ: So we've been waiting for that rule for a while. When it comes out, I'm sure we'll want to comment on it. It's very hard without knowing what it's going to be, even though we know the overarching goal as directed by Congress, to be able to make a recommendation based on something that we don't know what it is yet. But if it changes the direction of this analysis, I mean, that would create an opportunity for us to think about it some more.

MR. JADHAV: May I just quickly rephrase my question? What I would ask, then, has MACPAC considered specifically identifying that as a roadblock for CMS in its recommendation to furthering the adoption of behavioral health EHR?

EXECUTIVE DIRECTOR SCHWARTZ: We've talked about 42 CFR as a barrier in multiple times, and so we are eagerly awaiting that rule.

I'm not sure that MACPAC reminding CMS that it's due based on a congressional requirement is something that would hurry things along.

CHAIR BELLA: Thank you for your comment or question.

Any other comments from the public?

[No response.]

CHAIR BELLA: Linn and Rob, I know we didn't go line by line in the policy things. I think that's because the appetite is high for most everything on that slide. We don't want to break the bank today with what we're looking at.

All right. I don't see any other hands for folks who want to make a comment, which means we are done for the

day. I don't know about you guys, but this went much faster than we're doing it on Zoom.

We will be back tomorrow morning for kicking off at 10:30. We will be starting out with the votes on the four areas in which we're voting, and then we have two sessions to round out the day. So we'll welcome all of you to come back tomorrow. Thanks to Jim and the team for keeping us technically in sync, connected. Thanks to Darin for a little comic relief. Thanks to everybody for being here in person, and we will see you tomorrow. Bye-bye.

* [Whereupon, at 4:03 p.m., the Commission was recessed, to reconvene at 10:30 a.m. on Friday, April 8, 2022.]

PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Hemisphere Ballroom
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004
-and-
Via GoToWebinar

Friday, April 8, 2022
10:30 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
KISHA DAVIS, MD, MPH, Vice Chair
HEIDI L. ALLEN, PHD, MSW
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSC, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
TOBY DOUGLAS, MPP, MPH
ROBERT DUNCAN, MBA
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
VERLON JOHNSON, MPA
STACEY LAMPKIN, FSA, MAAA, MPA
LAURA HERRERA SCOTT, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

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P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: [In progress] -- it's determined that Commissioners after reviewing Commissioners' reportable interests found no conflicts on any of the areas and recommendations that we will be voting on today. So thank you for that review, Conflict of Interest Committee.

And, with that, Anne, I believe I'm going to turn it to you.

VOTES ON RECOMMENDATIONS FOR JUNE REPORT TO CONGRESS

* EXECUTIVE DIRECTOR SCHWARTZ: Yes. Actually, I'm going to turn it back to Ashley to go through the first series of recommendations.

MS. SEMANSKEE: Thank you, Anne.

I'll just go through our recommendations for an access monitoring system, and I'm going to point out a few changes we made to the text based on the Commission's discussion yesterday.

So this is Recommendation 1.1, and we changed the last line on the slide to ensure that public reports are made in a "research-ready format in a timely manner," and

the full recommendation is "The Centers for Medicare and Medicaid Services should develop an ongoing and robust access monitoring system consisting of a core set of measures for a broad range of services that are comparable across states and delivery systems. These measures should capture potential access, realized access, and beneficiary perceptions and experiences; prioritize services and populations for which Medicaid plays a key role and those for which there are known access issues and disparities; and be adaptable to reflect changes in measurement, policy priorities, and care delivery. CMS should issue public reports and data at the state and national level in a consumer-friendly and research-ready format in a timely manner."

And here we have Recommendation 1.2. In this recommendation, we added "consumer groups" to our list of key stakeholders based on the discussion yesterday. So the full recommendation is "The Centers for Medicare and Medicaid Services should involve stakeholders in the development and future modifications of a new system. The agency should actively solicit and incorporate input from key stakeholders, including but not limited to states,

beneficiaries, consumer groups, health plans, providers, researchers, and other policy experts. The process for establishing a new access monitoring system should be public and transparent."

And here we have Recommendation 1.3, and in this recommendation, we changed "periodic" to "annual." So the full recommendation is "The Centers for Medicare and Medicaid Services should field an annual federal Medicaid beneficiary survey to collect information on beneficiary perceptions and experiences with care."

And here we have Recommendation 1.4: "The Centers for Medicare and Medicaid Services should further standardize and improve the Transformed Medicaid Statistical Information System data to allow for meaningful cross-state comparisons of the use of particular services, access to providers, and stratification by key demographic characteristics, such as race and ethnicity."

And here we have Recommendation 1.5: "To assist states in collecting and analyzing access measures, the Centers for Medicare and Medicaid Services should provide analytical support and technical assistance."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So we'll

take one vote on all five recommendations as packaged, and I will note just at the outset of this whole voting session that Bill Scanlon, who could not be with us today, sent a note saying that he is supportive of all the recommendations that we'll be considering. He'll be recorded as not present, but I wanted to make sure that that was noted.

So I'll just call the roll, and again, Commissioners, you can vote yes, no, or abstain.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: I'm going to mark Bill Scanlon as not present.

Laura Herrera Scott?

COMMISSIONER HERRERA SCOTT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thank you.

Next.

[Pause.]

EXECUTIVE DIRECTOR SCHWARTZ: Welcome Amy and Chris.

MS. ZETTLE: Thank you. We'll now be presenting the recommendations to improve vaccine access for adults enrolled in Medicaid.

We'll start with Recommendation 1. It reads "Congress should amend Section 1902(a)(10)(A) of the Social Security Act to make coverage of vaccines recommended by the Advisory Committee on Immunization Practices a mandatory benefit and amend Sections 1916 and 1916A to eliminate cost sharing on vaccines and their administration."

Recommendation 2: The Centers for Medicare and Medicaid Services should implement payment regulations for vaccines and their administration. Payment for vaccines should be established at actual acquisition cost and a professional fee for administration, similar to payment requirements established for outpatient prescription drugs under 42 CFR 447.512(b) and 447.518(a)(2)."

MR. PARK: Recommendation 3 reads "The Centers for Medicare and Medicaid Services should issue federal guidance encouraging the broad use of Medicaid providers in

administering adult vaccinations."

Recommendation 4 reads "The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort with the Centers for Medicare and Medicaid Services (CMS), the Office of the Assistant Secretary for Health, and the Centers for Disease Control and Prevention to provide guidance and technical assistance to improve vaccine outreach and education to Medicaid and CHIP beneficiaries. Additionally, CMS should release guidance on how to use existing flexibilities and funding under Medicaid and CHIP to improve vaccine uptake."

Recommendation 5 reads "Congress should provide additional federal funds to improve immunization information systems (IIS). In addition, Congress should require the Secretary of the U.S. Department of Health and Human Services to coordinate efforts across relevant agencies within the Department to release federal guidance and implement standards to improve IIS data collection and interoperability with electronic health records and state Medicaid management information systems (MMIS). The Centers for Medicare and Medicaid Services should also provide guidance on matching rates available and ways to

integrate IIS and MMIS to be eligible for the 90 percent match for the design, development, installation, or enhancement of MMIS and the 75 percent match for the ongoing operation of MMIS."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So, on this one, we're going to take a vote on Recommendation 1 and then a vote on Recommendation 2 and then a vote on Recommendations 3, 4, and 5 as a package.

So we'll go with Recommendation 1 first on coverage of vaccines.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: No.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: No.

EXECUTIVE DIRECTOR SCHWARTZ: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: No.

EXECUTIVE DIRECTOR SCHWARTZ: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: No.

EXECUTIVE DIRECTOR SCHWARTZ: I'm marking Bill Scanlon as not present.

Laura Herrera Scott?

COMMISSIONER HERRERA SCOTT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Eleven, yes; four, no; and one, not present.

So the next one on Recommendation 2. Thank you. The one on payment regulations.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: No.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: No.

EXECUTIVE DIRECTOR SCHWARTZ: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: No.

EXECUTIVE DIRECTOR SCHWARTZ: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: No.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon is not present.

Laura Herrera Scott?

COMMISSIONER HERRERA SCOTT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Same as the coverage.

Okay. So then we'll do the last three remaining recommendations as a package. You've heard them already. So I'll call the roll one more time.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon is not present.

Laura Herrera Scott?

COMMISSIONER HERRERA SCOTT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So all the vaccine recommendations are approved. Thank you.

MR. NELB: I'm going to present a package of five recommendations related to the oversight of managed care directed payments.

The first recommendation reads "To improve transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should make directed payment approval documents, managed care rate certifications, and evaluations for directed payments publicly available on the Medicaid.gov website."

Recommendation 2 reads as follows: "To inform assessments of whether managed care payments are reasonable and appropriate, the Secretary of the U.S. Department of Health and Human Services should make provider-level data on directed payments amounts publicly available in a standard format that enables analysis."

Recommendation 3: "To provide additional clarity about the goals and uses of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to quantify how directed payment amounts compare to prior supplemental payments and clarify whether these payments are necessary for health plans to meet network adequacy requirements and other existing access standards."

Recommendation 4 reads as follows: "To allow for meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multi-year evaluation plans for directed payment arrangements that substantially increase provider payments above the rates described in the Medicaid state plan."

Finally, Recommendation 5 reads as follows: "To promote more meaningful oversight of directed payments, the Secretary of the U.S. Department of Health and Human Services should clarify roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare and Medicaid Services involved in the review of directed payments and the review of managed care capitation

rates."

EXECUTIVE DIRECTOR SCHWARTZ: Thanks, Rob.

So I'll call the roll for one vote on this package of five.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon is not present.

Laura Herrera Scott?

COMMISSIONER HERRERA SCOTT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thanks very much.

MR. PERVIN: All right. I will go through the behavioral health IT recommendations.

Recommendation 1: "The Secretary of Health and Human Services should direct the Centers for Medicare and Medicaid Services, Substance Abuse and Mental Health Services Administration, and the Office of the National

Coordinator for Health IT to develop joint guidance no how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability."

Recommendation No. 2: "The Secretary of Health and Human Services should direct Substance Abuse and Mental Health Services Administration and Office of the National Coordinator for Health IT to jointly develop voluntary standards for behavioral health information technology."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thanks, Aaron.

So I'll call the roll one last time on these two recommendations together.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon is not present.

Laura Herrera Scott?

COMMISSIONER HERRERA SCOTT: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. So that and the recommendation on the integrated care strategy that you all voted on at last meeting means that we have a June report with six chapters and 18 recommendations.

CHAIR BELLA: Nice job, team. Nice job, staff. Thank you very much. We could take odds on how many of those recommendations become -- the Congress takes up, but really nice job. Thank you all very much.

We will turn now to the last two sessions of the day. Welcome Moira and Sean to talk to us about managed care procurement.

COMMISSIONER DOUGLAS: I was going to say I want a signed copy with everyone's name on it.

[Laughter.]

CHAIR BELLA: Your parting gift?

COMMISSIONER DOUGLAS: Yeah.

CHAIR BELLA: Yes, no problem. Just tell us which one you want. We'll sign it.

Welcome. I think this is your first time presenting with us. We looking forward to your remarks.

UNDERSTANDING MEDICAID MANAGED CARE PROCUREMENT

PRACTICES ACROSS STATES

* MR. DUNBAR: Thank you, Melanie.

Good morning, Commissioners. It's a pleasure to be here in person with you all today.

For this discussion, Moira and I are going to share some research with you focusing on state procurement practices with respect to Medicaid managed care.

For the discussion, we'll provide a little bit of background on the prevalence of managed care in Medicaid. We'll walk through findings from a recent study that MACPAC concluded in March, and we'll also discuss some potential opportunities to enhance procurement practices that we observed from these findings.

As for the particular study that we did, I want to give you a little bit of background. With the assistance of an external firm, we reviewed federal rules, statutes, and guidance related to procurement. We conducted an environmental scan of 52 Medicaid RFPs across 28 states that were released between September 2016 and September 2021. We also conducted interviews with Medicaid officials in seven states, interviewed CMS officials, as well as MCO representatives, consumer advocates, and

national procurement policy experts.

This work, along with the rate-setting research that was presented at the last meeting, all feeds into the broader policy question of Medicaid managed care oversight and accountability that the Commission has been exploring; in particular, federal mechanisms that can advance program goals related to access, quality, efficiency, and value. We hope that your comments here today will help feed into a more pointed discussion during the next report cycle, and we look forward to hearing from you about areas where you see concerns or opportunities to enhance procurement and other managed care issues.

Now for a little context. You've heard in previous meetings--staff have presented research underscoring the growth of managed care into the dominant delivery system for Medicaid beneficiaries. As this current snapshot shows, just about 70 percent of Medicaid beneficiaries are enrolled in managed care, and Medicaid spends a little bit more than half of its funds on managed care.

In general, about 282 MCOs contract with state Medicaid agencies across the country. It's worth noting

that states vary in the number that they contract with, from as few as one to two and as many as 25. It is worth noting that a plurality of states do contract with about three to five MCOs.

Despite the large number of MCOs that contract with states and the high percentage of enrollees in managed care, you'll see that overall managed care enrollment is concentrated in a small number of plans. In fact, a little over half of all managed care enrollment is concentrated in six large multistate firms.

One of the reasons that managed care is growing is states see value in it. As they're procuring their managed care programs, states look to MCOs for more accountability, increased budget predictability, as well as improvements in areas such as quality, access, and care coordination. In fact, most states use competitive procurements for their Medicaid programs and in doing so try to make major changes to their Medicaid programs, including shifts to more value-based payment approaches, integrating care, as well as implementing initiatives related to SDOH and health equity.

In addition to increasing state interest in

managed care, there's been some market dynamics over time that have helped shape Medicaid managed care into a competitive contracting environment. In particular, the Balanced Budget Act of 1997 made it easier for states to offer managed care without a waiver, and it also made it easier for plans to participate by eliminating the requirement that a plan had to have 25 percent of its membership in commercial insurance.

As such, managed care contracts are now among some of the largest that states procure, oftentimes exceeding billions of dollars annually. Just for a couple of examples, California paid 24 MCOs a little over $50 billion to serve about 11.5 million enrollees, and even a state as small as Rhode Island paid 3 MCOs about $1.4 billion to serve its 300,000 enrollees annually.

Given states' increasing investment in managed care, it's important to better understand the impact that the MCO selection process and procurement can have on the delivery system as well as program goals.

On that note, I'm going to hand things over to Moira so she can provide an overview of the findings from the study.

Thank you.

* MS. FORBES: Thanks, Sean.

So, yes, as Sean mentioned, to learn more about how the procurement process affects how well states can achieve their program objectives through managed care, we did a study consisting of an environmental scan; we looked at the procurement documents from all the procurements, almost all of the comprehensive managed care procurements across all 40-something managed care procurements that occurred over five years. We also did interviews, comprehensive interviews, with seven states and a number of other stakeholders. So I'll go through the highlights from our findings.

First, we confirmed, I think, what a lot of us know. CMS really has no role in the procurement process until plans are selected and contracts are awarded. CMS, of course, has to review and approve MCO contracts to make sure they comply with federal requirements, they have the standard contract checklist. There are statutory requirements for what types of organizations are allowed to be Medicaid managed care plans: they have to be licensed as health maintenance organizations or provider sponsored

organizations. And there are some regulatory requirements for readiness reviews in certain circumstances. If there's new populations or moving into a new region or if they're expanding to include long-term services and supports or things like that, the state has to conduct a readiness review and send those to CMS as part of a contract review. But, apart from that, CMS doesn't really get involved in the procurement, per se.

So, going into this, we knew about state burden and about -- you know, protest was one of the issues that the Commission has had some questions about. One of the things we were trying to get at in this study is are there things, given this very limited role that CMS has, that the federal government could take on or there are places where there could be more federal rules or more guidance that could streamline the process.

One thing we heard from pretty much everyone is that because states conduct the Medicaid managed care procurements and because there's a lot of different state procedures and rules and because what states are trying to do in Medicaid managed care is so different among states, it would really be difficult to have something like a

minimum or a core set of federal minimum purchasing requirements or specifications. It would end up being sort of a check-the-box thing. There's just too much variation in the maturity of the programs and so on, and there was sort of universal agreement that that would not be helpful.

But CMS is involved in some aspects of some Medicaid procurements, and certainly, CMS sort of more broadly is a managed care purchaser itself. So we did look at some of those to see if there were some things we could apply to Medicaid managed care.

A couple of things we found: there's a couple examples of places where states get enhanced match for certain activities, which includes external quality review organizations and the Medicaid management information systems, or really all of their state systems at this point. To get that match, states have to demonstrate to CMS that they are doing certain things, that there is advanced planning, that they're following open and full procurement, things like that. So, there are sort of precedents where there's enhanced federal match tied to certain contracts. There's more CMS sort of oversight or more guidance and more involvement in that entire endeavor,

starting with the procurement.

As I said, CMS, you know, not the Centers for Medicare and Medicaid Services and CHIP services, but other agencies within CMS, certainly is a large managed are purchaser. The Center for Medicare reprocures all Medicare Advantage plans every year, starting with a public rulemaking process. There's an application process and also every year CCIIO develops updated rules and specifications for the qualified health plans if they wanted to be listed on the federal exchange. Those are enormous efforts that CMS goes through every year. So there's certainly knowledge within CMS about purchasing that we could look to. We didn't focus on that as part of this study, but it's certainly up there.

So, as we've said many times before, states use Medicaid managed care to achieve their program goals, and the procurement process is really when they take those major steps forward. The states we spoke with all said that they can make these incremental steps from year to year through contract amendments and so on, but if they want to add a new population, move to a new region, carve a service category in or out, that's a big enough change that

it needs to be done through the procurement process.

But what we also heard is that because procurements come around every few years, states really use that opportunity not just to make structural changes, but to think more strategically about their program goals, what are they trying to accomplish, and then design that procurement approach so that they can select managed care plans that are capable of helping the state reach those goals in addition to just fulfilling those basic requirements of the Medicaid program. And Sean referenced some of those specific goals. We heard about things like implementing specific delivery system reforms and better integrating complex services and care for vulnerable populations.

We also heard some very, very specific things like states that have a priority or a strategic goal around helping people move out of the justice system back into the community and wanting health plans to have dedicated positions to do that. So, whatever a state has identified in terms of its Medicaid strategic plan can get translated into purchasing requirements.

The tradeoff, of course, that states make when

they shift to managed care is that they do need to be very strategic in thinking about what that program design is and what kinds of managed care plans they want to contract with, and in particular, do they want to be more directive or prescriptive, or do they want to be more flexible and outcome-focused? Some states are very directive. Massachusetts has said we want our health plans to help us move to accountable care, and they have to work with providers, to contract with them to achieve that goal, and they are very clear about that.

Other states like Oregon have said we want to have a lot of flexibility, and we're going to have very specific targets for savings and targets for quality, but we're going to give you the flexibility in how you achieve that. So states sort of have to decide which approach you're going to take, and then you're locked into it for that four or five years that you have the contract.

In most states, that cycle is four or five years. Obviously, the procurement itself is a big effort. These are huge procurements, not just in terms of dollars but in terms of just the level of effort, and managing that effort while also running your program is obviously a huge lift

for the state. Most of the states, both that we talked to and then looking at those procurement documents and our environmental scan, it looks like it takes on average about 18 to 24 months when you look at the start of the public input process through actually releasing the RFP and reviewing the bids and then getting to implementation. So a year and a half to two years is a long time to be doing this on top of everything else the state is doing.

We heard from states that spend a long time on that front end on the planning -- and there's a lot of like, "Oh, my God. We spent so much time doing this," but none of them said it was too much time. Certainly, what we heard was the more time you invest, the better your return on the investment.

We did hear from a number of states that when they felt like their timeline was compressed, that was very challenging from them, and timelines are compressed sometimes for a number of reasons, often that there are some of those decisions that are being made about what should this program look like. There's disagreements between maybe the executive and the legislative or between the agency and some of the other agencies about what the

structure of that program will look like, and that ends up sort of bumping into how many contract renewals they can do. And so then they are in a hurry to get the program reprocured before their authority to keep renewing their existing contracts runs out.

And that leads to they may have to compress the public input timeline, they may have to compress how much time the MCOs have to respond, they may end up being rushed on implementation, none of which an agency thinks is a good way to handle the procurement.

And then, of course, there's protests, which at the very least extends the process. That creates cost for the state. It creates cost for the plans that are selected and not involved in the process. It creates cost for the plans who end up having to be extended when they maybe weren't planning to, and it certainly causes confusion for beneficiaries and for providers and a lot of disruption.

Another thing we heard from states is that they can and do get support in a lot of ways: they use their existing program support contractors, they get support just for procurement, they leverage state purchasing office resources.

They all stressed that the state agency staff needs to direct the process or be highly involved in the process. They need to address the purchasing specifications, reflect the program goals, get the evaluation team that has the appropriate expertise, but every state we talked to also had a different way of doing that. Some had very high-level state agency staff. Some pulled in people who were the ones who do the day-to-day health plan management. Some people pulled in staff from all over the agency. They all had pros and cons for the way they did it, but nobody was like this is the way to do it. There's no secret sauce.

They all agreed that you have to have that access to the purchasing expertise. Managed care procurement overall is not something you can totally outsource. What they're purchasing is integral to what the agency does, but they need to have both that program expertise and the purchasing expertise.

So, a little more about what's in the procurements that we saw. Always, every state has its own way of doing things. We saw some commonalities across the 50-plus procurements that we looked at and from the states

and from the national experts that we talked to. One is that states have been less likely to compete on price over time and to focus more on plans' ability to deliver on programmatic elements. It wasn't all the states. There are some that are still requiring plans to compete aggressively on price, and some states also require plans to negotiate, if not on price, then in other ways that they can deliver in extra ways to the state.

But between the actuarial soundness requirements and the examples of some states that have used pretty competitive price bids in the past and had plans that came in pricing aggressively and then been unable to deliver for the price that they offered, states are really focusing more on program and price stability.

States are also increasingly asking bidders to use what they're calling a show-don't-tell approach, like they're using clinical scenarios relevant to their population and their program and asking bidders to explain in narrative format how they would respond, although they're also asking bidders to provide a lot more data and evidence of past performance, results from other states.

States are really trying to distinguish which

bidders can deliver, and they're also trying to get bidders to put things in the proposals that could be scored more objectively. They want to identify the best bidders for their programs. The states are very focused on protests. They're trying to do what they can to reduce the chances of successful protests. They're working to develop those rigorous evaluation approaches.

There's a lot of tension: they want to have the subject-matter experts, a lot of states are including consumers on their evaluation teams, and they're putting regional people on their evaluation teams. They're trying a lot of ways to really bring in all kinds of different views to evaluate the plans in ways that will be meaningful to the program, but at the same, they're really focused on having a lot of rigor so that they don't have a successful protest. And it's a difficult thing to balance. It's resource-intensive. It requires a lot of different kinds of support and expertise, and it's one of the reasons that they need that time and they need that support and they need a lot of resources to do that.

So, we asked also what are other practices that support this effective procurement, which would be a

procurement that results in contract awards to qualify bidders sort of on the timeline that you're aiming for.

A couple of themes came out. One is having enough time, having these longer contracting cycles so states have time to plan the program changes, plan and execute the procurement, and then the managed care plans that you've selected can actually do the things they've said they were going to do. They have to implement these changes. You have a strategy; you hire the plans. Then they have to go do them. They have to contract with the providers. They have to work with the beneficiaries to implement these innovative things they've said. Then they have to see if they're working, fine tune, measure some results, you know, those sorts of things. So it takes a couple years. Then you can sort of sit back, think about, okay, what will we do different. That's why all the states said you want to have some amount of time, even though then you have a tradeoff with maybe some loss of institutional knowledge there.

The second theme was around transparency and public engagement. We heard from a lot of stakeholders that public input and buy-in to the state approach is

important, especially given that long-term nature of the managed care contracts, the effects of these contracts on providers and beneficiaries. It's clear, certainly, from our conversations with states -- and if you read state health news -- this, as Sean said, is a very competitive market.

The managed care plans, certainly, put a lot of effort into procurements long before they happen, and it's just shaping that market. You can see legislative and executive action in many states that's dictating what these procurements look like, how many plans, minimum and maximum number of plans, the number of regions, what types of plans can bid, time frames for purchasing and all of that.

Certainly, other program stakeholders have opportunities to offer input to states, but not all the states have a formal or an extensive public input process. About half the states in our environmental scan had a really specific process, like a request for information or public town halls or things like that. It wasn't universal.

There are no federal requirements for public engagement and transparency around a managed care

procurement, despite the significance of that effort to the way that the program plays out compared to other sorts of program changes that do have federal requirements for public transparency.

We heard from a lot of stakeholders about the effect that the public process has. They believe in the success of their programs, where those public processes happen at the state option.

And then, finally, one of the questions in our study was trying to understand the relationship between the approach a state takes and whether that -- how much that drives the outcomes the state can achieve, and we have certainly heard that as states have gained more experience, particularly over the last 20 years, they have become more strategic purchasers. They don't just automatically renew, using the same set of questions, the same program design every couple of years. They are more likely to leverage their purchasing power, require the managed care plans to compete on their ability to innovate and advance program goals.

As I've said, they all have their own approach to how they conduct the procurements. We didn't find any

evidence on what approach is the most effective, apart from those couple of practices that I mentioned on the previous slide.

The other point here is that the Medicaid managed care procurements, because of those -- because of their sheer size, they are difficult to administer effectively. They're very attractive opportunities for plans, but they require significant investment from the plan side too, and there's a small number of very large plans and a handful of almost as large plans, and only 40-something states have Medicaid managed care, and they only reprocure every four or five years.

So, each procurement is a very significant opportunity. It's difficult for states at this point to find ways to structure these procurements in a way -- they're almost limited by the market. You can't really find a way to let the little guys in and not also advantage the big guys. I mean, the market is very mature at this point, and states are, as I said, very mindful of the risk of awards -- I'm sorry -- award protests. They've very disruptive to program operations, they increase cost. They delay implementation. They cause confusion, and states are

aware that almost any strategy that they take to try and avoid protests is almost irrelevant because the size of some plans, the cost of protesting is just part of the cost of doing business. So it's just part of the process now, what we hear from many states. The opportunities are too big.

So, unfortunately, we hoped to find the solution to getting rid of protests and did not.

Here's what we did come up with. In terms of potential opportunities based on the study and what we learned, there are a couple of changes that we think could better support states in conducting effective Medicaid managed care procurements. The first is about providing states with technical assistance and more resources to support procurement.

CMS provides lots of toolkits and lots of roadmaps, and they're calling them something else now. I can't think, but lots of resources to states in all kinds of ways, technical assistance these days, and they haven't provided so much in the area of procurement, but this is an area where the states certainly felt that if they have the ability to share more with other states would be helpful,

especially given the periodic nature of procurement.

The other would be to consider some way similar to what's done for MMIS -- to have some kind of enhanced match for procurement activities so that states could get more of the external kind of support that would be helpful, that states are not always able to justify. It's difficult for states to get, sometimes internally, more support for admin activities.

The second group of options would be around additional federal process requirements, which would be to require states to have a public engagement process. Where CMS could do some sort of state readiness review, right now it only requires states to conduct a review of managed care plans, but if there had been prior procurement problems, protests based on technical failures, that CMS could do more to make sure that the state is ready. Again, the protests are disruptive to the program, to the beneficiaries, to the providers, and so, if there had been previous issues from a technical side on a procurement, there could be reasons for CMS to want to be more involved there. And some of these things could be tied, if there was enhanced federal match, to more planning.

Then the last thing I didn't really talk about in the presentation, but it would be additional contract review standards to ensure MCO commitments are incorporated into contracts. Managed care plans make a lot of promises in their procurements, and some states make sure those are carried through into the contracts. Not all states do that, and the federal contract review does not consider whether states are making sure those promises are carried through into the state contracts, but obviously, these are huge contracts being awarded on the basis of the promises, the commitments the plans are making in their proposals. So there is certainly some federal interest in making sure that what a managed care plan has committed to and gotten an award based on is certainly carried through into its formal contractual commitments.

So that's what we found from our study. I'm happy to go back to the prior slide, but as you know, we last month talked about capitation rate options. So we'll be doing more work over the summer. We're interested in your feedback on these ideas, or we can answer other questions about what we learned in our study. And then we'll take whatever feedback we get today. We can further

develop any of these ideas and come back this fall with further work, if there's things you would like to move forward into potential policy recommendations.

CHAIR BELLA: Wonderful. Thank you very much. A lot there.

I want to open it up for discussion about -- my bias says yes. We should be looking at some of these things, and so let's get specific comments from folks on particular areas of interest.

Bob, then Darin, Tricia.

COMMISSIONER DUNCAN: First of all, thank you for this information. I appreciate it, and I appreciated your recommendations.

As we get to additional federal procurement process requirements, I wanted to question on public engagement. Can you define when you say public engagement? Is that beneficiaries? Is that providers? Who were you thinking of? Because I do definitely think we need to include that broad set.

The second is I was wondering if there's a possibility, as we talk about health and equity, if we can incorporate that into a minimum recommendation based on

where CMS is headed and our conversations.

Then the last is I really appreciate the comment about promises kept of what's promised in the beginning and what is actually delivered. I do think there has to be some type of standard we hold people do.

CHAIR BELLA: Darin and then Tricia.

COMMISSIONER GORDON: Thank you for the work. Obviously, I think it's a really important area.

I think providing states with technical assistance and additional resources, I think there's something there, but as you note, the federal government really isn't involved in those processes. So I think it's really how the federal government can facilitate bringing the states together and elevating and sharing of best practices across the states.

Also, on your comment about the contract review standards to ensure MCO commitments are incorporated in the contracts, again, I think that was something that would possibly bubble in that sharing of best practices. As you noted, some states do that, but I do think more information sharing is incredibly important.

The enhanced federal match for procurement

activities, could you explain what that would look like, given that we noted that the state typically is using state staff that are doing other activities? Just a little bit of thought of that idea to help me understand what we might be considering.

MS. FORBES: So, we haven't looked into this a whole lot. We did this study, but what we could look into is how the advanced planning process works for the MMIS because it's our understanding that states have to provide information to CMS about what they plan to do, and then they are approved to execute that plan and receive higher match for doing that. So, we could look into that and see if there is something that could be somewhat parallel.

COMMISSIONER GORDON: Parallel. Okay. Thank you. That's helpful. Appreciate it.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: Yeah. I'm definitely in favor of some kind of minimum public engagement requirements.

I think the problem in terms of engaging some stakeholders is the lack of information about how plans have been performing in order to inform the areas that need

to be improved in the RFP, right?

So, there's some element here, but we often talk to stakeholders about reviewing the EQRO reports, looking at the state quality strategy, pulling out pieces that stakeholders may feel are missing. I mean, we often talk about do a search for maternal, for pediatric, for child and see what you find, right? And, if there's a lack of anything specific on those particular points, then that's something you want to raise as being an important element of the procurement process that we're going to see some emphasis on improving the quality of care for children. But there are many constituencies that that would certainly work for.

But I think that we really have to continue to hit hard on the release of data by -- at least the quality reports or quality measures by managed care plan in all the states, and somewhere we need to make that a requirement. Otherwise, we just are operating blindly.

CHAIR BELLA: Thank you, Tricia.

Toby, then Brian, then Verlon.

COMMISSIONER DOUGLAS: I just want to echo this is a really, really important area to study and to provide

recommendations.

I do think the direction, while it's not going to solve technical assistance resources, ways that we can come up with federal requirements will help. I mean, the continual litigation, it does get to supporting states with structures, process, both in terms of how to evaluate these very, very complicated -- in some cases, the staffing doesn't have the experience, the depth on how to evaluate managed care plans, and so it then leads to some of the risks of litigation or just the process leading up to the procurement, so knowing all the checks and balances in advance as well as during the review to continue to lessen those risks, so that we can hopefully see a problem, because the -- as we know -- and this doesn't get into it -- just the delays when there are litigation, the impacts it has on beneficiaries. It has impacts on the performance and all the broader implications of not being able to have timely contract changes.

So, I think the more we can come up with this type of structure to support and provide the resources to something that most states just don't have the expertise in doing.

CHAIR BELLA: Thank you, Toby.

Brian?

COMMISSIONER BURWELL: I agree this is an extremely important area that MACPAC should get into, and there's quite a lot of content there that we can get into.

I frankly think that this is a good start, but I think MACPAC needs to develop a greater body of information about the MCO contracting process before we would be ready to make recommendations.

I would really like to see a study or a chapter on kind of real-world procurement processes like, for example, all procurements that occurred last year or one year. I'm very interested. I know that's kind of a small market, and there are dominant players in the market, but just basic things like how many proposals were received, who the incumbents were, how much turnover is there in contractors, so how many were awarded. Was there a protest? How did the protest get resolved, and how long did it take?

If there are kind of processes around -- I know when incumbents lose contracts, how their members are dispersed among the new contractors, or sometimes if

there's a new contractor that comes into the market as a result of a procurement, sometimes they are automatically -- they get favored in the assignment process, so they can build up their measurement, their membership, those kinds of very, more operational things, and in terms of enforcement of contracts, what processes are in -- I mean, I believe there are annual assessments or audits where the states go out and ensure that contract requirements are being adhered to.

There's a whole range of operational things that I think we should -- MACPAC should become familiar with it before its ready to make procurements.

My other comment was I do think this is an area that the CMS has much less involvement and much less expertise, and my instinct is that I don't really have a good sense of where the federal government could improve the process. My instinct is for CMS to keep more of a hands-off approach on this. It's a state business. They have the right to procure and select the contractors they want. That could change, but I am much more in the camp of leaving the states along in this area than probably other areas of Medicaid policy.

CHAIR BELLA: Thank you, Brian.

Verlon, then Heidi.

COMMISSIONER JOHNSON: Thank you. Thank you for this. It's very helpful, and, Sean, nice job for your first time around. We appreciate you.

So, I appreciated the examples that you gave as well in terms of other areas, and I was just wondering -- I remember with the duals financial alignments, was there a lot of technical assistance, I feel with that? Did you look at that as well in terms of CMS's role with the duals?

MS. FORBES: We didn't look at the duals. No, no, no.

COMMISSIONER JOHNSON: Okay. I just remember being involved in that to some extent. So that's maybe one other area you might want to check into as well.

Then from the MMIS perspective, I think that was also a good opportunity too to see what's happening there, considering it's not as much, but it is a large volume as well, and so just having been involved in that process, I can really attest to the fact there is a lot of technical assistance provided to the states, a lot of back and forth. And so I think it would be really good to explore that a

little more too as well to determine if there's some way we can have some of the same strategy over here.

And other than that, just a great job. Thank you for this. I'm looking forward to really seeing this move forward.

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: Thank you. This is super interesting, and I agree with everything that's been said before. I think we have a lot of alignment and the belief that this is a good role for MACPAC to get more informed and potentially make recommendations.

I have a lot more questions than I have answers, but one of the questions I'd like to understand, the protests and litigations a little bit more. What kinds of things are we seeing lead to disagreements that end up taking so much time? I just didn't feel like I had a good handle on that.

I'm also curious about the MCOs that have a commercial market versus those that are Medicaid only. I have no idea which would be better for consumers. Is it better to have MCOs that are completely focused on their needs, or are the ones with a commercial payer mix able to

leverage their provider networks to have better access?

Along with that, thinking of this idea of the state as a purchaser and their ability to leverage their purchasing power, what I heard you say is they can't really leverage price, that they don't have -- that they try, but that there's not as much meaningful movement in price as maybe we thought that there would be with managed care, but that it's leveraged in other ways. So, I'm curious about other ways.

One of the things I wondered is, are any states leveraging their purchasing power as a state who purchases for other populations? For example, public employees. Has there been any effort to say, okay, we are going to bundle these populations to try to get more bang for our buck for the Medicaid population? That would be a very big move, but I would be curious to know if anybody has considered it.

That's it for me.

MS. FORBES: Do I comment?

CHAIR BELLA: Sure.

MS. FORBES: On the protest, the protests are a mix. I mean, there are states that have made -- protests

have been raised on the basis of technical errors, errors in scoring, potential conflicts of interest between members of the evaluation team with improprieties. So there have been -- five of the procurements that we reviewed, courts threw out, and they had to be reprocured because of failures of the procurement process.

But there are all kinds of grounds on which managed care plans can protest, and in some cases, states have had to weigh: Do I want to delay implementation of my program while this protest plays out, or do I want to go ahead and contract with this plan that is adequate but was not – that didn't meet what our threshold was? They are fine…they came in fifth, and we want to take four.

And so there are states that, you know -- and that's why plans protest sometimes because either -- I mean, sometimes it's worth them to sort of invest the money in trying to wear a state down, and there were states that we talked to that said, "Yeah, they got us." And that's part of the business.

Like I said, it's a very competitive market, and as Sean said, these are contracts worth billions of dollars, and they don't come around that often. So it's a

mix, but clearly, some plans are rolling the dice, and there are states that do things like if you protest and you lose, you can't bid next time, or you have to put up 1 percent of the contract value if you want to file a protest. But 1 percent of the contract value, again, is a million dollars, which if it's a billion-dollar contract and you're a Fortune 50 company, it's still not enough to dissuade you.

It is enough to dissuade a small local plan who might have real problems to protest. I mean, this is the problem that states are sort of struggling with is what kind of tools can they have. It's trying to balance the market when they're trying to encourage sometimes local provider-sponsored plans or these Medicaid-focused plans. That's what some of the states were sort of trying to -- the market is very sort of -- I don't want to say polarized. No, not in a bad way, but there's plans at both ends, very large plans and very small plans.

In terms of MCOs that are commercial versus Medicaid only, in the '90s, I think there was a sense that a commercial plan might have a better and broader network than a Medicaid-only plan, and then they got rid of the

75/25 rule. I don't know that there's any research or evidence -- I just don't know of anything that would suggest that the quality for the population -- I mean, Medicaid plans are very focused on serving Medicaid beneficiaries. Medicaid covers a lot of services that a commercial plan doesn't cover, and they've really built networks to serve their populations. So I don't know that we've compared different kinds of -- like the patient mix of different kinds of plans, I just don't know that we have any. We can look into that.

COMMISSIONER ALLEN: Yeah. My question is, would it be possible to look at that, using T-MSIS? I know the plan -- do you have plan data in T-MSIS?

MS. FORBES: Well, we do, but only for the Medicaid population.

CHAIR BELLA: Some of this stuff, we can probably take offline.

MS. FORBES: Yeah.

CHAIR BELLA: I mean, I think it's really good to surface.

MS. FORBES: Yeah.

CHAIR BELLA: I just have my eye on time. That's

all.

MS. FORBES: Yeah. But, in terms of states as purchasers and leveraging price, that's -- I mean, the benefit of that is I think that states are able to -- I think the benefit of the actuarial soundness rules and what we certainly heard in that project was that they're able to design programs, and that both the plans and the states know that what the state is buying is something that the plans will be able to provide, and that there's sort of that federal check within the actuarial soundness guidelines, that they'll be able to pay for what is included in that package.

So, I think that’s part of the reason that they're not leveraging on price so much is that they're getting a lot of -- the states certainly feel like they're getting a lot of value.

CHAIR BELLA: Tricia, you look anxious over there. Is it on that?

COMMISSIONER BROOKS: Yeah. Well, sorry. It goes back to Toby's comment about evaluation and to work we may do on program integrity.

Florida just levied the largest fine ever, $75

million, on poor payment processing, claims processing or denials. I think that's another element, where in PERM, we only look at whether the state paid the right capitation rate, but we don't know what the plans are doing inside that in terms of adequate or appropriate payment. And I think it's just another aspect of the evaluating the plans for the purposes of re-procurement.

CHAIR BELLA: Okay. We are at time. I'm going to let this run a little bit longer because there's stuff we still want to get out, and I don't think we need 45 minutes for the next session, but just please be cognizant of the fact that we are bumping up against the clock.

Stacey, then Martha, then Kisha.

COMMISSIONER LAMPKIN: Thank you. This is great that MACPAC is digging into this. I really appreciate it. It's a hugely important and influential state Medicaid agency process.

I had two quick questions and one observation. First question, and I think this is quick, is I know your focus wasn't on separate CHIP programs, but is there any takeaway about whether any of this would be different, particularly with respect to any federal requirements or

rules around separate CHIP plan procurement?

MS. FORBES: I'll have to look. I'm pretty sure they copied over, and it's completely applicable.

COMMISSIONER LAMPKIN: Okay. Thank you.

MS. FORBES: I'll have to double-check.

COMMISSIONER LAMPKIN: A second question is around, you know, you commented on the mix of plan types, and as I think about the evolution of the service delivery model and the growing focus on accountable care and placement there, I am curious about whether you saw many states with any kind of preference for provider-owned entities or whether there's a trend to a growing preference of provider-owned and local entities versus larger national plans.

If there is or if that's part of an evolution in the service delivery model, what the capital requirements for the local, regional, provider-owned plans, whether that's kind of keeping them out of the market. That question may be too complex to try to answer now, but I just wanted to put it out there as a possible area to explore further.

Last comment, real quick, we talked about the

challenges associated with the protest and enrollment disruption as a result of that. So my understanding is that there are typically continuity of care requirements in contracts that help try to minimize the impact on beneficiaries of that transition. Do we have any sense of how well those work? Is there any way to look? That might be something that MACPAC wants to consider in light of how trampled we are about protests and some of the disruption that may come about.

That's it.

MS. FORBES: So we haven't looked at that. I will say CMS is actually planning to issue guidance to states on how to handle continuity of care and eligibility transitions during these times because that is the specific area in which CMS has a concern. So they're going to issue guidance to states on how to handle that to make sure that beneficiary rights are being protected when there are these sort of unpredictable timing around plan changes, associated with protests.

CHAIR BELLA: Thank you, Stacey.

Martha?

COMMISSIONER CARTER: Thanks. This may be a

parking lot issue. I don't know, but I want to raise it because it sort of ties to the issue of promises kept and transparency, and that is related to how MCOs then contract with the provider organizations.

That's the role I've been in. Maybe a new MCO comes in, and they make promises about how timely payment and what their network is going to look like and the kind of services that they're going to provide, and they either do or don't do that. It leads to beneficiary discomfort, frustration, clinician frustration when they think there's going to be a network and then there isn't.

So, to the extent that we might want to look at that midlevel between the MCOs and the beneficiaries, there is this whole provider set of organizations and how they're satisfied or not satisfied with how they're being treated by the plans, because that rolls down into the care for the beneficiary. What complaints have the beneficiaries had? What are the denials, especially denials of services, that have come through that plan?

I think that transparency is really important, and as the person who had to make decisions about whether to contract with this or that payer, that would be really

helpful to know.

CHAIR BELLA: Thank you, Martha.

Kisha and then Dennis.

VICE CHAIR DAVIS: Thank you. I will pile on that I think this is a good place and direction for us to be doing.

I just would love to hear more, as we continue to explore this, on how states are using the procurement process to advance equity issues, to explore drivers of health, and getting beyond just, yes, the plan is going to screen, but what are the outcomes that are coming from that and how successful they are in really being able to push more in addressing those issues through the procurement process.

CHAIR BELLA: Thank you, Kisha.

Dennis?

COMMISSIONER HEAPHY: Thank you. I was really surprised that there are states that don't go through a competitive bidding process. I'm wondering how that affects quality.

Then with readiness, Kisha, your point is how is equity integrated into readiness review and the contracting

processes. Myself, as a consumer, I've been involved with writing RFIs to stay engaged in the procurement process, writing scenarios and being in the room with the plans and hearing the responses, but also, after that, also engaged in the ongoing, are they actually fulfilling the contractual requirements?

It seems that that's a really important consumer engagement. Ongoing consumer engagement is really important, but I think the area that I think, just from my experience, would need more understanding is the voices that aren't at the table, and how do we engage voices that are not at the table? How do we ensure quality measures and engagement involve populations that are not at the table? Think of African Americans, linguistic minorities, and other folks who voices really matter but just aren't there, so thanks.

CHAIR BELLA: Thank you, Dennis.

Fred has a quick, probably last comment.

COMMISSIONER CERISE: I was interested in Stacey's question about the provider-based organizations, if you're seeing any trend or preferences to the way states are accommodating that. Maybe it's because you didn't have

anything on it, but you guys didn't address that. I'm just curious if you either have something on that or if that's something you can take a look at.

MS. FORBES: So, one state that we talked to had a legislative approach to that in the procurement in which they specifically contracted it in an open way and specifically contracted with provider-sponsored organizations. That's the only state I know of that had an approach that allowed -- North Carolina. North Carolina. -- that allowed -- you know, and it was specifically set up to do that, and most of the other states we talked to said that -- I mean, I can get it to you offline, but, you know, it's challenging to sort of structure things in a way that doesn't -- unless there's a specific set-aside in a procurement for a specific type of plan, it is otherwise difficult to have scoring preferences to get you to a certain outcome. You have to have an actual set-aside.

CHAIR BELLA: So, it looks like a couple of you might think that other states apply, so let's shoot Moira a note. Maybe it looks like Texas and California, based on your guys were jumping out of your seats.

Okay. Since this is your last meeting, Toby, you

get some light.

COMMISSIONER DOUGLAS: My last and just to go full circle, I just get concerned hearing all this. The procurement can't solve everything, and we need -- as you think about problems here, there are stakeholders. There's a whole waiver engagement process. There's so many other ways. So what is the procurement about? What is the vehicle, and what are the problems that we're trying to solve in terms of ensuring a successful procurement?

So those are my final words. Thank you.

CHAIR BELLA: Yes. So, for the newer Commissioners, this process is like the first time we introduce a topic, we're throwing everything on the wall, and we will work our way through where we want to spend time, where we think we can find evidence, where we might want to bring a panel. We love having panels. So this is it. If it feels uncomfortable to anyone, this is exactly how we're supposed to be feeling right now, with all of this information, and these guys will take it away and naturally come back with specific areas that we might want to focus on going forward.

I think you got the main answer, which was is

there any interest here, which obviously is a resounding yes from the Commissioners. Do either of you need anything more from us at this time?

MS. FORBES: Anyone not talk? I think we've got it.

CHAIR BELLA: Okay. Great. Thank you very much.

Thank you, Commissioners.

We're in our last session. So we have an obligation to review reports that go to HHS -- or I'm sorry -- HHS reports to Congress. There are two of those in front of us for review. Our job -- Anne, do you want to reiterate what our job is in our review of these reports, please?

EXECUTIVE DIRECTOR SCHWARTZ: Sure. The purpose of reviewing these reports is to provide Congress feedback when they request certain reports from the Secretary, on our assessment about what was found and whether the Department answered the questions in the report.

CHAIR BELLA: Wonderful. Melinda and Lesley, welcome. I think this is your first time presenting to us. Great. We'll turn it to you.

REVIEW OF HHS REPORTS TO CONGRESS: (1) MANAGED

CARE AND THE INSTITUTIONS FOR MENTAL DISEASES EXCLUSION; AND (2) BEST PRACTICES FOR PRESCRIPTION DRUG MONITORING PROGRAMS

* MS. BECKER ROACH: Thanks so much. Okay. Good morning.

In this session, we'll review two reports to Congress issued recently by the Secretary and discuss potential areas for MACPAC comment.

The first report looks at managed care coverage for beneficiaries in institutions for mental diseases, or IMDs. It was issued by CMS acting on behalf of the Secretary.

The second report, which Lesley will discuss, focused on best practices for state prescription drug monitoring programs, or PDMPs. It was issued by CMS in collaboration with CDC.

For each report, Lesley and I will provide some brief background information, summarize key findings, and identify areas where Commissioners may want to provide comment. Following the meeting, staff will draft letters to the Secretary and relevant congressional committees reflecting your feedback.

The 21st Century Cures Act directed the Secretary acting through CMS to study the use of managed care in lieu of services to cover beneficiaries in IMDs. CMS was required to look at several areas, including the extent to which states allowed managed care plans to use this authority, the number of beneficiaries receiving services in IMDs, the number and lengths of stays in IMDs, and how plans determine when to pay for services in IMDs in lieu of other covered benefits.

The IMD exclusion generally prohibits payment for services in IMDs. "IMD" is a Medicaid-specific term that's defined as a hospital, nursing facility, or other institution of more than 16 beds that primarily serves patients with mental illness or SUD. Despite the statutory payment exclusion, there are several ways that states can pay for services in IMDs, including through managed care.

In the 2016 managed care rule, CMS clarified that states can pay for services in IMDs in lieu of other services under certain conditions. Among them, services must be medically appropriate, cost-effective alternatives to covered services, and they must be voluntarily chosen by the beneficiary.

Federal financial participation is only available for IMD stays that don't exceed 15 days in a given month. Many states were using the managed care in lieu of authority for IMDs prior to 2016, but they did so without this 15-day limit.

In the report, CMS found that 32 states made capitation payments for beneficiaries in IMDs as permitted under the 2016 managed care rule. They did so primarily to increase access to inpatient behavioral health care and to expand the continuum of care for beneficiaries with behavioral health needs.

Most states said that the effect on access to inpatient behavioral health services was unclear or was too soon to assess.

States reported that their use of the IMD in lieu of services authority has had varying effects on capitation rates, with about half the states experiencing an increase in rates and about half reporting a decrease.

States used different strategies to avoid making full capitation payments to plans when stays exceed 15 days. For example, many states cover these stays with state general funds or prorate capitation payments to

reflect the days of the month that the beneficiary was not in an IMD. A few states reported using other strategies like disenrolling beneficiaries from managed care.

The number of beneficiaries with at least one IMD say in lieu of covered services in the past 12 months varied widely across the states, ranging from fewer than 100 to nearly 50,000. The percentage of beneficiaries with at least one IMD stay ranged from less than 0.1 to 3.8 percent. The report doesn't explain the reasons for these variations, though CMS notes that coverage of IMDs prior to the 2016 managed care rule may be associated with higher rates of IMD use.

CMS found that the number of IMD stays per Medicaid beneficiary in the past 12 months ranged from 1.0 to 2.8 stays. Average lengths of stays ranged from 4.2 to 23.2 days, with roughly 80 percent of states reporting an average length of stay of fewer than 10 days.

Most states and plans reported that decisions about when to use IMDs focused on making sure beneficiaries received the appropriate level of care. IMDs are used when beneficiaries require an inpatient level of care and beds aren't available in non-IMD settings.

State contracts with managed care plans require that in lieu of services are voluntarily chosen, but few states reported having specific requirements or instructions related to consulting with beneficiaries about their options.

The Commission's comments in this report could highlight areas where CMS's findings align with observations from MACPAC's prior work as well as areas where the report raises additional questions. The report highlights the in lieu of services authority as an important pathway for covering beneficiaries in IMDs.

The Commission has previously discussed the role of IMDs in supporting access to inpatient and residential treatment, which depending on an individual's treatment plan, maybe the most appropriate setting for care. The Commission's prior work has noted that nearly all states make payments for services in IMDs through various exemptions and authorities, including Section 1115 demonstrations and managed care as discussed in this report.

To our knowledge, this is the first detailed picture of how states are using the IMD in lieu of services

authority under the 2016 managed care rule.

While the report offers important insights into the use of this authority, it also suggests areas where more information could provide a fuller understanding of the findings presented.

First, CMS found that IMD use varies considerably by state, but there's limited discussion about the factors contributing to those variations.

Understanding these circumstances, particularly in states with the highest rates of IMD use, can inform efforts to ensure beneficiaries receive care in the right settings.

The report also raises questions about how managed care plans engage beneficiaries prior to placement in an IMD and whether beneficiaries have the information needed to make informed choices.

As previously mentioned, few states reported having detailed requirements or guidance to make sure beneficiaries have a meaningful choice between IMD and non-IMD settings. Only one state instructs plans to consult with beneficiaries about how their health and quality of life may be affected by placement in an IMD versus the use

of an alternative covered service or setting.

Finally, the report raises questions about why states disenroll certain beneficiaries from managed care and the effect of that practice on continued access to services. As mentioned, CMS found that a few states suspend or terminate the beneficiary's enrollment in managed care to avoid making full capitation payments when IMD stays exceed 15 days, but they have reason to believe that these practices may be more common. While these strategies are described as ways to avoid making full capitation payments for long IMD stays, it's unclear why states appear to take different approaches when a beneficiary is in a public versus as private IMD. It's also unclear to what extent disenrollment from managed care may affect care continuity.

I'll stop there. We have time now for Commissioners to ask questions and provide feedback on these potential areas for comment before we shift gears to Lesley's presentation. Thank you.

VICE CHAIR DAVIS: Thank you, Melinda.

Just a reminder, I see you, Martha, but this is for areas of comment on this. We're not redebating IMDs.

Go ahead, Martha.

COMMISSIONER CARTER: Got it. We are not debating IMDs.

It's confusing to me. When we talk about IMDs, there are really two different areas that we're talking about, behavioral health and substance use disorder, and it seems like it might be interesting or helpful to disaggregate that so that when we're talking about policies and our questions about them, that whether we're talking about behavioral health, psychiatric care, or we're talking about substance use disorder. I don't know if that would be helpful, but it seems to lump it all together. It doesn't get to some of the -- it blurs the issues.

MS. BECKER ROACH: I can just mention the report does differentiate between states that are using the in lieu of services authority in managed care to cover inpatient psychiatric and/or SUD treatment, and we can try to be more specific about that in the comment letter.

COMMISSIONER ALLEN: I wasn't here for the IMD work, and so a lot of it, I don't understand. But I would assume that most of these admissions are coming from an emergency department, and is that true?

MS. BECKER ROACH: The report doesn't address that. So that's something we can get back to you on.

COMMISSIONER CERISE: I just have a clarifying question. To be eligible, the placement has to be voluntary, like the beneficiary has to have choice there as well, and so that rules out the involuntary commitments?

MS. BECKER ROACH: Yes. So in lieu of services, whether we're talking about IMDs or more generally, have to be voluntarily chosen. The report doesn't speak to sort of how this might intersect with involuntary commitments. It just notes that voluntary nature of in lieu of services.

VICE CHAIR DAVIS: Anybody else?

It seems like the questions that you've raised seem every appropriate from the letter. I think that's why you're hearing the silence. You've caught everything, and there's nothing that we think is missing, so nice work on this. We look forward to seeing the draft letter.

MS. BECKER ROACH: Great. Thank you.

* MS. BASEMAN: Thank you, Commissioners.

I'll now move on to the report about prescription drug monitoring program best practices. I'll start with some brief background on PDMPs, then summarize the

takeaways from the report, and lastly discuss potential areas for MACPAC comments.

PDMPS are electronic databases that track prescriptions of controlled substances. As of fiscal year 2018, all but one state has PDMPs.

State boards of pharmacy or departments of health typically operate and maintain PDMPs. State policies governing the operation of an access to PDMPs vary. For example, states can specify which providers are required to track the PDMP -- or sorry -- to check the PDMP and at what frequencies, what substances are tracked, and if PDMP data can be integrated into electronic health records or health information exchanges.

Section 5042 of the SUPPORT Act directed the Secretary and CMS to report on best practices for the use of PDMPs, best practices for protecting privacy of Medicaid beneficiary information in PDMPs, and model practices for data-sharing agreements between state Medicaid programs and PDMPs.

This section also established the criteria for qualified PDMPs and required states to comply with these new standards by October 2021.

Lastly, this section included details on the 100 percent enhanced federal match available to states to comply with the new PDMP standards.

CMS focused on the 14 states and one territory that received the enhanced federal match for this report. These states planned to use the enhanced federal match to bring their PDMPs into compliance with the new federal standards as well as other operational improvements in the categories listed on the slide. Examples of these improvements include creating a patient-matching algorithm, integrating PDMP data with electronic health records and health information exchanges, upgrading technology and licenses, and improving data reporting infrastructure. Six states planned to use the enhanced federal match to allow PDMP access to non-clinician entities, including Medicaid agencies.

Lack of coordination between Medicaid agencies and the PDMP was a significant challenge in implementing qualified PDMP changes. Coordination is especially problematic when the state Medicaid agency and the state entity operating the PDMP are not located within the same state agency. Under this scenario, the Medicaid agency and

the PDMP must enter into a cross-departmental agreement.

Few states have successfully integrated PDMP and Medicaid data, although the report notes that several states are currently working on this.

State and federal private laws, which limit the ability of Medicaid staff to access fields in the PDMP, are a significant barrier for data integration.

Report authors note that there was not enough time to discern best practices specific to Medicaid. The report listed a range of promising practices for PDMPs more generally listed here on the slide. Among the most promising include establishing formal lines of communication between state agencies requiring access to the PDMP and granting PDMP access to medical staff who do not have prescribing authority.

The report also highlights from case state studies. Colorado maintains a formal workgroup between health information exchanges, the PDMP, and various state agencies, including Medicaid, to promote collaboration.

Nebraska includes all prescription medications in the PDMP, not just controlled substances.

Lastly, Rhode Island requires pharmacists to be

enrolled in the PDMP to track dispensing patterns.

The report highlights that a key lesson was that states had insufficient time, only two years, to use the enhanced federal funding and bring their PDMPs into compliance with the new standards for qualified PDMPs. Some states also expressed the need for additional federal guidance to facilitate data sharing across states.

States encountered challenges related to coordinating multiple federal funding streams for PDMPs, each with their own requirements for reporting.

The report also identified opportunities to increase the use of PDMPs. These include ensuring as close to real-time data as possible, integrating PDMP data into electronic health records, and registering providers for PDMP access during licensure or renewal.

Given the limitations of this report, MACPAC could highlight the need for additional research and information on best practices for data sharing between PDMPs and Medicaid agencies. Selecting a broader range of states based on their status as innovators may yield additional insights on how to ensure that Medicaid beneficiary information in PDMPs remains secure as well as

how Medicaid agencies and PDMPs can productively share data.

Future state reporting to HHS and an additional CMS report in late 2023, both of which pertain to PDMP best practices and are required by the SUPPORT Act, may also provide helpful insights on PDMPs and Medicaid.

In terms of next steps, Commissioners now have an opportunity to discuss the report and possible areas for comment. Staff will then draft a comment letter reflecting this discussion.

This concludes the presentation, and I'm happy to take questions. Thank you.

CHAIR BELLA: I saw heads nodding on need for additional research. So I'm thinking you're on target there.

Other comments from Commissioners?

Martha.

COMMISSIONER CARTER: All right. Yes. So I think this is great. I think we should support this certainly and support further work.

I wanted to highlight something you actually said in the end of the first paragraph, a problem that I

encountered that may not still be the case, but that when people pay for prescription drugs with cash, they often don't get entered in the PDMP, which given my interest in substance use disorders is a huge problem. To the extent that we support the work on PDMPs and also compliance with using them, I think that's a good idea.

CHAIR BELLA: Okay. Martha.

Laura.

COMMISSIONER HERRERA SCOTT: I thought you said someone else's name before.

Just a few things, just on the federal funds. So I'm thinking about all the places. Department of Justice has also been a big funder. To the point that you made earlier about they all have the requirements for PDMP and how do you rate all that to meet the state's requirements, the cash issue is a state issue. So, in some regs, it says cash, you have to put it in. In some states, it's silent on it. So thinking about the medical societies in states -- so for some of the reporting requirements and data sharing, it was really limited about some of the advocacy groups that represent physicians and physicians being concerned about being targeted for prescribing. So those

would be some of the things as we think about our comment, just to include just the role, some of those organizations.

And then the consent processes. So, for states that have the PDMP and the HIE, you can consent, opt out of the HIE, but does that also then remove your information from the PDMP, from the HIE? Some states, no, you can't take it out. Other states maybe. So that would be something, the rules of the HIE and the PDMP being vetted in that.

CHAIR BELLA: Thank you, Laura.

Fred?

COMMISSIONER CERISE: Just a comment on the integration with the electronic health records. I know from our providers, it's an issue, that the simpler it gets, the more likely people are to use it, and there's a cost associated with that. To enhance uptake, I think it can be done there to make that more the norm and to address the cost, because individual provider is going to -- you know, it's always going to be a barrier if every place is to come up with that, so just stress that I think it's a good thing to include.

CHAIR BELLA: Thanks, Fred.

Other comments?

[No response.]

CHAIR BELLA: Anything else people want to make sure is looked at or addressed?

[No response.]

CHAIR BELLA: Toby, Brian, Stacey, this is your -- no? Everything is good?

Okay. Do either of you need anything more from us?

[No response.]

CHAIR BELLA: Okay. Thank you for your work on this and for presenting the suggested areas for comment. Much appreciated.

Okay. We have come to the end. Do any Commissioners have any final comments or questions about anything?

[No response.]

CHAIR BELLA: Pat yourself on the back for passing our 18 recommendations.

I want to formally again acknowledge and thank Stacey, Brian, and Toby. For those of you that haven't already heard in the public, this is their last meeting

with us. In the fall, we will have some new faces around the table. We expect the three of you to continue to participate and to provide public comments and perhaps even to make in-person appearances in the audience when we're able to do so.

I want to thank the staff, as always, for the work. It's phenomenal. Thank you very much.

Thank you, Jim and team, for keeping us technically on our ties.

And, also, this is Anne's last meeting. So we have all had a chance to celebrate Anne and thank Anne, but I would be remiss not to do it one more time publicly to say thank you for what you've done for this organization.

We also expect to see you in the audience or be providing mentorship to us and to the rest of the team.

Would you like to close us out of our final meeting?

EXECUTIVE DIRECTOR SCHWARTZ: Close out in the sense of asking for public comment?

[Laughter.]

CHAIR BELLA: I'll take that back. Let's go for public comment, and then we'll have a close-out from Anne.

Would anyone in the audience like to make a comment on the subjects we were discussing, even though I jumped the gun on the goodbyes?

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I see no hands. Nobody wants to come in and try to follow that.

Okay. We'll give it just a minute longer. Do you see anything? If you'd like to make a comment, please use your hand icon.

[No response.]

CHAIR BELLA: Okay. Anne, I'm going to turn it to you to close us out, please.

EXECUTIVE DIRECTOR SCHWARTZ: So thank you, Melanie. What's the saying? We've come to the point of the meeting where everything that needs to be said has been said, but I'll say it again one more time.

I want to thank all of you, Commissioners, and of course the staff as well for making this such an incredible experience. I appreciate also the attention of our audience whom we have not seen in person for several years but whose comments, whether they are verbal in the meeting

or just communicating with the team, otherwise really strengthens our work.

It's been a privilege to do this, and I know that I'm leaving the organization on a very solid foundation. I look forward to hearing what you're going to do next.

CHAIR BELLA: Okay. With that, we are officially done. Thank you, everyone.

* [Whereupon, at 12:05 p.m., the Commission was adjourned.]