PUBLIC MEETING

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COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:31 a.m.]

CHAIR BELLA: Hello, everyone. Welcome to the March MACPAC meeting. We're excited to get started. We're going to kick off this morning with a panel on directed payments. And, Commissioners, the goal of this panel is obviously to hear the work, but also, we're working toward decisions about recommendations we might want to include in the June Report.

So, Rob, welcome, and we will turn it over to you.

DIRECTED PAYMENTS IN MANAGED CARE: DECISIONS ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* MR. NELB: Great. Thanks so much, Melanie.

So following up on the Commission's discussion at the December public meeting, I'm going to walk through some potential recommendations that the Commission could make on directed payment for the Commission's June report to Congress.

I'll begin with some background about directed payments and review some of the findings that I presented in December, and then I'll spend most of the time talking

through five potential recommendations related to the transparency and oversight of directed payments, which I've listed here in shorthand.

At the December public meeting, Commissioners also discussed the possibility of making a recommendation related to setting an upper limit on directed payments. However, there wasn't consensus in that area, and so, as a result, in the June chapter, we're only planning to include a discussion of that issue. And I'll conclude today's presentation by giving a bit of a preview of some of the topics we plan to cover.

So, first, some background. Directed payments are a new option that was added in the 2016 managed care rule, which allowed states to require managed care plans to pay providers according to specified rates or methods.

Since 2016, the use of directed payments has grown substantially. For example, as of August 2018, there were 65 approved arrangements in 23 states, and in our most recent review of directed payments approved as of December 2020, we found that there are more than 200 arrangements in 37 states.

We don't have great information about spending

associated with directed payments. However, we were able to find spending information for about half of the approved arrangements as of December 2020, and the spending is quite substantial, totaling more than $25 billion, which for context is more than a disproportionate share of hospital payments as well as UPL or upper payment limit supplemental payments.

In addition, it's important to note that there's currently no upper limit on directed payment amounts in statute or regulation, and so the amount of directed payment spending may increase in the future.

In our review, we classified directed payments into several categories, which are important to keep in mind as I walk through some of the potential recommendations for today.

So, first, it's important to note that directed payments are distinct from pass-through payments, which are a mechanism that some states have used prior to 2016 to make additional payments to providers indirectly by increasing capitation rates.

The 2016 managed care rule requires states to phase out the use of pass-through payments. So many of

those states have not transitioned them into directed payments.

In terms of directed payments, there are two broad categories to keep in mind. First are directed fee schedules, which require plans to pay certain minimum or maximum rates for services, and then there are additional payments to providers, which are often lump-sum payments, which are more similar to supplemental payments in fee-for-service.

Since 2020, states no longer need to seek prior CMS approval for minimum fee schedules that are based on state plan rates. However, they still need to seek prior CMS approval for other types of directed payments.

In addition, the 2020 rule allows states to obtain multiyear approval for value-based payment arrangements but still requires other types of arrangements to be approved by CMS every year.

This figure shows the number of directed payment arrangements and projected spending by type. You can see that although about half of directed payment arrangements are directed fee schedule, the vast majority of directed payment spending is attributable to uniform rate increases

and other types of additional payments to providers.

As we discussed in December, we complemented our review of directed payment approval documents by interviewing state officials and other stakeholders in five states. When we asked these stakeholders about the goals of their directed payment arrangements, we heard that many arrangements were intended to preserve prior supplemental payments and often did not have a clear link to quality or access goals, which is required in the regulations.

As a result, many stakeholders reported that it was often difficult to assess whether directed payments were meeting their objective, and this was evident in some of the evaluations that we reviewed.

In our interviews, we also heard conflicting views from actuaries and CMS about how directed payments that are intended to promote access should relate to existing managed care access standards, such as network adequacy. In theory, if a managed care rate is actuarially sound, it is supposed to be sufficient to ensure access without the need for additional payments to providers, but in practice, we heard that actuaries don't seem to play much of a role in assessing whether directed payment

amounts are reasonable after they have been approved by CMS.

So, based on these findings, Commissioners expressed interest in making some recommendations related to the transparency and oversight of directed payments, and I'll walk through these now.

So the first proposed transparency recommendation relates to the public availability of information that CMS already collects. The proposed recommendation text reads as follows: "To improve the 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."

Public availability of this information is important because directed payments are such a large and growing portion of Medicaid spending. It's also consistent with the type of information that CMS already makes available on its website for state plan amendments and Section 1115 demonstrations.

In addition to approval documents, the proposed

recommendation text also highlights the importance of managed care rate certifications since these rate certifications provide additional information about directed payment amounts that are not always available in the approval document.

Finally, the recommendation highlights the importance of public availability of the evaluation plans and evaluation results so that the public can better understand directed payment objectives and whether they are being met.

Overall, we don't anticipate that this recommendation will have a direct effect on federal or state spending since states are already required to submit this information to CMS. However, there may be some administrative effort for CMS to make this information publicly available. We also don't anticipate that this recommendation would have a direct effect on health plans, providers, or enrollees, but over time, it's possible that greater transparency may result in some changes in directed payment methodologies.

The next proposed transparency recommendation describes new information for CMS to collect, and the

recommendation 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 payment amounts publicly available in a standard format that enables analysis."

This recommendation is similar to recommendations that the Commission has previously made around other types of supplemental payments, and now that directed payments are larger than DSH and UPL payments, it's especially important to collect similar provider-level data on these payments.

As you know, states have long been required to submit hospital-level DSH audits every year, and beginning this year, states are now required to submit provider-level information on UPL supplemental payments.

Collecting actual payment information is not only useful for researchers and policymakers, but it would also help CMS ensure that the payment amounts are consistent with what was actually approved since CMS doesn't currently have a way to monitor this.

We don't anticipate that this policy would

increase cost, but it would likely require some administrative effort, especially for CMS to develop reporting standards to implement the necessary IT changes.

During our interviews, many of the state officials we spoke with noted that they already collect provider-level spending information. So they may not be as much for states, but there's still probably going to be some administrative effort involved with putting that information in the standard format for CMS.

Depending on the data collection approach that's used, health plans may need to submit some additional information, but we don't anticipate any additional effect on providers or enrollees.

Our third proposed recommendation relates to the transparency of directed payment goals, and it reads as follows: "To provide additional clarify 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."

This recommendation is intended to address the concerns that we heard during our interviews that the link between directed payments and access goals is often unclear. Specifically because managed care rates are already required to be sufficient to ensure access, it's also not clear what improvements to access states are buying when they use directed payments to make additional payments to providers above rates that were previously certified as actuarially sound.

To help resolve this ambiguity, it would be helpful for states to distinguish directed payments that are needed to meet existing access standards from payments that are intended to improve access above this level. Such a distinction could help inform how directed payments should be evaluated and incorporate it into managed care capitation rates.

We recognize that it may be difficult for some states to draw a clear distinction between these goals, and so the first step the recommendation proposes that states start by quantifying how directed payment amounts compare to prior supplemental payments. For example, if a directed payment preserves the prior pass-through payment that was

previously part of an actuarially sound capitation rate, then it might be reasonable to assume that the payment is necessary to meet existing access standards. However, if the directed payment substantially increases payment rates above levels that actuaries previously certified, then it might be reasonable to expect that the directed payments result in improvements in accessing quality above existing standards.

In the long run, this distinction could also help inform future policy development similar to the approach that CMS has used with some delivery system reform incentive payment programs, or DSRIP. For example, CMS could encourage states to incorporate payments needed to maintain access into base payment rates that any remaining supplemental payments could be tied to more ambitious quality and access goals.

Overall, we don't expect that this recommendation will have an effect on federal spending and shouldn't have very limited administrative effort for states and the federal government. However, over time, a greater transparency may result in some changes in directed payment methodologies that could affect health plans and providers,

but at this point, it's too early to tell exactly how payments might change in response to federal requirements as states clarify their payment goals.

Our fourth proposed recommendation relates to evaluations and reads as follows: "To allow for more meaningful assessments of directed payments, the Secretary of the U.S. Department of Health and Human Services should require states to develop rigorous, multiyear evaluations for directed payment arrangements that increase provider payment rates above the rates described in the Medicaid state plan."

This recommendation is intended to address many of the problems that we identified in our review of directed payment evaluations. Specifically, we found that many directed payment arrangements didn't have any evaluation results, even after multiple renewals. In addition, we identified some circumstances where performance on quality measures actually declined, but the payment arrangement was still renewed without changes.

Currently, CMS requires states to evaluate directed payments every year, but we heard during our interviews this often isn't enough time for states to

collect base plan information and other data needed to do a meaningful assessment of performance, and so, in this recommendation, we're proposing that states develop multiyear evaluation plans that will hopefully be more meaningful.

Although states are required to evaluate all types of directed payment arrangements, this recommendation focuses on the subset of arrangements that make additional payments to providers. They account in the vast majority of directed payment spending and, thus, merit a more rigorous review.

Overall, we anticipate that this recommendation will not have a direct effect on federal spending, but it could result in some increased administrative effort for the federal government to develop guidance and some effort for states to strengthen their evaluation plans, if needed. However, the hope is that requiring multiyear evaluation plans rather than single-year evaluation plans would help to reduce effort over time.

Health plans and providers may be required to report additional information about performance on quality and access measures, that states strengthen their

evaluations, but this burden could be reduced if the directed payment evaluations are coordinated with other existing quality reporting efforts in managed care.

Finally, we don't anticipate a direct effect on enrollees, but of course, over time, the hope is that better evaluations will help ensure that directed payments do a better job advancing quality and access goals for beneficiaries.

Last but not least, this final recommendation relates to CMS's oversight process and reads as follows: "To promote more meaningful oversight of directed payments, the Secretary of Health and Human Services should coordinate the review of directed payments and the review of managed care capitation rates by clarifying roles and responsibilities for states, actuaries, and divisions of the Centers for Medicare and Medicaid Services."

As I mentioned earlier, we've heard conflicting views from stakeholders about the extent to which actuaries should be involved in assessing directed payments. In general, actuaries must assess whether rates are reasonable and appropriate, but if CMS approves a directed payment amount, then there's very little for the actuary to review.

Some of the confusion that we observed may be attributable to the multiple CMS divisions that are involved in improving direct payment preprints and incorporating them into managed care contracts. Specifically, it wasn't always clear who was responsible for overseeing what.

As a result, the recommendation rationale outlined a few potential areas for more guidance: first, clarifying who, if anyone, is responsible for reviewing directed payments amounts; second, clarifying whether capitation rates should be sufficient to comply with access standards before or after accounting for directed payments; and third, providing more guidance about what additional federal review is needed after CMS approves a directed payment preprint in order to help reduce administrative burden.

As with other recommendations, we don't anticipate that this recommendation would directly affect federal spending. It may result in some additional administrative effort up front, but hopefully, better coordination reduces this burden over time.

It's also worth noting that if CMS is able to

provide more clarity about who's responsible for overseeing directed payment amounts, it may affect the amount of directed payments approved by CMS in the future.

We don't anticipate any direct effect on health plans and providers, but hopefully, a more coordinated approval process would help reduce the amount of time it takes for CMS to review directed payment arrangements, which is one of the concerns that we heard during our interviews.

Finally, we don't anticipate a direct effect on enrollees, but over time, better enforcement of existing access to standards could help improve beneficiaries' access to care.

Now that I've walked through the recommendations, I just want to conclude with some discussion of a few next steps.

So, first, as I mentioned at the outset, the draft chapter we're preparing will include a discussion of policy issues to consider if CMS were to establish an upper limit on directed payment amounts, but it won't include a recommendation in this area.

One option to consider is setting a limit based

on an external benchmark such as Medicare, which is currently used to establish the upper payment limit in fee-for-service. As we discussed in December, there are some states that are currently using directed payments to pay providers more than Medicare, and so this approach could potentially result in reduced payments.

Another option would be to set a limit based on historic spending, similar to what was done with Medicaid DSH allotments in the '90s. This approach would prevent providers from losing funding, but as you know from our prior discussions of DSH, setting limits based on historic spending would result in a wide variation in spending by states.

In order to analyze these issues we would need more information about directed payment spending. We are hopeful that we may be able to get some information in the future as a result of CMS's new directed payment preprint. But in order to analyze this issue more thoroughly it would be helpful if some of the transparency recommendations that we have discussed today were adopted.

So that concludes my presentation for today. I look forward to your feedback and will work to incorporate

it into the draft chapter that I'll present at the April meeting. At that time, the Commission will also vote on any final recommendation, likely as one package.

To help with your discussion today, here is just a brief summary of the recommendations that I reviewed, kind of in shorthand so they all fit on one slide. Thanks.

CHAIR BELLA: Thank you, Rob. We'll open it up to Commissioners. Let's kind of run quickly through each of the recommendations. Do folks have comments or questions on number one? Stacey, then Tricia, then Darin.

COMMISSIONER LAMPKIN: I generally endorse the spirit of all these recommendations, but I have some specific comments about each of them. Number one, on the better transparency, I am fully in support of going in this direction and just wanted to add a professional comment about the publication of actuarial certifications and endorsing that as a component of the information that would become public under the version of this recommendation that we saw in our materials. I just wanted to assure Commissioners that I think that is doable, that it is rare that proprietary information would have to be included in a certification.

That's all I have on this recommendation, but you'll see me raising my hand several times, Melanie.

CHAIR BELLA: Okay. It may not be the best thing to go recommendation by recommendation. Why doesn't everybody, we'll just have you give all your comments. That seems to be a better way to do it. So Stacey, please continue.

COMMISSIONER LAMPKIN: Okay. Thanks. On number two, provider-level data, we talked about, Rob, several different times of directed payments, and I have a couple of technical questions about some material earlier in the slide. But I think if we can use an example of mandated fee schedule provider payment like, for example, say before the directed payment was in place the personal care assistants, on average, were paid $15 an hour, for example, and under the directed payment it is now $17 an hour, something like that.

For that kind of directed payment we would likely be able to see those payments in T-MSIS, through encounter data submissions, and that sort of thing. So our bigger concern here -- and besides which there would be tons of providers to look at provider-level detail for a broad-

based directed payment like that -- is the focus of this recommendation less on that type of directed payment and more on the type of directed payment that is more of a lump sum or supplemental type payment?

MR. NELB: Yeah. I think our interest is more those additional payments to providers, which in our review it doesn't look like that information is in there consistently. And so that is definitely the bigger concern.

COMMISSIONER LAMPKIN: Yeah. And I support this recommendation as long as the cost of the lift to do it has the payoff on the benefit of the material. And so, you know, for me it is more important to require this on the types of directed payments where the information is not available through encounter data and T-MSIS.

And on the third recommendation, I think this is really important. It is very muddy right now. We haven't heard much about CMS's vision or expectations on how to think about rates, and network adequacy in general, and I know we'll cover that later this afternoon as well. But direct payments really kind of muddy the waters there.

And I think guidance on this, on how to think

about what types of access and adequacy over and above contractually specified network adequacy are we trying to attach here? Is it potentially related to quality standards as well as specific network adequacy or the importance of having certain providers in network to meet the needs of certain subpopulations. Clarification on exactly what these are trying to achieve I think would be very helpful on this one.

And then I generally agree with 4. Again, it may be an area where it should be targeted to where the cost of the lift is balanced with the benefit of the information. So that may be on your larger, more targeted directed payments rather than the broad-based ones.

And then 5, this one is the thorniest one for me because of the implications for the actuaries. When I read it from this perspective I think it relates a lot to recommendation 3 and how to think about think about the goals of the directed payments and what they're trying to achieve here, and what the actuary's role is.

And those are my comments on the recommendations, but if we can step away from the recommendations for just a second and go to the chapter that we're working on, I just

want to encourage us to make sure that we put a really good background on there about why this is emerging as an issue for us. So a chunk of the dollars that we know are going through directed payments today, Rob, I suspect were dollars that were already in the system but they have been converted from either supplemental payments, as you noted, or average payments that the MCOs negotiated and controlled to something that is more directed by the state.

But it is the integrity of managed care that really is being changed from the way we historically thought about what the MCOs, those risk-bearing entities, were responsible for to now how does this volume of directed payments change that and what are the implications of that for making sure that the capitation rates are appropriate for the contractors? So I want to make sure we get that background really solid.

Thank you.

CHAIR BELLA: Thank you, Stacey. Rob, any questions for Stacey? If not, we'll to Tricia.

MR. NELB: Sounds good.

COMMISSIONER BROOKS: I just have a couple of quickies. First of all, on recommendation number 1, I just

really want to emphasize timely transparency. You know, getting things a year and a half after the fact are not terribly useful in real time, so I'd like to make sure that's emphasized.

I have a question on number 3. Going back and comparing directed payments to prior supplemental payments, five years from now will that be useful? I don't understand all of the details, and I understand that we are trying to get at whether what we're doing now is simply backfilling from what is no longer allowed. But I'm just curious about that comparison and whether that stands up over time or at some point becomes no longer useful.

MR. NELB: Yeah. So with this I think we were thinking of, at least at a start, getting the information sort of when states are making that conversion, what the payment amount was before and after to help kind of clarify the goal. You know, these passthrough payments, there is no information about what was being spent before, so that's a big gap in what we know. Thinking of some of the states that we interviewed that they converted the passthrough payments into directed payments and then over time they have been increasing the amount of the directed payment. I

think that's important to keep in mind as you're thinking about what the states are trying to achieve with the direct payments. Hopefully as we get more information about directed payment amounts we will be able to see how that changes over time.

Yeah, looking at prior supplemental payments was intended more as a first step, especially in cases where they're making that transition, and then hopefully the transparency recommendations will help us inform how payment amounts are changing over time.

COMMISSIONER BROOKS: Thank you.

CHAIR BELLA: Darin, then Fred, then Heidi, then Bob.

COMMISSIONER GORDON: So I'll alignment myself with many of the comments that Stacey made. I will say that I don't think we should take kind of a suspect tone about directed payments. I mean, I think there is an issue of better understanding them and appreciating them, but Rob, as you pointed out, in some cases this was, in order for states to move from fee-for-service to managed care there had to be a vehicle to carry forth some of the things that were allowed in fee-for-service into the managed care

world. Otherwise, you would be cutting significant amount of money out of the system, and then basically you would never be able to make that transition.

But also, as we move from passthrough payments to directed payments -- because I lived this and experienced it -- what would have been considered passthrough payments was one thing. Kind of where Stacey was is more those lump-sum, large payments, particularly to hospitals. But they broadened that when they came to directed payments, because when you think about minimum fee schedules, when you think about minimum-max, when you think about value-based purchasing arrangements, when you think about uniform rate increases, which has happened in my 26 years of Medicaid, where they want to make sure that if a legislature is saying I'm going to put 3 more percent in the rates and 3 percent makes it to the providers, it really broadened when we started saying what also should directed payment be on, what was over in the other category of a passthrough payment, or what existed pre fee-for-service.

And what I've always struggled with is where we will have expectations on managed care at a greater degree

of managed care states and managed care spending than we do on the fee-for-service side, yet there are some parallels. And I just think we have to understand, I think a lot of the comments that were made, and I think some of the recommendations that are made, I think they are all fine, but it is just not like this thing has been evolving and the definition of directed payments has become much broader than what we used to see in passthrough payments, or even what we see on the fee-for-service side.

So that's just a general comment.

Similar, Stacey, on the transparency of existing directed payments, I think we need to be clear on what that is, because whenever the legislature does require across-board rate increase for certain provider classes, getting into provider level of that on each one of those versus understanding that it is 3 percent from where they're starting from, from this year to that year, I just think it can become unnecessarily burdensome.

Same thing with value-based purchasing, because we said we're doing VBP, we're paying retrospective episodes of care for all of these different episodes, do I get into each individual provider or do we want to

understand what the model is at a high level? But I think the carryover of that transparency, when you talked about where we pushed for transparency in supplemental payments, it's really about those larger payments that are a little bit less clear, and I think we just need to emphasize that.

Clarifying the directed payment goals, number 3, in relation to network adequacy, not all of these are done for network adequacy purposes. So a min-and-max rate, like we did that because we had some rates that were by larger provider systems that were getting excessive, and we wanted to stop that from happening because it was taking so much money out of the system that smaller providers were getting less and less, and it was harder for us to sustain access there. So we put the top one there, which wouldn't appear to be addressing access, but it was to stop having funding get siphoned away and ignoring some of those smaller providers. So it does get complicated. It's not always clear on that, but with the VBP it wasn't about access. It was about sustainability and improving quality. That's what it was about.

So again, I think we need to be clear on not every directed payment is necessarily related to adequacy,

so maybe it's determining those that are and that is the intent or the reason why they are doing them, and in those cases make sure that there's clarity around the goals. But other directed payments may be what is the purpose, what is the goal you are trying to achieve.

On the guidance for directed payment evaluations, I agree with Stacey's comments, just the balance. Like for example, when general assemblies -- and it happens in every state across the country, you are seeing labor market issues at levels we haven't seen in a great while, and there is, through ARPA or through direct legislative intent of increasing funding for direct care workers in certain situations. Do I need to do a big evaluation on that? I mean, the legislature requires me to do it regardless, so, I mean, I don't know if that's really going to be worth our while on that, or do we, again, back up and bucket things where we're saying where evaluations may make sense. Like our VBP stuff, it was all started from CMMI. We had to do a lot of reporting and evaluation on that. So do we need to do another over here on the CMS side?

So I just think we've got to understand. I loved your slide where you just put the buckets, because thinking

about that, the only bucket I think you're missing, Rob, is that other, and that's the one I think we're all talking about, and that's where we're spending most of our energy. Because these four aren't the ones that I think really are the issue, personally.

Oh, the last comment was not one of the recommendations but verbiage around thinking about how you do an upper limit on everything. Well, in my mind when I do think about that I do think it's fool's error and I don't know how we will get to one that really addresses everyone's interests and concerns and the like. But in these models, typically budget neutrality is going to be your upper bound, right? That's going to be the confining element that restricts a state from just being crazy about it. But I do think we need to understand or at least acknowledge that that is a limiter, to some degree, maybe not a specific limiter to supplemental payments but overall program spend.

That's it. Thank you.

CHAIR BELLA: Thanks, Darin. We have several folks that still want to talk, and a little over five minutes, so I would ask everybody to -- if you agree with

Stacey and Darin that's great and you don't necessarily have to tell us that. You can just make your new points. And Fred, we'll go to you, and then Heidi, and then Bob. Although, Rob, did you have something you wanted to ask Darin?

MR. NELB: That's fine. Budget neutrality we can talk about in the chapter. If a state doesn't have their managed care through an 1115 demonstration then budget neutrality doesn't apply, so something to keep in mind. And then I think it's a good point that all directed payments are not created equal, and as we were trying to word the recommendations it's hard. This term "directed payments" applies to many categories, but as you know we are trying to focus on the particular ones that raise the most concerns.

CHAIR BELLA: Yeah, I would say Stacey and Darin and others, I mean, your review of the chapter to make sure that the tone, the context, all of it is going to be really important outside of these recommendations, that your points sort of elaborated today.

Fred?

COMMISSIONER CERISE: Thanks. Rob, overall I

think the tone is good and I think you're hitting on good points. I don't disagree with any of the previous comments.

On recommendation 2 you talk about non-federal sources and the difficulty in trying to track that by provider. I wonder if there's ability to do that by big groups, you know, by provider groups or by hospital types or groups. Because if we are trying to inform what is going on here I think that is part of the story and it would be helpful to the extent that we can identify source of non-federal share.

Also on number 2, again, trying to be more descriptive in terms of the provider level payments and where they are going, and are you able to describe characteristics of the provider groups. And again, thinking of what is your percentage of Medicaid, what type of facility are you. Is it a not-for-profit? For-profit? Public? Children's? Rural? Those types of categories would sort of help get at what you're trying to do with the directed payment.

On recommendation 3, yeah, I appreciate your comments about actuarial soundness, but we do know -- I

mean, you've given us a lot of data to show that there is difference in access among Medicaid and other payers. And so I wonder if we need to draw the line somewhere, and you talked about this in your potential solutions, around Medicare, or is there some external benchmark that we can look to.

You know, historic spending is interesting, and I know that it gets to if we're replacing previous supplementals are not, but historic spend could be low, it could be high, and think of the extent that you could look at an external benchmark like Medicare would be more helpful.

And the same thing on reporting and looking at what's the intent there. If you're getting people up to Medicare, maybe you don't need a lot of description of what you're getting out of the program, but certainly, for those where you're exceeding Medicare, you'd want to know what's the purpose of that. And I'd put a little more emphasis on evaluation when you start getting to the higher levels.

CHAIR BELLA: Thank you, Fred.

Heidi, then Bob, then Dennis.

COMMISSIONER ALLEN: Thank you. Thank you for

all of this, Rob.

One of the kind of motivating issues that I didn't really see reflected -- and I don't even know if it's easy to articulate, but I'm curious about how all of these back-channel methods of paying providers impact providers' perceptions of treating Medicaid patients and the stigma that patients experience when they encounter these systems, particularly in cases where Medicaid may be very generous when you add up all of these sources of revenue. It's so opaque that there's nothing to counter the narrative that if you're serving Medicaid patients, you are losing buckets of money, and I think that that dominant narrative does influence policy.

It does influence -- you know, I worked for a large health care system that when Medicaid expansion was on a ballot or before the legislature, we got emails saying you need to contact your legislators because we'll have to lay people off if there's an expansion of Medicaid. And it was just entirely untrue, but there's nothing to point to, to say, "No. Actually, you received good money for serving these Medicaid patients."

I don't know if it's possible to put that in

there, but I would hope that we could make that as part of our motivation.

The second thing is that in Proposed Recommendation 2, I would like to emphasize the T-MSIS recommendation for making that data better. T-MSIS is only as good as the accuracy of the information that's in it, and if we are ever going to use it as a tool for like policymaking bodies and researchers, it has to be good. So, to me, it's just such a wasted money every time we find these major categories that are bad. It undermines the whole purpose of this enormous investment of having T-MSIS. So, if we can emphasize that, I think it would be great.

CHAIR BELLA: Thank you, Heidi.

Bob and then Dennis.

COMMISSIONER DUNCAN: Thank you. I appreciate the comments from my colleagues, and so I've just got a question and observation.

As we look at these recommendations and we think about the duress of a lot of the states and people under the current public health emergency, is this something we should stage and start with the first one, transparency at first to understand? As Darin said, this has been an

evolution of going from a former payment system to this. So should we understand and know more before we create some regulations in work that we're not sure is going to address the issues we need to address? It's just a question I have.

CHAIR BELLA: Rob, do you have any comment on that?

MR. NELB: Yeah. I would actually frame these, that's the recommendation as that first step, to get better transparency and understanding about directed payments and then -- at the December meeting, we did talk about a next step, which would be about actually setting limits or changing the rules around directed payments. And I think we decided to put that as the second step, but nothing in these recommendations would change current regulations for what's approvable under directed payment authority. So I don't anticipate a major effect on providers or states.

COMMISSIONER DUNCAN: Thank you.

CHAIR BELLA: Dennis.

COMMISSIONER HEAPHY: Thanks. I really appreciate the comments from everybody, and I'm wondering, Rob, about -- I'd really like to find out more about the goals themselves, since there are multiple goals, and the

alignment of the directed payments towards achieving those goals and how the achievement of those goals is measured. So, in other words, you have the directed payments. What are the goals that those directed payments are meant to achieve, and how would they measure over time?

MR. NELB: Great. Yeah. And that was part of our review, and we'll include more detail about that in the chapter. They are intended to promote access, but when you look behind it, there's not always clear measures of what that means, and so that's sort of what we're hoping to clarify more.

COMMISSIONER HEAPHY: And that's my comments based on it. It just seems there's a lot of unknowns there in the information, and so, if you could get greater clarity, that would be really helpful.

MR. NELB: Mm-hmm.

CHAIR BELLA: Any other Commissioners wish to make comments before we wrap up?

[No response.]

CHAIR BELLA: Okay. I am hearing general support for bringing these back. We have some comments and clarifications, some tightening, I think, of the

recommendations. We also have demonstrated the importance of what the chapter is going to say and how the chapter lays the foundation and then also how the chapter lays the foundation for a next phase of work that we might do once we get these out there, but I'm not hearing any opposition, overwhelming opposition to Rob bringing any of these back. Is that correct?

[No response.]

CHAIR BELLA: Let the record show there are heads nodding.

With that last statement that I made, does anyone want to make any further clarifying comments? Otherwise, these will come back materially in this form, and we will take it back up in April.

Darin.

COMMISSIONER GORDON: Just I want to reemphasize that one point that I made earlier. I mean, if we have 91 percent of these, as we've classified them here on the slide, is going to uniform rate increases and VBP, I don't think that's necessarily the area that all our prior discussions have really been focused around. It's been more of those kind of UPL-type arrangements or those lump-

sum ones. I just think we need to be -- we need to almost refine a little bit about what we're focused on by these recommendations so as to, I think, just be a little bit more precise in those recommendations, if that makes sense.

CHAIR BELLA: Verlon?

COMMISSIONER JOHNSON: Yeah. And I just want to acknowledge, Bob, your comment about staging in terms of looking at the transparency first.

And, Rob, as you said, when I look at this, I look at this as priorities. So I'm glad that you reiterate that and say that because I agree with Bob. That's a first step here to make sure we have that transparency.

CHAIR BELLA: Rob, any comments to what Darin or Verlon just said?

MR. NELB: I think that's the extent, and we can follow up with you after the meeting and get the right wording.

"Uniform rate increase" is the term that's used by CMS, and within those, I think we saw a variation. And some of them were, as you described, they're in like sort of, you know, increasing a rate for, you know, certain workers by a certain percent or whatever, but then within

that category, there are some that are more of these lump-sum payments that were continuations of UPL or pass-through payments and so since where the wording, you know, is a bid muddled. So we'll try to clarify that when we come back in April. I just wanted to point that out.

COMMISSIONER GORDON: Very helpful. Thank you.

CHAIR BELLA: Rob, thank you. You've done a great job of organizing this for us, and we'll look forward to having it come back in April for a vote. Thank you.

MR. NELB: Thanks.

CHAIR BELLA: Thank you, Commissioners.

We're going to move now to -- Aaron is going to bring us back to prior conversations we've had on EHR update by behavioral health providers, and he is bringing us, I think, something that's very responsive to where we could and could not get in our prior discussions, and so looking forward to this discussion. And, Aaron, we'll turn it to you.

IMPROVING THE UPTAKE OF ELECTRONIC HEALTH RECORDS BY BEHAVIORAL HEALTH PROVIDERS: DECISIONS ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* MR. PERVIN: Thank you, Melanie.

Good morning, Commissioners. In September of 2021, Commissioners heard from an expert panel about the value of EHRs within behavioral health and the effects it has on patient safety, clinical quality, and integration of care.

In December of last year, Commissioners asked for information on how Medicaid authorities could be used to finance EHR adoption within behavioral health and how to improve quality standards for behavioral health IT products. This session builds on that discussion by proposing two recommendations to address both issues.

If the Commission is interested in including these recommendations in the June report, the Commission will have an opportunity to vote on the recommendations and review the draft chapter in our April meeting.

I plan on starting with a brief bit of background, reminding us of where we've been and where we're hoping to move, along with some updated information that was requested by Commissioners in our last meeting. Then I'll move on to specific recommendation language before discussing next steps.

First off, MACPAC documented how health IT can

support care integration efforts, but that behavioral health providers were left out of previous incentive programs to digitize health records and adopt health IT.

In our December meeting, Commissioners agreed that Medicaid should play a role in financing EHR adoption for behavioral health and asked for further information on how Section 1115 demonstration authority and directed payments under Medicaid managed care could finance EHR adoption. Commissioners also agreed that there should be quality standards developed for behavioral health IT products but asked for more information on how these standards would affect providers.

There are two principal barriers to EHR adoption within behavioral health. First off is that behavioral health providers tend to lack the capital to invest in expensive software and hardware and training associated with EHR adoption. Most behavioral health providers cannot afford an EHR and miss out on some of its benefits, including clinical integration of services.

The second primary barrier is that behavioral health providers often do not know what kind of product to buy. Behavioral health IT has unique technological

requirements. Behavioral health IT requires an EHR that can hide, or segment, substance use disorder information that is protected under Part 2. Many EHRs do not do this properly, which limits data sharing and care integration efforts.

We reviewed CMS guidance on how Medicaid can finance EHR adoption, especially for providers that were left out of previous meaningful use programs. Our findings suggest there are multiple ways that Medicaid can help pay for EHRs but that states lack guidance from CMS on how to deploy these authorities properly.

Firstly, 1115 demonstrations can be used to support delivery system reforms if the demonstration is able to meet certain quality benchmarks. These reforms can be used to improve provider health IT infrastructure when those improvements are in support of larger quality goals, but states often lack detail on how to do this properly.

Secondly, managed care organizations could have a role to pay here. In the last session, Rob discussed how directed payments can relate to network adequacy and quality of care but that there's a lack of transparency on them. MCOs could offer EHR incentive payments to

behavioral health providers as part of a directed payment strategy to improve quality.

In a review of directed payment preprints, we found that only one state is currently using this authority for behavioral health providers.

Medicaid Information Technology Architecture, or MITA, could be used to support information sharing through a health information exchange, but guidance on how states can use MITA for behavioral health has not been updated in almost 15 years. This guidance would need to be updated to help support information sharing.

Now on to the quality of EHR products. We talked a little bit at our last meeting on the value of having voluntary standards versus having these standards mandatory for all providers. Again, one of the principal challenges for providers is that there's no industry standard for behavioral health IT. There's a ton of choice in the market, and EHRs are vastly different qualities. Behavioral health providers are often confused by which products might meet their fairly complex Part 2 segmentation needs and which do not. Having a voluntary standard would help this. A voluntary standard would help

providers know what kind of products can keep SUD information private while sharing the rest of the patient record.

Secondly, voluntary standards exist for other practice settings. The Office of the National Coordinator for Health IT, or ONC, developed pediatric IT standards through a collaborative process with stakeholders. Pediatric IT has similar privacy and segmentation needs as behavioral health; in this case, a child's disclosure of their sexual history. This standards development process could be replicated for behavioral health.

Thirdly, a voluntary standard could include SUD consent management systems that have been developed by SAMHSA and ONC. According to stakeholders, these consent management systems are not quite ready to be mandatory for all providers, but if they were part of a voluntary standard, they could be further tested within the market.

Lastly, a voluntary standard could eventually become mandatory over time. For example, since the pediatric IT standard was developed, some of these pediatric functions and data fields had become mandatory through ONC’s certification program. Furthermore, CMS can

also make a behavioral health EHR function mandatory for Medicaid providers as part of a condition of participation.

This brings us to our recommendation around financing of EHR adoption. The Secretary of HHS could 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 behind this 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 a few authorities that can be used to purchase EHR technology and promote information sharing.

Furthermore, if the Commission decides to move forward with this recommendation, a component should be around how other federal resources could support the technical assistance with EHR use. Providers typically need technical assistance around purchasing and using an EHR so that it can be properly incorporated into workflows.

Under previous incentive payment programs, this

assistance was done through ONC grants to community health IT assisters through the Regional Extension Center program.

Our second recommendation is around improving quality of behavioral health EHRs. The Secretary should direct SAMHSA and ONC to develop voluntary standards for behavioral health IT.

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

Our findings suggest that a voluntary standard would provide a non-financial incentive for adoption because specifications could include many functions that are critical to behavioral health. This includes Part 2 or SUD segmentation. This includes psychotherapy note segmentation. This could include telebehavioral health functions and also clinical decision support tools for those with mental health disorders.

Furthermore, once these EHR functions have been market-tested and are ready for prime time, they could be made mandatory for widespread use among all providers at a later date. A voluntary standard could provide a glidepath to eventual incorporation into mandatory certification requirements.

So, in our conversation today, we want to know whether the Commission wants to move forward with these recommendations. If the Commission wants to make any changes to the recommendation language, now would be the time to do so, and depending on what Commissioners decide, we will bring these back for a vote at our April meeting along with a draft chapter on behavioral health.

I'll leave this slide up with our two recommendations, to help facilitate the conversation. I welcome all of your feedback on both the language within here and the rationale behind them.

With that, I'll turn the conversation back over to you all.

COMMISSIONER DAVIS: Thank you, Aaron. I see Martha has her hand raised. Just a reminder for folks that we are looking for alignment on the recommendations that we

will bringing back again at the April meeting, to make the final decision on. Martha.

COMMISSIONER CARTER: Aaron, thank you for the work that you've done on this and for incorporating our discussion and feedback into these recommendations.

I am essentially in support of both recommendations. I would like to see, either in the recommendation number 2 or perhaps in our narrative discussion that we are not just interested in behavioral records for behavioral health providers in their own world, but we're really interested in making sure that there are records that can be used in a truly integrated system, where you've got primary care, oral health, vision, enabling services, social services, all in the record at the same time.

And so there are unique benefits, extreme benefits, and challenges to that sort of system, and we, as far as I know, have nothing that really meets the needs. So somehow I want to make sure that we are looking at this broader goal and not just behavioral health in its own world, that occasionally save out their records when they have to do a records release.

My second point is around SUD services. Again, in this new model, more providers that are not behavioral health providers are providing SUD services, and they may or may not be required to comply with Part 2. So in that context, we need electronic health records that your family doctor or your local physician assistant can provide SUD services in a compliant manner. And sometimes those types of setups don't have to comply with Part 2, but they may. Well, I won't get into Part 2, but they may, and so it's really important that that emerging model is supported with the technology that they need.

And third, I think we really have to not underestimate the lift that's required. I do see a big difference between the example of sequestering of pediatric sexual history and the privacy needs of ongoing psychiatric or SUD treatment. In a previous meeting I noted the automatic pharmacy feed. It's not just something that you're going to set aside and sequester once. It's an ongoing, every day, on-demand feed.

So it's a big lift, and I want to recognize that, and at the same time state that it is essential to providing truly person-centered, integrated care that we

get to the place that we have electronic health records that can be fully functional and compliant in all these areas.

COMMISSIONER DAVIS: Thank you, Martha, for those comments. Do we have other comments? I'm seeing general agreement and nodding heads with what Martha was sharing. Yeah, Melanie.

CHAIR BELLA: I'll just make a broad comment, and I said this at the outset, thinking that Aaron's done a nice job of bringing it back. I like the glidepath of the starting out voluntary and then moving, kind of putting a marker in the sand and seeing how that goes. I think that strikes a nice balance of where we were in the past, and if others feel differently then we should get that out on the table now.

COMMISSIONER DAVIS: Seeing lots of agreement here. Yeah, Verlon.

COMMISSIONER JOHNSON: Yeah. I mean, I don't have any questions related to this. I just did want to say thanks to Aaron. Literally, this is an area that I'm very close to in terms of IT and all of that. And so as I looked at the guidance I just wanted to say publicly, you

have hit every single point that I would probably make in terms of how we thought about this and that, so just thank you for all that you did around this issue. And I am very much in support of what you said, Melanie, as well, in terms of the voluntary approach first.

COMMISSIONER DAVIS: Thanks, Verlon. Any hesitation around the recommendations as they are written? I think, as Melanie mentioned at the outset, Aaron has really done a good job of finding a meeting in the middle of where we landed after the last meetings. If there is any opposition to that or consternation that still exists -- - yeah, Martha.

COMMISSIONER CARTER: Can we tinker with the wording on recommendation 2 to somehow make it clear that we're looking at not just for behavioral health provider information technology in their own world but with the goal of developing some integrated system? Aaron, I'm not sure how you would do that. I'm not going to try to wordsmith it here. But I think we need to make clear that that is the ultimate goal. I mean, I think it's really important that behavioral health providers get a good, usable IT system and that they have the means to do that, but I think

we need to keep our larger goal in mind.

MR. PERVIN: I can jump in.

COMMISSIONER DAVIS: Go ahead, Aaron.

MR. PERVIN: No, we can definitely tinker with the language. We can play around with it a little bit more and then bring it back to you all in April. It is going to be a little hard to develop to some applied right now, but we definitely can bring it back in our next meeting.

COMMISSIONER DAVIS: Great. Thank you. I think that's a really important point, highlighting the integrated care team of the goal that we are working towards and building something that supports all of that. Yes, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. Just to add to what Aaron said: we can both look at the specific words in the recommendation and also make sure that that point is clear in the supporting text.

COMMISSIONER DAVIS: Okay. And I think with that, Melanie, I will turn it back to you for any public comment.

CHAIR BELLA: Here I was rushing everybody on directed payments. We can go back to that if we want to.

Before we go to public comment, Aaron, do you have any further comments or questions for the Commissioners?

MR. PERVIN: No. What I am hearing is consensus on these two recommendations. I am also hearing that we want to tinker a little bit with the language on recommendation 2, and highlighting more that the goal of behavioral health EHRs is to conform with larger integration strategies and that that should be incorporated under the language for the rationale. But other than that, it appears there is broad support, and I think we are ready to draft the chapter.

CHAIR BELLA: Okay. Thank you for that summary. Martha, are you all good? Okay. And thank you, Kisha, as well.

CHAIR BELLA: We are going to turn to ask if there is any public comment. We will take comment on our last session, which was directed payments, as well as this discussion. If you would like to make a comment please use the hand icon. And I'll just remind folks that if you could please introduce yourselves and your organization, and that we ask you to keep your comments to three minutes

or less.

So we'll just give it a minute to see if anyone would like to speak.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. It does not appear that we have anyone who would like to make any comment for the record. So with that, Aaron, thank you. It looks like Aaron already left us. Thank you, Commissioners, for getting through that. That will come back to us next month. We are now ready to take our break. We will come back at 1:00. I would ask you all to be back promptly at 1, and we will start with our discussion on health equity. So thank you all and see you in a little bit.

* [Whereupon, at 11:40 a.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: Welcome back, everybody. We can get started. Kisha, I will turn it over to you. Welcome, Audrey.

VICE CHAIR DAVIS: Thanks, Melanie. We are excited to have this session on leveraging Medicaid policies to advance health equity. The Commission has had several sessions over the past year where we have explored health equity, but this is the first one where we will be reporting back to Congress and including this in the June report.

Audrey is going to walk us through a preview of the chapter, and I look forward to hearing the discussion that follows. Go ahead, Audrey.

LEVERAGING MEDICAID POLICY LEVERS TO PROMOTE HEALTH EQUITY

* MS. NUAMAH: Hi, everyone. Good afternoon. Hello Commissioners. During today's session I am going to walk through the general framework of the health equity chapter. As Kisha just said, this will be the first time in a report to Congress that MACPAC will have a dedicated

focus specifically on promoting health equity and addressing disparities in Medicaid.

Based on prior conversations with the Commission, we have identified key themes that we will organize the chapter around. I will talk through each one at a high level, but please know that the chapter will include more details.

After I go through the general framework of the chapter I will provide an overview of the key themes listed here. Next I will discuss ongoing MACPAC work in health equity. Finally, I will close out with next steps for this health equity chapter and ask you to provide any feedback on the framework of the chapter and the identified key themes.

As we have 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 will focus on inequities in Medicaid on the basis of race and ethnicity. We will highlight what is known about the disparities in access and in outcomes for these groups. The chapter can also identify key considerations or challenges in addressing such disparities.

Based off of prior Commission conversations, ongoing staff research, and interviews with states and subject matter experts, we know there is a lot of ground to cover when it comes to applying a health equity lens to the Medicaid program. While Medicaid alone cannot remedy societal health equities or their causes, there are policy levers that can eliminate disparities in access to care and health outcomes in beneficiaries. The chapter will review concepts for understanding racial disparities and inequity, describe what is known about health disparities and inequity in Medicaid, and provide an overview of federal and state Medicaid efforts to address health equity. We do not anticipate being ready to make recommendations at this time. However, the chapter can identify priorities and lay the groundwork for future MACPAC work.

Now we will discuss the key themes.

Federal actions to advance health equity is the first theme. The chapter will summarize historical and current efforts by HHS and CMS to address health equity. Under the Biden administration, CMS has stated that it is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by their programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that beneficiaries need to thrive.

The chapter will describe recent CMS actions to do so within the Medicaid program, although it has been relatively limited in scope. For example, CMS recently released a funding opportunity for outreach and enrollment grants that focus on strategies that reduced racial and demographic coverage disparities. The Commission may want to discuss the importance of CMS taking concrete actions to addressing health equity that could be implemented at the federal level or in partnership with states.

The next theme we will discuss is data collection

and reporting. As we know, having robust data is foundational to all health equity work. The chapter will describe the availability of race and ethnicity data and the strengths and limitations of various data sources. The chapter will also describe 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 will describe why beneficiaries do not always provide this data. The chapter will also highlight how inconsistent data collection methods can exacerbate problems.

Staff will be publishing an issue brief soon that reports on data quality assessments for each state. Staff are also kicking off work to dig deeper into potential solutions for data improvement and hope to bring findings to the Commission this fall.

In the past, the Commission has discussed the need for improved race and ethnicity data collection and reporting to ensure greater consistency, completeness, and quality of data. The Commission has also said that the absence of complete race and ethnicity data should not

prevent our health equity work from progressing. We can reiterate these points in the chapter, and if there are any other views you would like to include the chapter we would like to hear from you today.

The next thing we will examine is the importance of state leadership and infrastructure in promoting health equity in Medicaid. The chapter will also discuss the challenges states face, such as changing political landscapes and staff being asked to take on equity initiatives without sufficient resources. The chapter will also describe what can be learned from states that have adopted health equity plans. These plans may include medium- and long-term strategies and actions to embed the advancement of health equity as a priority into their programs and to reduce health disparities.

The Commission may find it worth addressing the importance of having commitments from senior-level state leaders to ensure that the programmatic and policy changes for advancing health equity have staying power.

The Commission has spoken several times about the importance of beneficiary engagement. The chapter will outline how it is especially important to do this work from

a health equity perspective. Structural racism has resulted in a lack of trust in the system, which may discourage the use of health services and ultimately lead to poor health outcomes for beneficiaries of color. We will describe opportunities to engage beneficiaries of color at multiple points during the policy and program development process.

The chapter will also describe barriers to beneficiary engagement. For example, due to the composition of advisory committees, such as high-level providers and health plan administrators who also participate in these meetings, beneficiaries may feel intimidated to share their own experience. Other barriers include the lack of compensation for their time and expertise and logistical issues. The chapter will also share strategies some states are using to overcome these challenges. This can be an opportunity for the Commission to discuss what role CMS could play in assisting states to embed a health equity approach to beneficiary engagement.

We are aware of high Commissioner interest about the restart of regular redeterminations when the COVID-19 public health emergency (PHE) ends, and the chapter could

describe state efforts to build an equity focus into enrollment and renewal processes. While this is an area of concern for all Medicaid beneficiaries, the chapter could lay out concerns of the likely disproportionate effects on certain communities. And thinking beyond the PHE, the chapter could describe 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.

The Commission may wish to express concern about potential coverage disruptions for Medicaid beneficiaries, especially for communities of color when the PHE ends. The Commission may also want to weigh in on the ways to maximize already available opportunities, policies, and practices that promote equity in all enrollment and renewal processes.

The chapter will also describe how states are using delivery system levers such as contracting, payment, and quality performance strategies to advance health equity roles and address disparities in care and outcomes. The chapter will describe 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 conduct internal staff health equity training.

The chapter will provide 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 capitation withholds to incentivize reduction and racial disparities and value-based payment arrangements that require MCOs to set performance targets for reducing disparities on certain measures and to address social drivers of health.

The chapter can also describe how some states are building health equity into a managed care quality strategy and the expectations they are setting for MCOs. Some states, such as Michigan and Minnesota, are requiring MCOs to stratify quality measures by race and ethnicity. Some Medicaid programs, such D.C. Medicaid are requiring that MCO quality assessments and performance improvement plans include mechanisms to reduce racial and ethnic health disparities in utilization and outcomes, while others, such

as Illinois Medicaid, are requiring MCOs to address culture competency. Finally, some states are using external quality reviews to support their equity efforts.

The Commission may wish to comment on the opportunities and responsibilities of plans and providers to address equity, given the role MCOs play in Medicaid. Many of these initiatives are fairly new, so monitoring their effectiveness may be an area for future Commission work.

Medicaid beneficiaries' closest contact with the Medicaid system is through interactions with providers. This is why a key element of advancing health equity is to ensure that providers are representative of the communities they serve and that the entire workforce, regardless of identity, is culturally competent. This next section of the chapter will discuss possible roles for Medicaid in promoting the development of a culturally competent workforce and the challenges of doing so. The chapter will also describe the importance of a culturally congruent care for Medicaid beneficiaries, and will note the challenges to achieving.

The chapter will also touch on how states are

using a non-clinical workforce, such as community health workers and doulas, to connect beneficiaries to services and advocate for their needs in a culturally competent way. Staff are completing a review of CHW coverage and are beginning to assess doula coverage.

The Commission may want to reiterate prior comments on the importance of ensuring a culturally competent workforce, which we can reiterate in the chapter, and if there are any other views you would like to include in the chapter we would like to hear from you today.

The chapter will briefly identify ongoing work that staff are doing that relate to improving health equity and reducing disparities in Medicaid. As you can see from this slide, these are some of the projects that are currently underway. If there are any specific ideas for future work it would also be great to hear that from you all today.

Commissioners, as we look towards next steps on MACPAC's equity work, staff would appreciate your feedback on whether the general framework of the draft chapter, as presented today, captures the key themes that the Commission would like to present in the June 2022 report to

Congress. In addition, any specific points within the key theme areas that you would like emphasized would be helpful to know. We would also like to hear from you if there are any adjustments you would like us to think about.

Between now and the April meeting, staff will add further detail and examples for each theme area and incorporate your feedback regarding these key themes. Staff will present a draft chapter during the April meeting.

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

VICE CHAIR DAVIS: Thank you, Audrey, for that great overview. I wonder if we can actually go back to what was the initial slide, that has the overview of all of the key themes, so we can all kind of have those at the ready, and then we will open up for Commissioner comments.

Yeah, Heidi, and then Verlon.

COMMISSIONER ALLEN: I just want to say, first of all, how excited I am that we are putting this chapter forward. I think it is just great. I think it's a fabulous start to our work and a really important way to organize how we address this in future sessions.

A couple of comments related to the chapter. When we talk about beneficiary engagement I prefer if we didn't talk about it like beneficiaries are being intimidated in settings where they are asked to weigh in. I didn't hear that in our panels, from our panelists, as much as I heard that they need support in being prepared to talk about whatever topics are on the docket, much like we receive support here in weighing in on our recommendations related to Medicaid, that they need that support to get up to speed so that they feel like they know what people are talking about. But I didn't want us to, in any way, imply that they have less expertise on Medicaid than other people at the table.

I would also like us to add to that section that it is so important that their voice is heard, because really, if you want to create a bad experience for somebody you bring them in, you take their time and energy, and then you just completely ignore them. So I think that's really an important point to be made, that there needs to be some mechanism where their advice is taken into consideration.

In terms of monitoring disparities -- and I don't know if this would go here in the chapter or something for

future work -- but it reiterates for me the need to have a national survey that monitors access by racial and ethnic minority groups, particularly because you might have to aggregate across states to be able to do subgroup analysis on different racial minorities within broad categories, which is really important because some of the variation is hidden in the groupings of, for example, Asians. There is a lot of variation within those categories, and you can't get them necessarily if you're looking state by state, simply because of a numerical issue.

And then work that I'd like to see us do in the future in this area, I would like us to -- and I don't know where this exactly falls, but I would like us to look at the segregation of care delivery sites, which I think is a really important issue related to equity, and I'm not quite sure where our levers would be for this. But, for example, at Columbia University we are closing the Vanderbilt Clinic, which is a clinic that serves only Medicaid patients, and you could see that clinic and know that it looked very different than the other clinics that Columbia serves, and that just seems, and I think it's supported by the literature, to be such a significant source of

disparities that Medicaid patients are grouped into a Medicaid-serving clinic, or a Medicaid-serving hospital. So I'd like to see that added to our future agenda work.

And lastly, I am wondering if graduate medical education and the money that Medicaid pays for that, you know, in combination with the money that Medicare pays, if that could be used to enforce any kind of quotas in the workforce, to have a more diverse stream of physicians.

So that's my feedback. Thank you so much for your hard work.

VICE CHAIR DAVIS: Thank you, Heidi. Verlon and then Martha.

COMMISSIONER JOHNSON: Thank you. This is great to hear, and as Heidi said, I'm extremely excited about the work that you all did around this. It is a very important issue and one we really need to pay attention to as Commissioners, so I appreciate that.

I just have two points. Under the federal actions, I do completely appreciate the Biden administration's and CMS' attention in highlight of this issue, but do agree that we do need to have more actual steps around it. Not to mitigate or say anything is wrong

with just an outreach to health-related social needs -- I think that's important. I think that the next step and more action should be around the data collection. And I think that you did a really good job of kind of outlining that there, but I still want to acknowledge that, at least for that particular section.

In the state leadership and infrastructure area that you talked about, I cannot agree more, the importance of having commitments from the senior level from state leaders. I think that is how we really make sure that we are pushing the needle and getting things done, and that is really important.

But I will say to that, having said that, I do think it is important that just going beyond the idea of making sure there are plans in place and that we are making sure we are addressing the issues and having conversations around it. We also need to make sure we have the right voices in the room to be part of those plans and those discussions. Representation does matter, and listening to voices that could have a different perspective and a different dynamic makes all the difference in the world.

And I will just be honest. I have been in

Medicaid for quite some time, and it has not escaped me that in many situations I was often the only woman of color in the room. So really making sure that we are thinking about that dynamic of being more intentional about having representation at the state level, at the federal level, could really add a lot of different value to this.

And again, now we are doing some great work and have some great ideas around beneficiary engagement and making sure that we have representation there, as well as making sure there is cultural competency related to the providers. But let's not forget about the fact that we need to make sure we have it at the highest levels too, because that's where the decisions can really help us move the needle forward. Thank you.

VICE CHAIR DAVIS: Thank you, Verlon. I've got quite the list here. Martha, then Fred, and just so folks know I saw your hand, I've got Brian, Kathy, Stacey, Dennis, and Laura.

COMMISSIONER CARTER: Thanks, Kisha, and thanks, Audrey, for this work. You know, we often give examples of what is already in place and working, and I would like for us to, of course, highlight the work of the community

health centers. And just really briefly, in 2020, there were 29 million people served by health centers. Half of them were covered by Medicaid. And 62 percent of health center patients identify as a racial or ethnic minority, 25 percent are best served in a language other than English, and 69 percent of health centers say that they routinely screen for social determinants of health.

And we know all this because HRSA's Bureau of Primary Health Care has required the community health centers, for decades, to collect data by racial and ethnic grouping, not only demographic data but their quality data. And so, you know, blood pressure in control, sort of the classic quality measures are reported by race and ethnicity, and HRSA and the Bureau of Primary Health Care feel this is so important that they actually score and grade the health centers on measures related to reducing disparities, increasing access. So this is a federal program. I mean, it's not the only game in town but it's a big program that's really been working for a long time on disparity issues. And so I would like to highlight the work that the health centers are doing as a model. And I think that hits a couple of your levers.

I think that another part of the health centers is beneficiary engagement. A lot of people don't know that it is requirement that the majority of the board members of a health center have to be patients of the health center and reflective of the community served. That is huge, and you don't see that anywhere else. And that's absolutely a requirement, and health centers are visited every three years to make sure they're staying in compliance.

Despite all that wonderful stuff, there are MCOs that don't contract with health centers, and so we've already got the system in place that would increase access and diversity and improve equity, and we still have barriers in some states with MCOs not contracting with their local community health center.

So I think I would like to eventually see us work toward a recommendation in that area, but I know you'll want to go back and do your own work on this.

Lastly, another program that I think is really important is the Bureau for Health Workforce. I'm aware that at least in some recent grant applications, they're actually requiring a cultural competency component, and sometimes they're requiring that -- or they give extra

points, anyhow, on the scoring system for contracting with the community health center because of those -- because they want to make sure that they're recruiting diverse student applicants, and that they're training in communities of need because then they'll go back there. So I think a conversation with the Bureau of Health Workforce would be a really good thing.

VICE CHAIR DAVIS: Thank you, Martha.

Fred?

COMMISSIONER CERISE: Thanks, Kisha.

Audrey, this is a great report. Thank you, and I think it hits on a lot of important points.

I think about the equity issue in a couple of different ways, at least in our health system, and one is those people that are getting into care. What's their experience like? Are they getting good clinical care? Are they having a good experience? That piece of the equation. Then the other piece is who is not getting into care and doesn't have access?

I think there's a lot in here with the former. The latter tends to be tougher, and if you look at where the needs is -- and this, I'm sure it gets to be a bit

controversial, but there's huge need in non-expansion states. The administration tried to take this on with Build Back Better, and to the extent that -- you know, I think HHS has good ideas. CMS leadership laid it out in that Health Affairs blog, but to get into those areas where people just are not getting access to the system, and it's unlikely to change quickly.

If you look at people in the coverage gap, 35 percent of the people are in Texas. Another 19 percent are in Florida. So can the administration do things to lean into some of those areas where you have big pockets of uninsured? Whether that's working with the major -- you know, the big counties that have desires to work with the administration to put programs in place -- and I know this gets tough to do, like some state partnerships and expansions and things like that, but you can -- CMMI look at leaning into some of these big problems.

I'll give you an example. You know, we looked at end-stage renal disease and mortality. One-year mortality for people who don't have regular access was 16 percent compared to 3 percent for those who do. That's a huge difference, and the state could do something with that.

And other states have done things with that to cover outpatient emergency dialysis, but then you've got some states who choose not to cover that.

So what types of things can the administration do where they can work with wiling states, counties, providers to lean into these areas where you know you've got large pockets where there's inequitable access. That's a tougher one to do, I'm sure.

I think a lot of the stuff we are talking about in this report are things that CMS has on their radar. They're going to do these things. So, if we want to put something forward that's a little tougher and different, try to look at those areas and lean in there.

One other comment -- and they'll find a lot of willing partners in that space with big populations that they could make a difference in.

On the state leadership piece, I like that. You might think about what a commitment would look like. Is there a scorecard? Is there something that identifies what that activity would do, whether it's things in ease of enrollment and access or how they measure outcomes? But would you give some incentive to states, and then how would

you tell if they were demonstrating a real commitment with their agency leadership?

That's my only other comment. I thought it was a great report. Thank you.

VICE CHAIR DAVIS: Thank you, Fred.

We'll go to Brian, and then it will be Kathy and then Stacey.

COMMISSIONER BURWELL: I echo other people's praise of this chapter. Audrey, you've done a really good job.

I want to bring up the whole idea of whether we should address the concept of welfare stigma because I still think that's very prevalent in the Medicaid program, despite improvements that it's made. I think public perceptions of the Medicaid program and of people who are on Medicaid explain, to a large extent, the lower quality of care that is provided to that population. And the segregation of our health care system according to whether somebody's on Medicaid or not, as Heidi talked about, I think those factors will exist.

I believe there's probably a fairly strong literature on people's perceptions of the Medicaid program

and how that has led to underfunding, low provider rates, lack of access, et cetera. We could almost write a whole chapter on that relationship, and it kind of gives a history of why we are where we are now with the program that is structurally unfair to certain people of color.

VICE CHAIR DAVIS: Thank you, Brian.

We'll go to Kathy, and then it will be Stacey and then Dennis.

COMMISSIONER WENO: Yeah. I could echo a lot of comments. I'll try and edit some of my thoughts here.

I would agree a lot with what Verlon was saying. I was starting with that. I think, you know, a lot of us have sat on Medicaid and advisory panels of all types where we've had no people of color in the room, especially -- you know, I come from the Midwest. I can think of fewer times that there were people that were impacted by what we were talking about than -- that were not in the room at that time.

So I think it's important for us not only to have beneficiary engagement, you know, to talk about what the issues are but also to involve them in the solutions.

I did a lot of work in the early 2000s with CHIP

enrollment and the most impactful enrollment and renewal. The things we did involve working with people in the community, whether they be parents of beneficiaries who would reach out to each other to do enrollment and renewal or even working with people in churches as well as working with -- in my later work in rural health when we were dealing with workforce issues, we looked a lot to Alaska where they were using community health workers that were present within their own cultural community to do clinical services. And there's a big movement in dentistry right now for mid-level providers that look more like the populations that we want to serve.

And lastly, what Martha was talking about, HRSA's Bureau of Health Workforce funded an awful lot of community-based-type programs in oral health, things like school-based services and community-based services and now telehealth where we are reaching people where they are.

So I think the engagement of beneficiaries and solutions is really the key here.

VICE CHAIR DAVIS: Thank you, Kathy.

We'll go to Stacey and then Dennis.

COMMISSIONER LAMPKIN: Thanks. Again, Audrey, I

too think that this is going to be a really important contribution to the conversation and understanding of what states are already doing, but also what states may be able to practically do.

I just had two or three thoughts as I read through this and thought about the material that you've included, and it may be that these are more things for future thinking than things about the chapter specifically. But I'd defer to you on that.

And first came in the category of federal actions to health equity. I mean, it sounds like from what we have right now that there are a couple of concrete things to call out but not a ton of concrete things already in place. So we have stuff that we know is in the pipeline that would call out some kind of toolkit, technical assistance, the kinds of things that we've seen CMS do fairly well to help push initiatives in early days? So I had a question about whether we have any insight into that. We can help states and other stakeholders understand better a little what's coming.

And then the other thought that I had related to the state Medicaid agency leadership question. As I was

reading that and thinking and also hearing Fred's comments earlier, it made me think a lot about the long-term care ombudsman programs and whether there's any kind of model there for a health equity champion or something like that that could kind of coordinate efforts and potentially be able to tap into some level of Medicaid funding to the extent that they're supporting the Medicaid program but perhaps even be broader than Medicaid to get at some of the non-expansion issues that Fred was alluding to?

And then last on kind of financial incentives, this is kind of something that's coming up a lot in other conversations that I'm having. What can be done in capitation rates? I think you allude to it there and give some examples of non-capitation but kind of tangential things, and I just want to make sure that when we talk about that, we talk about that in conjunction with other initiatives and policy and/or environmental changes, because capitation rates don't drive anything in a vacuum. They have to work in tandem with contract requirements or environmental initiatives that can change the utilization or unit cost that kind of drive the capitation rate development. So I just wanted to make that point.

Thank you.

VICE CHAIR DAVIS: Thank you, Stacey.

Audrey, did you have any response to that first question that Stacey asked about what might already be in existence in terms of toolkits or other sorts of guidance?

MS. NUAMAH: That was one thing that we are currently doing a lot of digging around. CMS has health equity toolkits more broadly. They have a whole health equity plan, but it's for Medicare. We are still starting to dig in to see if they're doing anything for Medicaid specifically.

Similarly, they offer health equity technical assistance (TA) where states can submit TA requests, but we haven't gotten much information just yet about how many states are using it. Is Medicaid using it? Is it Medicare? Is it marketplaces? Because it just says health equity more broadly. So we are doing more digging to see if there's anything more specific than that. So far, the signals that CMCS leadership have given us is that it's coming, and that we should look towards the approvals for the Section 1115 waivers that are coming. This will be a good place to see how they're thinking about health equity

initiatives, but so far not much yet.

VICE CHAIR DAVIS: Great. Thank you.

Dennis and then Laura and then Tricia.

COMMISSIONER HEAPHY: Thanks, and thank you for the work on this, Audrey.

I have a lot of things that were going through my head. First, I was grateful that you are going to include information on racism and the impact of racism and beneficiary perspective. I hope that that's central to this because those stories and those perceptions and those realities need to be given voice, I think, in the chapter or in an ongoing basis.

I also -- as I was reading it, I was just pondering, thinking as we are addressing inequities considerations and other social causes, how do we ensure that we're not just equalizing gaps in need or unmet need? So if the pie remains the same, by increasing -- by addressing equity in one population, we're not really just spreading around unmet need across all populations. So I just want to make sure that as we're looking at that unmet need that's in the community, that we're also looking at things like capitation rates, ensuring that the capitation

rates are actually appropriate to the populations being served, populations that have been underserved, and so that's there. That's really important.

The other piece here is disability, the intersection of disability and race, and I always think about folks I know who have -- folks of color, whether it's Black or Latino, whatever it may be, and how to ensure that these populations that face disproportionate levels of inequities due to both their race and their disability status don't end up like it's being in Chapter 10 of a book that will be done, that will come in like 10 years from now, because it just -- these are folks who are, even during COVID, most disproportionately impacted.

So I want to make sure that -- we talk about race, ethnicity, language, and disability (RELD) all the time, and we leave out the "D" when we're implementing things, so really to target and make sure that people know that these populations are really being disproportionately impacted.

VICE CHAIR DAVIS: Thank you, Dennis.

Laura and then Tricia.

COMMISSIONER HERRERA SCOTT: Thank you, Audrey.

Just to echo everyone else's comments, you know, great work.

I just wanted to focus on one area so I'm not being redundant, specifically around culturally competent workforce. So, you know -- and maybe it can go in the data collection and reporting, but what can we say about the providers that serve members? And if there's more that we can say about their race and ethnicity in the different areas, so not just -- you could imagine network adequacy -- but cultural adequacy. And if we can't get race and ethnicity in our providers, then at a minimum, what kinds of training and education are states doing around cultural competency?

And then lastly, thinking about the nonclinical workforce, especially since you called out the community health workers and doulas, especially community health workers, is there an opportunity to partner with other state-based initiatives that are federally funded, such as the AHECs that are funded out of HRSA that are generally in rural areas, but they do a lot of education and training for nonclinical supports? And how could Medicaid state agencies work with those providers that are training this

workforce that can then serve these patient populations?

VICE CHAIR DAVIS: Thank you, Laura.

We'll go to Tricia and then Darin.

COMMISSIONER BROOKS: Thank you.

Audrey, my apologies. I had to step out for another meeting. So I missed your presentation, but I just have a couple of comments, and I apologize again if this has been discussed prior to my rejoining this meeting.

In the memo, it talks about 60 percent of beneficiaries identify as Black, Hispanic, or other non-White or ethnicity, and then it says 30 Hispanic, 20 Black, 20 other, which adds up to 70, if we're counting the same thing. And I always looked at race and ethnicity as separate because you can be White Hispanic or White non-Hispanic or Black Hispanic. So can you explain to me a little more about that data?

And I just -- before you start, let me make my other point so you don't need to come back to me. There's a section that talks about beneficiary engagement and the importance of providing some kind of compensation to engage beneficiaries. I'd like to see that specifically include child care, and I would like for there to be some emphasis

on engaging beneficiaries to some extent based on the share of Medicaid they represent.

We've done focus groups in the past, and I ask, "Was it parents? How many parents were interviewed?" and 3 out of 20 might be parents. But kids make up 50 percent of the Medicaid population. Now, I want to make sure that we get the voice of what's happening to kids very clearly in the work that we do and make sure that kids aren't just, you know, an afterthought because they're relatively inexpensive to cover.

So, with that, I will let you help me understand the data. Thank you.

MS. NUAMAH: Thanks, Tricia. Those numbers, 30% Hispanic, 20% Black, 20% other, don't add up to 60 is because there's overlap among the different groups and some people are double-counted. We'll make sure that it is more clear in the chapter and have the true breakdown as best as we can get it, so that it makes more sense. Thank you for calling that piece out.

VICE CHAIR DAVIS: Thank you, Tricia and Audrey, for the clarification. We have about five minutes left in this section, and we have Darin, and then we'll go back to

Dennis.

COMMISSIONER GORDON: Audrey, thanks for the work on this. I think you hit all the different categories. I think there is like this balancing of how do you separate state Medicaid agency leadership from some of the other categories, given that some of the contractual language that that would deploy, or the delivery system levers they deploy would, in essence, have to come from the state. But I think you've done it well in the outline, or in the high-level framework. It's just something we'll have to continue to balance when it kind of gets fleshed out into a chapter.

The only other thing -- and it's more of a question than anything else -- could you expand? The community health workers, I think, are a phenomenal tool that is starting to be used more and more. And you talked about how you were going to look at that and you're looking at doulas. But in the context of community health workers, is it going to be just looking at how different states use them or trying to look at all states broadly, I know which is a pretty big lift. I just wanted to understand that better, how we're going to incorporate that, given that I

don't think we've done a lot of work in that area previously.

VICE CHAIR DAVIS: Anne, did you want to jump into that point too?

EXECUTIVE DIRECTOR SCHWARTZ: Sure, and just to note that this is work that got started before Audrey joined us. We are ready to publish relatively soon a brief on community health workers that describes, first of all, the different terms for people who do some of the same functions but they may be more specialized than others, some of the Medicaid authorities and how community health workers are paid, and some examples from states. And I think that will be a good jumping-off point to bigger policy issues. But that's coming out, and that's going to be separate from the chapter.

COMMISSIONER GORDON: That's helpful. Thank you.

VICE CHAIR DAVIS: Thanks. We'll go Dennis, and then Bill, and then we'll wrap up.

COMMISSIONER HEAPHY: Thank you. I went back and looked and I didn't see the word "trauma," and I think there's an important place for trauma-informed care, the experience of trauma folks, Black folks in particular.

And then the other thing, as we were just talking, is not just can be helpful but certified peer specialists and certified recovery coaches, and the importance of those roles, and how would key leaders of these folks be in the community, and then addressing health disparities.

VICE CHAIR DAVIS: Thank you, Dennis. Bill?

COMMISSIONER SCANLON: First I would just echo what we've heard today, that this is an incredible piece of work that you've done, and on such a critically important topic. Let's hope that the attention it deserves occurs.

Mine is a relatively minor point but I think over the longer term it could turn out to be somewhat important, and that is the issue of theme that has come up repeatedly, not just today but in previous discussions, is the question of a lack of data or the problems with the data. And while having comprehensive, sort of adequate surveys is the gold standard, I think we need to be realistic about if we can get that, if so, wonderful. Getting it on a repeated basis is probably impossible, and at the same time we do need to be concerned about how things change over time.

So to that end, I think we really need to

consider how we can efficiently gather information through administrative systems that is valid and reliable. Race and ethnicity are complex categorizations, and so when you're collecting information you want to do it right and you want to be able to then use it to maximize your benefit, and that involves being able to link data across systems.

So I think we should be giving enough attention to what can we get from an administrative perspective that will help us, over time, monitor hopefully progress, to make sure we identify gaps that need addressing. Thank you.

VICE CHAIR DAVIS: Thank you, Bill. I just have a few comments as we wrap up, and just to echo what everybody has said, this is really a great chapter, Audrey, and I think brings together a lot of the work that we have been doing and a really great launchpad for where we go forward.

I really want us to continue to explore the data. I know that we will. But I think that's an area where we could start to work towards making a recommendation. There are a lot of things that the federal government could do

here, even just in terms of creating some standardization around what labels we should be using and how that works across systems.

I also think we may want to wrestle a little bit with the tension around self-reported data, which is the gold standard, versus purchased data, and, you know, other places where insurance companies and other folks are getting race and ethnicity data and how that plays out. So that might be something that we want to look at.

I also think in the chapter we can outline with a little bit more specificity where we are going over the next year. You kind of outlined next steps, but what's the plan for the 2022-2023 season, and following after that?

And I think just in general, when we talk about health equity -- and we maybe have even done this today, we've kind of put health equity in a box. Here's the chapter on health equity and we're going to talk about it. But health equity, more than anything else we do, is something that runs through and cuts across all of the work that we do. And so how are we really challenging ourselves as a Commission to make sure that health equity is a thread that runs through all of the work that we do? Applying

that health equity lens to each of our chapters and each of our topics that we address is really important.

And then last to the issue of representation, yes, it's important to have that representation in state workforces and all of the different areas, but it's also important to have that representation here on this Commission. And this aspect, the Commission doesn't control. We don't get a say in who our members are, but I think that it is important to have that representation, both in terms of who our beneficiary representatives are -- we've done a good job of having folks from the disability community represented -- but we haven't done as good a job in terms of beneficiaries from the minority communities, to have them represented. And especially in terms of the breadth and diversity of the Commissioners, there is certainly work that we can continue to do there. So highlight that representation is important on all levels.

And with that we'll turn back to you, Audrey, if there are any other questions that you have for the Commission or additional information that you need.

MS. NUAMAH: I think I'm good. Thank you all so much for all the feedback. I look forward to taking it

back and incorporating it as best as we can into the April chapter.

VICE CHAIR DAVIS: Thank you, Audrey. Thanks, everybody.

MS. NUAMAH: Thanks, everyone.

CHAIR BELLA: Thank you, Kisha, and thank you, Audrey, and to the rest of the Commissioners.

We are going to move into the session on integrated care strategy for duals, and Kirsten and Ashley are joining us. I see both of them. Welcome, and we will turn it over to the two of you.

REQUIRING STATES TO DEVELOP AN INTEGRATED CARE STRATEGY FOR DUALLY ELIGIBLE BENEFICIARIES: REVIEW OF DRAFT CHAPTER AND RECOMMENDATION FOR THE JUNE REPORT

* MS. BLOM: Great. Thank you, Melanie. Good afternoon, Commissioners. I am here to review our draft report chapter on integrating care for dually eligible beneficiaries and the accompanying recommendation.

Next slide, please.

Integrating Medicaid and Medicare for the dually eligible population has the potential to improve outcomes

and promote more effective and efficient coordination between Medicaid and Medicare, potentially reducing spending. It could also be a tool to promote health equity.

MACPAC has three goals for integrated care: increase enrollment in integrated care, increase availability, and promote greater integration in existing models.

Next slide, please.

By way of background, just over 12 million duals were enrolled in both programs in 2020, with most eligible for full Medicaid benefits. Of the full benefit population, about 1 million were enrolled in integrated care. Integration occurs on a continuum of coverage, with some models offering fully integrated coverage and others integrating some Medicaid and some Medicare benefits. Fully integrated coverage occurs where all Medicaid and Medicare benefits are covered, and it is available in fewer than 15 states.

Next slide, please.

Fully integrated care has several key elements. It covers all Medicare and Medicaid benefits for full

benefit dually eligible beneficiaries, with the exception of benefits the state has carved out, under one entity, with one set of member materials. A fully integrated program provides care coordinators to members and establishes care teams to develop individualized care plans to meet the unique needs of beneficiaries.

A fully integrated program includes beneficiary protections, which we talked about before, such as an ombudsman to assist enrollees with issues that might come up related to their coverage, and it includes a mechanism for beneficiary input, similar to what the MMPs currently have where enrollee advisory committees are established to provide regular input to the plans.

Finally, in a fully integrated model financial alignment occurs when a single entity receives payments to cover both Medicaid and Medicare services.

Next slide, please.

There are a number of models that offer fully integrated coverage, including the MMPs and Washington's managed fee-for-service program, Medicare Advantage fully integrated dual eligible special needs plans, or FIDE SNPs, and the Program of All-Inclusive Care for the Elderly, or

PACE. PACE is the most widely available of these models, available in 30 states.

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Other integrated models exist but do not offer fully integrated coverage. Coordination-only D-SNPs offer minimal levels of integration, usually related to information sharing between the D-SNPs and the state. Highly integrated dual eligible special needs plans, or HIDE SNPs, are a subset of D-SNPs that are required to cover either Medicaid LTSS or behavioral health benefits.

Of these, the coordination-only D-SNPs are the most widely available, present in 36 states. HIDE SNPs and FIDE SNPs, that I talked about before, are available in around 15 states.

Next slide, please.

The integration levels that are available to beneficiaries of course vary from state to state. As an example of how that integration varies, this map displays integration levels in D-SNPs across states. States without D-SNPs are shown with a striped pattern, so states like Wyoming and North Dakota. I'm not sure how well you can see this. But there aren't very many states that don't

have D-SNPs.

States with minimal or low levels of integration, those are the shaded gray or white states, that have coordination-only D-SNPs but no HIDE or FIDE SNPs.

States with low levels have some HIDE SNPs. States with moderate levels are shaded light blue. They have HIDEs or FIDEs or both, but don't operate with exclusively aligned enrollment. You will recall we talked about that before. That occurs where the plan is responsible for all Medicaid and Medicare benefits for its members. States with high levels of integration -- those are shaded in green on this map -- have some FIDE SNPs but operate with exclusively aligned enrollment. And then finally, the fully integrated states, which you can see in the dark blue shading, and in those states all the D-SNPs are either FIDE or HIDE and operate with exclusively aligned enrollments.

Next slide, please.

We understand that integrating care can be a heavy lift for states, and we have asked states directly about the barriers that they face. States have told us that a lack of capacity is a challenge. This includes

competing priorities for state leadership, which can make it difficult for states to move forward on integrated care; limited capacity among states to have to manage integrated care initiatives while also juggling other responsibilities; and a lack of expertise in Medicare, including the benefits of Medicare Advantage plans that they might offer as well as how to set up a contract with a D-SNP.

States also talked to us about experience enrolling dually eligible beneficiaries in Medicaid managed care and how having that experience prior to setting up an integrated model can make integration easier, since most programs are built currently on managed care. It can also be tough to use certain tools of integration, such as default enrollments, where individuals are automatically enrolled into a Medicare Advantage plan when they turn 65, if that person wasn't already enrolled in Medicaid managed care prior to becoming a dual.

Next slide, please.

The purpose of an integrated care strategy is to help states make progress toward more coordinated coverage for dually eligible beneficiaries and potentially improve

outcomes. People who are dually eligible tend to have worse outcomes than beneficiaries in Medicare only in some areas. For example, they are more likely to report being in poor health and more likely to be institutionalized, according to the analysis in our most recent data book.

Given the barriers that states face in standing up an integrated model, states could benefit from additional federal support, including technical assistance and financing.

Many states are looking for a place to start. An integrated care strategy could be that first step, along with high-level guidance from the federal government, informed by the experience in the MMPs.

Next slide, please.

This slide shows the high-level components that an integrated care strategy should include: the approach to integration, including a type of delivery system and model to be used; who will be eligible and what benefits will be covered, some or all Medicaid benefits, taking into account any state carveouts; how will eligible beneficiaries enroll and whether or not there will be an automatic enrollment mechanism. The strategy should

describe key beneficiary protections, such as an ombudsman. It should also include a data analytics component, with a plan for exchanging Medicaid data with Medicare, and a plan for quality measurement.

The strategy should also consider how to promote health equity, to help ensure the needs of diverse subpopulations of duals are being met, such as individuals who are age 65 and older but perhaps relatively healthy relative to people who are younger and qualified for Medicare based on a disability.

Next slide, please.

This is the draft recommendation for consideration today. I will read it.

Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components: integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data

analytics, and quality measurement. The strategy should also consider how to promote health equity. To support states in developing this strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

Next slide, please.

Our rationale for this recommendation is that the strategy provides states with a framework and a place to start for raising the bar on integrated care for dually eligible beneficiaries. Additional federal funding enhances states' ability to do so. It can be used to finance the administrative costs of designing the strategy, hiring new staff with Medicare expertise, or training existing staff. It could take the form of an enhanced FMAP or a grant program.

This piece on funding is consistent with our June 2020 recommendation, but it goes further by linking the funding to the development of an integrated care strategy.

So that is where I will close. We will leave up the slide with the draft recommendation on it. And with that I am happy to take any questions.

CHAIR BELLA: Thank you, Kirstin. Thank you, Ashley. I would like just to get any questions or comments, and we will see how we're feeling about this recommendation. We are moving to a vote either today, or tomorrow if we have edits to the recommendation. Laura, I will start with you.

COMMISSIONER HERRERA SCOTT: Thank you, Kirstin. Can you talk a little bit about the rationale behind the two years? That seemed like a long time for the strategy development.

MS. BLOM: Sure. In talking with states there are more states that are on the lower levels or sort of haven't done anything in this area yet, than that have, and so our concern was that for those states they haven't done a lot of thinking on this and would really need time to come up with a thoughtful plan. But I'm definitely interested in your feedback on that.

CHAIR BELLA: Laura, did you want to say anything?

COMMISSIONER HERRERA SCOTT: Yeah. I mean, I guess I was thinking if the ultimate goal is to think about what states do need to integrate, then two years for the

strategy would put us two years before the work began, and clearly would take longer based on the available funding, the amount of support, technical assistance, et cetera, that they would need. And the sooner that we knew that information as far as the gaps in the strategy, then we could consider identifying those resources needed at the state level to start integration. So it just seemed like a long time for a two-year window.

CHAIR BELLA: Can I take comments on the time period from Commissioners? Do other folks have a view on that? Darin, is that your hand? Darin, and then Tricia.

COMMISSIONER GORDON: Yeah. I mean, I do think if you think about what all will have to go, you know, the process that a state is going to have to go through to do this, because you're talking potentially recommending a move from the current system and current plans in your state to one that some of them may or may not be able to participate in, you also, in order to have stakeholder input, I mean, if you want to do this well, because one way or the other you're going to have that discussion, you're looking at probably even in just the designing and trying to work through the concept is going to be at least a year

in order to get it done.

But that time period doesn't feel too long or too short for me. It feels about right, not because I like it. I always would like things to be faster. After living in it, it's probably not unrealistic.

CHAIR BELLA: Yeah, I mean, what's going through my head is I'd like to have it done in 60 days. However, we also need to have meaningful stakeholder input in all of those pieces, and so that could be what's contributing to the two years. But Tricia and then Dennis.

COMMISSIONER BROOKS: I guess I was actually thinking that this would be a period of time for the strategy development and implementation, and I thought two years was too short.

But what happens, I mean, this is seemingly just focused on developing the strategy. What about the implementation? Do we develop the strategy and then we do or don't act to implement it?

CHAIR BELLA: Well, I mean, I think the way we got -- we haven't been ready as the Commission to say every state must have an integrated care program for its beneficiaries by a date certain, and so what we've said is

let's signal how important this is, and let's get Congress to signal how important this is, and start by asking every state to at least think about a path that they would pick for their dually eligible consumers.

So I think, Tricia, I see this as a stepping stone, but I haven't thought the Commission was quite ready to require that every state actually implement a program by a certain period of time.

COMMISSIONER BROOKS: That makes sense, but it's interesting to think about it from the perspective of having states go through a strategy-planning process that then may or may not ever be required.

CHAIR BELLA: Darin, is your point --

COMMISSIONER GORDON: Yeah. Tricia, I hear you, but if you look back like what happened with CMMI grants when they were looking at delivery in -- payment delivery, it wasn't uncommon that they'd give planning grants and get people to go through the process and see whether or not they could put together something they thought could work, but not every state, when it was all said and done, felt they could actually implement it. And CMMI didn't give them implementation grants, but I do think it does move you

down the field and starts the conversation and provides support for the states to start bringing people together, understand their data, understand what their opportunities are.

But you're right, at the end of that, there may not be the political will to make the changes that are necessary, but at least, you know, gets the focus and at least starts the conversation.

COMMISSIONER BROOKS: Thank you. That's helpful.

CHAIR BELLA: I think it's a really important point, though, and, Kirstin, I'd ask you to think about that when we write the chapter to make sure that like this isn't just like going nowhere. And it would be important to sort of thread the needle to we've said states need support, not just temporarily, that they need dedicated resources to support their work in this area, and so I would hate for people to think that we think like this would be one and done. So let's think about that as we put context in this as it pertains to where we might go with this next as the Commission -- if and when Congress would take this up as we recommend.

Thank you for those comments.

Dennis and then Bill and then Darin again and then Kisha and then Brian.

COMMISSIONER HEAPHY: This is not worse as much as looking at concept, and that's to consider how to promote health equity as opposed to, you know, quality measurement that integrates promotion of health equity. So that's seamlessly part of the recommendations as opposed to an add-on, because I think sometimes it just stands out as that it also considers how to promote health equity as opposed to that integrates health equity into -- that it integrates health equity.

And the other thing that struck me, the second that struck me was that it doesn't mention CMS, and so that's just something I did. That just -- I think, oh, it doesn't say what CMS's role would be in this. So I just raise that as a question. It literally just popped out at me this second.

CHAIR BELLA: I think, typically, Dennis, when we have HHS in there, that's how we do the recommendations, but, Anne, you should say more on that.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. I mean, typically, in a case like this where there's a funding

piece, we would talk about the Secretary rather than CMS, but ultimately, the Secretary is going to delegate to CMS.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: And let me make sure. Kirstin, were you following the request on the health equity edit? Because, Dennis, I don't -- I'm not sure. So you're asking that we change the sentence that says the strategy should also consider how to promote health equity?

COMMISSIONER HEAPHY: I didn't have any specific language. It was more just that the strategy integrates health equity as a goal as opposed to promotion. It just seems that we see it added into a lot of things lately that also -- that should consider how to promote health equity as opposed to that integrates health equity into its goals or something.

CHAIR BELLA: Yeah. I think we're probably trying to stay away from using the word "integrate" again in that sentence.

COMMISSIONER HEAPHY: Sure. That's fine.

CHAIR BELLA: But maybe it's something we could work on in the text of the chapter when it goes into detail about what we mean by kind of the next layer and layer

behind the recommendation.

COMMISSIONER HEAPHY: Yep.

CHAIR BELLA: Okay. I understand that point. Thank you.

Let me look at my list. Bill.

COMMISSIONER SCANLON: Yeah. I was going to agree with Darin. I mean, I think that the two years -- we need something like two years to be somewhat realistic, and even the two years, I think, in some respects, in many states, it's going to be optimistic because this is an important enough set of decisions that you can imagine sort of the governor and the legislatures being involved. And we know the state legislatures do not meet every year in every state, and when they meet in some states, not on an annual basis, they sometimes -- even still they meet for very short periods of time. So there's going to be a real timing issue here, and you don't want to create opposition to this by having people point out it's unrealistic.

The two years maybe gives the hope that it will be done because I would -- having experience at GAO, reporting on how many deadlines are not being met, we don't want to add this to the list of deadlines that are not

being met.

CHAIR BELLA: Thank you, Bill.

Darin, I'm skipping over you to go to folks who haven't talked yet, and then I'll come back to you.

Kisha, then Brian, and then Toby.

VICE CHAIR DAVIS: Thanks.

I'm in favor of the recommendation. I do appreciate, though, Dennis' comment, and I understand what you're saying of how it's written makes it seem like health equity is tacked on rather than integral to the following components. And so I think what you're saying is the strategy should include the following components, dah-dah-dah-dah-dah, and promote health equity rather than being something separate and tacked on, which I would also agree with.

And I'm appreciative that we call out specifically in the recommendation, the importance of looking at health equity. I do think that we could do a better job in the chapter of saying what that means to look at health equity. This is a marginalized population already, our duals population, and from an equity standpoint, how do we expect that this integration improves

or potentially worsens or has no effect on equity for these populations? And I think outlining a little bit more on what this population looks like, we have a couple, just like call-outs on high school graduate rates and race, but I think that we could certainly do a lot more to describe what this population looks like from an in a racial and ethnic background and potential implications from an equity standpoint on integration.

CHAIR BELLA: Thank you, Kisha. Definitely important feedback on the chapter, certainly.

Brian, then Toby.

COMMISSIONER BURWELL: If you think of a strategy as how to get from Point A to Point B, I think the report also has to include information about where states are at Point A, where they're starting from, and I don't think -- I think a lot of states don't know what -- where their dual population is currently enrolled and how they're getting health care. So I would just recommend that we say something about states having to do research or a scan about where their dual eligible population is now and what health plans. They could be in MA plans. They could be in the look-alike plans. They could be in different plans on

the Medicaid side. They could in PACE. So I would just like to add a baseline component to each strategy report.

CHAIR BELLA: Okay. Thank you, Brian.

Toby. And then I'll see if anyone else who hasn't spoken wants to talk, and then we'll circle back around starting with Darin.

[Pause.]

CHAIR BELLA: We can't hear you, Toby, if you're talking.

COMMISSIONER DOUGLAS: Can you hear me now?

CHAIR BELLA: Yes.

COMMISSIONER DOUGLAS: Okay. Sorry about that.

The two-year time frame is realistic based on all the reasons everyone stated. I think one of the areas that I think would help make this more real is just around time frames or making it clear that a strategic plan should include some expectations on what would be the time frames for implementing different strategies. That can be revisited, but included, so it's not just strategies without a clear set. And I do like the idea of maybe adding in a component about the current state, as Brian said.

CHAIR BELLA: Thank you, Toby.

Any Commissioners who haven't yet comments wish to comment?

[No response.]

CHAIR BELLA: All right. Darin, back to you.

COMMISSIONER GORDON: I'll be quick. I admit it's already been covered by comments that followed. So I'm good. Thank you.

CHAIR BELLA: Oh, okay.

Well, Kirstin, Ashley, do you have any questions or clarifications on what you've heard?

MS. BLOM: No, I don't think so. I think we're good.

CHAIR BELLA: Okay. I'm going to suggest that we do a couple things. One is to just sort of see what we might do around the health equity language in the recommendation. We can see if we can make that clearer or if we want to rely completely on what we're going to do in the chapter. In other words, we won't take a vote on this today. I'm hearing support for the recommendation. If we voted on it today, we would probably pass it today, but let's go ahead and just like give ourselves the evening to

take another look at it, bring it back tomorrow for a vote.

And then I think we got some really important feedback about some elements to either enhance or sort of embed in the chapter to kind of signal where we would go after this and to make the equity piece a little bit stronger.

Any other comments from Commissioners before we go to public comment?

[No response.]

CHAIR BELLA: I'm sure this goes without saying, but I'm very happy with this recommendation. Thank you all for moving this ball forward. Now we just have to get Congress to be as excited about it, right?

Okay. I don't see any hands. So I'm going to turn to our public comments. We will take comment from the public on the integrated care or the equity discussions. I would remind folks to please raise your hands, announce who you are representing, and please keep your comments to three minutes or less. If you would like to speak, please use the little hand icon.

I see a few hands popping up. Maybe I can unmute. Camille.

PUBLIC COMMENT

* MS. DOBSON: Camille Dobson. Can you guys hear me?

CHAIR BELLA: Yes.

MS. DOBSON: Camille Dobson, deputy executive director of ADvancing States. We represent the aging and disability agencies that deliver LTSS to Medicaid and non-Medicaid clients.

I just had a couple of comments about the equity session, it's so timely. You know, there's tons of writing going on in the Medicaid space around all kinds -- equity and lots of different areas. I just wanted to make sure of two things.

One, I know that the analyst -- I'm sorry, I forgot her name -- did mention about community health workers and other sorts of nonclinical staff. I would obviously recommend inclusion of HCBS providers, both the staff being culturally competent and looking like the clients that they serve, but also equity and access to services for the HCBS population, so to call those out as well in your sort of nonclinical section.

The other thing I would mention, I'm not sure the

Commission staff is aware, but I wanted to highlight ADvancing States has started a health equity workgroup with a group of states and health plans and providers to talk about this issue. We had a presentation two weeks ago at our meeting from NORC who has just released two studies on health equity, one putting out a framework for Medicaid agencies to think about health equity and then a second study, to Bill's point, about data, data gaps, and a study that they've done across the country of states' ability, or lack thereof of collecting race, ethnicity, and language data. So they might be good background for the staff on that chapter.

We're hopefully going to put out a paper at least initially about some of the activities that the states are taking, some of them very, very innovative work on health equity in the HCBS space specifically.

Then, secondly, on the duals strategy, I commented last month when the recommendation came out that it's generally a good idea. States will not -- don't have the capacity to really work on this issue without some additional funding. Obviously, we do not want Congress to enact the requirement without the commensurate funding. So

I know that's not under your control, but obviously, that sort of goes without saying.

And the second issue about the time frame, I appreciate the feedback from Darin and the other Commissioners that two years is a blink in the eye for a Medicaid agency, and the states are right now struggling with figuring out how to get ARPA money out from $30 billion out to their providers and in initiatives and also facing the unwinding of the public health emergency in the next year. So two years is probably not enough time. I recognize that the Commissioners want things to move faster, but reality sort of impinges.

And one more thing on the states' plate at this point is, as important as integrated care is, I think would lead to not the kind of results that I think you'd want to see. So I'll leave you with that.

CHAIR BELLA: Thank you. Thank you very much.

MS. HUGHES: Pamela Parker, you can unmute your own line and make your comment.

MS. PARKER: Thank you. This is Pam Parker from -- representing the SNP Alliance, and we just want to say we're very supportive of this direction, given the new

rules that have just come out from CMS. This seems to help shore that up and match things a little bit better. So we think it's very timely that this be going through at the same time as everybody is considering those rules.

We think that -- there's one thing that concerns me a little bit in the language, and that is that it doesn't address the authority that CMS may have to do some of these things to actually help the states integrate. And this is one big piece of integration, of course, that's been missing is this kind of a requirement or a suggestion to states, and we're wonderfully excited to see that happening.

But at the same time, does CMS really have the authorities that it needs to be able to line up Medicare a little bit better to work with states? In general, what we've run into, you know, devil in the details on this whole area, has been that we run into little things that CMS doesn't seem to think they have authority to do. And just like a simple example has been integrated member materials. There's something in Part B that makes them so they can't integrate the review process and things like that, and CMS -- some of the folks in CMS have mentioned

these things over time. But you never know when you're going to run into one of those.

So, if there was some way at least in the chapter or something, you could talk a little bit more about Congress enhancing the authorities of CMS or MMCO, whoever, the Secretary, to, you know, somehow have a little bit of flexibility to get over some of the processes, and it's always in the operational processes where we run into these problems, so that we can line up Medicare and Medicaid a little bit more.

So the other thing that I would just say -- and again, maybe it's something you could talk about in the chapter somewhere. I don't know. But there's a little bit of concern that we may end up with 50 different state programs and then one big Medicare program, and it's kind of the same issue there. How do you align those when Medicare is kind of our way or the highway? And then we've got individual states, and how do we channel these into maybe a few types of models or a few types of templates for where we're all going? Certainly having your elements identified in this statement is great, but it could be that we're going to need a little bit more consolidation of

approaches in terms of some preordained templates, so that there's some overall guardrails. And you probably can't do it 50 different ways when you're dealing with Medicare.

So those are just my immediate reactions, but we're really supportive of this direction and really appreciate the work that you're doing.

CHAIR BELLA: Thank you, Pam.

It looks like we have one more person ready to talk.

MS. HUGHES: Mary, you have been unmuted. You may unmute your line for your comment.

MS. SELECKY: Hi. This is Mary Selecky with the National Association of Community Health Centers, and we represent FQHCs.

I just wanted to very briefly share with you the work that NACHC is doing in the area of health equity. We've been very active in promoting the availability of FQHC services through telehealth, and here we're concerned that states cover as many FQHC services as possible through telehealth and that they allow telehealth to be delivered through all of the mechanisms, including audio only.

We are also interested in promoting digital

literacy among clinic users so they can become more invested and knowledgeable about their health status.

Another area that NACHC is very actively involved in is workforce development, and here we're looking at policies that promote the availability of providers who are -- in particular, who are representative of the communities being served, and policies that would increase funding for the public health workforce, such as the National Health Service Corps.

NACHC is also looking at reducing scope of practice barriers that would increase access to care.

And finally, I would be remiss if I didn't mention NACHC is very involved and active in the SDOH space. The association has issued a tool called PRAPARE which allows health centers to gather data and help evaluate clinic users' needs, and recently, we rolled out technical assistance on coverage and payment of services that address SDOH.

And with that, I conclude my comments.

CHAIR BELLA: Thank you very much, Mary.

I do not see any other hands. Any further comments from Commissioners before we take a short break?

[No response.]

CHAIR BELLA: Anne, can we run five minutes late into the next session? Can we have folks come back at 2:35?

EXECUTIVE DIRECTOR SCHWARTZ: Sure.

CHAIR BELLA: Okay. We'll give you a little over 10 minutes. Please be back here at 2:35, and we will start the next session on rate setting. Thank you, everybody.

* [Recess.]

CHAIR BELLA: Okay. Welcome back, everybody. Let's go ahead and get started. There's Moira. Welcome. We are going to launch into our last two sessions, both of which involve managed care, and Moira, I will turn it over to you. I would just ask Commissioners to keep in mind that this is a body of work that we're talking about, some of which will move forward to the June report, some of which is laying groundwork for the next report cycle. But it all does tie together.

So, Moira, I will let you take it from there.

MANAGED CARE RATE SETTING AND ACTUARIAL SOUNDNESS: FEDERAL OVERSIGHT AND IMPLICATIONS FOR EFFICIENCY, ACCESS, AND VALUE IN MEDICAID

* MS. FORBES: Thanks, Melanie, and that's a good introduction.

It has been several years since the major managed care rule changes went into effect, and we are at a point where we can really start to examine how managed care is performing, what are we getting, are there things we should be doing differently, and so on.

Today Chris and I will present findings from two projects relating to rate setting. We will also be presenting findings from a companion study on the procurement process at the April meeting. And while each of these projects touches on their own issues, all of this work falls under a larger policy question which is: do the federal oversight and accountability mechanisms for managed care advance program goals, such as efficiency, access, quality, and value?

The projects we're presenting this month and next are setting the stage for more pointed discussions in the next report cycle. So we are going to share a lot of information with you today, some of which is background for all of these sessions. And we hope to hear what you are most concerned about or where you think the opportunities

are so that we can get going on that next phase of research.

With that I am going to start with some context, and this is the first time we've talked broadly about managed care in a while, and then provide some background on the rate setting process and the actuarial soundness standard. I will share findings from a study we just completed in February. We worked with an external actuarial firm to review the federal rules and policies, and actual rate setting documentation from seven states. We conducted interviews with states, actuaries, health plans, and CMS staff, and then based on all that work we identified some opportunities to improve managed care rate setting, and we look forward to your discussion of those.

First, context. We focused on the actuarial soundness standard, because capitation payments are the basis of payment in Medicaid managed care, and actuarial soundness is the payment standard for capitation payments. The key points on this timeline are: Congress created the actuarial soundness standard in 1981. There was nothing detailed in regulation until CMS finalized the first comprehensive managed care rule in 2002. And that rule, in

2002, said that states had to have an actuary certify that the rates they develop, the states had to develop the rates and have an actuary certify that they were actually sound for the program and population of services.

So that has been the rule for about 20 years, although about 7 or 8 years ago CMS brought in actuaries from the Office of the Actuary, or OACT, to help with reviews of the adult expansion population, because that was a new population in Medicaid and there was no historical experience to compare to. And in doing that the actuaries suggested a lot of changes, that they could ask for the documentation, the review process, and CMS ended up putting a lot of that in a new rule that was finalized in 2016.

And then in 2020, they had to make a bunch of additional changes, in part because of some of the challenges when they were implementing some of the stuff from 2016. So the basis of payment has really been around for 20 years, with a lot of modifications and improvements that they made in 2016.

As to why we are looking at managed care, we talk all the time about managed care spending is growing, but this chart really shows how much it's grown just in the

last 10 years. You can see it's gone from about $92 billion in 2010 to almost $350 billion now. Obviously, the Medicaid program as a whole has also grown a lot at the same time.

But while everything grew, the amount spent on managed care grew faster than the program as a whole. As you can see, the majority of Medicaid spending is now through managed care, not fee for service. It has been about or over half since fiscal year 2017.

And this is true across most eligibility groups. We compared spending in 2010 to 2019, and the share of Medicaid spending in managed care versus fee for service has grown in every eligibility group. Even just 10 years ago, managed care was still seen as something that was primarily concentrated among what we would call "moms and kids," the eligibility groups represented in the child and adult columns here. You can see that among people with disabilities and people over 65, almost as much of their spending now, the green bars, is through managed care. It is almost 40 percent. That is what we had in the moms and kids groups 10 years ago, the blue bars there.

So an overview of managed care rate setting and

the actuarial soundness standard. We will be putting a much more detailed brief out about this on the website later this month.

As we showed just now, it's a lot of money in the aggregate, and it is growing, which is enough of a reason to talk about this or to put this on the agenda. But what we really want to dive into in this work is to look at the individual level capitation rates, and that's because payments to MCOs influence a lot of the things that are critical to operating successful managed care programs, like whether MCOs will contract with a state or renew their contracts, whether they can stay solvent and make investments in activities to support enrollees, and whether they can pay providers enough to build a robust network that provides access to high-quality care.

So what we wanted to look at was the degree to which federal rate setting standards support meaningful development and review of capitation rates, because adequate rates support good program outcomes.

A quick overview of capitation payments, which are the basis of payment in managed care. State Medicaid programs pay MCOs to cover a defined benefits package for

an enrolled population through fixed periodic payments, called capitation payments, because they're made per capita. Capitation payments are established prospectively. They are part of the annual state managed care contracts that remain in effect for a year, regardless of changes in health care costs or service use, as we just saw during the pandemic. Capitation rates must be actuarially sound, and a certified actuary must attest that the rates submitted to CMS meet this standard.

So this standard, the actuarial soundness standard, is unique to Medicaid. It is defined in regulation and it requires that rates must be developed in accordance with generally accepted actuarial principles and practices, appropriate for the covered population and services--and appropriate was expanded in 2016 to add projected to provide for all reasonable, appropriate, and attainable costs--and so on. They must be certified by a qualified actuary, and to be considered actuarially sound they also have to be developed and documented in accordance with various other rules and requires. For example, states must ensure that rates are adequate to meet access to care standards and that they are developed by rate cell with no

cost subsidization of rate cells, and a number of other things.

States manage the rate development process. They can use their own actuaries. Most of them contract with an outside firm. There is a fairly standardized process to develop and document rates that involves getting baseline data and projecting future costs, making adjustments, and so on.

There are a lot of places where states can make choices, such as whether or not to have a risk corridor or whether or not to require medical loss ratio remittances. And there are places where actual judgment needs to be applied in making assumptions, such as if a state is going to move prescription drugs from fee for service into managed care, would that expect to change utilization of brand-name drugs and save 5 percent or 10 percent, things like that.

After states develop the rates, document them, and an actuary certifies them, they are sent to CMS where the federal review focuses on compliance with the actuarial soundness requirements. There is now an annual rate development guide that CMS puts out and uses as the basis

for their review, and there are multiple parts to that review.

Federal actuaries review the state certification, the underlying assumptions, and the rate development documentation. So they are assessing whether the rates are reasonable or appropriate. They look at the covered benefits and the populations, and they look at whether the rate development, including the assumptions, are all documented. And they may question the states about areas of ambiguity or inconsistency with federal rules, particular if the state and the CMS actuaries are reaching different conclusions.

Other CMS staff look at the policy side, like whether the rates comply with federal policies, like the IMD exclusion. And they check for consistency among the contract, the rate certification, the directed payments preprints, and the waiver if there is one.

The rates are part the contract, and CMS will not approve either the contract or the rates until both are finalized by the state, and approval is necessary before states can claim federal match.

So as I said at the beginning, we wanted to learn

more about the extent to which current rate setting standards and the rate development and approval process relates to Medicaid program objectives, given that the majority of Medicaid program spending is in managed care, and it is $350 billion a year. So there are a lot of ways that states can advance their program objectives through managed care, and we have other work going on. Like they can do this through how they design their waivers, how they design their programs, through their procurement approach and contracting, and they can make decisions into how they set up payments.

So this project is looking at just how they use the payment levers, and we certainly understand that there are a lot of ways that states can design a managed care program to achieve different objectives.

Along with our actuarial contractor we conducted this extensive study of the statutes and the rules and the guidance. We also looked at the relevant actuarial standards of practice, which are the professional guidelines for credentialed actuaries. And again, to understand how the states are actually applying and interpreting the regulatory framework and guidance we were

able to obtain and review the three most recent capitation rate certifications from seven states. We conducted interviews with state Medicaid officials, with health plans, with actuaries, and with staff from CMS, and we were really trying to get at that question of how does this work from two angles. How do federal rate setting standards and processes support the meaningful development and review of capitation rates, and then how have states interpreted and applied the federal rules to achieve their goals?

So overall we didn't find a strong relationship between managed care payment approaches and other program goals, such as improved access and quality. Federal rate setting guidance provides states with a lot of flexibility to use a variety of rate setting tools to align state spending and MCO outcomes. Federal oversight procedures focus on compliance and whether rates provide for all reasonable, appropriate, and sustainable costs. Federal reviews don't explicitly examine whether rates represent the most efficient use of Medicaid funds, provide for adequate quality of care from enrollees, or assure that MCOs meet network adequacy and access to care standards. We also found that CMS defers to state actuaries unless

there are clear federal standards.

So the federal rules give states the flexibility to use managed care payment approaches to advance program goals, but the federal rules don't really encourage it as long as they're sufficient to cover anticipated costs.

On the next two slides I'll go through some specific findings.

Related to our first angle, which was the federal oversight side, the current rules provide consistency and guidance in many areas of rate setting, and we heard from lots of the states and the actuaries at MCOs that they all appreciate this, although they said in some cases some of the new provisions have also come with some new questions.

We also found that there is little regulation or guidance in some areas, particularly the requirement that rates are adequate to ensure access. As I said, CMS focuses primarily on ensuring that the rates comply with federal requirements for actuarial soundness.

When CMS identifies concerns with actuarial soundness or the state's overall managed care payment approach, it has limited ability to require changes unless there are clear federal standards. The rules are written

that the state certifies actuarial soundness, and actuaries can have differences of opinion. So CMS defers to states unless it can show that a state decision is not actuarially sound. CMS cannot disapprove a portion of the rate certification. It can only approve or disapprove the whole thing. So CMS tries to work with states to resolve questions and issues.

And the fourth bullet, where we say process considerations, that really means CMS has to review rate certs and contracts from 40-something states. It is mostly within the same couple of months every year, and, of course, it is also trying to update the rate guide and put out new policy, and the states are also trying to run their programs. So the timeline is challenging for everyone. They are doing their contracts and they may be doing procurements.

We also heard a lot about how much more complicated everything got after state-directed payments were introduced. So the time pressure on all of this may contribute to the focus on compliance.

And finally -- and this is an issue that has come up many times and was raised again in some of our

interviews -- MCOs really have no official role in the current process, in the development or certification or review of capitation rates. But we heard, clearly, that they would like more transparency or a more active role in rate development or review.

For our other question about how states and their actuaries interpret and apply federal rules to achieve their policy goals, we found the federal rules and the actuarial soundness standard provide a lot of room, substantial flexibility and opportunity for interpretation by states, and consequently, as always, states do things a lot of different ways. It varies by state.

We asked them all, we were very explicit, what are your goals for managed care. They all have a lot of different things they're trying to achieve. But in terms of how they're trying to move the needle through the rate setting process specifically, mostly they are looking at overall program costs and efficiency and plan profits. A lot of states use tools such as quality or performance withholds, but we also heard there's not always a clear connection between program goals and the rate-setting process.

A lot of the states also use the flexibilities available under the managed care payment rules, particularly the availability of in-lieu-of and added services and remittance under the medical loss ratio to cover things that aren't covered under fee for service, which is allowable and part of why states used managed care. That's a key flexibility.

We did hear that states would like more guidance on what is allowed, because a lot of times the process is that the states develop programs and rates, and submit them to CMS, and then CMS asks a lot of questions about the assumptions, which takes time and it causes uncertainty, and everyone just finds it difficult when the rate setting guidance has not always caught up to program developments that are either coming out of the states or even coming out of other parts of CMS.

So in terms of some of the opportunities, based on our review and everyone we talked to and everything we read, we identified a number of potential opportunities for changes that could improve federal oversight of managed care payments. Some of these are small-ish and some of them are more involved. Maybe I'll go through them all and

then I can answer questions or explain them a little more.

The first group are for CMS to provide additional sub-regulatory guidance in specific areas that we have identified as being areas where there's not enough clarity. This includes some of those emerging rate issues where states are trying to figure out how they can leverage rate setting to accomplish some of their program goals within the actuarial soundness standard. So that is like how to deal with the social determinants of health or how to promote health equity. And the second, which we've touched on in other discussions today, is how to better direct states on how to align the goals of state-directed payments with the actuarial soundness standard, since those processes are now somewhat separate.

The second group are changes that could be made to the federal rate review process, which would be things like developing a schedule for changes to the annual rate guide, and shortening the timeline for rate reviews, and clarifying the roles for state and federal actuaries in reviewing state-directed payments. And these kinds of process changes, the intent would be to reduce the amount of back and forth between states and CMS during the review

process in order to shorten the timeline. The end goal of all of that, apart from just reducing burden, would be to help align the rate approvals with the contract periods. All the actuaries we spoke to talked about the importance of that.

The last group are things that would probably require statutory or rule changes. The first is to build in more transparency requirements to the rate development process. As I said, this was something that the MCOs brought up, but there is certainly a parallel on the fee-for-service side when you make a state plan amendment that changes like hospital or nursing facility payments there are public nurse requirements. So this is sort of a general transparency issue. I mean, it wouldn't just have to be sharing information with the MCOs. This could be a broader area for transparency in the rate development process.

The other area is to give CMS the authority to defer non-compliant components of a rate certification. As we said, one of our findings is that CMS can't disapprove a portion of a rate cert, only the whole thing, which is effectively like a nuclear option because the program can't

operate without approved rates. If CMS had partial deferral authority it could disapprove a portion of a rate cert while allowing the remainder of the program to proceed.

So that is what we identified. At this point we would like your feedback on the opportunities we have identified here and anything else raised in your materials, whether you are interested in following up on any of these areas. If you would like to move forward with any of these ideas we can come back. It would probably be in the fall, with more work on these. And as I said, Chris is going to present next on a more narrow aspect of rate setting, so if it is appropriate we also just combine all of our fall and work from this discussion with whatever comes out of that session.

But we would like to hear your reactions and I'm happy to answer any questions. I'll go back to this previous slide, but I can go back farther if there are other things you have questions on.

CHAIR BELLA: Thank you, Moira. I have a feeling we're going to have some questions and comments. Who would like to start? Heidi, and then Darin.

COMMISSIONER ALLEN: Thank you so much. I'm still trying to wrap my head around all of it. It's certainly a lot.

My first comment is that several times in the materials we've look at so far we talk about efficiency, access, and value as being goals, and I really feel like rate setting is also an equity issue and we should be thinking about it as an equity issue because access is an equity issue and inequitable access certainly leads to health disparities.

Some things that I would like to see more work done on, and I'm having trouble kind of taking what I picked up in the readings and in this discussion today and aligning them with the kind of potential policy changes, and maybe you could tell me where you see these fit into policy changes that we could recommend. But, you know, one thing that came out really significantly in the report for me is the implications of using prior years utilization to benchmark future years utilization. And I'm trying to understand if rolling that over actually could roll over access issues.

And I think that there's somewhere in the

materials that it says the previous utilization patterns used to project capitation rates represent adequate access. And I think that's just such a key point is understanding if they don't, what would we do to recommend something different?

I also don't understand how actuaries look at the Medicaid program and assess access and then look at ESI or other forms of coverage and figure out what access capitation rates would be for them. And it feels like they must be using different information, and I would love to know more about how we could be benchmarking capitation rates or access in Medicaid to other forms of coverage.

So I think that's it for me. I look forward to what other people have to say.

CHAIR BELLA: Thank you. I had actually mentioned Darin next, but Stacey, I'm going to ask you, without putting you on the spot, can you kind of like just give us the birds-eye and the in-the-weeds view here? It might help the rest of us kind of form some of our own thinking.

COMMISSIONER LAMPKIN: Yes. Thank you. I do have a couple of things that I think could help with some

framing, and then I am happy to respond to individual points of concern or questions as we go, to the extent I can. I also have a question for Moira too, at some point.

But one of the things I think it's helpful to keep in mind is I think Moira shared with us, I think you called it elaboration of the appropriate language in the regulation, but that's also the actuary's definition of actuarial soundness, which is to say that for the business that is being rated -- and I'm putting an emphasis there because I want to come back to it -- the capitation rates provide for all reasonable, appropriate, and attainable cost. There is more but that's kind of the crux of it.

So that "for the business which is being rated" means the managed care program, of course, but also the contract terms that exist. So if you think about why CMS is saying, "We can't approve the contract without the rates, and we can't approve the rates without the contract," it's because those two go together. The rates need to represent, using the terms of the contract and the populations and the services being covered, everything the MCO has to do, what is the reasonable, appropriate, and attainable cost?

And so the reason that historical utilization is helpful, Heidi, is because it's our best picture of how that population has used services in the past, and then we need to consider what's changing.

And so let's take an example of access. We could spend some time on the network adequacy side but I want to just use health equity as an example right now, and add some color to my comment earlier about capitation rates by themselves, there's only so much they can do, because they need to be linked with incentives and environmental change and contract change.

So here's an example of that. Let's say I, as an actuary, working for my state, go in and do some analysis, and I see for a particular geographic area, for a particular population in the state, I see that utilization patterns among kind of my own black enrollees are very different from white enrollees, let's just say. Let's say I see less primary care utilization, less pharmaceutical utilization in the black population, but more hospital utilization, more ER utilization. That is signaling to me an access problem, right? There's something going on here.

I can't just say I'm going to change the

capitation rate, in the absence of any incentive or contract change or anything that helps ensure that the MCO is going to do something to change that pattern, right? If I do, if I increase the rate, for example, there is no guarantee that that money goes where it's supposed to go or does what it's supposed to do. The rate needs to be linked with the state saying to the MCO, "Look at what we found. You need to go fix this," or "Here's an incentive," like the example, I think, that was in our material, of a withhold that then could be paid out if service is achieved.

I'm sorry. I don't want to get carried away, but my point is the rate goes with the contract and the environment and the incentives, or the environmental changes that make change the patterns of care that are being delivered.

I could go on and on but I'm going to stop and turn it back, and let me know if you have another question that I can help with.

CHAIR BELLA: Do you want to go and ask your specific questions? Do you want to make your specific comments?

COMMISSIONER LAMPKIN: Well, thank you. I was just --

CHAIR BELLA: Or yours. I think we're all probably kind of listening with bated breath to all of the things you're saying.

COMMISSIONER LAMPKIN: Well, it's a little bit of a small question in a way, but I think it does go to that overarching observation that you're not seeing the rates really reflecting or driving towards the state's goals.

And so one of the curiosity questions that I had reading this, and the briefing materials, Moira, was whether any of the folks that you talked to raised any concern about the regulation that caps the amount of incentive funding at the 5 percent level. Did you hear any concerns that that was limiting states and their actuaries from designing reimbursement systems that help drive towards goals?

MS. FORBES: I don't know if Chris is on. He was on all the interviews with me. I don't remember anyone raising a concern specifically about the 5 percent incentive cap. I mean, I will say my takeaway, which was something of, honestly, a surprise, from all the interviews

we did -- and we were also doing a lot of interviews for the procurement project at the same time, which honestly touched on a lot of the same issues -- was that there are a lot of different -- I mean, you know this, Stacey -- there are a lot of different tools that they have. There are a lot of different places where they can make assumptions about like how much profit to build in, or whether to use withholds, or whether to use incentives. There are so many different levers that if states feel constrained by one thing, and whether that's a federal constraint or a legislative constraint or a programmatic constraint, or whatever it is, that there's some other lever they can use.

And so our takeaway was that states have a lot of mechanisms to do the kinds of things that they want to do and that they're not feeling that the set of options available under the actuarial soundness standard or within the range of things allowed is a problem.

I think the flip side of that is what we heard from the actuaries was "we often don't know what they're trying to do on the programmatic side" or "we find out too late," or "we don't know what assumptions they're using, so we're sort of flying blind." It was like, "we could do a

bunch of things but we don't know what they're doing." It was more like there's a disconnect.

COMMISSIONER LAMPKIN: Well, that's really interesting that that was some of the feedback.

I will say, kind of related to some of the timing, the review timing and the challenges with the review, part of the challenge of the whole process relates to how the state's legislative session and budget spanning timing happens and intersects with rate development timing, and how early you need to get materials to CMS so that they can review. There tends to be some compression there so that there were often late-breaking policy or incentive changes that come out of a legislative process, for example, that may not have been captured our known about during the rate development process, despite everybody's best attempt to monitoring.

CHAIR BELLA: Stacey, any other comments?

COMMISSIONER LAMPKIN: Why don't I stand down a little bit and see what other folks have to say. I think that we could talk more certainly about the potential areas for policy changes, but I don't want to hog the conversation. It would be easy to do.

CHAIR BELLA: Well, let's put a pin in that and come back to it, because this is sort of laying out a menu of things, and which things we want to take. So let's make sure that we have all those on the table.

Darin, and then I was so enthralled I lost track of other hands. Who else? Bob, Brian, Fred. Okay. Let's go to Darin.

COMMISSIONER GORDON: So I'll give Stacey a lot of stuff to react to, I'm sure. I will say one comment related to Heidi's comment. I think it's a fair point. And Stacey's response, I mean, I grew up doing Medicaid managed care and working with actuaries in setting rates. I mean, Stacey is spot on.

The one friendly amendment I will make is, and we saw this before, when you do know that there is an area within your state where there has been historic underutilization because of health disparities -- and this is incumbent on the state -- you can make sure that you're not exacerbating those. And what I mean by that, I remember when we had a new set of actuaries come in and they were applying managed care assumptions in our state, and they wanted to take some of the assumptions in our

middle Tennessee region and apply them to our west Tennessee region, which would have caused our west Tennessee region to fail, because there was historic underutilization and underreporting. So if you thought they could manage the system tighter than what they had historically, you are setting them up to fail. But we understood that because we understood that market. We understood the data from history and what's been going on, and some of these we've been trying to do on the ground to address some of those issues.

So Stacey is 100 percent correct, but it's also incumbent on the state to make sure that an actuary is making a reasonable assumption. In the absence of that data point it could exacerbate some of those inequities. So in that case I do think there's a bridge or a role to play there. But it gets to Stacey's point. It's like, you know, she was making kind of facial expressions. I was making facial expressions to Moira's point that she heard back that it's not helping, that their involvement with their rates.

You know, we were intimately involved. Even when I was the director I was intimately involved with

understanding what some of the assumptions were, conveying what's going on in the program, things that are being contemplated, things that have changed, different things going on in the provider community, almost to the point to where it's exhausting.

But it's important. I mean, the actuary can only be as good as the data you're giving them, both the actual encounter data but also the programmatic and policy things that are going on, to help them get a more accurate picture of what's going to come.

So I do think hearing those comments, Moira, is that I'm wondering if this is not another area like in duals, have we done enough to really help states to understand best practices and engage actuaries to be the most effective, and I think that's something we should consider.

I do think that 5 percent incentive gap, I mean, I remember us bumping into that and hearing that from some other states. I do think that's been an issue. I wouldn't say it's the issue of some of the limiting factors in being able to get plans to do what you need them to do.

The thing I will point out is I lived in a world

of managed care, 100 percent managed care, with no actuarial rates, and I lived in a world of 100 percent managed care with actuarial rate setting, and I will just tell you that if you don't have that frame of reference then you may not fully appreciate some of the value of having actuarially sound rates. And so we had plans failing before we had actuarially sound rates. We had many plans failing.

You also have to think about, from a state's perspective, the interventions that you're wanting to happen, are you adequately funding the plans to do those interventions? So it's not just on the medical side but even on the administrative side. If you're looking for one-on-one, face-to-face visits at least three times a month, are you adequately funding that? And if not, then you probably aren't getting the results you want.

But those are things that I think we have to think about what is being communicated before we paint with too broad of a brush, because I know in some markets there's probably a lot of room for improvement and others may be taking big steps there.

I do want to get to the timeliness thing real

quick, because you look at the CMS dashboard, I mean, I remember when CMS was asking to look at the rates. I mean, right now, and according to their website, the mean is 105 days before they approve that. And they have some that are actually, you know, they say 360 days plus.

You know, I would like to see somewhere in here that we do talk about other ways to increase the timeliness of CMS approval. I heard from a state just two weeks ago that, you know, they feel it's holding up them doing some of those programmatic changes and rolling these things out, because they haven't gotten approval. So I think that's a key component.

And the last comment I'm going to make, the one thing I'm not seeing -- because I was there before CMS was reviewing them and I was there when CMS started reviewing them -- I was a little surprised by that comment that CMS had tools to tell us what they could do, because I kind of felt like they told me I could do certain things. So I was a little surprised by that comment.

But one thing I have not seen, most of the discussions with CMS -- and this is in me talking with states all around the country too, and I'd love to be

proved wrong on this -- most of the discussions with CMS and actuary with regards to rates is about rates being too high, or they're including too much with regard to directed payments, or they don't feel they understand or appreciate, they don't have adequate support. I have yet to hear from CMS that they feel the rates are not high enough to achieve the base funding of the program. And I just want to point that out there, because I do think because if you're going to get involved in the rate approval process you can't just have the lens of looking at, is it too much? In some cases you have to look at, is it adequate? And I have yet to hear any feedback from, you know, hear a state tell me that they were told that the rates were not adequate, and it's something that I think has to be a part of the equation.

MS. FORBES: Melanie, can I respond to that real quick?

CHAIR BELLA: Sure.

MS. FORBES: Darin, one thing I just want to throw back to the Commission, I take your -- oh, well, two things. One is if it wasn't clear, CMS certainly was clear with us that they push back on states when they find a state is not in compliance, that they absolutely do that.

So there is a difference between states not being in compliance and states not being actuarially sound.

But you said that there may be more we could do around best practices. But I think one of my questions for the Commission is, is there something else that CMS can do in the federal review process to do more than just focus on compliance, to try and -- and believe me, no state said, "Please, have CMS all up in our business." Nobody said that to me. I'm asking you all. But is there more, to make that process more meaningful, so that programmatic side and the payment side, to make sure that those connections are being made, either on the guidance or on the review? Because I know best practices is on the front end, and I'm saying is there something on the back end? And you don't have to answer that. I'm just saying that was the question.

COMMISSIONER GORDON: I do want to throw a response out to that because I don't think you can do it as part of the process, because I really think it's part of the review of an actual rate request proposal that's before CMS. Again, we're already talking that the meeting is over 105 days. I think that would be challenging, at best. It

will be challenging.

I think it needs to be more on the front end of working with states about, you know, here are some best practices and how to engage the actuaries, here are the types of things. I mean, states articulate it very, very well that you have to connect the dots, you can't work in silos on the programmatic and policy changes that are being contemplated, or systemic dynamics that are occurring in your markets are not being adequately communicated to your actuaries.

And I think, intellectually, people might get that, hoping they'll thing about how that looks like in practice. And I think that needs to be separate and apart from the actual rate approval process. In fact, I think if you get some of that worked out and you build some of that capability to work with actuaries better in that regard, then I think the rate review process might actually go smoother and quicker, would be my hope.

But I think it would be dangerous trying to integrate that into the rate approval process. I think it would just bog it down even further than it already is.

COMMISSIONER LAMPKIN: I agree with what you are

saying, Darin, with respect to best practices. The one place where there may be a gap or a place for things to fall through the cracks is like I said about the timing and legislative timing and so forth. If contract changes don't make into the capitation rates because there's some kind of breakdown in communication, that's problem, right? And so some part of CMS's process, if it's too siloed into contract review and rate review, if directed payments is the only thing that they're really worrying about, the translation, then they may miss some other important contractual changes that they want to validate or account for.

COMMISSIONER GORDON: Definitely. And I think you made the comment, or someone made the comment that you can't have the waiver looked at over here and rates over here, and I thought that was a very important point. That's almost at too high of a level, given that some of the stuff that's happening is really in that contract review process. And maybe that's what you said. Like the amendment for the MCO and the rates had to be looked at in tandem and understanding what's being asked. I totally agree with that. That's a good point.

CHAIR BELLA: This is what it would be nice to be in person, because you two could sit next to each other at dinner and talk about this for hours. We'll have to do that in April.

Okay. I'm going to go to Bob and then Brian and then Fred and then see who else would like to make a comment.

COMMISSIONER DUNCAN: Thank you, Melanie. Moira, first of all thank you for this conversation and work you put together. I would like to talk a little bit about the sub-regulatory guidance issue. So a caveat. In my past life I ran a health plan, and so when we looked at, to Darin's point, with administrative expenses and addressing social determinants of health, those investments came from our administrative expenses. So what we did is we saw that expense go up, but in the health trends we saw MLRs get better. So as the rate setting process is looking at those trends, they didn't take into account the administrative expenses, so they were working against each other. So I'd love to see some type of work of how we factor in the social drivers of health into that rate calculation.

And the other is, again, when we talk about past

experiences and then you factor in the trend and the assumptions made on the trend, that is again an assumption. And so if there was some type of standard or something set on the trends I think it would be helpful in that rate setting process.

CHAIR BELLA: Thank you, Bob. Moira, a comment on that? Otherwise we'll go to Brian.

MS. FORBES: No, that's helpful. That tracks with other things we heard, so we'll make sure to bring that up.

CHAIR BELLA: Okay. Thank you. Brian, and then Fred.

COMMISSIONER BURWELL: So I'm really excited that the Commission is getting into this area. I feel like where we were when we started talking about supplementary payments, and I think the work that we did in that area was seminal, and I think we could play the same role here.

I don't have real experience, as Stacey and Darin have, so I just hear stories on the street, and some of the things I've heard is that this process is flawed. It ends up not with rates that aren't actuarially sound and things go wrong. And particularly I'm obviously interested in

MLTSS and the shift from fee-for-service to managed care and the rate setting process that occurred in that transition. And I think it's fairly well known that two states ended up with very low rates, partly because of campaign promises made by a new governor, who beat down the rates. I think there was an actuary that refused to sign, certify the rates, and got fired. Whatever.

I mean, that just seems like a flawed process to me. And they ended up with very low rates. Bad things happened to beneficiaries. All kinds of things hit the fan. How do we avoid that?

I've also heard of rates that were excessively high and there was excessive profitability, and the state tried to go back and recover some of the overpayments, and the plays were saying, "Hey, a deal is a deal. You know, you sign a contract. We're not giving you any money back." I mean, those things are probably four to five years old, those kinds of outcomes. Are they much less likely to occur in 2022, or do we still have problems with the system?

I guess that's Stacey and Darin. Stacey first. You get first choice.

COMMISSIONER LAMPKIN: Yeah. I wonder, Brian, if some of the anecdotes that you are saying aren't a little old and maybe predate the 2016 review the more rigorous CMS rate review that has evolved since the Affordable Care Act and the new managed care rule. The new managed care rule also brought the medical loss ratio and the ability for states to establish that threshold, which essentially operates like a profit cap to MCOs.

COMMISSIONER BURWELL: But not all states use --

COMMISSIONER LAMPKIN: Not all states use it, but all states certainly are required to track it, and they use it, and they put it in their contracts as a way to manage an event with excessive profitability.

COMMISSIONER BURWELL: Why hasn't the federal government made that mandatory, a minimum MLR?

CHAIR BELLA: We'll leave that as a question we might want to ponder. I want to get around to the rest of the Commissioners, unless, Stacey, you have a thought on that. Otherwise we'll --

COMMISSIONER LAMPKIN: I have so many thoughts, Melanie, but I agree we might want to put a pin in them for today.

CHAIR BELLA: Okay. Thank you. Let's go to Fred and then Toby.

COMMISSIONER CERISE: So my question is around alignment of directed payments with actuarial soundness. You know, Heidi referenced this, the rate setting as an equity issue. And when directed payments are thrown in there it really obscures what is actually going on. But when they are not included in the discussion of the calculation it certainly does lead to the discussion of Medicaid rates as a percentage of every other rate, right, as percentage of Medicare. And, you know, so the conclusion is that we implicitly devalue the care for the poor by having lower rates in Medicaid than anything else.

And, Stacey, I heard your discussion about the actuaries -- you know, you were giving numbers for the programs that the state is describing. But I wonder if, in those directed payment programs, where it's broad-based and they're being spread, could you just pull those into the radar, somehow force those into the radar, and then really try to reserve those directed payments for those cases where you truly are targeting some program infrastructure or some special populations that you're addressing.

Because what will happen is, I have seen the graphs Rob put up that shows Medicaid total payments may exceed Medicare in a lot of cases, but it certainly doesn't look and feel that way to providers when you're just looking at your managed care rate.

Anyhow, sort of a plug to do more to align those directed payments with the base rates.

CHAIR BELLA: Stacey, did you want to comment on that?

COMMISSIONER LAMPKIN: I think so. So let me go back to the example that I used this morning for the fee schedule one of the personal care attendants, if we can. So if you think about in the absence of directed payments the dynamics that are supposed to happen in a managed care environment, which is the managed care plans have the incentive to go out and contract and negotiate with providers, and providers have the ability to negotiate rates, and MCOs can emphasize high-value care, you know, if that makes sense given their model.

What a directed payment does, in the example of the PCA example that I used this morning, is saying the providers need another thumb on the scale here. MCOs were

able to negotiate and they meet our contracted, maybe our net adequacy standards, but we still don't think personal care attendants are being paid high enough. We want to require the MCOs to pay $17 an hour, or what have you. And so that becomes a contract requirement. The actuary then sees a contract requirement that personal care attendants be paid $17 an hour instead of whatever historically MCOs have negotiated, and you actually make some investment, and that directed payment is then put into the base payment stream. So Fred, like what you said.

Is that the kind of thing that you were suggesting, or anything?

COMMISSIONER CERISE: Yeah. Yes. Yes and no. I think that's a good example of one where it's actually directed. It's not the lump-sum payment.

COMMISSIONER GORDON: I think that's where you were going.

COMMISSIONER CERISE: Yeah. The lump-sum payment ones, when it's broad and it's just covering, you know, a lot of times that seems like, you know, you're propping up your Medicaid rates with some other means of financing, some other vehicle to get your rates reasonable instead of

just making your rates reasonable. Does that make sense?

COMMISSIONER LAMPKIN: Yes, and, and so some of that certainly gets trickier because of the funding source, for sure. Theoretically, you should be able to say, you know, let's raise hospital rates, in that example, let's raise the base rates, and let MCOs manage the care. But MCOs are going to have an incentive to make sure that only care that needs to be delivered in the hospital is delivered in the hospital, and other care, or ambulatory care services, are happening outside the hospital.

And if some of the funds are being used for the non-federal share are coming from hospital taxes or other sources like that, it complicates the financing and the building of the capitation rates in the absence of a directed payment, is I think some of what's happening. There may be more complexities than that, as well.

COMMISSIONER CERISE: Yeah. I think you just get much looser on what's allowed and what you'll recognize if the source of non-federal share is not a state dollar, right? I don't hear you.

COMMISSIONER GORDON: I was saying the source of the non-federal share I don't think is necessarily the

issue here. I hear you. I have the same discussion a lot, is they would view, when supplemental payments were separate, is a separate entity than what I was getting paid for a service. But now with directed payments, I think that's becoming less and less of a divided conversation. It's becoming more integrated, because when states, having moved from that being separate to make a directed payment, there is a lot of complexity in that. Then we heard from hospitals that you couldn't see that discrete payment and know exactly what you got.

But I think now, the way it should be, when Stacey was talking about, when asking about programmatic discussions, all of our actuaries got all of the information on everything, the example Stacey gave but also supplemental payments to the hospitals to understand how that all fit together. And in the absence of that stuff I do think you're putting actuaries in a tough position, because they are only seeing part of the picture. But now that it's in directed payments it should be in the contract, and they should be able to see it, they should be able to factor that into their overall analysis.

CHAIR BELLA: Fred, is there anything you want to

put on the parking lot for Moira to kind of dig into more out of this discussion?

COMMISSIONER CERISE: I mean, it's captured in her sub-regulatory guidance, and, you know, looking at the goals of the directed payments with the actuarial soundness. I'll just leave it at that.

CHAIR BELLA: Okay. Toby and then Heidi, and then we're going to start to transition to the last session.

COMMISSIONER DOUGLAS: First, I definitely would be sitting at dinner with Darin and Stacey, having a good time on this.

I just want to stress again both the points Stacey and Darin made about the importance of this connection between the programmatic policy side of the house and the actuaries. Both my time in state but then in national plans where I've seen it work and where it doesn't work is where there is that disconnect. And in many cases you have contracted actuaries, who are really talented but without the clear connection to the programmatic and policy levers they're not able to be making truly accurate and the right assumptions. And I agree. I don't think that this

is something that we can create in guidance, but it gets to fundamental, CMS's view of making sure that they are providing the right review process to ensure that there is a clear understanding of the policies and it's not just, for example, a financial decision that we've seen in some cases, where the actuary having the rates based on financial levers rather than policy, or there are missteps on understanding that the policy side isn't giving clear direction on what are the needs around access to care or innovations that they're trying to advance, or changes that might lead to nuances on policy decisions on what counts as medical or admin. All those are where you have a strong understanding, and so you've got to build that. Especially also the actuaries are contractors. They come and go. The staff are going to stay and need to understand this and represent it.

So, I mean, this get to just underlining how do we build the bench and the teams and continue to push that as a Commission overall.

CHAIR BELLA: Thank you, Toby. Heidi, and then Dennis actually has a question for Stacey. Dennis wants to be at dinner talking about this with Stacey too. But

Heidi, we'll turn to you first.

COMMISSIONER ALLEN: I want to be at dinner talking about this with Stacey too. I want to understand better the access feedback loop, because what I hear is that we use utilization, which is a measure of care received, not a measure of care needed, to project future care received, again, not care needed. And in the absence of benchmarking with other populations and their care, even within the same MCOs, where do we get our information about when we have inadequate access, and how does that feed back into changing the rates to make sure that they are actuarially sound to ensure access?

I heard Stacey describe a process where somebody might look in a region and say, you know, black recipients are receiving less than white recipients in this area, and yet we have really known areas of poor access in Medicaid with behavioral health. And yet I don't see this actuarial soundness being used as a tool to say, okay, we really need to increase rates in these areas where we're not buying enough access.

I have heard that probably Medicaid pays hospital close to what other insurers receive, but I don't think

that that is true in all delivery systems of care with mental health.

And so how are managed care companies learning about their access, and how are they required to respond, and does that have anything to do with the process that then an actuary would look at to determine whether a rate was sound or not? That's kind of where my mind is.

COMMISSIONER LAMPKIN: And I would just go back, Heidi, to saying like what is the mechanism that's going to change the situation on the ground? That's what the actuary needs to know. So, for example, it could be an MCO initiative. It could be MCO-driven initiatives. For many states that I'm familiar with, the actuaries surveyed the MCOs early in the rate development process and asked a myriad of questions about what are your initiatives, what are you working on this year, or what's your feedback on what we need to be thinking about? If they say, "We're working on health equity in this area and here's what we're doing. We've got this program and this program and this program," that gives the actuaries something to say, "Okay, maybe the utilization patterns are going to change in this area. I need a rate for that."

But in the absence of anybody working to solve that problem, the actuary changing the rate is not going to solve the problem by itself. That is just the key, is like what is the actual mechanism that changes the pattern? Then the rate needs to match that so that the funding is there.

CHAIR BELLA: Thank you, Stacey. Dennis, you get the closing question.

COMMISSIONER HEAPHY: I am way in at the deep end here. So if the MLR allows for administrative allowances for access, how do you measure the actuarial soundness of that administrative allowance of the MLR, over time? Is it by increased access? Like how do you determine the soundness of that administrative allowance of the MLR?

COMMISSIONER LAMPKIN: Um --

COMMISSIONER HEAPHY: Does the question make sense?

COMMISSIONER LAMPKIN: That is a great question. That question is to me, Dennis?

COMMISSIONER HEAPHY: Yep.

COMMISSIONER LAMPKIN: So again, this is one that is informed by the health plan's historical experience in

terms of the administrative expenses they use, and if they are specific care management protocols required in the contract, the actuaries can look at that historical administrative expense and say, does that reasonable in the context of what the contract requires there?

If new administrative requirements are added to the contract, or if administrative requirements are subtracted from the contract, the actuary can consider whether they are material enough to change that underlying expectation of administration. The actuary will also kind of look at the level of administration versus enrollment, if enrollment is growing or declining, how would that affect the MCO's administrative expenses. There's quite a bit that goes with that piece.

COMMISSIONER HEAPHY: And just a quick follow-up. That would also mean that the actuary would actually have to have the information needed about the goals of the allowance. Correct? I heard that the person actually has to have the information needed to measure accurately. Correct? Because again, there's this misalignment between what that actuary has, the information they have, and the information in terms of -- yeah, I'll leave it at that.

COMMISSIONER LAMPKIN: I mean, certainly we, as actuaries, want to make sure that we get as much information as we can from the states on what their expectations are, how they interpret the contract language, how they will enforce contract requirements. All of that is part of what we think about, and the historical experience that the plans have had, in building a reasonable administrative expense target.

COMMISSIONER HEAPHY: Okay. Thank you.

CHAIR BELLA: Clearly we need more time on this issue, so it is exciting to see the level of interest and the opportunities I feel are endless for where we might go with this. And Moira, good luck. Just kidding.

Do you have any questions or comments, based on what you've heard, and hopefully you'll be coming back to us with some structure around this where we might take the pieces. I think, if anything, hopefully you're taking away a significant amount of interest on the part of the Commissioners to look quite a bit at this and how it all fits together.

MS. FORBES: Yes, and as I said, we'll have a conversation with Chris and we'll talk about procurement

next month, and I think after all of that there will be more opportunity to talk about this, and dinner. I'll just get a report back from someone there.

CHAIR BELLA: I think you'll get drug along. Okay. Thank you very much.

CHAIR BELLA: We are just going to move smoothly into the last session, and I see Chris is here. So we're going to talk about a roundtable on risk mitigation and rate setting. Welcome, Chris.

RISK MITIGATION AND RATE SETTING: REPORT ON DISCUSSION AT EXPERT ROUNDTABLE

* MR. PARK: Thanks, Melanie. As Moira mentioned earlier, this is really focused on a very narrow slice of managed care rate setting, and in particular, risk mitigation and response to unexpected shocks to the system. This came about because of the COVID-19 pandemic and some of the issues that were popping up with managed care rates.

I'll start with a brief background on rate setting and then discuss some of the types of shocks that can create financial uncertainty and the need for risk mitigation. Then I'll go through the findings of the expert roundtable, including the use of various risk

mitigation strategies to deal with shocks and thoughts on the administrative challenges to implement tools when unexpected shock occurs. Finally, I will go through a couple of potential policy options to improve the rate setting process in response to a shock, and then next steps.

I won't spend much time on the background, since you just heard this in Moira's section, but a couple of things to emphasize here are that the capitation rates are in effect for a one-year rating period, and any risk mitigation must be specified in rate certification prior to the start of the rating period, and a midyear change to the rates generally requires a recertification from the state's actuary and a reapproval from CMS.

States and MCOs may face a number of unanticipated events or system shocks during a contract period. One way to distinguish a shock to the Medicaid system that goes beyond the normal risk inherent in rate setting is to consider the degree of predictability of the event and the certainty of the effect on per capita costs, as shown in this diagram. For events with low predictability, the ones that are highlighted in blue,

states and plans may need to implement risk mitigation after their rating period has begun. Shocks with low certainty of price effects may include events such as the COVID-19 pandemic, natural disasters, or an MCO insolvency or facility closure.

Other events may have more certainty of price effects, such as the introduction of new, high-cost drugs. While the price of these drugs is known when they enter the market, the potential size of the target population enrolled and the initial uptake of the treatments is uncertain. And there is potential for uneven distribution of disease prevalence across MCOs and can result in one plan having a disproportionate share of costs.

Other situations, shown in the green box, such as eligibility expansion to a new group, create uncertainty in rate setting due to the lack of historical experience and potential for pent-up demand. However, these situations are planned or predictable, and appropriate risk mitigation strategies can be implemented in advance of contracts starting.

Certain events may move from low predictability to high predictability over time. For example, the start

of the COVID-19 pandemic was not predictable, but states and plans' actuaries had greater certainty that the pandemic would continue into rate setting periods for 2021 and 2022, and could develop their rates accordingly and implement risk mitigation strategies as needed.

The focus of the roundtable discussion was on the events of low predictability, in the blue squares.

MACPAC contracted with Milliman to conduct an expert roundtable on risk mitigation strategies in Medicaid managed care. The roundtable included federal and state officials, actuaries for both states and health plans, and provider organizations, and Darin and Stacey were able to attend for a portion of the roundtable.

The roundtable sought input from participants on the following topics: Are there any shocks that cannot be addressed with the current risk mitigation tools, and if so, what additional tools would be helpful? And are there any administrative or process challenges to implementing the tools when an unexpected shock occurs, and are there any suggestions on how to improve the process?

This is just a list of all the types of risk mitigation. I will be going into these in more detail in

the next few slides.

To start, Moira mentioned minimum medical loss ratios earlier. They require states to spend a minimum percentage of premium revenue on benefit expenses and other allowable activities. If an MCO does not achieve the minimum MLR established by the states then the states may recoup the difference between the plan's actual MLR and the minimum MLR threshold.

Roundtable participants didn't spend much time on this option. Many states have implemented minimum MLRs, and these requirements are already in the contract. Also, plan representatives don't prefer minimum MLRs because while they protect states from excessive plan profits they do not protect plans from financial losses.

Risk corridors are two-sided in that they limit both plan gains and losses. Risk corridors are generally structured so that the states and plans share the losses or gains within certain bands. Many participants thought that risk corridors worked well for long-term shocks and where uncertainty and risk is broadly spread across beneficiaries and services, as was the case with the COVID-19 pandemic.

In the rate setting guidance, CMS encouraged

states to implement risk corridors as a way to mitigate risk during the pandemic.

Roundtable participants discussed the tradeoffs between specificity and complexity. While multiple risk corridors could be created to target specific risks, plan representatives stated that managing multiple corridors can be difficult and may result in higher administrative expenses if the parameters of the corridors are not similar.

CMS representatives expressed concern about broad, continuous use of risk corridors, that is the expectation of the risk corridor could deprioritize the actuarial soundness of their rates.

Plan representatives also expressed concerns about the timing between when the shock occurs and when the states decides to implement their risk corridor. Implementing a risk corridor retroactively, long after an event occurs, is problematic, since plans have been making strategic decisions and acting with the expectation of no risk corridor.

States may adjust capitation rates for uncertainty around population acuity by assessing the

actual acuity during the rating period and making a retroactive adjustment to the capitation rates. This acuity adjustment is not budget neutral and may increase or decrease state spending. Thus, the use of this mechanism may be constrained by the state budget. This mechanism could be useful as a way to make a midyear rate adjustment to assess acuity changes as beneficiaries enter or leave the program, for example, after the COVID-19 public health emergency ends and beneficiaries lose eligibility or disenroll from the program.

However, they need to wait for actual experience will affect the timing of when such an adjustment can be made, making it unsuitable for a quick response to an unexpected shock.

Risk adjustment is similar to an acuity adjustment in that the state adjusts capitation rates to better reflect the health status and expected costs of the populations enrolled in each MCO. Risk adjustment is done on a budget neutral basis, meaning that the increased payments to one MCO are offset by decreased payments to other MCOs, and that the state's total spending on capitation payments doesn't change.

As such, participants noted that risk adjustment would be useful to address plan-to-plan uncertainty and risk but not overall program uncertainty. For example, risk adjustment could be helpful to mitigate the risk that one plan bears a disproportionate share of costs for a high-cost drug or a population, but it would not address the overall spending increase that all plans could face with the introduction of a new high-cost drug.

A high-cost risk pool may be funded by withholding a portion of each plan's capitation rate. MCOs then receive funding from the risk pool based on the number of claims or individuals meeting the pool criteria. Participants noted that these strategies are useful to narrowly target risk associated with specific events. For example, many states have implemented high-cost drug pools to mitigate the financial risk of high-cost specialty drugs and spread the cost equally across plans.

Plan representatives noted that risk pools may not address a shock fully if the size of the pool is insufficient to cover total costs. However, state officials suggested that some plan risks should remain in place and maintain incentives for managing care.

Some actuaries and provider representatives stressed the need to consider how any funds redistributed through the risk pool flow down to providers. For example, for providers who are sub-capitated, their payments should also reflect some of the distribution for the risk pool.

States may have decided to remove some costs in the capitation payment and pay these as supplemental payments, also known as kick payments. These kick payments are made on the occurrence of an event such as a delivery. Or states may choose to carve out a certain service of population out of managed care and cover the cost under fee-for-service. Actuaries noted that kick payments and carveouts are best used in situations that are either hyper-specific, such as when the new hepatitis C drugs were introduced, or applied broadly to a specific condition or population, such as children with high-cost conditions such as cystic fibrosis.

A few participants mentioned that carveouts can provide consistency for beneficiaries if they switch plans. A few actuaries discussed if and when certain events, such as the introduction of new drugs, should be considered as part of a normal managed care risk versus a significant

shock. New drugs come to the market every year, but not all of them create a large enough shock to disrupt the system, so there needs to be some consideration in place as to when you might carve it out or do a kick payment versus when it should be part of the capitation rate.

Some state officials mentioned that it is important to balance incentives so that the plan still manages care appropriately, even if they are not at risk.

You have heard about directed payments in earlier sessions today. While directed payments have broad uses under managed care, we are specifically talking about a narrow use -- targeted payment rate changes to stabilize a provider network during a system shock. During the COVID-19 pandemic many states used this directed payment option to target payment increases for many providers to offset revenue decreases and keep providers open until utilization bounces back.

Actuaries and states commented on how reacting to a shock is more challenging in a managed care environment compared to fee-for-service. States may not make payments to providers for services covered under the managed care contract. Any changes such as a fee schedule increase may

require approval of a new directed payment or a modification of an existing one to make sure that plans target the funds appropriately.

A few regulatory barriers to discuss that potentially prevent optimal use of various risk mitigation techniques in response to a shock. Several state officials and actuaries mentioned that the 2020 update to the managed care regulations that require risk mitigation mechanisms be documented prior to the start of the rating period make it more challenging to respond quickly in the event of a system shock. Unexpected shocks do not align with the normal rate setting process and the need to submit a rate recertification and have CMS reapprove the rates can delay the response.

As mentioned before, plan representatives appreciated this requirement that the risk mitigation mechanism be defined in the contract at the beginning of the period. They indicated that it is quite challenging when states retroactively implement risk corridors several months after the rating period, because they have already made strategic decisions on how to allocate resources.

States and actuaries expressed a need for

additional CMS guidance on what supporting materials are required to gain approval for a midyear change to implement the risk mitigation strategy.

During the roundtable, participants generally agreed that existing risk mitigation tools are sufficient and did not suggest that new tools were needed. There were some concerns of the ability to act quickly depending on the documentation required for rate recertification and the timing of the CMS approval.

Some participants suggested that CMS could institute an expedited rate review process that would be triggered under certain situations to allow for states to make changes quickly. For example, a public health emergency declaration could trigger an expedited process for states to make certain changes to the capitation rates such as implementing risk mitigation. This process could be similar to the Appendix K option that states may utilize during emergency situations to request an amendment to approved 1915(c) waivers.

Federal regulations define a rating period as 12 months. That means that the terms of any risk mitigation mechanism are generally expected to be settled at the end

of the rating period and do not carry over into the next period.

Some actuaries suggested thinking about how utilization and spending trends tend to smooth out over time, and wondered if there might be potential for rolling financial experience forward over several years. This could be particularly useful, depending on the timing and duration of an unexpected shock. A decrease in utilization in the first rating period may be offset by certain utilization in the second period, due to pent-up demand.

Allowing risk corridors to combine financial experience over multiple rating periods could reduce some administrative complexity and provide states and plans with a little bit more budget predictability by reducing the number of financial settlements.

So that ends my presentation. Staff would appreciate your feedback on the roundtable findings and potential policy options. We would be interested to know if you are interested in moving forward with either of the policy options and what additional information or analyses would be helpful for you to move forward in your deliberations. If the Commissioners would like to move

forward with any recommendation we can develop it for further discussion at subsequent meetings. Due to the timing, it is too late to include it in the June report, but we can continue this work into the next report cycle.

And with that I will pass it back to the Commissioners for any questions or comments.

CHAIR BELLA: Thank you, Chris. It is always so helpful to hear findings from roundtables and people outside of the Commission.

I'm going to open it up for questions. I'd like you each, when you do that, though, please state sort of where you are in terms of interest in moving forward in the policy options, because that is an important piece of information for Chris to leave with.

So who would like to -- Stacey, do you want to kick us off?

COMMISSIONER LAMPKIN: Sure. I think when this question first came up -- I'm trying to remember when we started batting it around, and I think it was, like, much earlier in the pandemic when we were seeing states and actuaries and MCOs just grappling with the fast-moving environment, what to do. Providers are struggling? How do

we get the money? You know, there was just a lot of questions about how does a managed care service delivery model operate in an environment that has this, you know, dramatic an environment.

And so I think something like Hurricane Katrina, had Louisiana been managed care at the time -- and, Fred, I don't think it was, but that sort of thing where you just have this extreme situation, does managed care have the tools it needs to be able to manage through it? And that was what raised the question. What we saw in 2020 was a lot of figuring it out and flexibility and how do we make this work and all the different parties working together fairly effectively, which was reassuring.

So, for me, this question then becomes more like what did we learn from that process, and is there anything that is worthy of formalizing a little bit more that might make that process a little easier the next time a state or the country faces something fairly extreme like this, and in that context, some of the expedited rate review opportunities feel like they could be worth exploring. What kind of trigger will allow us to move into a process where we can collectively move more swiftly to adapt to a

very changing environment? So I would like to see the Commission poke at that a little bit longer, a little bit more, if other Commissioners are also interested.

The multiyear risk mitigation, this one is complicated. It kind of goes back to that earlier question. You know, we talked about how interrelated these topics are today. That earlier question about when states have that minimum loss ratio with a rebate and when they don't and should it be required and how should it be required, I think there are certainly arguments in favor of having it be a multiyear opportunity for states. I think that we need to spend a lot more time pulling at pros and cons of this one, but it might be worth doing that. It's not clear to me that the Commission should recommend this, but there could be some interesting things that are uncovered in that exploration.

CHAIR BELLA: Thank you, Stacey.

Darin, I'll go to you next.

COMMISSIONER GORDON: Yeah. Obviously, I agree with Stacey.

The one thing that we're not addressing based on some of the feedback -- and I've heard it even prior to

hearing it at the roundtable -- was around a retroactive nature. I think there was a general belief that everyone understood that some retroactivity was needed because they didn't have the expedited rate review process, and it kind of caught everyone, obviously, by surprise.

But I do think having some kind of commentary -- and I think it just requires more discussion about thinking about what is appropriate from a retroactive perspective because, I mean, Chris, you heard the feedback. But, if you're talking about going back, which it did actually occur this time, prior to the first declaration of a pandemic, like into the prior year, that's hard to be able to reconcile why that is appropriate, given that the actual emergency and that the evidence didn't occur until, you know, I'll say March, March of 2020.

So I don't know. Somehow I do think -- and I don't know the right way to thread the needle, but I think something about that point that was raised in the roundtable and figuring out is there something, is there a policy position to be taken to help mitigate that to the greatest extent possible, I think that's one thing that I think should be incorporated in some form or fashion.

CHAIR BELLA: Thank you, Darin.

Toby?

COMMISSIONER DOUGLAS: I'd just align myself with both Darin and Stacey.

On the expedited rate review, given we have this in many other areas, there's no reason why states and CMS can't speed up during these very urgent situations.

But multiyear, I think it could go both ways, and we really need to look at it more. What if a state has it wrong? You're sitting there for a couple years with the wrong rates, and how does that play out? I think part of the year-to-year really helps us reassess what's going on, to reset, and so, again, not 100 percent. We'd have to assess it more, as Stacey said, but I wouldn't want to go forward. But the expedited rate review, definitely.

And then on the retro, I mean, I guess it gives me a lot of pause that that's going on, just given how rates should be set, and again, there's no retro when there's an underpayment. You got to have it both ways on this one, but I don't know what we do with the policy option on that.

CHAIR BELLA: Others?

[No response.]

CHAIR BELLA: So it sounds like there is interest certainly in looking at the expedited rate review. Is there anyone who feels differently than that? Please wave at me.

[No response.]

CHAIR BELLA: Okay. And then some uncertainty over the multiyear risk mitigation. What would it take to kind of -- is there information Chris can bring back to us that you all want to understand better to decide whether to go forward? Help me understand a little bit more how we leave him with clear direction to help.

COMMISSIONER GORDON: I personally would just like some use cases. Again, just give me some examples, and let's think that through in a couple of different risk mitigation scenarios, what that might look like, because I can think of situations where it might work, but then there's others that I'm not as clear on, so probably just need to take some time. And I think those use cases could probably help with that.

COMMISSIONER LAMPKIN: I agree. I think this comes up from time to time, often enough that it's worthy

of a little study and articulation of what the pros and cons are, using use cases or what have you. It just isn't clear to me that once we see that that this would be something that the Commission would want to push, but it's worthy of unpacking a little bit.

COMMISSIONER DOUGLAS: I would agree just on that because states -- I mean, it goes back to just the administrative. A lot of states would love to go to longer periods just because of all the time and effort it takes, but we just need to understand the implications and use different examples of how it would play out.

CHAIR BELLA: Chris, does that sound doable?

MR. PARK: Sure. I might need to like -- may want to talk to Stacey and Darin a little more as to what other types of use cases, you know. In terms of this particular project, it came up during COVID because no one knew exactly when utilization might bounce back, and when that happened in 2020, 2021, that was the particular case that came up. Over a long period, the rates may be sufficient over like a two-year period because all the decrease in 2020 would bounce back in 2021, but there are certainly other types of situations. So I think I'll need

to think about exactly what other use cases there might be and certainly come back with some more information.

CHAIR BELLA: Just so I'm clear, part of what we're trying to do with the use cases is understand if there's a problem to solve that we need to get into, outside of COVID perhaps presenting itself.

COMMISSIONER GORDON: Well, thinking of COVID, but there's different risk mitigation levers, and so thinking about that over a two-year period, how that might play out, what the issue might be, because it's not just setting a rate. We're not talking about just setting a multiyear rate. We're talking about risk mitigation levers being measured over a two-year period of time. So there's different levers and maybe just thinking through that.

I'm with Stacey, just having an opportunity to just unpack it a little bit to think through that, because I've heard, in some cases, folks talking in the past about it would be good if you were measured over a two-year period, but that wasn't a very discrete risk mitigation situation. And I just don't know if that holds as well in others. I just need to maybe spend a little time with that.

CHAIR BELLA: Okay. Chris, does that help? And you certainly can -- I'm sure they would be more than happy to talk offline.

COMMISSIONER LAMPKIN: We can invite him to dinner.

CHAIR BELLA: Exactly, exactly.

Okay. Is there anything else that we need to talk about on the other issue that was raised then on the retro piece? Are we asking Chris to do any work in this area?

COMMISSIONER GORDON: I would like to see if he can formulate a potential policy on that particular issue. It came up in the roundtable, and I've heard about it pretty consistent -- I just -- again, that's one that I'd have to think of what that is. It's not to take a lever off the table, but even the guidance that allowed for the retroactivity of that situation, there was some misinterpretation of folks grappling with even trying to figure out how far they could go back. And I think that's just an issue we heard. So I figure we need to at least think through is there a policy recommendation there.

COMMISSIONER LAMPKIN: But the guidance that's in

place right now currently is no retro.

CHAIR BELLA: Right.

COMMISSIONER GORDON: Except they allow the waivers that would permit it, that you had to follow these 1115 waivers to permit it.

COMMISSIONER LAMPKIN: Okay.

COMMISSIONER GORDON: Yeah. So I'm just -- I'm wondering is this just a cleanup and the 1115 waivers allowing the retroactivity of those adjustments, or is this a pathway that can allow it to happen going forward?

CHAIR BELLA: I guess what my question is -- and obviously, I'm not as close to this -- it's actually just a can of worms, and is that the can of worms we want to reach into?

COMMISSIONER GORDON: I think similar to the multiyear risk mitigation, I think I could tell you after we have some conversation about it. In fact, that's why I was like I couldn't think of what the policy option would be, but it is one that I've heard from states, all across the country have heard about it, in the roundtable, that us not at least exploring it, I think -- I think that would not -- that wasn't going to be helpful. I think we at least

need to explore is there a policy choice, or if not, because it would open up a can of worms, then so be it. But I think it deserves some conversation.

CHAIR BELLA: Chris, do you have any comment on that or any question on that?

MR. PARK: Not at this time, but at I look into the issue a little bit more, I may have some questions for Darin on follow-up.

CHAIR BELLA: Okay. Stacey, anything else to add on that?

COMMISSIONER LAMPKIN: No. Thank you.

CHAIR BELLA: We're going to start having all the MCOs are out meetings now if we're talking about retroactive risk mitigation strategies. That's definitely a way to increase the audience size, I think.

COMMISSIONER GORDON: We have about -- and then we can get all that -- we can balance it out.

[Laughter.]

CHAIR BELLA: Okay. Any other comments on this for Chris from Commissioners? And if not, we are going to turn to public comment, and, Chris, I'd ask you to hang with us for a minute just in case anything in public

comment needs your response. Anybody else from the Commission?

[No response.]

CHAIR BELLA: Okay. We'll see if there's anyone in the audience who would like to comment. If so, please use your hand icon, introduce yourself and your organization, and please limit your comments to three minutes. We'll take comment on both of the last two sessions.

MS. HUGHES: All right. We have one hand raised. It looks like -- excuse me if I pronounce this incorrectly -- Rhys. You have been unmuted by the organizer. You may unmute yourself and make your comments.

PUBLIC COMMENT

* MR. JONES: Thank you, and good afternoon. My name is Rhys Jones, and I represent America's Health Insurance Plans, or AHIP.

In 40 states, Washington, D.C., and Puerto Rico Medicaid program contract with Medicaid health plans to serve more than 60 million people. We really appreciate MACPAC's review of rate setting and risk mitigation and transparency recommendations and all the comments from the

Commissioners today, including Melanie's comments about more MCOs to look in.

Law and regulations require states contracting with Medicaid plans to set actuarially sound rates and CMS to review and who approves those proposals. This process is important to in assuring federal funds are used effectively and efficiently and that Medicaid plans and their providers are accessible and can deliver covered services to Medicaid members.

On average, the federal government pays over two-thirds of Medicaid program costs. So CMS has a really compelling interest in overseeing and ensuring the sustainability and integrity of the federal investment to Medicaid.

COVID-19 and the public health emergency have had profound effects over the past two years, as we've seen, including major fluctuations in Medicaid enrollment and utilization of health services. With these impacts, as MACPAC continues to explore the interactions of rate setting access and risk mitigation, we think there are some areas worthy of further analysis.

First, effects of the COVID-19 pandemic on

utilization patterns in 2020 and 2021, as has been alluded to, and their implications for actuarial projections in the rate settings in future rating periods, the rating methodology requires that actuaries use the prior three years, and so the utilization patterns we see in 2020 and '21 will continue to have effects on -- as base period data going forward for the next few years. Risk mitigation arrangements implemented in this space were a response to the pandemic, but which apply retroactively to periods prior to the start of the pandemic is another concern. And that was called out in Mr. Park's review.

Accelerated rate review, an option through which states can receive rate approval based on a summary actuarial review, even for rating periods that overlap the COVID-19 PHE, with all of its attendant problems with utilization.

Anyways, thank you for considering these recommendations, and please let me know if you'd like any further details. Thank you.

CHAIR BELLA: Rhys, thank you for joining and making comment.

Anyone else who would like to make a comment?

[No response.]

CHAIR BELLA: All right. I don't see anyone.

Just as a reminder, folks are always welcome to submit their comments via email as well, and the address is on your screen. It's comments@macpac.gov. We welcome those at any time.

Any last thoughts about anything that we've discussed today from Commissioners?

[No response.]

CHAIR BELLA: No? All right. We want to say thank you to the staff, thank you to Anne, thank you to Jim and everyone behind the scenes.

At the risk of jinxing us, this might be our last virtual meeting for a while. So we will see you all -- I know, Darin. I know. I probably did just jinx it. Anne?

EXECUTIVE DIRECTOR SCHWARTZ: So I just want to say a couple things. One, for the audience, the Commission may be in person in April, but the audience will be virtual. So do not fear when Melanie mentions no longer being virtual, that you won't have access.

The second is, Dennis, would you please check your email and get back to me? Thank you.

CHAIR BELLA: And then for tomorrow, we will start tomorrow at 10:30. We will first take a vote on the innovative care recommendation that we discussed earlier today. We will then quickly move into our first of two sessions tomorrow. The first one is looking at considerations for the HCBS benefit, which is an area of work that we've had a longstanding interest in, and we will finish off the day rounding back to our conversation on coverage of adult vaccine, moving toward a recommendation for the June report.

So thank you all for your engagement today. We will see you tomorrow morning at 10:30 Eastern.

* [Whereupon, at 4:09 p.m., the meeting was recessed, to reconvene at 10:30 a.m. on Friday, March 4, 2022.]

PUBLIC MEETING

Via GoToWebinar

Friday, March 4, 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
WILLIAM SCANLON, PHD
LAURA HERRERA SCOTT, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Welcome, everyone, to Day 2 of our March meeting. We are going to kick things off, coming back to our integrated care strategy recommendation, and it looks like -- Kirstin, are you going to give us the updated recommendation based on yesterday's discussion?

VOTE ON INTEGRATED CARE STRATEGY RECOMMENDATION

* MS. BLOM: Yeah. We can just go to the next slide. Let me see here if I can do this. I'll just read the -- whoops. Well, when it comes up, I'll just read through the revised version. Sorry about that.

CHAIR BELLA: You're fine. I think what -- the only thing that's changed is an update to the conversation based on how we talked about equity and the words around making sure equity is a part of all of it, correct?

MS. BLOM: Yes. Right. So you can see in the middle of the paragraph where it says "The strategy should include the following components," we have those listed, and then we added "and the structure to promote health equity."

EXECUTIVE DIRECTOR SCHWARTZ: So, Kirstin, could

you just read? We need to read it for the transcript.

MS. BLOM: Sure.

EXECUTIVE DIRECTOR SCHWARTZ: So if you could just read it, and then we can go to the vote.

MS. BLOM: Okay. Will do.

Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years, with a plan to review and update the strategy to be specified by the Secretary. The strategy should include the following components: integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement, and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

CHAIR BELLA: Thank you.

Does anyone have any questions before we take a

vote?

[No response.]

CHAIR BELLA: Okay. Anne, I'm going to turn it to you, then.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I'm going to call the roll, and, Commissioners, just remember you can vote yes, no, or abstain.

Heidi Allen.

CHAIR BELLA: Oh, I'm sorry. Do you need me to mention the conflict of interest?

EXECUTIVE DIRECTOR SCHWARTZ: Oh, yes, yes, yes. Thank you. Sorry.

CHAIR BELLA: Okay. So I want to let it note for the record that -- I'm finding the exact language so we have it properly. Okay. So the conflict of interest we need for MACPAC must review Commissioners' reportable interests to determine any potential conflicts with any recommendations. For this recommendation, our Committee met on February 11th. The Committee was chaired by Kisha Davis, our vice chair. The Commissioners reviewed reportable interests and found no conflict related to this recommendation.

EXECUTIVE DIRECTOR SCHWARTZ: Okay, good. If I remind you and you remind me, it all works, so okay.

On to the vote. 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.

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: 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. Sixteen yeses, and we're done.

CHAIR BELLA: Wonderful. Thank you, everyone. Thank you, Kirstin and Ashley, for your work on this. Very exciting to see this piece and move forward in this area.

All right. We are going to quickly pivot to a related subject and one that we've had longstanding interest in and will continue to deepen our work, which is around the home- and community-based services benefit.

So I see Kristal. I am looking for Asmaa. Oh, yes. You're both right in front of me. Welcome. Thank you for being here. We are looking forward to having this be one of many conversations for this particular set of Commissioners. So I will turn it over to you to take it from here.

CONSIDERATIONS IN REDESIGNING THE HOME- AND COMMUNITY-BASED SERVICES BENEFIT

* MS. ALBAROUDI: Great. Thank you.

Good morning. Today I'll be presenting on considerations in redesigning the Medicaid home- and community-based services benefit.

I'll begin with an overview related to challenges to HCBS as well as the delivery of home- and community-based services. I'll provide an overview of a roundtable that MACPAC convened late last year, some design considerations, issues for discussion, and then I'll wrap up with some next steps.

Next slide, please. So in thinking about the challenges related to the administration of home- and community-based services, the fundamental issue of delivering LTSS under Medicaid is that the law mandates

that states cover institutional care but does not require them to provide coverage for HCBS, leading to Medicaid's institutional bias. Essentially, institutional services must be available for all beneficiaries who are eligible, but HCBS can be limited through the use of waivers, some of which include waiting lists.

Relatedly, despite federal and state efforts to promote rebalancing as well as Medicaid spending on HCBS outpacing institutional care since 2013, Medicaid's current benefit design can act at cross-purposes to these efforts by making nursing facility services easier to access than HCBS.

And, finally, we often hear stakeholders speak of flipping the benefit so that Medicaid policy would make HCBS the default rather than institutional services. Presumably, this would increase access to HCBS. Flipping the benefit leads us to consider several different areas: first, which services would be mandatory and which would be optional; who would be eligible; how such changes could be implemented; and whether there should be accompanying changes to the nursing facility benefit. One driving question is whether a core HCBS benefit could address these

outstanding issues and improve access.

A second challenge is the complicated system of waivers and state plan authorities in which HCBS is delivered. It's difficult for both states and beneficiaries to navigate.

Under the current system, states are frequently managing several programs and benefit packages, each associated with its own set of eligibility criteria. Medicaid authorities used for the provision of HCBS also vary within and across states. Beneficiaries may need services that are offered under different state plan and waiver programs. To the extent that there are waiting lists, beneficiaries may be unable to access certain HCBS, even though they qualified based on their functional needs. If their needs are left unmet in the community, they are at risk for institutional care.

Next slide, please. For HCBS waiver programs, separate from meeting level-of-care criteria and belonging to a waiver's target group, a beneficiary must also belong to a Medicaid eligibility group. Medicaid policies to determine eligibility for long-term services and supports focus on finances, so things such as income and assets, and

measures of functional status. In other words, people become eligible because they have low income and assets and meet specific state-based thresholds for clinical and functional impairment.

Beneficiaries who use LTSS are a diverse group spanning a range of ages with different types of physical and cognitive disabilities. They include adults age 65 or older, people living with physical disabilities, intellectual disabilities, developmental disabilities, individuals with serious mental illness and other behavioral health conditions, as well as children with special health care needs.

HCBS includes a wide range of services to help individuals with disabilities live within the community. They often require services and supports for many years or even decades, and the types and intensity of services they require vary, both across and within subgroups. These services include but are not limited to personal care services, adult day services, supported employment, and even home delivered meals. While HCBS does include a range of services available to beneficiaries, the literature has documented racial and ethnic, geographic, as well as

population-specific disparities related to both access and quality of care in HCBS.

Next slide, please. The Medicaid authorities to provide HCBS across states are variable, offered either through a Medicaid state plan or waivers. The combination of authorities has resulted in a complex design, as I noted earlier. While states often use multiple different Medicaid authorities to provide HCBS, Section 1915(c) waivers are the most common.

Next slide, please. Late last year, MACPAC convened a roundtable under contract with the Center for Health Care Strategies to explore the idea of designing a core HCBS benefit in Medicaid. Participants included federal officials, state officials, representatives from state associations, beneficiary advocacy groups, and other experts, as well as two MACPAC Commissioners, Brian Burwell and Dennis Heaphy. We did not task roundtable participants with sketching out a new benefit design or making specific recommendations.

Next slide, please. Really, the intention of the roundtable was intended to be a starting point for MACPAC to present the Commission with some considerations on the

design of a core HCBS benefit, to streamline access to, and flip the incentive for HCBS rather than institutional care. A core benefit may provide the opportunity for states to offer a set of services adequate enough to support community living with reduced administrative complexity. Such a benefit could support diversion from institutions, which aligns with beneficiary preferences, and it may result in more efficient use of federal and state resources.

Next slide, please. Based on the roundtable discussion, we have identified some key takeaways. Throughout the day, stakeholders proposed several different potential benefit structures for a core benefit. However, the discussion really centered around a tiered model approach that would include a core HCBS benefit supplemented by higher tiers with more expansive services.

Participants repeatedly emphasized that a core benefit should be designed to promote person-centeredness and equitable access to services. Additionally, as I'll discuss in greater detail, state officials prioritized maintaining state flexibility as opposed to promoting uniformity and standardization of the core benefit.

Participants also generally agreed that the implementation of a core benefit would require support at the federal and state level, and finally, workforce capacity is essential in any discussion related to improving access to HCBS.

Next slide, please. The key takeaways from the roundtable are high level but important. If the Commission were to recommend a redesign, we do have a fair amount of work to do to more fully describe what that would look like. Both MACPAC staff and CHCS identified a variety of factors and tradeoffs involved in designing a core benefit that would incentivize HCBS over institutional care.

Specifically, we asked participants to consider several different areas. The first is related to services to include in a core benefit. The second is around administration and monitoring of such a benefit, and the third is related to determining the eligibility for a core HCBS benefit.

We asked participants to raise issues, concerns, and generate ideas about the benefit rather than reach a consensus or propose recommendations. I will discuss the themes that emerged from the conversation and our own research, but today we are seeking Commission input on any

or all of these issues.

Next slide, please. Person-centeredness was viewed as a key component in the design of a core benefit. Participants agreed that services included in the benefit should support meaningful community living and person-centeredness. Currently, federal regulations require that states must develop a person-centered service plan and implement a person-centered planning process that is driven by the individual accessing HCBS.

Several participants suggested that one mechanism to tailor services to beneficiary needs is to use a budget-based model design. This model design would support self-direction by providing beneficiaries with a service budget that allows them the flexibility to cover services based on their needs and wants rather than be limited to a specific set of services.

Experts also discussed the service structure of the benefit, specifically that a core benefit package should include services that would improve access to and incentivize use of HCBS.

Offering a core benefit that includes a limited set of services to all populations with LTSS need could

help avoid or delay institutional care. Participants did elevate a number of services that they thought were key to the benefit. They include but are not limited to housing supports, personal care services, enabling or assistive technologies, care navigation, and transportation. Among these, personal care services are commonly used across HCBS populations. However, the other services discussed are also crucial to support community living.

Next slide, please. While the notion of a core benefit does imply some level of standardization, the benefit design should address the diverse needs of people who use LTSS. One concern is that if the core benefit is not tailored to meet the diverse needs of people who use HCBS, services included in the benefit may be inadequate to meet the specific needs and preferences of beneficiaries. However, offering a core benefit to all populations with LTSS needs at a minimum may improve access to HCBS for a limited set of services.

Participants did differ in the extent to which they thought that a core benefit should be tailored and standardized to accommodate varying HCBS beneficiary needs. Some participants suggested a standard benefit that would

include a limited set of services applied across all states and HCBS populations. Others supported a design consisting of several core benefits, each of which would serve a different HCBS population but would also be applied in a standard manner across all states.

Regardless of whether the core benefit is tailored to meet diverse HCBS needs, the design of a benefit should improve equity in offerings across states while encouraging state innovation. Standardization could result in administrative simplification that would ensure access to a minimum level of benefits for beneficiaries across states. Standardization, both in terms of services offered as well as eligibility criteria, may allow policymakers to compare the effect of the core benefit or even quality of services across states, as some panelist suggested.

Next slide, please. Issues of standardization and state flexibility came up frequently. Panelists highlighted the tradeoff between standardization and maintaining state flexibility to support innovation. For example, while state officials valued the existing flexibility available under the HCBS delivery system to

innovate and tailor their programs, there was concern that a level of uniformity across states may negatively affect innovation.

Some participants offered that the goal could be a balance between ensuring a minimum level of access to a core benefit while simultaneously promoting state flexibility to provide supports to beneficiaries in ways that they need and prefer.

Other participants agreed with continued support of state innovation, but they emphasized that the establishment of a core benefit should be adequate enough to meet people's needs and ensures all individuals have access to services across states to avoid creating additional disparities.

Now, in thinking about the design of a core benefit more broadly and as I noted earlier, the roundtable participants really focused in on a tiered model that would work alongside the current system of HCBS delivery. The model would include a core set of services for all eligible beneficiaries and additional tiers of supplementary services for those with more intensive needs. It would work within the current system of state plan and waiver

services with some modifications, and it could also allow states to maintain their current flexibilities with regard to waivers and state plan options that would serve as wrap-around benefits for upper tiers.

Next slide, please. Separate from services and design of the core benefit, consideration must be given to the capacity for implementing such a benefit. Specifically, a new benefit design should take into account financial, administrative, and direct care workforce capacity. Several participants expressed concern about the challenge involved in implementing a new design, given existing limited state resources and capacity, particularly if this benefit results in increased access to services.

In addition, and as noted earlier, participants throughout the day repeatedly emphasized the need to consider workforce capacity in discussions related to HCBS. In thinking about administrative complexity, the design of a core benefit could lead to administrative simplification, but this is not a given.

While some participants expressed interest in administrative simplification, state officials were more interested in retaining current flexibilities than in

streamlining administration. For example, some state officials expressed interest in a core benefit as an additional tool rather than an approach to replace current Medicaid authorities to provide HCBS.

Next slide, please.

Participants briefly deliberated on whether the core benefit could be designed as either a mandatory state plan service or a new optional benefit. One participant suggested that given limited state use of state plan authorities, rather than adding another 1915 program a core benefit may be structured under Section 1905 as a mandatory state plan service, with states having the option to wrap additional services via other authorities.

They also discussed existing disparities in HCBS by race and ethnicity and geography, and emphasized the need to promote equitable access to care that is also culturally competent. Specifically, they commented that a robust data collection infrastructure would be essential to monitor and ensure access for groups currently experiencing disparities.

Next slide, please.

In addition to the structure and monitoring of a

core benefit, roundtable participants touched upon determining eligibility for such a benefit. They were asked to consider, for example, potentially standardizing the eligibility criteria, establishment of federal minimums, and modifying current criteria. Panelists discussed that standardizing eligibility criteria could promote equity across states. However, it may have negative effects on states with more generous policies. They also noted interest in a streamlined eligibility process that could promote access to a core benefit.

Participants expressed support for streamlining HCBS eligibility via, for example, expedited or presumptive eligibility as mechanisms to allow for quicker access to home- and community-based services. MACPAC has a project underway related to presumptive eligibility.

Next slide, please.

Today we present to the Commission several issues for discussion for the three areas of consideration just reviewed. First, in regard to services to include in a core benefit, the Commission's discussion may center on how a core benefit would support meaningful community living, the types of services that are critical to improve access

and incentivize HCBS use, and finally, to what extent should the core benefit be tailored and standardized to accommodate the diverse HCBS needs. Specifically, for example, you may consider standardizing the types and scopes of services, allowing variation in services within defined parameters, for example, by population or geographic region, or allowing states to define and set their own scope of the services.

Next, the Commission may wish to focus on several key areas related to administration and monitoring. You may look to weigh in on whether a core benefit would work with or replace the current system of Medicaid HCBS authorities as well as the effect of the core benefit on state-specific factors currently available to manage HCBS delivery, such as waiting lists. Further and really key to the discussion of incentivizing HCBS over institutional care is whether the benefit would be a mandatory or optional benefit.

Commissioners may wish to consider what key components are necessary in implementation of such a benefit to ensure that it promotes equity and addresses disparities, specifically considering quality metrics,

state requirements to identify and report on certain demographic data, as well as policies and programs that support HCBS access in rural regions. Commissioners may also want to discuss what state entity may be responsible for the administration of a core benefit and the incorporation of such a benefit in MLTSS in applicable states.

And finally, the last area of consideration is around eligibility. Specifically, you may want to discuss if and how financial and current functional eligibility pathways may be modified for establishing eligibility for a core benefit.

Next slide, please.

Based on the Commission's discussion of the design considerations as well as roundtable participant insight, staff can flesh out the discussions and suggestions further to inform continued work on designing a core benefit.

Thank you for your time, and we look forward to your discussion of the design elements. I will turn it over to the Chair.

CHAIR BELLA: Thank you. I'm going to start by

asking Brian and Dennis if they want to make comments since they were participants, and I know this is of great interest to them. But I want to say thank you again. This is a complex subject that you've broken out very well, and I think has really laid the groundwork for us to make progress on the direction we want to head in thinking about a core benefit. So I'm excited for this discussion.

I don't know which one of you would like to go first. You can duke it out. I see Dennis. Would you like to go first? No. Okay. Brian, you're up. How's that for a democratic process?

COMMISSIONER BURWELL: That was an easy fight. It's like Clay-Liston.

I have mixed feelings about a number of things. I want to emphasize the discussion that occurred in the roundtable about the tradeoff between flexibility and standardization. While states and other participants in the roundtable, you know, very much agreed that the current system is very complex with all the different authorities, a lot of excess paperwork and renewals and CMS involvement that they would rather not have, but they were also very wary of a standardized federal program, either at the

Medicaid or not on Medicaid, that would reduce states' ability to be flexible in how they design and deliver services.

I think there was some feeling around, you know, is it better to have the devil that you live with or the devil that you don't. And while the current system may be very paperwork-heavy and complex, it does allow states to essentially design different programs for different populations, reflecting really the diverse nature of the HCBS population and their diverse needs, while also being innovative to test new models for delivering HCBS services such as person-directed care, et cetera. So I just think that's a dynamic that makes it difficult to make a decision about whether a core benefit is really something that we should move forward with.

But my other worry or concern is the amount of change going on in the HCBS system already, with the HCBS initiative and potentially the Build Back Better initiative. I think after the three years of our HCBS initiative states will be in a much different place than they are now, particularly around workforce, around waiting lists -- I think a lot of waiting lists will be eliminated

over the next three years -- and with the use of technologies to provide support to people in their own homes as a complement to direct care workers and help address the direct care workforce crisis.

Also, like others on the Commission, I am very supportive of promoting models of care that integrate Medicare and Medicaid, and if our two-year strategy recommendation goes through I think another solution would be states would increasingly use dual eligible models to provide HCBS, which would particularly impact this idea.

And the third thing is with the growth of the in- demand for long-term care services across persons of all socioeconomic categories, I see the political support for a more expansive solution to LTSS is growing quickly. I don't know if it's going to happen in the next five years but I think it is inevitable that this country will eventually adopt a much broader financing program for HCBS services that is not linked to the Medicaid program. I don't know if that would directly affect this but I think that's another development that may affect whether we should move forward with this option.

So that's a lot. I could keep going but those

are initial thoughts.

CHAIR BELLA: Thank you, Brian. I have a clarifying question for Asmaa and Kristal. In reading the materials, my assumption we're having the discussion about doing future work on this because the states, while they are very keen on preserving our flexibility, I assume none of the states were saying there's no world in which we wouldn't want something like this to exist. But the conversation more was around the tradeoffs and how it might ease some administrative burden.

But can you help clarify, I mean, if the states are saying, "We're not interested in this," that's a big thing for us, and I didn't read it as that. I read it as there are some big tradeoffs here, but there may be some reasons that states may also see benefit to at least going part way down this road. So can you just clarify that a little bit?

MS. ALBAROUDI: Yeah, absolutely. So that's correct. No state or any participant objected to the idea of a core benefit. They were all supportive of a core benefit. I think the discussion was really centered around how we would standardize the core benefit's level of

standardization and how it would fit within the current HCBS delivery system. And I think that's where additional discussion and work has to be done.

CHAIR BELLA: Okay. Dennis, would you like to comment, or do you want me to circle back to you?

COMMISSIONER HEAPHY: I'll comment. I was here thinking in my own mind, am I biased and just reimagining that meaning in my mind? So it would be helpful if you guys could -- I think there was agreement that we need to address the institutional bias in the system. Is that correct? Because that, for me, was a starting place. And so starting from there and recognizing an institutional bias is really something we need to turn around.

What I remember of the meeting was real support for moving forward, and what Melanie was just saying and what I read in the document. And I think for me -- and again, this may be my own bias in remembering this, and even discussing -- it seems to me that there was interest in a core benefit across states. What that might look like across states may vary, depending on the state's capacity. And the concern might be uniformity and expectation of uniformity in the benefit across states. Is that accurate?

MS. ALBAROUDI: Yes, that's accurate. So there was support for implementing a core benefit across states, but I think the difference really centered around what that core benefit would look like, how tailored it would be towards the varying populations that receive HCBS.

COMMISSIONER HEAPHY: Right. Because to me, part of the conversation, as I recall, was about equity between states and access to a core benefit, and that comes from conversations in general about the ability of people with disabilities to move from one state to another because the benefits vary so much from different states. And so how do we, in looking at core benefits, and not they fix that problem, but keep that in consideration, how do we build a more equitable system, not just within populations in a state but across states?

And I don't know if this is the time, but just to put it out there that probably one of the greatest needs folks have are for home-based services, PCAs and other home services, and a potential core benefit that would be required nationally. I don't know what your thoughts are, or if either you or Kristal have looked at that, in terms of what we heard.

MS. ALBAROUDI: Yeah. So I can give that some more thought and kind of turn back to the discussion that was had and come back to you, Dennis.

COMMISSIONER HEAPHY: Thanks.

MS. ALBAROUDI: Of course.

CHAIR BELLA: Okay. Thank you, Dennis. Tricia, did I see your hand earlier? No. Okay. Toby, and then Bill.

COMMISSIONER DOUGLAS: Great. Great presentation, Asmaa. Really well presented.

A quick question on just the intersection with managed care, how much that came up, and how a core benefit and integration and what Brian touched on with duals into the discussion.

MS. ALBAROUDI: Yeah, so it really came up very briefly, so I would encourage if the Commission would like to kind of explore that more we would, of course, be welcome to your thoughts in advance on it.

COMMISSIONER DOUGLAS: I think it would be important to understand how it fits together over the long haul, especially as states are moving more and more in that direction and then as we are having our analysis on duals

and integrated products. Thanks.

CHAIR BELLA: Thank you, Toby. Bill?

COMMISSIONER SCANLON: Yeah, and thank you. I mean, I think that what you've done is you've illustrated quite dramatically sort of how complicated this area is, and given a very good structural framework for us to be thinking about different aspects of it.

I would sort of offer -- I guess maybe to complicate our lives -- that it is even more complicated and there is need for more detail than what we even have now. It comes down to what services is an individual going to receive, and when you talk about differences across states, at one point at GAO we looked at those sort of differences across states but we were looking first within a state, where people were entitled to the same benefit. And we asked what was happening for people with different circumstances. And the variation in the services they actually were going to receive under the programs was dramatic.

And that is key to answering what I think are the two fundamental questions, are individuals' needs being met, and secondly, what are the impacts on their

caregivers? Because a balancing factor, in all of these discussions about home care, is that we're not willing and able to provide 24/7 care for someone so that informal caregivers are going to play an incredibly important role. And what the consequences for them are, depending upon their circumstances, their health, et cetera, is a very important consideration to take into account when one is thinking about what is the right home care benefit to provide.

The other thing I think that we have not discussed is a dirty word, and it's the budget. Dennis just used the word "capacity" varying across states. There is an issue of budget, and in budget you may think of it varying on capacity, but it also varies on the basis of preference or choice, what states are willing to spend.

I mean, this is an issue of where you have to remember, do not ignore history because you may end up repeating it. Before 1981, there was only, I think, one state that was [inaudible.] significant home care, and that was because there was a sense that they did not have budgetary control. And the waivers that were enacted in 1981 provided that control. There has been a lot of

learning from it. I think they have been incredibly successful. I mean, you need to rebalance what's already happened.

Today it is easier to get into a nursing home because nursing home occupancies have dropped. Historically, nursing homes were closed and it was not easy to get into nursing homes, and it was hardest for people that had the greatest need for nursing homes.

So I think we can't ignore the fact that the world has changed, but states are still going to face the budgetary pressures, and the question is going to be, if we design something like this with a federal description of what should be done, what's going to be the latitude within that definition that states will use to be able to control their budgets? And will it be enough? And if it's an optional benefit, then there's the option, the possibility that they won't offer something at all. If you want to look at an optional benefit that is in short supply, look at dental services for adults. Almost 20 states do not have a dental benefit for adults, because they feel like they cannot control it well enough and it would cost them too much.

So I think there's much to be done in terms of thinking about the additional complexity here as well as the issue of budgetary control, because I think that is absolutely essential to preservation of a positive benefit.

CHAIR BELLA: Thank you, Bill. I have a couple of comments while folks are gathering their thoughts, and one is kind of following up on what Bill said. I mean, as we think about the tradeoff between standardization and the tools states have, I mean, I think of them as tools, right? Waiting list is a tool. The waiver versus state plan, all of those things.

And so I think about these issues a lot, but do not feel like I could possibly opine yet on particularly the administration and monitoring questions there. Because I think what would be helpful, and maybe others can chime in.

If we have sort of three options, one is full standardization, one is full state flexibility, and then there's something in the middle, what does that something in the middle look like, and where does that state level sort of -- how is that seesaw kind of working as we think of a balance? So it would be helpful to kind of bring back

to us, I think, some of the hybrids or some options that allow us to preserve some state flexibility or state tools while also moving toward more administrative standardization?

For example, when you talked about in the discussion, the notion of tiers and perhaps there's a core and then states have the flexibility through the tiering to do a little bit more, is that a hybrid that we could think about? So there is a little bit -- there is a core standardization, and then there are tiers. And the states, if I read it correctly, could handle the tiers maybe through the way they're doing it with HCBS waivers today, and so those are the kinds of things that it leaves me pursuing it would be helpful to bring back, that we can react to because I think it's just -- it's hard to get past the concept of like facing flexibility, yet we need standardization without having something a little bit more concrete in front of us.

Tell me if I am right in interpreting that is an example of something concrete that we could opine on, a core with then state options for tiers. Is that the right way to think about that?

MS. ALBAROUDI: Yes, that's exactly right.

CHAIR BELLA: Okay. How do others feel about -- what do you need -- I mean, I think everyone is interested in this. I think it's also very -- it's hard to get past some of the concepts and how we sort of tackle those, which is probably why we've been sort of stuck for a little while. What would help people be able to provide more concrete feedback on these types of questions?

Heidi and then Darin and then Laura.

COMMISSIONER ALLEN: I'm clearly not an expert in this, but I'm finding the conversation really helpful. And the background materials were wonderful.

When I hear the word "tier," what I think about is categorical eligibility and how clunky that is and how difficult it is for people to move from one tier to the other. You meet almost everything for another tier but not quite.

The idea of a budget-based model actually intrigues me because it makes me wonder if rather than having tiers, you have a budget assigned to people based on their probability of medium- and long-term care. So the more likely it is that you would be in institutional care,

maybe the bigger your budget would be and have a smaller budget for somebody who's maybe -- you know, doesn't need anywhere near that support, but you're still allowing people to make choices about what would best serve them rather than the state making decisions for populations, which I think is sometimes also clunky.

But the budget itself might be able to be used as some way of maintaining state control of what that would look like. It would also be responsive to geographic variation and workforce and other circumstances.

So I would like that potentially as an alternative for thinking about tiers, what something like that would look like.

CHAIR BELLA: Thanks, Heidi.

Darin?

COMMISSIONER GORDON: Yeah. I'm where Melanie is. I think, directionally, I think a lot of us are probably nodding our heads. I think it's just trying to figure out what that end produce looks like. It's that middle space that I'm still trying to think of all the different levers and options one might have, because clearly core standardization, I think, is going, you know,

be too much for me because it's going to take away from a lot of really creative innovations that are out there currently going on by states, but at the same time, do you think not having some kind of core, some base is odd, given just the strong historical institutional bias that's been out there?

So I'm with Melanie. If I can get a little bit more help in looking at what those options, what a floor might look like, what some of those options might be. You know, I think about that in the context also of, you know, what would some kind of hybrid look like with regards to some of the waiting lists that are out there, because just thinking of the scoring aspect of this and what that might look like, but depending on how we propose a hybrid approach, it may minimize or mitigate that to some degree.

So, yeah, I align myself with Melanie. If we can get a little bit more clarity there or a little bit more build-out there, then it maybe will help me wrap my head around it a little better than I have so far.

So thank you. Thank you for your work on this. I really appreciate it.

CHAIR BELLA: Thank you, Darin.

Laura?

COMMISSIONER HERRERA SCOTT: I was thinking about some of our past meetings when we were talking about some of the workforce issues. So I'm even just thinking about capacity and the infrastructure in states to flip the switch if we were, you know, moving in that direction, and I don't know if we have information related to capacity to support this work.

DR. VARDAMAN: I can jump in and just mention some past work we did around waiting lists that I think is relevant. So, a few years ago, we talked to some states about how they manage their HCBS waiver waiting list. A number of states did say that workforce capacity, like even if they were able to eliminate their waiting lists, would limit their ability to expand access to HCBS. So I think it's something that is relevant here and has been noted. You know, there's a lot going on in states around HCBS workforce issues that we're also continuing to track.

CHAIR BELLA: Laura, anything else on that?

[No response.]

CHAIR BELLA: Other Commissioners? Kisha.

VICE CHAIR DAVIS: Thanks for this.

You know, just to the question of kind of what additional information would be helpful, I mean, I think we're all kind of learning and taking it in. I'm excited about this being a body of work for the upcoming year. I can see it may be a chapter a year from now and, you know, that it's something that we continue to build on through the course of the next year.

I think for me, really making it a little bit more concrete, I mean, you know, potentially, certainly having some panels or speakers on this, maybe bringing in some of the folks from the roundtables, some folks who are doing some of the modeling and having some of the -- you know, some forward thinkers on it and what the models could start to look like, I think, would just help to make it a little bit more tangible and focus us in where we really want to put our stake in the ground and then build on.

CHAIR BELLA: Yeah. I was thinking the same thing about having -- like getting some folks in front of us so we can benefit from that, that discussion too, not that we're not benefitting from the roundtable, but I think we all wish we could like port ourselves back in time to the further discussion.

Dennis and then Verlon and then Brian.

COMMISSIONER HEAPHY: Yeah. It would be helpful too to get more information about workforce capacity and pay because we know that there's such differentials in the payments to people, and we definitely want to see the folks get a living wage. And that seems to be an issue across states. So I think it would be helpful to get data on payments across states and how that affects possibly workforce capacity and whether it's actually consumer-run personal care services, versus agency-run personal care services. For me, that's something I'd really like to get more and more about.

CHAIR BELLA: Thank you, Dennis.

Verlon?

COMMISSIONER JOHNSON: Yeah. I just want to circle back to, I think, two points I heard earlier, one from Brian about timing and really looking at what we can learn from ARPA and potentially Build Back Better. I feel like there are a lot of opportunities there that we saw around workforce, of course, wait lists and all of this, and so, as Kisha said, I see something coming up like in another year or so and just really want to be mindful of

that and not get too ahead of what we may be learning from some of the things that states have done around those efforts already but definitely glad we're focused on this.

And the other thing is what Toby had stated about managed care. I've been looking at this for a while, and when I look at managed LTSS, I mean, we're looking at, at least what -- over half states who are really using this to manage those more complex populations, and so rather for this being a footnote in this, I really want us to make sure that we're being mindful about doing research and really figuring out how this really would fit into a core benefit if we wanted to go that route. I think that's really important for us to keep at front of mind.

CHAIR BELLA: Thank you, Verlon.

Brian?

COMMISSIONER BURWELL: So, in regard to workforce capacity, I do think that the ARPA initiative is an empirical opportunity to do some good research on expanding capacity, to increased wages. Most all states are devoting a very high percentage of their ARPA money, which is a lot, a lot of money to increases in wages for direct care workers, and these are significant raises, so -- and also

more investment in training, in career development ladders, quality, and so, you know, I think there will be a lot of information on the relationship between wages and capacity.

So I will add one last thing to kind of build in on what Bill said. It's about there's always been a fear among states about the demand for HCBS, given the fact that three-fourths of all HCBS services are provided informally and only around 20, 25 percent formally. So that is an important issue, and ways in which the public sector can support families and other informal caregivers in their caregiving capacities through respite programs is another really important development in thinking about the future of HCBS services.

CHAIR BELLA: Thank you, Brian.

Did I miss anyone's hand?

[No response.]

CHAIR BELLA: We have a little bit of time, and because this is very different than the vaccine that's coming up, I'm going to go ahead and take public comment so we can hear this now, as Asmaa and Kristal are with us.

I think then we have an opportunity to figure out how to chunk out this work. Clearly, there is interest,

and we want to start taking it on and figuring out the right path forward. They are very interrelated, but there also are some areas that I think we can separate and to bring -- you know, bring -- then bring the pieces back together, and so we can kind of assess, assess how to best go forward.

But right now, I am going to go to the public. I'll come back to any last comments from Commissioners, but if there are folks in the audience who would like to make a comment for the record, please use your hand icons. And I'll remind you please introduce yourself and your organization, and do your very best to limit your comments to 3 minutes or less, please. We'll open that up now.

Do you want me to open it up?

MS. HUGHES: No, I have it. Sorry.

CHAIR BELLA: Okay.

MS. HUGHES: Patti, you have been unmuted by the organizer. Please make your comment.

PUBLIC COMMENT

* MS. KILLINGSWORTH: Good morning. Patti Killingsworth. I'm the chief of Long-term Services and Supports with the Medicaid agency in Tennessee. Greatly

appreciate the Commission's focus on this really important topic.

There have been a lot of great ideas surfaced. I'd like to comment on several and reserve the right to supplement with written comments, if I may, just sort of thinking things out of it more.

I want to focus first on Dennis' comment about rebalancing and really, I think, a critical need to address what are longstanding institutional biases in the regulation itself, in the law. I think states are doing as much as they can, but ultimately, we have to get to the place where we turn freedom of choice on its head, where we eliminate the mandatory nature of an institutional benefit, and where we eliminate the institutional bias as it relates to using Medicaid dollars to provide room and board at least in situations where people are very, very low income. I think it ultimately makes it much easier for people to receive care in an institution than in their own homes, which is unfortunate.

Melanie, you talked about all of the different authorities being tools, and I think they are until the point that it becomes mandatory, and then the tool becomes

a bit of an anchor. And an anchor is not a bad thing. An anchor can keep something focused, but it can also weigh down. And so I agree with Bill that there needs to be a lot of thought given into if something is going to become mandatory, how we do that in a way that states can still manage within their budgets.

We saw in the early years so many of the "flexibilities" -- and I use quotation marks around that -- that were provided for home- and community-based services came with so many strings attached that states, including our own, were often unwilling to pursue those authorities because of fear of being able to really manage the budget.

One of the things that we haven't really talked about is how to align incentives. At the federal level, at the state level, at the health plan level where we're talking about managed care really in favor of home- and community-based services, one of the things that the ARP Enhanced FMAP dollars have done is to align incentives, to really give states enhanced match for home- and community-based services.

I do think the short-term nature of that has limited some of the flexibility that would be available to

states, but if that enhanced FMAP were to become a permanent fixture and states were essentially incentivized to offer home- and community-based services over institutional services, I think that would be a game changer for sure.

Brian also spoke about workforce and the really critical importance of addressing workforce. I think that's come up several times, and I agree wholeheartedly. We can't really rebalance the system and expand access to home- and community-based services without addressing what has become the most critical workforce shortage I've observed in 25 years in LTSS. I think it is going to force us to be much more creative, both from a financing perspective around how we incentivize states to increase wages for the frontline workforce and how that affects things like budget neutrality, cost neutrality in the various Medicaid authorities.

But I think we also may have to be more structured in how we think about training and equipping and professionalizing this field and leveraging, as Brian pointed out, enabling technologies wherever possible to give people not just the value of their own independence

but also to better manage the available workforce that we have available.

I have more. So I will submit them in writing, but I want to be respectful of your time. Thank you so much. I appreciate it.

CHAIR BELLA: Patti, thanks for taking time to join us today and for participating in the roundtable. You are one of our main go-to people in the states on this issue. We appreciate that and welcome any additional comments.

MS. KILLINGSWORTH: Thank you.

MS. HUGHES: Daria, you have been unmuted. You may unmute your line and make your comment.

[No response.]

MS. HUGHES: Daria [phonetic], if you don't see it, there is a little microphone icon under the orange arrow in the upper right corner of your screen. It appears you're unmuted now.

UNIDENTIFIED PARTICIPANT: Sorry. That was a mistake. So I don't really have a comment. I'm sorry about that.

CHAIR BELLA: That's no problem.

Are there any other folks who would like to make a comment?

[No response.]

CHAIR BELLA: Okay. I'll turn back to the Commissioners. Any last comments, thoughts, requests of Asmaa and Kristal?

COMMISSIONER HEAPHY: This is Dennis. I'd like to hear or learn more about the per-person spending dollars in the managed LTSS across states. We see that increasing and decreasing compared to the fee-for-service system. I don't know if you'd be able to get that granular data, but that's something that would be really helpful because there is a distrust among folks with disabilities of managed care. And a lot of it is among different things. One of those is a reduction of access to LTSS under a managed care system.

DR. VARDAMAN: I can jump in and just mention that we are planning to do some digging into T-MSIS claims to take a look at spending for people who use LTSS, particularly HCBS. We're not sure how deep and how granular we can be on some of that just yet, but we'll definitely bring back to you what we can.

CHAIR BELLA: Thank you, Kristal.

Darin, did I see your hand? Closing words?

COMMISSIONER GORDON: Yeah. You know, I think it's really important if we think about this as kind of thinking of it from the transition of where we are today to this kind of new way of approaching these services. I think it's really important, but thinking about that through the lens of how states might be able to manage that transition -- and I'm thinking about that from a financing perspective. I think it's going to be critical.

I think part of the comments that are here today, I think there's like a general directional interest in trying to get there, but the details matter in that transition. We don't want to lose sight of that because, if we make it too abrupt, it could actually prevent the ability to go to this new way of thinking, so appreciate it.

CHAIR BELLA: Okay. Asmaa or Kristal, do either of you have any additional information you need from us?

[No response.]

CHAIR BELLA: Okay. Well, thank you. We look forward to having this come back and to really digging in

on these issues. Thank you very much.

Okay, we are rolling into our last session which is on access to vaccines for adults. Amy and Chris are here. As you all know, this is a conversation we've been having, and we are here today to talk about recommendations that we might vote on next month for the June report.

So I will turn it over to Amy and Chris. Welcome back.

ACCESS TO VACCINES FOR ADULTS ENROLLED IN MEDICAID: DECISIONS ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* MS. ZETTLE: Great. Thank you, Commissioners, and thank you, Melanie. So today we are going to continue our work on vaccine access for adults enrolled in Medicaid. The focus of our conversation today will be to consider five draft recommendations for possible inclusion in the June report to Congress.

We will begin with a brief discussion of the barriers to access for adults in Medicaid, and then we will walk through the five draft recommendations and their potential implications. And then lastly we'll discuss next steps.

Over the course of this work we've identified a number of barriers to vaccine access in Medicaid. These barriers were detailed in the March report to Congress, which will be out shortly, and we want to just quickly review these again, because each of the draft recommendations that you will be considering today aim to address these four barriers.

So the first barrier, and most fundamental, is limited coverage of vaccines in Medicaid. Vaccines are not a mandatory benefit for all adults in Medicaid, and Medicaid has more restrictive vaccine coverage policies than most other types of insurance.

The second barrier is low provider payment for vaccines and their administration. We consistently heard in our interviews that low Medicaid payment rates are discouraging some providers from administering vaccines and thus reducing access for Medicaid beneficiaries. The literature also support this concern.

The third barrier is having a limited set of providers who can administer vaccines. To improve access, adults need a broad range of settings for vaccinations, beyond just primary care. Adults are more likely to access

care through pharmacies, emergency rooms, and specialists.

And lastly, vaccine hesitancy is growing, and adults need more information, support, outreach about routine vaccinations. As we have discussed, the vaccine schedule for adults is somewhat complex, and while some vaccines are universal, like flu, others are dependent on risk factors, age, or vaccine history.

So we have five draft recommendations for your consideration today, and they aim to address the barriers that we just discussed. First, we start with a recommendation to address limited coverage in Medicaid. In the March chapter, MACPAC notes that addressing coverage is necessary to improve vaccine access for adults, but it isn't sufficient. And the chapter notes that other barriers should be addressed as well.

The next four draft recommendations address the remaining barriers, and they focus on ensuring adequate provider payment, expanding provider networks, and improving beneficiary support and education.

We presented multiple policy options at the January meeting, and the options that we are discussing today have the greatest support from the Commissioners, and

together they address the barriers that have been discussed.

Turning now to the first draft recommendation. To improve coverage of vaccines our recommendation is 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.

This approach would ensure that all adults in Medicaid have coverage of recommended vaccine regardless of their eligibility pathway. This would improve access to vaccines and help to prevent disease, hospitalization, and death. Right now federal law mandates coverage without cost sharing for all ACIP-recommended vaccines for those in the new adult group. However, coverage for all other adults enrolled in Medicaid is optional.

This recommendation would take those existing coverage requirements for adults in the new adult group and apply them to all other Medicaid-enrolled adults. This recommendation is similar to the vaccine provision in the

Build Back Better Act, which passed in the House in November, except that bill also phases out the 1 percentage point FMAP increase on vaccines and their administration that was made available under Section 4106 of the ACA.

This recommendation, we would expect it to increase federal and state spending. The CBO estimated that federal spending under the Build Back Better provision would be $2.8 billion over 10 years. Since this recommendation is silent on the phaseout of the 1 percentage point FMAP increase, we are looking to get an updated estimate on this specific recommendation.

Adults who are not in the new adult group would stand to gain under this recommendation, specifically, those who live in states that currently don't provide coverage of all recommended vaccines and those who face cost sharing requirements. For providers, we heard that coverage policies that vary by eligibility can be quite confusing, and by equalizing coverage across eligibility groups it could remove this confusion and allow providers to focus on the clinical recommendations offered by ACIP and not necessarily coverage status within the state.

Our second draft recommendation focuses on

ensuring adequate payment for vaccines, and under this recommendation MACPAC would recommend that CMS should implement payment regulations for vaccines and their administration. Payment for vaccines should be established at the actual acquisition cost and a professional fee for administration, similar to the payment requirements established for outpatient prescription drugs.

There is evidence that some Medicaid programs may not be paying providers enough to cover the purchase and administration of vaccines. As a result, providers may be less willing to purchase, store, and administer vaccines. Ensuring adequate payment could increase provider participation and, in turn, improve access for beneficiaries.

This recommendation would ensure payment adequacy by aligning those payment methodologies that are already in place for prescription drugs and applying them to vaccines.

Federal and state spending would increase under this recommendation. Particularly in states where payment rates are not currently covering provider cost you'd see spending increase.

In addition, this recommendation could create

administrative costs for states, as states may need to conduct a survey to determine what that average acquisition cost is in their state and conduct studies to determine what the cost is to administer vaccines.

Under this recommendation, beneficiary access would increase, because more providers would likely be offering vaccines to Medicaid enrollees. And providers would have greater certainty that the vaccines they purchased would be adequately paid for when they administer them.

Moving on to our third draft recommendation, this recommendation aims to expand provider networks offering vaccines, and the recommendation reads CMS, the Center for Medicare & Medicaid Services, should issue federal guidance encouraging the use of pharmacies and other providers in administering adult vaccinations in Medicaid.

One lesson that we learned from the COVID-19 experience is how important it is that adults have access to vaccines across a multiple number of settings and providers. Adults are less likely to have medical homes and are less likely to access care in a variety of settings.

So while many states do allow vaccine payments to pharmacies and providers other than physicians, this is not universal. So, for example, 31 state Medicaid programs pay pharmacies to administer vaccines, and 29 state Medicaid programs pay nurse practitioners. Four states paid midwives to administer vaccines.

States can use existing authorities to expand types of providers eligible to administer and bill for vaccines, but federal guidance could encourage additional states to adopt or expand these policies. Depending on how states respond to this federal guidance, spending across the states and across the federal government could increase, but we wouldn't really have a score because states, again, already have the authority to do this now.

There would be some administrative burden on states if they need to submit state plan amendments or enroll new providers into the program.

If states respond favorably to the guidance and expand their networks, more adults would have access to recommended vaccines through a variety of providers, and existing Medicaid providers could begin to offer vaccines, where they weren't already.

And now for recommendation 4. This recommendation and the next recommendation looks to improve beneficiary support and education. Recommendation 4 reads that the Secretary of Health and Human Services should direct a coordinated effort with CMS and the Office of the Assistant Secretary for Health, and the CDC 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.

Beneficiary advocates and other experts have shared that federal and state agencies could really be doing more to educate and encourage Medicaid enrollees to become vaccinated. Because these efforts could be directed by different federal agencies, the Secretary should coordinate these efforts to avoid duplication and identify ways that states can target outreach. This coordinated effort and technical assistance across HHS agencies could help states identify a range of options that could be used to improve beneficiary education and outreach and the various federal funding streams that could be available.

The guidance could also include specific examples of how states could use existing Medicaid authorities to fund public health initiatives and to increase education and outreach. Guidance and TA could specifically be used to target and address racial disparities which exist in the program.

Federal and state spending could increase, depending on how states respond to the guidance, and if states respond by implementing more education and outreach we could see increased spending on those efforts, specifically, and also resulting in increased vaccinations.

Our last recommendation is to Congress, and it reads, Congress should provide additional federal funds to improve immunization information systems. In addition, Congress should require the Secretary 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. CMS should also provide guidance on matching rates available and ways to integrate IIS and MMIS to be eligible for the 90 percent

match rate for design, development, installation, and enhancement of MMIS and the 75 percent match for ongoing operations.

State and local immunization information systems are the central registries for vaccine records, and they can be used to support vaccination efforts. While these system can serve as an important tool, they need significant improvements to interoperability, data quality, and timeliness. In a recent survey, only 45 percent of these systems exchange data with Medicaid programs, and only about 21 percent exchanged data with other states and regions, and only 53 percent of clinicians and pharmacists reported documenting vaccinations to the systems.

Improving these systems would require financial investments. The House of Representatives passed a bill that would allocate funding award grants to improve state and local system. The Senate hasn't moved on the bill at this time.

It is also important to note that this recommendation includes the Secretary coordinating federal guidance and technical assistance across HHS agencies to help state and localities identify ways to improve their

systems and improve interoperability.

This recommendation would increase spending by the amount that would be allocated by Congress, and the recommendation would help states to improve their IIS and take advantage of additional federal funding.

This policy could be operationally complex to implement, depending on which components of the systems need changed and the upgrades that would be required to integrate MMIS and IIS and also develop interoperability with electronic health records.

An improved IIS would offer providers a more complete picture and an accurate record of a beneficiary's vaccine history, and it would also ensure that beneficiaries receive appropriate vaccines. They could also be used to facilitate targeted outreach and reminders and increase the likelihood that beneficiaries receive needed and recommended vaccines.

So lastly, we would like to get your feedback on these five recommendations and hear from you on what you would like to see included in the June report to Congress. If there is support for making recommendations, we would return in April to present the draft chapter, and the

Commission would then vote on the recommendations at that time.

CHAIR BELLA: Thank you, Amy and Chris. We have really seen quite the evolution of these recommendations throughout the several meetings that we have been addressing them. And so if we could go back -- I think that's where you're going -- to slide 4 that has the summary of the recommendations. And I saw Martha's hand, so we will start there, and then Fred.

COMMISSIONER CARTER: Thanks for bringing this back to us for more discussion. I had comments on draft recommendation 3 and 5. I'd like to see recommendation 3 strengthened a bit. I was really struck by the data that only 29 states reimburse nurse practitioners and only 4 reimburse midwives, nurse midwives, certified midwives. And it seems like we should have a no-wrong-door or all-open-doors kind of approach to vaccine administration for adults. So I think I'd like to see the recommendation talk about reimbursing all reasonable, already credentialed providers. These are already participating providers in Medicaid, so to the extent that they are already in the network, why are we not reimbursing them? I think that is

a fairly simple fix for the states. They flip the switch and open the code. Somebody who has done this more can probably speak to that.

And I would defer to Kathy on whether that should include dentists, because I know they were involved, very involved in some areas in COVID vaccination campaign. So would they want to take on adult vaccines as a whole? I can't speak to that. But certainly nurse practitioners, physician assistants, nurse midwives, there should be an open-door policy there.

And then for recommendation 5, I was struck by the data that only 53.4 percent of clinicians reported documenting vaccinations in an IIS, and wondered if you know whether states requires that now. And if they don't, shouldn't they? Shouldn't it be required for good coordination of health care that if you administer a vaccine that you then report it to the IIS? There may be technological problems with that, but I'd like to see what is already required. And that's it for me for now.

COMMISSIONER DAVIS: Amy, any response to that, if it's required by any states?

MS. ZETTLE: I'm not familiar with any

requirements but I can go back and look. I know with COVID it certainly became a bigger issue. Some of the reasoning that we heard when we did additional interviews on this topic was that, we heard one group say it's sort of a chicken-and-egg situation. The registries aren't really timely. They're not integrated to the EHRs. And so since they're not already set up to be used and accessible to providers they are not using them. But then it's hard to get the investment because providers aren't using them. So that's what's happening on the ground, and I think certainly why there may be some hesitation at this moment to require their use at the state level. But we can certainly bring that back and see if there's any state-level data on whether they're currently being required.

COMMISSIONER CARTER: And maybe look at what would the barriers be to getting rid of that chicken-and-egg thing and say we need to improve the systems and then we need to require, for good patient care and good coordination of care, that vaccines are entered.

COMMISSIONER DAVIS: Thank you, Martha. Fred?

COMMISSIONER CERISE: Thanks, Amy. I think it captures the discussion we had last time pretty well, and

we're sort of distilling it now around some specific recommendation. So I appreciate that.

One, just to follow up on Martha's comment, I wonder, is the reason the No. 3 is sort of an encourage, is that because the varying things in states about different scopes of practice arguments and things like that, that you get into?

I mean, listen, we use pharmacists to do this all the time. I know they can do it, and I just wonder if that's the reason for the softened there and that, you know, we get into areas that, you know, we don't control. So maybe you can comment on that.

But my question for you was around the pricing and the recommendations that we kind of left behind. I was wondering if -- not to revisit that, but maybe you can remind me of where the discussion went and landed and why left off some of the stuff around either negotiating -- ensuring the CDC-negotiated pricing, so the federal price negotiations on this, or taking advantage of Medicaid drug rebate program, something to look at the cost side of it at the same time that we're talking about mandating it and making used more widespread.

MS. ZETTLE: Yeah. So, to that question, on the policy option that we brought back in January was around leveraging the CDC rate to really get at this issue of adequate payment -- so the goal there would be if you reduced the price there, it would sort of get at the issue of adequate payment and help with cost.

What we heard from some members of the Commission was that that seemed particularly complex to implement, and that's consistent with what we heard in our interviews too, that that would be -- it would be a little complicated. So we left that off because we didn't hear any overwhelming support for that option, given its complexity.

And then as far as the Medicaid drug rebate program, kind of similar. The goal of that when we raised it was to get at the idea of coverage, because under that program, vaccines would be covered if we included them, and making it a mandated benefit was sort of a simpler approach. But you're right. Then it would doesn't provide a rebate.

COMMISSIONER CERISE: I'd just be curious of others' opinion on that on whether or not we should consider where to take advantage of -- try to make sure

we're getting best price at a time when we would be making a recommendation to mandate coverage.

VICE CHAIR DAVIS: Do others have thoughts on the pricing issue?

Darin.

COMMISSIONER GORDON: Yeah. That's the one I'm struggling with. I don't like -- it feels like we're stepping into an area that we haven't before of saying here's the appropriate reimbursement level for something, and just running these programs, there are unintended consequences when we do stuff like that. In many cases, there may be limitations on what you could do to actually get at a better price because we've now set this in statute from a regulatory perspective.

So I'm with Fred. That one gives me a little unease because it's dynamic. When we talk about the actual acquisition cost, is the acquisition cost the same for all wholesalers when it comes to these vaccines, or does it vary by wholesaler? How does one approach that or think about that? Does that create the incentive for acquisition cost from wholesalers to go up because we've set this new standard?

And so that's the one I just struggle with because I feel like we're taking a point in time position and not thinking about its implications in the market and might that actually drive us to where we're paying more than what we would have otherwise. So I do have some concerns with that particular item.

VICE CHAIR DAVIS: Darin, does that lead you more in favor of Recommendation 1 in the mandate or differently?

And then I see your hand, Toby.

COMMISSIONER GORDON: Yeah. Well, I've been consistent ever since I've been on this Commission. I always get concerned about mandates because we look at them in vacuums, and we think, well, this is a good thing to do. We're going to expand access. This is great. Yes, it is going to cost money, but it's a good thing to do. But we've heard it's not done in a vacuum. That means there's other things a state may not do or there's things that states pull back on that they're doing currently because there isn't just the unlimited flowing of state funds to support these things.

So I get concerned anytime we do that and we're not funding it, and that's where I've been consistent on

that throughout the process. I think, directionally, I appreciate what we're trying to do, but I will have a concern about mandating the benefit and putting additional cost on states, again, recognizing that it's going to have other implications that we will not see right now, but we would see if this went forward.

VICE CHAIR DAVIS: Thank you, Darin.

Toby and then Stacey.

COMMISSIONER DOUGLAS: Yeah. I want to further what Darin is saying but a little bit more nuance. I just continue to come back to make sure we're balancing state and federal, that this is a joint program. Mandates have all the implications that Darin said.

That being said, there is clearly a precedent on benefit, mandatory versus optional. So, as much concern -- I can support that, but when we get into the idea of anything around payment rates, that is a really -- you know, that state role defined with all of what we continue to look at ensuring access, adequacy, but would not want us to start venturing down into that area where that is clearly state's responsibility.

That also goes into No. 3, that we just need to

balance this of how those rules go within the context of access and encouraging it but understanding within the context of how each state is looking at its network and meeting all the requirements and the construct in the state-federal relationship.

VICE CHAIR DAVIS: Thank you, Toby.

Stacey.

COMMISSIONER LAMPKIN: My comments are similar to Darin and Toby's, and I think when we last talked about this, I expressed more personal support towards recommendations that were oriented towards removing barriers that states have rather than requiring states to do something that they already can do. If I'm understanding all this correctly, Recommendations 1, 2, and 3, but mostly 1 and 2, these are all things that are within a state's control right now to cover the vaccines or what they pay for the vaccines.

So, to the extent that we mandate or recommend a mandate or something that kind of locks them down, that affects their ability to prioritize within their state in a federal-state program. So those are my concerns there.

VICE CHAIR DAVIS: Thanks.

You know, I'm interested to hear more on how folks feel about the mandate. I think for me, thinking about vaccines as a preventive measure and being one of those things that really can make a huge difference -- you know, we've seen in the course of COVID that of the things, not wanting to mandate everything, but that being one of the things that really does make a huge difference from a public health standpoint, and certainly, here as, you know, the counter to that of an unfunded mandate and what that does to states and their ability to prioritize, so interested to hear from others, especially around Recommendation No. 1.

Yeah, Heidi and then Melanie.

COMMISSIONER ALLEN: I would just say that I still support a mandate. I think that the fact that states could be offering it right now and aren't shows the need for a mandate.

I think the fact that we have populations in Medicaid for which it is mandated and then populations for which it isn't is also confusing to consumers. It makes it hard to have a unified message for the Medicaid program, you know, go get vaccinated, you can, it's free, because

you can't say that. You have to say go get vaccinated, you can, it's free if you're enrolled through the ACA. You know what I mean? And I think that vaccines are very, very cost effective, and if we're following recommendations from a recognized body of experts, then I think that we are -- that these are vaccines that matter and that have future impact in people's health, and not everybody will take them up, even if they're mandated. So it's not a one-to-one, you mandate it, every single person then goes and does it. But it might reduce a cost barrier for a population for whom that would be a very big, important thing to do.

VICE CHAIR DAVIS: Thank you, Heidi.

Melanie.

CHAIR BELLA: Yeah. I'm not one who's big on unfunded state mandates, having been in that position, but I am struggling because it felt to me as a Commission, we were all for this when it was in the Build Back Better Act. And so why are we questioning -- I mean, what we're debating is the merit of promoting a policy that would ensure coverage to vaccines for the most vulnerable populations that are served by Medicaid, and so why would we be questioning now whether that's something that is good

for us to say is important? That's what I'm not understanding.

I think we're trying to be careful not to push certain payment levels. I mean, we've tried to -- I think Amy and Chris have tried to thread this needle quite a bit, and while Build Back Better has additional funding for states, this one wasn't. This one wasn't specifically federally funded, and so I'm trying to understand what's changed in our last discussions when we thought this was important, because it hasn't come through. And so, in my mind, it is still important, and it's on us to continue to reiterate that importance.

COMMISSIONER HEAPHY: This is Dennis.

VICE CHAIR DAVIS: Yeah. Go ahead, Dennis.

COMMISSIONER HEAPHY: For me, I agree it is a very simple upstream intervention to reduce downstream costs, and so for me, I'm struggling with why the mandate isn't positive. This goes to what Heidi was saying as well. It really is something that we implement to reduce downstream costs. It's an injection, the cost of injection versus the cost of a two-week hospitalization for pneumonia or flu turned into pneumonia. I just think it's really

important.

COMMISSIONER JOHNSON: Yeah. I'll just echo the same amount of support. I went back to look at the slide, the two areas that really stuck out, benefits to gain coverage to recommended vaccines and removes -- I'm sorry -- to providers. Right there, we're talking about a huge increase in access for people who really need this, and as you said, the most vulnerable populations. So I still continue to support a mandate in this recommendation.

VICE CHAIR DAVIS: Thanks, Verlon.

Tricia?

COMMISSIONER BROOKS: I agree with everything folks have said. I do think requiring states to cover vaccines are an important public health initiative.

That said, I'm really sensitive to how vaccines in particular are such a political lightning rod right now, and I worry a little bit about the divide that we have in this country over vaccines and other policies. And so I just -- I struggle a little bit with the timing. Is this now the time to do this and really cause a deepening chasm between states that will balk at this and states that would cheer it on or already do it?

VICE CHAIR DAVIS: I'll just respond to that because, I mean -- and I see Melanie. Mandating coverage doesn't mandate getting a vaccine, and we already had mandated coverage for COVID-19. And the debate is not about whether you should pay for it or not, and I think, if anything, it moves that question out of the way. And I worry about us continuing to have a two-tiered system where some have it available and others don't, especially within the Medicaid system, and I think, you know, especially when this is already mandated for a certain subset of Medicaid patients and not for other, then you are perpetuating an inequity that doesn't necessarily need to be there.

Melanie.

CHAIR BELLA: Yeah. I was just going to ask if you could refresh my memory, Amy and Chris. We talked to states that aren't covering it, and what reasons did they give us?

MS. ZETTLE: Yeah. So we did. We interviewed a variety of states, some of which cover all, and some do not. The ones who don't -- I mean, it was cost, though the one state that we spoke to, it's worth noting has the vast majority of enrollees in managed care in which they have

sort of worked that out with the managed care plans to provide vaccines as included in the benefit. So they feel that their coverage is -- not all vaccines are covered, but, you know, the main ones that you think of are, but cost, I think, would be the number one factor.

Chris, did I miss anything else?

MR. PARK: I think that's right.

Based on the CDC study, most states are covering like 9, 10, 11 out of the 13 vaccines that are recommended by ACIP, and where they're not covering it, sometimes those are vaccines that may be more likely to be given to children or like less prevalent diseases or potentially like shingles where it's 50 and older, and a lot of those people will get it when they're on Medicare versus when they're, you know, between 50 and 64.

Cost is certainly a factor, but there are other things, I think, going into the decision as well because, like Amy said, in one state where they're not really covering adult vaccines, they worked with the managed care plans to offer those as value-added services for some of the more prevalent, common vaccinations like flu or hepatitis. So they're still kind of willing to cover them

through other means.

CHAIR BELLA: And can I just ask one more sort of level-setting question? In the congressional world, this was part of -- well, do we have a sense of is this an area of interest or an area of concern for anyone over there?

MS. ZETTLE: So it was included in BBB.

I mean, Chris, we haven't heard a lot of the conversation as far as sort of whether or not it would be included in a slimmed-down version or not. We really don't know, and I wouldn't want to speculate on the priority level.

CHAIR BELLA: I guess I'm thinking about Tricia's kind of lightning rod comment and wanting to like -- we would be making this decision because we think it is the right thing to do from a public health and coverage and access decision, and I wouldn't want that to be misunderstood in the current political climate as anything other than that being the rationale for doing it. So that's why I was also asking a little bit about that.

VICE CHAIR DAVIS: Yeah, Darin.

COMMISSIONER GORDON: Yeah. You know, to Tricia's comment, Kisha, I got there with you with regards

to this is a access for those who want it. It's not requiring people to have vaccines. That's how I got comfortable with that particular aspect.

One thing I do want to circle back to, let's not confuse someone's lack of support for unfunded mandates to not thinking something is important. That's a dangerous place to go, and some of the comments kind of made it sound like we were making that connection. I don't think that's an accurate interpretation of at least my position, which I think it's an important thing. Unfunded mandates have been consistent, and again, we could say they should pay for it; we think it's great. That's not the only way for us to emphasize something is important. If the only way we can emphasize something is important is through unfunded mandates, I think we have a very slippery slope we're about to slide down. So let's separate the two issues. I believe it's an important issue. I don't believe in unfunded mandates. If the federal government wants to pay more for it to make it even more accessible, then I support that.

COMMISSIONER DAVIS: Thank you, Darin. That's good clarification. Stacey and then Tricia.

COMMISSIONER LAMPKIN: I don't know that I was necessarily waving my hand as much as nodding my head to Darin's comments. I think that's the case. I think where do you draw the line is the question. I mean, states make different choices between coverage and how they handle things that we might think are good, but that's what they have the authority to do under the way the program is designed, is to make the choices and priorities that are aligned with their local environment.

When we talked about postpartum coverage several meetings back, I mean, this is one where we really talked about this same kind of question along, but we had a funding component to that which I think is what helped me, at least, feel favorable towards that particular recommendation.

COMMISSIONER DAVIS: Thank you, Stacey. We're going to go to Tricia, and then I want us to, in our last five minutes, to see if we can come to a consensus or thoughts around the funding part. Go ahead, Tricia.

COMMISSIONER BROOKS: So I just want to make clear, if we were to vote on this recommendation I would vote yes. I question the timing, not because it's a

mandate on individuals to get vaccines. They can choose. It is the issues that we have in Medicaid and the different perspectives that different states bring to it. You know, you squeeze the balloon in one place and it's going to pop up in another.

So if that's the cautionary note, we need to find a way to unify our political beliefs in support of good public health policy, not necessarily drive wedges in there.

COMMISSIONER DAVIS: Thank you, Tricia. What I'm hearing from folks is that there is support for a mandate, and that really, the conversation and the discrepancy is around funding or not. And we've had conversations previously around some different options for funding and never really go to consensus, and hence, Amy and Chris didn't bring those back today.

You know, thinking about a go-forward point, is there a desire to go back and revisit some of that and pairing that with a recommendation for April? Darin.

COMMISSIONER GORDON: Before I answer that question, could you all remind me. Is this one that we did ask CBO to give us their sense of what the impacted would

be financially?

MS. ZETTLE: Yeah, so the provision that was included in BBB, which phases out that 1 percentage point increase for some states was $2.8 billion over 10 years, but because we're silent on that provision we would need to get an update on that.

COMMISSIONER DAVIS: Thanks. Yeah, Anne.

EXECUTIVE DIRECTOR SCHWARTZ: So this is going to muddy the waters a little bit but I think it's important to say it. We have a situation now, because this is an optional benefit, that many states are covering it and they're getting federal funds for it. They're getting financed for it at the regular match. So if you decide to fully federally fund these services, you are providing additional resources to states that are already covering them, in order to bring others along. So I think that's something that's worth considering.

And I would also just say, from the politics perspective, you guys can do what you want but I would say a recommendation for 100 percent financing for this would not be particular welcome from either side of the aisle.

COMMISSIONER DAVIS: Yeah, Darin.

COMMISSIONER GORDON: Yeah, I appreciate that. Anne, I recognized that as well, but I think part of why it wouldn't be acceptable on either side of the aisle is because it is going to have a big cost to it, and yet we're not giving equal weight to some of those states that are going to feel that they have to cover it through a mandate that they have added costs.

I'm not saying it's easy. I'm not saying it's going to make people happy. I've just been consistent on that issue, and I know it has implications for folks who have already gone down that aisle or down that road. But it helps that some of the comments Chris was making earlier about how many states, even though they're not covering them all they're covering almost all of them, and it's only a few so the cost is probably low.

But again, it's just a consistency thing from my perspective, because I've been in a state and it's just like, well, this little thing and this little thing and this little thing, and the next thing I'm taking whole benefits away from populations that I wish I wouldn't have had to take it away.

EXECUTIVE DIRECTOR SCHWARTZ: Let me just add one

more thing about why this is different from postpartum, and that was because no state, unless they got a waiver, had the option to go beyond 60 days. So I want to just mention that as well, so our discussion is complete.

COMMISSIONER DAVIS: Thank you, Anne. Heidi and then Fred.

COMMISSIONER ALLEN: Just because I'm new to the Commission, so was it $2.8 billion? Is that what you said, Amy? Over 10 years. Is that a huge cost to Medicaid, because to me that doesn't sound like a huge cost over 10 years for the entire Medicaid program. And this is actually probably the moment of the most empirically grounded possibilities that there would be cost savings related to doing this than almost anything else that we could do in Medicaid.

So I hear more people talking about a principle of an unfunded mandate, but is this where we want to take our stand on that, or is this something that is reasonable to align inconsistencies across the program and to do good in public health and something we could get behind, for this instance, not for every other thing that might come before us in the future?

COMMISSIONER DAVIS: Thank you, Heidi. Fred.

COMMISSIONER CERISE: You know, I share a lot of Darin's concerns. I talked to Peter. So I called Peter before the last meeting, because I was concerned about the ACIP recommendations and what that means. You know, what is considered in that recommendation? And I wanted to understand better the cost-effective analysis and the economic analysis that's done, because not all vaccines have the same cost effectiveness. They all have a different quality that's associated with it, and you can imagine some that could be very high. But Peter shared with me ACIP considers that in their assessments.

You know, relying on that ongoing assessment by ACIP to consider that, would have a big implication for state programs, which is why I went back to the issue of federal contract pricing and where could you modulate that. Because if you just say we're going to cover it and we're going to use wholesale acquisition price, as Darin said, if it's going to be covered then that's going to go up.

So I would be comfortable taking another look at it, with a look at what we could pair with that in terms of price negotiations. Because in the earlier presentation it

was a little hard to appreciate but it did talk about either a low increase or a decrease in overall cost to state and federal government with that CDC price attached to it.

COMMISSIONER DAVIS: So if I can summarize this, because we are already a little bit over. But what I'm hearing, for the other recommendations, for 2 through 5, general support, some comment on number 3, of opening that up to be more general in terms of how they think about providers, certainly pharmacists who want to create access, but not disrupting the primary care home. I like Martha's terminology around no wrong door. And again, I am hearing support for mandating, but additional considerations for how that is funded.

And so Amy and Chris, thoughts for us on what you think you can bring back to us in April. Yeah, Darin.

COMMISSIONER GORDON: One thing is, so I was clear if I wasn't, between 1 and 2 I'm more concerned about us getting into the pricing of the way we pay for the thing, probably even more so than I even do the mandate aspect of it. Because when you said there's general consensus on 2 through 5, I just wanted to be clear. I

think that was also the point that Fred was making as well.

COMMISSIONER DAVIS: Yeah, Martha.

COMMISSIONER CARTER: I'm not sure we want to go here either, but is there room for us to provide additional information to the CBO to calculate cost avoided in additional vaccine administration? I don't know that there is, but it doesn't seem that that was taken into account. And I think there's a lot of good data on that. So that might help our case a bit.

COMMISSIONER DAVIS: Thanks, Martha.

You know, Darin, to your point, I agree that I don't think that we want to get into the technicalities of how they want to pay, and I think that's a lot of where we -- you know, the different kind of choose your own adventures that we had last time, and basically landed on you should do something, and you should implement a regulation on vaccine payment, and we didn't get too prescriptive about doing that. And then how does that jive with not saying definitively that it should be covered at a set rate, and saying that this is something that we want to mandate. And so I think that's where I am wrestling.

CHAIR BELLA: Kisha, I might suggest that we just

kind of do an informal show of hands to see where folks are. We've done that in the past. That kind of helps us get a sense we haven't heard from some folks. So that might be something we do on number 1, and then we decide if we're bringing it back and what we might bring back with it.

COMMISSIONER DAVIS: I think that sounds like a good plan. Folks, today with number 1, as it's written, who would be in favor of that?

[Show of hands.]

COMMISSIONER DAVIS: I see you nodding, Dennis. I see 11. And then who would not be in favor?

[Show of hands.]

COMMISSIONER DAVIS: One and a half.

COMMISSIONER CERISE: Just in isolation, you know, it's hard to say I'm not in favor. I could be in favor of that, given some of the other considerations that I mentioned.

COMMISSIONER LAMPKIN: And I didn't raise my hand because I'm really wrestling with it. I don't know right now.

CHAIR BELLA: Fred, what would Peter say? I'm

just curious.

COMMISSIONER CERISE: First he says hello to the Commission, and then he would give it a thumbs up. So yeah, he was encouraging about it.

COMMISSIONER DAVIS: So I think with that, I think bringing it back in this form, I think there's a lot that we can do in the chapter that discusses, that brings forward this discussion and where we are wrestling with. But I am still seeing pretty general consensus around mandating the coverage.

Amy and Chris, other information in our direction that you would need or like to see from the Commissioners?

MS. ZETTLE: I think on 1, I think that makes sense. We could certainly add context around sort of the discussion that was had today around second thoughts. That's doable.

MR. PARK: Yeah. The only thing I would add there is if you did want to add in something like the negotiated price or other ways to discount the price. I'm not sure we would be able to get a CBO score on that by the April meeting, and so that's where the timing could be affected.

COMMISSIONER DAVIS: Thanks. We'll go to Brian for the final comment here.

COMMISSIONER BURWELL: I have a question. Is the intention that we would eventually vote separately on each recommendation, 1 through 5?

COMMISSIONER DAVIS: Yes. Unlike the ones that we have done earlier, these don't necessarily move as a package, so we will be voting on them individually.

COMMISSIONER BURWELL: Thanks.

COMMISSIONER DAVIS: Any other comments here from Commissioners before I turn it back to Melanie for public comment?

Amy and Chris, thank you. Thank you for this robust discussion.

MR. PARK: Actually, I do have a question. Darin and Fred and maybe some others had some concern about recommendation 2, and just wondering if that's something where there is a consensus on bringing that back.

COMMISSIONER CERISE: I worry about the price and what a mandate will do there. So I would be interested in relooking at some of the considerations around guaranteeing best price.

COMMISSIONER GORDON: And how do you get there? What concerns me most there is that the way the Medicaid program works today is states administer it, they set the pricing and then CMS holds them accountable for access. And I just don't like blurring those lines where CMS is going to set the pricing and then all of the repercussions when you do that are just going to be borne by the states to have to deal with it. Fred, it's just a dynamic price. It's dynamic. And leaving that responsibility to the states, and the federal government holds them accountable for access is a model that works elsewhere and I think it's the appropriate way to handle it.

CHAIR BELLA: So we didn't spend as much time on number 2. Obviously, we didn't put as much time on any of them except for number 1. I would say, Chris and Amy, bring it back. We may spend a little bit more time on 2, but I would say, yes, bring them back. They may not all become recommendations. They may become more descriptive in the chapter. Is that fair, everyone? Fred, are you good with that? Okay. I can't see other heads. Bill? Everybody did. Bob is thumbing up. Laura's thumb is up.

Kisha, do you have any closing remarks?

COMMISSIONER DAVIS: I don't think so. Thank you for this. This was a robust discussion. More to come in April.

CHAIR BELLA: Okay. We're going to open it up to public comment now. If anyone joining us in the audience would like to make a comment, please use your hand icon. Please remember to introduce yourself and your organization, and limit your comments to three minutes or less please.

Nobody wants to wade into this with us today. Either that or they're super hungry or something. Oh good, we have a taker.

PUBLIC COMMENT

* MS. HUGHES: All right. Clarissa, you have been unmuted. You may make your comment.

[No response.]

MS. HUGHES: Clarissa has no audio icon. I'm concerned she can hear us but maybe doesn't have the mic to talk.

CHAIR BELLA: Okay, Clarissa. We may not be able to get to your comment in this forum but would encourage you to share your comment via email to comments@macpac.gov.

It looks like we don't have audio there, so again, for anyone, please email us, comments@macpac.gov. I don't see anyone else who is interested in making a comment.

Are there any final words from Commissioners or Anne?

[No response.]

CHAIR BELLA: No? Okay. Well, our next meeting is April 7th and 8th. We will be taking votes on many of the things we've talked about today. I want to thank the MACPAC staff and everybody behind the scenes, and thank Anne and thank the Commissioners for your engagement over the past two days. We'll look forward to literally seeing you in April.

And with that we are wrapped up for the March meeting. Thank you, everybody.

* [Whereupon, at 12:29 p.m., the meeting was adjourned.]