PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Thursday, December 8, 2022
10:01 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

AGENDA PAGE

P R O C E E D I N G S

[10:01 a.m.]

CHAIR BELLA: Welcome, everyone, to the December MACPAC meeting. We appreciate you all being here.

We are going to get started with our session on race and ethnicity data. Jerry and Linn, welcome. We'll turn it over to you. Thank you.

POSSIBLE RECOMMENDATIONS FOR IMPROVING MEDICAID RACE AND ETHNICITY DATA COLLECTION AND REPORTING

* MR. MI: Thanks, Melanie. Good morning, Commissioners.

The Commission is committed to prioritizing health equity across all of its work. During this work cycle, we've been examining opportunities to improve the completeness and quality of Medicaid race and ethnicity data.

In September, we provided background on race and ethnicity data collection and reporting standards and an overview of the challenges with these processes.

In October, we continued our discussion with findings from a literature review and federal, state, and stakeholder interviews.

Today we will describe the state Medicaid data collection and reporting process, opportunities for improvement, and two draft recommendations and the rationale.

The Commission is not voting on these two recommendations at this meeting, but we will use the meeting to refine the recommendations.

I'll start with some background on the data collection and reporting processes before handing it off to Linn. Linn will then describe data quality priorities, areas of improvement, and present possible recommendations and rationale.

So, moving on to the state data collection and reporting processes, state Medicaid programs collect race and ethnicity information on applications. These questions are optional as race and ethnicity information is not a requirement for Medicaid eligibility. Self-reported data is considered the best method and gold standard for collecting information that reflects and individual's identity.

States have flexibility to determine which race and ethnicity categories to collect on their applications.

While CMS provides states with the model application that aligns with the 2011 HHS guidance, many states develop their applications to account for state-specific priorities or integrate their applications with multiple benefit programs.

There are multiple factors in state design of race and ethnicity questions on the Medicaid application. These include relevant HHS and CMS guidance, the HHS model application, state requirements, and population priorities, and other benefit program requirements in states with integrated applications. Applicants provide self-reported information on the state's Medicaid applications. When individuals are completing the applications, they may receive assistance from state and county eligibility workers, application assisters, and navigators who can help them explain the purpose of race and ethnicity questions to the applicant.

States must report race and ethnicity data to the Transformed Medicaid Statistical Information System, or T-MSIS, that at minimum, align with the 1997 OMB standards. State eligibility in MMIS vary widely by state. Some states do a race and ethnicity data in a format that allows

for simple ones when matching between systems. Other states may not store data in consistent formats, requiring states to reformat and aggregate data during transfers between the eligibility system, MMIS and T-MSIS.

States are responsible for their eligibility and MMIS systems and contract with IT vendors to design and maintain these systems.

CMS provides states with technical assistance in the form of technical specifications and guidance on formatting and submitting race and ethnicity data to T-MSIS.

State Medicaid program eligibility data, such as race and ethnicity, are stored and transferred between multiple data systems before they are submitted to T-MSIS. First, applicants submit their application, and these data are stored in the state eligibility system. In some states, the eligibility system and MMIS are integrated, while in others they are separate, requiring an additional transfer of data from the eligibility system to the MMIS.

Next, states process the MMIS data so they are formatted correctly for submission to T-MSIS. CMS then cleans and repackages the raw submitted data into the

research-ready T-MSIS analytic files, TAF.

MACPAC staff have access to the raw T-MSIS data, while many health services, researchers, and stakeholders have access to the TAF.

I want to quickly note that states may supplement their application data with other data sources, such as managed care organization data, for their own internal analyses. However, these data never update or change the state's eligibility systems, MMIS, or the data they submit to T-MSIS.

Now I will hand it over to Linn.

* MX. JENNINGS: Thanks, Jerry.

All right. So, as we discussed in September and October, improving high-quality race and ethnicity data is an administration-wide priority, and collecting and reporting comparable, complete, and accurate data are important for measuring and understanding racial and ethnic disparities. So, in these next few slides, I'll discuss these three priorities.

So, to begin, in the most recent review of state Medicaid applications, all states collect and report race and ethnicity that at minimum align with OMB categories,

and so where there are high-quality data that align with these OMB categories, these are often comparable across states. However, states don't consistently collect more granular categories, such as those included in the 2011 HHS guidance, and this may limit comparability of those categories across states.

So, for the barriers to collecting comparable data, race and ethnicity data collection priorities may not always align with federal requirements, and this sometimes makes it difficult for states to aggregate the data in T-MSIS reporting format.

And then on the reporting side, similarly, the data are stored in the state eligibility system at MMIS, and they aren't always formatted in a way that aligns with T-MSIS. So some states struggle with the mapping and with multi-race and ethnicity selections and mapping that to T-MSIS. However, in conversations with experts in CMS, we have heard that through state-level efforts and CMS-provided technical assistance that these issues are becoming less common.

The CMS DQ Atlas assesses data completeness of TAF race and ethnicity data as the percentage of records

with non-missing values.

There are many barriers to collecting complete data, and these include concerns about how the information may be used, fear being denied coverage, and then lack of understanding of the race and ethnicity questions.

And then on the reporting side, similarly, state officials have shared difficulties with transferring race and ethnicity data from the eligibility system to MMIS, and this has affected, in some cases, the completeness of the data.

And the CMS DQ Atlas also assesses data accuracy of TAF race and ethnicity data as the number of combined categories where the TAF and the American Community Survey Medicaid populations differed by less than 10 percent. And so the barriers to collecting accurate data are similar to those with collecting complete data and include difficulties choosing a category if the options don't align with the individual's identity.

And then on the reporting side, as Jerry described previously, states collected race and ethnicity data to address state-specific needs, but those data fields in the eligibility system, the MMIS, and T-MSIS aren't

always aligned. So this has also sometimes impacted the state's ability to report accurate data.

Before moving on to the recommendations, I want to address some of the changes that we've made in our work since the October meeting. In October, we presented potential policy approaches for three potential recommendations based on our interviews that we conducted early in the summer in June and July. And one of the policy approaches was focused on improving TA states, specifically related to the mapping of race and ethnicity data and the values to meet the T-MSIS format.

And so following the October meeting, we had further discussions with CMS, reporting T-MSIS -- to T-MSIS and the technical assistance provided to states, and CMS indicated that it is possible to report multiple race and ethnicity values and share the technical specifications that have been provided to states on this process. CMS does also continue to provide technical assistance to states, and in May, CMS added race and ethnicity as a focus area. And then in August, later this summer, the agency added the -- or that they're tracking the reporting at multiple race and ethnicity values as a new priority item.

And so given this updated information, we no longer believe it's necessary or appropriate to include this recommendation on data reporting, and CMS is actively -- since they're actively working on addressing this, but this will be noted in the chapter and emphasizing that TAs continue -- or continues to be needed.

So the two draft recommendations we're presenting today reflect the Commission's discussion on approaches to address the challenges with collecting more complete and accurate data, and these recommendations direct HHS and CMS to improve the usability of race and ethnicity data as they consider approaches to improve the collection and reporting of these data across all data collection efforts.

So the first recommendation would direct the Secretary of HHS to update the model single, streamlined application, and HHS would also direct CMS to update guidance on how to implement these changes on the Secretary-approved application. Updating the model application, race and ethnicity questions, would help improve applicant understanding and comfort with providing the sensitive information, and making updates to the text provided with the question may increase applicant

understanding of the reason for collecting these data and how they might be used by the Medicaid program, and that the response doesn't affect their eligibility.

And updating the model application, state and state guidance for improved collection, the administration should use research-tested approaches that can be modified to fit state-specific needs, and these updates should also be coordinated with other administration efforts, including the anticipated revisions to the OMB minimum standards and other demographic data collection efforts.

HHS should also consider the implications of any of these changes to data collection on other -- on the federal health insurance exchange, which also uses the HHS model application.

The second recommendation would direct the Secretary of HHS and CMS to develop model training materials to be shared with state and county eligibility workers, application assistors, and navigators to ensure applicants receive consistent information about the purpose of the race and ethnicity questions.

Assistors are vital to the application process, and the Commissioners and stakeholders agreed that

providing state and county eligibility workers, application assistors, and navigators with the training to ask these applicants the race and ethnicity -- for race and ethnicity information is an important component in improving applicant response rates.

The training would improve assistor knowledge about why these questions are included and how the information may be used, and then also provides assistors with language to use when explaining these questions to the applicants.

In our interviews with states and assisters, we heard that they often don't receive training on asking these questions, and additionally, the CMS-provided, federally facilitated, marketplace assistor training doesn't include information on how to ask these questions.

So, to address these gaps, CMS should develop a training module that specifically addresses race and ethnicity questions, and then when developing the training, they should consider developing a customizable training module, drawing on evidence-based approaches, and provide states with TA to update their training for their state-specific needs.

If the Commission decides to move forward with these two recommendations, we'll return in January with refined recommendation language and draft-supporting chapter for Commissioner review in common. The draft chapter will draw upon previous sessions and discuss the challenges with collecting and reporting high-quality race and ethnicity data, approaches to improving the completeness and accuracy of these data, and rationale and implications for any Commission recommendations.

So it would be most helpful today to focus the discussion on the rationale and supporting evidence.

Thank you.

CHAIR BELLA: Thank you, Linn and Jerry.

Can we go to the slide with the first recommendation on it, please? Anybody have any general questions? Otherwise I think we'll just take these recommendations one at a time, starting with the first one.

Laura.

COMMISSIONER HERRERA SCOTT: So, on the TA to the states I can't remember if it came out of a focus group or a panel, but -- so are the states aware that the technical assistance exists? Like, how is that being communicated,

since we brought it up in October and now we're not going to move it forward, but just to make sure the states know what exists for them.

MX. JENNINGS: Yeah. So, in talking to CMS, they released a new kind of tool for states. That was released officially in February and has kind of been rolled out with states since, and they have many different priority items on that. So, depending on the state's needs, they look at different -- I guess different items on that priority list.

And so states, I think, especially with regards to race and ethnicity, is a new focus area. So I think states are becoming more and more aware of those priority items. And then CMS is helping them assess where they still have to improve their data. So it seems like it's an ongoing and new process with states.

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: So is it our understanding that CMS is going to issue new rules? Like, one of the -- two of the things that seem very clear from our research on this is that a combined race/ethnicity question is best and that there's still -- there's only a handful of states that are doing that, and that multiple race and ethnicity

categories are best. But there are a handful of states who aren't doing that.

Is there not a place for MACPAC to say we feel like this needs to happen, or is our general recommendation that the best standards be used? I guess I'm just trying -- there's a little disconnect for me in MACPAC's research that we've done. We feel like there needs to be best practices. Are we recommending that these -- are there certain best practices that we want to recommend should be mandated to states through this process, or is there not a space for us to engage in that?

MX. JENNINGS: I think the approach we've taken at this point is that there are best practices that Census released, and so putting that in as some of this evidence base that when the model application is updated, that should be used in deciding what those model updates are.

But the understanding I have is that we shouldn't be telling them which specific best practices, but they should be using the best evidence available, because our research is focused primarily on understanding kind of the barriers to collecting and understanding. States use many different processes that help improve response rates. So

there should be some flexibility, and we want to just -- we want to have the best practices out there.

COMMISSIONER GORDON: Yeah.

MR. MI: And I wanted to quickly add on the multiple race and ethnicity piece. So we started interviewing states in July 2022, and as Linn previously mentioned, CMS kind of rolled out their new outcomes-based assessments to a select few states starting in February, and in August -- and we started our interviews in July. And so starting August 2022, they started adding multiple race and ethnicity as a priority item.

And after states received that on their OBAs that having insufficient multiple race and ethnicity values is an issue, they have six months to actually act on it. And so I think the timeline does not perfectly align, and since it is an ongoing active CMS effort, I think it's probably a better idea to sort of just monitor how that is going and give them time to actually do the work.

CHAIR BELLA: So, Heidi, just to reinforce, I mean, we didn't spend the time researching what the best -- the evidence base are. I think that's why the language is very specific and the recommendation, though, to point to

the use of evidence base, but we wouldn't be the ones who have done that work to recommend what those would be.

Tricia, did you have a comment? No.

Darin?

COMMISSIONER GORDON: I think the recommendations are good, but one of the things that you brought up was about the transferring of the information to T-MSIS, some of the challenges there and consistencies. Neither the recommendations tend to address that. It's like you collect it, but we're not addressing the issue. Then that needs to then flow through the rest of that process and the transferring of the information as well. Is that something that we just don't have enough information of what the standard or expectation for CMS is on transferring that information, or is it something we feel CMS is going to address outside of our recommendations, anyway?

MR. MI: Yeah. So, really quickly, about that,-- so we don't have enough information to really make a recommendation on it, but also, when we were speaking with CMS, we heard that it's actually the state's role to coordinate with their IT vendors to make sure that the transition from eligibility system to MMIS to their

submission of T-MSIS is smooth. And so it's not actually CMS's role to ensure that -- you know, that the submissions themselves are like smooth from their system perspective, if that makes sense. It's more of a state role to speak with their -- and work with their IT vendors, if that answers your question.

CHAIR BELLA: I mean, at the end of the day, though, CMS has to be keeping an eye on everything the states are doing if we're -- so what I also think -- I do want to talk about these recommendations. I also want to say this is going to be something we're working on, right, many years, and so if there are things, you know, maybe that's something -- Darin, the question you just asked, maybe we put that on our list of let's keep an eye on some of these other things, if there's an opportunity for us to further explore those things later. I'm not saying that we necessarily have to, but I just want Commissioners and the public to know this is like the collection of data, and data transparency is a core theme for the Commission. And so these recommendations are a piece of that but not the only thing that we'll be doing in that vein.

Heidi?

COMMISSIONER ALLEN: So that really -- thank you for saying that, because my biggest concern with making a recommendation, that we update the model application, which is in my understanding is something that happens less than once a decade, is that we are not making a strong stand that we need to be collecting data on disability, sexual orientation, and gender identity.

And I understand that we haven't delved into that topic, and that there's a lot of questions about best practices, and we're not aware of what they are. But it really does make me -- as a sexual minority myself and who has suffered from lack of data collection everywhere, that we know there's disparities or we say we know there's disparities, but it's really hard to capture them because nobody collects the data.

And thinking about the vulnerability of the Medicaid population and how urgent it is to understand those disparities, if they're going to be updating this form for race and ethnicity but do not address sexual orientation, gender identity, disability, and language, we're just setting ourselves back of another decade of not having the information that we need.

Plus, there is numerous efforts around other federal data collection initiatives to collect that information that we should be aligned with.

So I would love to see it as part of our work plan that we are -- if we're talking about the model application, that we're thinking of it holistically, and we're thinking of all disparities, disparity populations, that we want to make sure that we're able to understand in this kind of window of opportunity that we might have to say what the next decades of data look like.

CHAIR BELLA: On that, Tricia? Because you got a couple people ahead of you, but go ahead.

COMMISSIONER BROOKS: I just wanted to ask the question, because I don't think there's anything that prohibits HHS from updating the model application, you know, frequently, right? So it's not like we're missing -- I totally agree with your comments, Heidi, but I don't necessarily think we have to wait another decade to see an additional update to the model application.

CHAIR BELLA: Thank you, Tricia.

COMMISSIONER BROOKS: I guess in the form of a question, is there anything that prohibits HHS from

updating the application more frequently?

MX. JENNINGS: I'll have to double-check on that, but I don't believe so. It hasn't been updated.

I guess just to address the SOGI and disability, since it is something that has come up in Commissioner discussions, part of our reason for starting with race and ethnicity was that there are federal standards and it is collected on the Medicaid application. The scope of our focus has really been to understand the barriers to collecting and improving the quality of the data that currently exist in T-MSIS, and with SOGI and disability, since those aren't collected on the Medicaid application -- and although there are validated measures for collecting those, there aren't federal standards. And so at this point -- and especially with SOGI not collected and a lot of administrative data and even on national surveys, there might be different barriers to collecting these data and different kind of work that we need to do to understand those data collection -- or those populations. So it is an area that we'll continue to look for opportunities to work on.

COMMISSIONER BROOKS: Okay.

CHAIR BELLA: Yeah. I think the way you framed it, Heidi, is the right way to think about can we make sure that we're including this as we detail out the future work in this area and we can keep track of as standards are developed and states start collecting.

COMMISSIONER ALLEN: Mm-hmm.

CHAIR BELLA: Okay. Sonja, then Kisha, then Dennis.

COMMISSIONER BJORK: Thank you. I wanted to support Heidi's comments on the issue and just mention that we -- in the spirit of our continued attention to this issue, we did receive a letter from Professor Sara Rosenbaum suggesting that we look into some of the standard claims forms, the UB-04 and the CMS 1450 and 1500, because they will soon be revised and updated. And it could be that there's an opportunity to add race and ethnicity in that form as a way to help in our efforts and our promotion of accurate and just more and better data collection on race and ethnicity. So I'm hoping that we can keep an eye on that or look into it and see if there's an opportunity for our Commission to weigh in.

And then, secondly, the exploration of other

resources, like, for example, HRSA, how all the federally qualified health centers do a lot of reporting to HRSA, and they see a great majority of the Medicaid beneficiaries. And so it could be another source, another good source of race and ethnicity data. Thank you.

CHAIR BELLA: Thanks, Sonja.

Kisha, I'm going to skip you for a second.

Bill, on this one?

COMMISSIONER SCANLON: Yes. I'm familiar with the idea of adding sort of other sources of information for race and ethnicity, and I have to underscore that I am absolutely committed to the idea that we must have valid, accurate, comprehensive race and ethnicity data, but I'm very concerned about how we go about that. Okay.

This discussion is something that I was a part of when I was a member of the National Committee on Vital Health Statistics, which advises the Secretary on HIPAA, and HIPAA is the -- I'll call it the vehicle for the approval of these standardized forms. And these forms are updated very infrequently, and part of the process is because it's a huge sort of undertaking.

Putting that aside, there's this question of,

okay, what is the sort of value of adding race and ethnicity to claims forms? And the issue is where are the gaps that we have now in terms of getting the kind of data that we want, and what you've talked about in terms of the model and the problems with the model, those are the problems that should be addressed. If we think about adding a new source, we have to ask ourselves about what's going to be the issues with that new source and asking every provider -- and we're talking well over a million different providers. And you talk about -- so this issue of lack of training, sort of lack of understanding, think about how that's compounded when you've got a million people submitting something.

So one of the concerns that I've always had is that fix the problem most efficiently, which is to go to the primary source, which is collection of information at enrollment, get it done right then, and you do not need to repeat it when you're going to end up with a lot of inconsistencies and a lot of data that you're going to have to think about how do I use this, how do I reconcile the differences, how do I make the most valid comments or most valid conclusions out of data that have problems.

So, again, I think the approach with these recommendations and the approach that CMS has right now is the right way to go.

CHAIR BELLA: Thank you, Bill.

Kisha and then Dennis.

VICE CHAIR DAVIS: Thanks, Bill. I really appreciate that comment, you know, do it right and do it right the first time, and that will save you in the long run.

I just wanted to put in strong support for both of these recommendations, recognizing that they may not go far enough, but this is part of the beginning of the work plan. And we've been talking about race and ethnicity data for quite a while. So really pushing to move this across the finish line and recognizing that, yes, there are still things -- there's still ongoing work that needs to happen around SOGI data and disability data, and we need to keep that moving forward. And I think addressing that in the chapter is something that needs to happen and there needs to be continued work on but want to make sure that we are not taking our foot off the gas for making this improvement on race and ethnicity data, while at the same time looking

for where are the next kind of level of improvements that have to happen.

CHAIR BELLA: Thank you, Kisha. Totally agree with you.

Dennis.

COMMISSIONER HEAPHY: I appreciate what Kisha and Bill said and also what Heidi is saying.

And I think for me, what dol I think is really important is that as you're strengthening the collection of race and ethnicity data, that it is being done in a manner that also ensures you're able to get -- capture intersectional data as we move along and better understand how we're going to collect disability and SOGI data. And so I think that has to be built into whatever data collection systems you're building for race and ethnicity. I don't know if that makes sense to the folks that just presented, but for me, unless we build out a platform that's going to make it possible to look at this data intersectionally, then we're not really going to do justice to folks from racial and ethnic, minority populations that have faced disparities frequently, that they're compounded by disability or SOGI status.

CHAIR BELLA: Thank you, Dennis.

Linn or Jerry, did you want to make a comment on that?

MX. JENNINGS: No. I think that will be something we kind of address in the rationale in the chapter, so thank you for raising that.

CHAIR BELLA: Thank you.

Martha?

COMMISSIONER CARTER: I want to first say that I'm in support of both recommendations.

And I want to add on to what Sonja said, that the community health centers have been also collecting SOGI data for several years now, many years, and so there are best practices that are at least emerging.

And one great resource is the Fenway Institute, the National LGBT Health Education Center in Boston. So there has been a lot of work. Like Sonja said, some of the health centers are very good at collecting all of these demographic data and some not so good. So there could be some lessons learned from those challenges.

I also want to question or pose a potential negative, especially around SOGI data and the potential

lack of protections around that information at this point, and I know we're going to go into this more, but just to raise the question, you know, the specter of how could these data be used in a negative way.

CHAIR BELLA: Thank you, Martha.

Okay. Any other comments on draft Recommendation 1 that need to be aired before this comes back to us in January?

[No response.]

CHAIR BELLA: Okay. Let's go to draft Recommendation 2. Any feedback on this recommendation that you would like to see addressed before it comes back in January?

Tricia.

COMMISSIONER BROOKS: Just a quickie. I think the rationale, when we talk about a training module, sounds singular versus training materials. So I would just like to see that be consistent.

The other comment I wanted to make is that at one point we did talk about putting forth a recommendation that CMS make this, you know, a really high priority, and I think we've come away with the understanding that it

absolutely is. But I'd like to make sure that any chapter or issue brief we do on this really emphasizes the importance of that in the future as well, because administrations do change their philosophy and ideology over time.

CHAIR BELLA: Thank you, Tricia. I believe the intent is to go into detail in that in the chapter. So we'll just ask that we make it strong that any administration would be prioritizing this. Thank you.

Other comments on this recommendation?

[No response.]

CHAIR BELLA: Okay. We are a little ahead of schedule. We'll go ahead and take public comment because I see a hand. We can open it up to public comment, please, and I'll just remind folks that do want to speak, please introduce yourself, your organization you're representing, and keep your comments to three minutes or less.

PUBLIC COMMENT

* [Pause.]

CHAIR BELLA: I promise you there was a hand. The hand is now gone. I'm not seeing things, although I do not see a hand.

We can go ahead and wrap up this session, Linn and Jerry, as long as you have what you need.

MX. JENNINGS: Yeah, I think we do. Thank you very much.

CHAIR BELLA: Okay. Thank you for this work, and as you can tell, there's great interest in having this be a longstanding part of our work with opportunities for addressing multiple things in the future. Thank you.

All right. We will go ahead and move into the next session. We're going to talk about nursing facility payment principles and possible recommendations to bring back to us in January. So, Rob and Drew, welcome.

POTENTIAL NURSING FACILITY PAYMENT PRINCIPLES AND RECOMMENDATIONS

* MR. GERBER: Good morning, everyone. Today Rob and I will be presenting potential nursing facility payment principles and recommendations. To begin today I'll walk through an outline of our nursing facility payment chapter for this report cycle, and I will also review the payment principles that we introduced back in the September meeting, touching on economy, quality, and access, before turning it over to Rob to discuss how these ideas come

together in the idea of efficiency.

These principles lead into our two potential recommendations, one on data transparency and another regarding state rate reviews. Rob will also note other policies we considered in making these recommendations before ending with our next steps going forward.

Over the past three years, the Commission has conducted a number of analyses of nursing facility payment, ranging from a compendium of state fee-for-service payment methods to analyses of staffing and Medicaid payment rates relative to costs. This body of work will culminate in a report chapter that synthesizes these findings and outlines policy principles for states to consider when setting nursing facility rates and payment methods.

We anticipate the chapter to begin with the necessary context for understanding Medicaid nursing facility payment, including the characteristics of facilities and their residents, Medicaid's role compared to other payers, and broader industry trends such as closures in rural areas and the effects of the COVID-19 pandemic. Then we plan to segue into discussion of payment principles before ending with recommendations.

Economy, as we introduced back in September, we have been viewing this as a measure of what providers are paid.

To appropriately analyze Medicaid nursing facility payment policy we require data on all types of payments that facilities receive. Nursing facilities received base rate payments in both fee-for-service and managed care, while some facilities may also receive lump sum supplemental payments. Notably, residents themselves contribute a significant amount toward their share of cost as part of the base payment.

To better understand the net payments providers receive it is also important to consider provider contributions to the non-federal share. These are often funded through provider taxes, intergovernmental transfers, or certified public expenditures.

As you can see in this pie chart, in 2019 the majority of payments received by nursing facilities were fee-for-service base rates paid by the state Medicaid agency, while about a third of payments came through managed care. Nearly 10 percent of the base rate payments received by providers were paid by the residents

themselves, while supplemental payments made up an additional 5 percent of total Medicaid payments.

Costs are one of the few benchmarks that can be used to assess Medicaid payment rates because Medicare rates are not comparable, since they are for different services for residents with different needs. However, costs are an imperfect measure of payment adequacy. For example, costs reported by a facility may be too low if they do not have enough staff to provide the appropriate level of care for their residents, whereas costs may be too high because of related party transactions that inflate them.

Historically, Medicaid nursing facility payments were required to cover the costs of efficient and economically operated facilities. Known as the Boren Amendment, this requirement was repealed in 1996, and replaced with a requirement for a public process to determine rates. However, Section 1902(a)(30)(A) of the Social Security Act still requires payments to be consistent with the principles of economy, efficiency, quality, and access.

Looking at quality and access or what can be

considered measures of what is obtained as a result of the provider payments. In our work we focused on nursing facility staffing levels as a measure of quality and access where Medicaid payment policy may have the most influence. Higher direct care staffing hours per resident day has long been associated with better outcomes for patients, and the pandemic has exposed and exacerbated the staffing challenges that we see in our 2019 data.

States have a variety of tools they can use to improve staffing, such as increasing payment rates, incentivizing facilities to spend more of their revenue on staff, or setting minimum staffing standards that exceed the federal requirements. Currently, the Centers for Medicare and Medicare Services is conducting a staffing study that will inform a proposed rule which will look to increase federal minimum staffing standards.

High Medicaid facilities have worse staffing rates, as have seen in our analyses, which contributes to health disparities. As you can see on the right side, in the two right columns, the third quartile and highest quartile, facilities with the highest shares of residents whose primary support was Medicaid, these facilities were

more likely to be poorly staffed, and they were also more likely to have a greater share of Black and Hispanic residents than facilities with the lowest share of Medicaid-covered residents, which you see on the left side of the table.

Some potential principles for using Medicaid payment policy to address staffing disparities, the relationship we saw in the previous table indicates that Medicaid payment policy may be positioned to address these disparities, and statutory languages provides some potential principles.

Staffing rates in facilities that serve a high share of Medicaid-covered residents should be no worse than staffing rates in other facilities in the same area, which aligns with Section 1902(a)(30)(A). Although other non-Medicaid factors play a role in staffing rates, Medicaid policy can help reduce these disparities by payer mix.

Medicaid-covered residents should also have access to sufficient staff to meet their care needs. CMS is planning to reassess this requirement as part of revising the federal minimum staffing standards. In the proposed chapter, we do not plan to say what that minimum

standard should be, but we can address the potential implications of changes to federal standards and the unique needs of Medicaid-covered residents in the chapter.

I now will turn it over to Rob to bring these principles together.

* MR. NELB: Great. So thanks, Drew. Now we will look at the last statutory goal, efficiency, which we define as a measure of what is spent relative to what is obtained.

Overall, the work we've been doing over the past several years I think has illustrated some potential ways to improve efficiency. In particular, we've identified some states that appear to have relatively high payment rates but low staffing levels, and in those states it may be possible to change payment methods to better incentivize facilities in those states to spend more of their revenue on direct care staff, which would help improve efficiency. However, more detailed state-level analyses are needed to identify the best approaches for each state.

So in the chapter we plan to highlight some examples of recent state reforms that might be a good model for other states to follow. For example, we plan to

highlight some recent reforms in Illinois, which came after sort of a multiyear review that the state did of its payment policies when it was changing its acuity adjustment system. Through that review, the state identified ways to help reduce unnecessary costs as well as direct more payments to direct care workers to help improve staff retention.

Because most Medicare-covered nursing facility residents are dually eligible for Medicare and Medicaid, better alignment between these programs also has the potential to help improve efficiency. In the chapter we plan to highlight our past work on Medicare's acuity adjustment system in order to discuss the importance of considering Medicaid implications of any changes to Medicare policy. We also plan to highlight recent value-based payment efforts at CMMI and discuss some of the challenges and opportunities for better aligning Medicare and Medicaid payment incentives for this population.

All right. So in order to help advance some of these payment principles we have identified two potential recommendations for the Commission to consider. The first relates to transparency, and it reads as follows:

To improve transparency of Medicaid spending, the Secretary of HHS should collect and report facility-level data on all types of Medicaid payments for all nursing facilities that receive them, including resident contributions to their cost of care, in a standard format that enables analyses. In addition, HHS should collect and report data on the sources of non-federal share necessary to determine net Medicaid payment at the facility level.

This proposed recommendation is similar to MACPAC's prior recommendations for the transparency of hospital payments and it reflects the Commission's longstanding view that complete data on all Medicaid payments to providers are needed to inform assessments of Medicaid payment policies.

Recently Congress did pass legislation to require states to report more provider-level supplemental payment data, but there hasn't yet been action on some other aspects of the recommendation so there is still a need for greater transparency.

One of the main differences between this recommendation and our prior hospital payment one is the fact that we are highlighting the importance of complete

data on resident contributions to the cost of care, which are unique for Medicaid long-term services and supports because of post-eligibility treatment of income rules.

As Drew mentioned, in our recent analyses of nursing facility payment rates, we found that these contributions were substantial, accounting for almost 10 percent of base payments. But we also found that available data on these contributions was incomplete, especially for managed care payments to providers.

Our analyses also found several limitations with available data on supplemental payments. Although the quality of these data may improve with that recent legislation, we still thought it was important to include supplemental payments in our recommendation in order to underscore the importance of collecting data on all Medicaid payments to providers.

And finally I just want to point out the importance of collecting data on the sources of non-federal share in order to calculate net payments, because as Drew mentioned, provider taxes and other provider contributions are very common for nursing facilities.

It is important to note that CMS currently

doesn't have a process in place to collect these data, and so this aspect of the recommendation would likely have the highest administrative burden.

Overall, we do expect some increased administrative effort as a result of the recommendation, but the hope is that the increased transparency would be worth it because it would help enable more stakeholders to know what providers are being paid, which would enable more public engagement during the rate-setting process.

Our second draft recommendation is also long, and it relates to rate studies. It reads as follows:

To help inform assessments of whether Medicaid nursing facility payments are consistent with statutory goals, the Secretary of HHS should update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents and quality outcomes. HHS should provide analytic support and technical assistance to help states complete these analyses, including guidance on how states can accurately identify the costs of efficient and economically operated facilities with adequate staff to meet residents' care needs. States and HHS should make

facility-level findings publicly available in a format that enables analysis.

This proposed recommendation builds off of an existing regulatory requirement that states make an annual finding that fee-for-service nursing facility rates are reasonable and adequate to meet the costs of efficiently and economically operated providers, which was first put in place after the Boren amendment.

Although CMS has not reviewed state rate studies since the repeal of the Boren amendment, CMS officials did confirm that this regulation is still technically a state requirement. And although providers can no longer sue to enforce payment requirements, rate studies are still an important tool for informing public engagement in the rate-setting process.

And, of course, as Drew mentioned, the public engagement process is what ended up replacing the Boren amendment in the '90s.

The current regulation is only limited to fee-for-service rates, but when updating the regulation CMS would have an opportunity to consider whether similar requirements should also apply to managed care payments,

since many states currently cover nursing facility services through managed care.

In addition, the current regulations only discuss the requirements to compare nursing facility payments to cost, but our proposed recommendation also highlights the importance of looking at how payments relate to quality outcomes, which would include health disparities.

Although it is possible to do some analyses of Medicaid payment rates nationally, like we recently tried to do, the recommendation calls for state-level analyses because they would allow for more accurate assessments of payment rates, given the incomplete data available at the federal level and also state-specific differences in their policies. However, the recommendation also calls for the federal government to play an active role in helping to support states in this effort by providing more guidance and technical assistance.

In terms of implications, we see, sort of similar to the first recommendation, there would be increased administrative effort but hopefully a benefit of greater transparency, enabling more stakeholders to participate in the rate development process.

Finally, I just want to close the loop on some policy ideas that we discussed at the September meeting, but that we decided after further review we don't have quite enough information to make specific recommendations.

First, we had heard from our technical expert panel an interest in updating federal staffing studies, but given the fact that CMS currently has a staffing study underway it didn't seem like this recommendation was necessary at this time.

And second, Commissioners had expressed interest in encouraging more support for nursing facility payment demonstrations, and in the chapter we do plan to talk about some of the recent CMMI demonstrations. However, given the mixed results of those demonstrations and the fact that we haven't articulated sort of a new model for CMS to test, it didn't seem like we were ready for a specific recommendation in this area at this time.

All right. So that concludes our presentation for today. We welcome your feedback and plan to incorporate it in the draft chapter. And then, of course, we will return with the draft chapter and any recommendations you'd like to pursue for a vote at a future

meeting.

To help guide your conversation today here is a sort of more condensed summary of the two recommendations, for your consideration.

CHAIR BELLA: I very much appreciate this slide. Thank you. Thank you both for the presentation. Bill.

COMMISSIONER SCANLON: Yes, and let me start by saying what an incredible job you've done in terms of a subject that's not very often looked at, and even more frequently less understood. You've laid out sort of the right kind of framework for us to be thinking about this problem, and that is a major contribution on its own. Historically, confusion about this issue caused a lot of difficulties and continues -- I shouldn't say historically -- continues today.

I'd like to focus on the recommendations, and I'm going to advocate for the first recommendation being expanded. The National Academy of Medicine issued recommendations in a report earlier this year that was very strong about the need for transparency, total financial transparency. And that involves not just the revenues, which are critical, but also the costs that homes and

facilities incur.

In some respects it is almost like the web of costs. It's not just sort of the costs that might be reported on facility, a facility cost report, but it's the costs that are involved in organizations that are related to that facility. It could be other facilities. It could be companies supplying services. There is a range of different entities that may be involved.

Having complete information is very critical, because you have raised the issue of related transactions as one of the concerns about the good use of Medicaid dollars. We need to know what's happening to those Medicaid dollars, and that sort of is going to require that we have complete information on the cost side of the equation.

It is going to be a big lift. There is no question about that, because each state now has their own cost recording requirements, and they are focused, I would say probably universally, on the facility, not on the organizations that may be involved with the facility.

At the same time, this is a very dire situation. The COVID disaster in nursing facilities was catastrophic,

but quality problems in nursing homes didn't start with COVID and they are not going to end when we have control over COVID unless we address some of the underlying issues. And adequacy of payment is one of those that we have to make sure has been handled as part of the process of assuring quality in nursing facilities. So I think that we have to be willing to make the investment to actually get the kind of change in care that residents deserve in nursing facilities.

I will also make an argument that doing a better job or a more complete job with respect to Recommendation 1 will help with Recommendation 2. There is no doubt in my mind that there needs to be incredible input from CMS to the states to help guide them in terms of how do you do Recommendation 2, how do you do it in a way that protects your interests, namely the states, as well as does it right in terms of actually assessing adequacy in the appropriate manner.

When the Boren amendment existed, I was involved in a number of the cases and I worked with states. States often, in my small sample, probably under 10, they would get in trouble because they would not have interpreted the

requirements in the appropriate way, in something they had done and they had to backtrack. We need to help the states not be in situations like that as they try to think about what we can do with respect to Recommendation 2.

I'm going to put out an idea here that existed when the Boren amendment was still in force, that states were, at that point, proposing, which was that there be safe harbors, that if a state's payment system was doing things in a certain way that that was considered to be in compliance with the Boren amendment. I think it would be good for CMS to be thinking about what are good practices that you can tell a state, "If you do this, we know you are going to be in compliance with Section 1902." Because otherwise it becomes a question of a complicated analysis, with lots of areas for potential judgment, and the difficult process of decision-making as to whether or not compliance has been achieved.

So again, I think this is not going to be an easy process or a quick process, but it is an essential process, and we really need to be thinking about how we improve things in this area.

Thank you very much again for what you've done in

terms of illuminating what should have been illuminated long ago on this topic.

CHAIR BELLA: Bill, just to be sure we're crystal clear, can you restate exactly what you want to see in number 1?

COMMISSIONER SCANLON: In Recommendation 1? In Recommendation 1 it would be to improve the transparency of nursing facility -- let me think of the right word here -- finances, I mean, both revenue and costs.

CHAIR BELLA: What you're wanting is to be more specific on the cost side.

COMMISSIONER SCANLON: Yeah, and to be more articulate about it, I would suggest you go to the National Academy of Medicine report and find some of the language that they used in terms of what should be included.

CHAIR BELLA: Thank you. Do you have a comment, Rob?

MR. NELB: Yeah. We welcome Commissioners' thoughts on modifying this recommendation and are certainly open to different options here.

I guess a couple of things to note. The National Academy's recommendation was sort of a change to Medicare

cost reports, which do collect data nationally on different facilities.

I guess there's sort of a question, like we can't make a Medicare recommendation. I don't know if we can make the Medicare cost report recommendation or how that would work, or maybe we phrase it in a way that doesn't say you have to use Medicare cost reports but you could. So there are some questions there.

And then I guess, Bill, you talked about wanting to go sort of beyond the facility level, about the larger change. So far, this recommendation is more focused on the facility level, but we talk about wanting it in a format that enables analyses. So I guess some of the hope is that as some of the more new data coming down the pike on chain ownership and some of those related parties comes, that you could connect whatever facility-level information you get from Medicaid with that to understand it. But the devil is in the details, I guess, with some of these things.

COMMISSIONER SCANLON: There's no question about that, and we can put the programs aside here.

And I think we can put the programs aside sort of here. We're talking, I think, about the need for data on

the finances of facilities, and the Medicare cost reports are designed in a way that you can identify and, in some respects, isolate the costs that apply to Medicare. That doesn't mean that the cost report itself doesn't have more information.

The idea here would be that you have a cost report that a state could use to identify the information required for its Medicaid purposes, but there also might be other information.

One of the things you don't want to do -- and this is a problem that occurs repeatedly in terms of when we are seeking accountability in health care. Someone on the payer side will say you have to tell me this -- this is to the provider -- you have to tell me this, you have to tell me this. The providers then deal with multiple requests. They would be much better off if there was, in some respects, a standard sort of form, I'll call it, that all payers could use then and get the information that they need. It applies here in the cost side. It also applies on the quality side.

We do not need quality information on patients with diabetes with different -- I'm blanking on that -- A1C

levels at different levels, and give us the data on their measures and on their measured results, and we'll then add them up. Okay. If I'm a provider that -- I'm sorry -- a payer that requires or wants somewhat different information.

Standardization can be very helpful as long as there's enough detail in what's standardized, and it will be simpler for providers. It will be much more effective in terms of payers. So that's where I'm think I'm headed.

CHAIR BELLA: Thank you, Bill. We will come back to Bill's suggestion on the Recommendation 1.

But I'm going to go to Fred.

COMMISSIONER CERISE: Thanks for the report. I agree with Bill. It's a great overview.

Just to follow up, first off, I'm in support of the recommendations. In order to understand what the costs are, I agree you have to -- or what the -- how the cost compares to the revenue, you've got to have the full assessment of what the sources of revenue are, and so including base, the supplementals, so what the resident contributes, and then, also, as you've mentioned, understanding the non-federal share, because that's going

to discount what a number of these nursing homes are paid. And you want to get a full and accurate picture, and it's the same story we've said with other provider groups as well. Without that, you really can't understand what the financial situation is.

Because of that and because that's so difficult to get at and while that's happening, the staffing standards seems like -- I mean, I know that's not a recommendation, but that's a more straightforward thing to look at. So I think the attention to that is well placed. Well, that's a more direct way to try to get at better outcomes and setting some minimal staffing standards.

But back to the cost, you mentioned that the states all have a different definition of what allowable costs are, and I'm wondering how difficult it is to impose, like we do in other programs, to say these are allowable, these are not allowable, and to try to get at the teasing apart what the related party transactions are, the rent for the facility, the overhead for the parent organization, those sort of things that that are used to inflate costs. Can you get at a standardized, you know, under definition of what is an allowable cost?

MR. NELB: Sure. It's complicated, and there have been proposals to try to standardize definitions. But, as we know, many states do pay according to costs. So, if you require states to use a certain cost definition, that's requiring them to pay according to a specific method, which Medicaid historically doesn't do.

Just maybe as an example, where it gets more complicated are things like the real estate costs, and so like on a Medicare cost report, the facility, you count like the depreciation, whereas a lot of states use fair market value to think about how much that property sort of is worth. So there are fundamentally different methods, and so some states use one. Some do the other.

I suppose there could be a way in terms of better reporting that maybe -- you know, currently on Medicare cost report, there's that fixed amount that's there, and that could be made available in a way that doesn't require states to necessarily use that method in their payment rate. But that's where -- just an example of somewhere some efforts at standardizing, I think, are helpful for comparing or cost facilities, but that may affect state's ability to make certain policy judgements of how they want

to pay for particular things.

And then there are other, more nuances, I guess, with some of the staff about like what is -- yeah, just accounts for Medicaid versus accounts for other payers. And we think about some of the therapy services or whatever that are not -- that are typically paid for by Medicare for a dual-eligible patient, and so just some tricky accounting, I guess, to sort of figure out. You know, you have -- you're paying -- the facility is paying for a certain staff, but then figuring out whether that staff person is Medicaid, whether it's a Medicaid cost or whether it's a cost of another payer, is tricky.

Sorry. I don't have the answer, but hopefully, that illustrates some of the questions that might come up.

COMMISSIONER CERISE: Yeah. I guess the concern is, you know, the states will get pressured to include certain things, and when 50 states are getting different inputs, it becomes difficult for -- you can see how you can end up with big variation, because depending on who has more influence on what states, right?

And then my last comment just around CMMI, realizing that we may have seen mixed results, I would

still encourage those demonstrations, because you can imagine staffing models that go beyond what the nursing ratios are to include other providers that go beyond nursing that may have an impact on overall cost. If you've got nurse practitioners or physicians that are there or on call, that can limit transfers back and forth to hospital, things like that. I think there are other sort of global models that don't -- that I haven't -- at least didn't see in that writeup that could be -- provide good information.

COMMISSIONER SCANLON: I just thought it might be helpful if we added another term to the conversation, which would be "reported costs" versus "allowable costs," because I have dealt with states that where you reported a cost, but it wasn't all allowable. And then I think the idea would be if we had some uniformity and reported costs, that would be a benefit, and the states would be totally free to apply whatever rules they had or requirements they have in terms of what's going to be allowable.

I would think there's no need in this process to be thinking about how one might restrict what latitude is in terms of setting allowable cost.

CHAIR BELLA: Thank you, Bill.

Other comments?

[No response.]

CHAIR BELLA: Okay. Let's just go to the recommendations directly. Is anyone not in support of moving forward with the recommendations? And then we'll talk about possibly expanding Recommendation 1.

Martha?

COMMISSIONER CARTER: I'd like to see an expanded version -- and Bill can help wordsmith it -- because I agree in with your concept. I don't know what words. So I'm not in support of the recommendation as it stands. I think it needs to be expanded.

CHAIR BELLA: Okay. But you are supportive of moving forward --

COMMISSIONER CARTER: Of the concept, yes. Yes, definitely.

CHAIR BELLA: Okay. I think I understand conceptually what an expanded Recommendation 1 looks like. I don't know if operation -- like I feel like there's something I'm missing about what the barriers to expanding might be.

MR. NELB: Yeah. I mean, I think we can back --

maybe it helps to look at the full version, but basically, I guess we could add sort of a second or a third sentence, right? So, in addition, should collect data on non-federal share and then should collect data on costs, right? And then I suppose we just -- in the rationale, we could maybe talk about there's a variety of ways you could do that, including Medicare cost reports, but we're not recommending a change to Medicare cost reports.

And then we could -- Bill, I think you make a good point. The distinction that the requirement to report costs would not affect state's ability to set their own allowable costs. So maybe that could --

COMMISSIONER SCANLON: I think that would be helpful, and I think it's also very important in the chapter to underscore how much we expect that CMS is going to need to do to help the states sort of in this process. And if a standardized cost report is something that CMS can develop that states can use, that's fine. Whether there's any limitations that should be imposed upon whether states don't use that cost report, that's another issue. I think not having that standardized cost report now, not knowing how it might compare to what states are doing, I think that

would be premature to make a recommendation like that.

But I think we have to understand ¬¬the -- we're moving in the right direction. We don't have all the specifics at this point, but I think we do need the information on both sides of the equation, both the revenue and the cost.

MR. NELB: And then maybe just one other point, it does sound like, Bill, you're -- everything else in this recommendation is talking about at the facility level, right? That's sort of been our unit of analysis, but perhaps when we say we -- you know, HHS should collect data at the facility level and for all related parties or something that can be --

COMMISSIONER SCANLON: That's correct. That's essential.

MR. NELB: Yeah.

COMMISSIONER SCANLON: We've too much evidence that that's very critical.

MR. NELB: Right. Yeah. We have -- okay. So that's helpful to wordsmith.

CHAIR BELLA: Dennis?

COMMISSIONER HEAPHY: Thank you. This is really

interesting. I'm reading what you guys put forward as well.

I'm just wondering. Maybe this is too simplistic, but where in this does this lead to improved quality in terms of the recommendations? I support the recommendations as you put them forward. But maybe, Bill, if you can answer that question for me. I'm looking for the lead -- to lead to quality or define quality somewhere in here, because we're focused on cost. And I think we talked about it last time, and type of ownership and related parties is really important data that we don't have right now. But, for me, I'm just wondering about where quality would come in. Would that be in the chapter itself? For me, that's a piece of this that's just not present, especially given all the deaths that happened on COVID. I keep thinking, okay, this is really important. We need to get to the bottom of this, but how is this going to improve the quality of the lives of people -- of nursing home residents? And yeah. Does that make sense?

MR. NELB: Definitely. Currently, we mention quality outcomes in the draft Recommendation 2. The idea was you'd use that information you have about payment rates

and then compare it to quality outcomes.

COMMISSIONER HEAPHY: Right.

MR. NELB: But we're open to ways. If want to change it here or have certain points, we should better emphasize in the rationale.

COMMISSIONER HEAPHY: And I did see that, and that's my question, I guess, for Bill and both of you. Should that go in the recommendations or just go the chapter? I don't know. I'm just throwing that question out there.

CHAIR BELLA: Bill and then Heidi.

COMMISSIONER SCANLON: Dennis, I would argue that this is -- having adequate payment is a necessary condition for assuring sort of quality of care but definitely not a sufficient condition. And I don't know how much we want to go into this into the chapter, but there's the issue of sort of oversight.

CMS through the star ratings were trying to have information and competition play a role in terms of assuring quality.

We have quality problems that are not going to be addressed just by looking at the payment. We have to look

at these other elements as well, and that may be a subject of a future MACPAC report. It's not the work that we are doing here at the moment, but this work is important. And we should acknowledge in the chapter that it's not the end.

CHAIR BELLA: Thank you, Bill.

Heidi?

COMMISSIONER ALLEN: I'm wondering if we could put that more explicitly in the Recommendation 2, where we say "consistent with statutory goals to ensure quality" and eliminate disparities by payer type. I think that trying to articulate the parts of the statutory goals that this information would allow us to do explicitly might end up being the next stage for saying, okay, we have this information, we're going to use it to do these things.

I hear what you're saying, Bill, about necessary but not sufficient. But we can at least be explicit about the fact that it is necessary in our recommendation.

CHAIR BELLA: Laura.

COMMISSIONER HERRERA SCOTT: So this was -- I was going to ask the question earlier, but Dennis kind of teed it up now. So thinking about the table that you had that showed that the lower-star facilities had Medicaid, the

payer mix was leaning more towards Medicaid, I mean, do we know at least for those one to two stars, what they were missing from a quality perspective? And that we could -- back to Dennis's point about quality, where are we today as we think about the additional information, what we might learn by having the cost data as well?

MR. NELB: Yeah. So those were just focusing on the one- or two-star staffing ratings.

COMMISSIONER HERRERA SCOTT: Oh, staffing.

MR. NELB: They also -- you know, high Medicaid facilities also tend to have lower quality ratings as well.

But the idea, I think we found -- you know, there's a link in the literature between if you improve staffing, hopefully that would lead to improve quality. There's other things as well, so that difference there.

And I guess where it comes in with this recommendation is sort of looking at, you know, whether the rate is sufficient to allow the facility to staff at whatever the recommended level is, it's sort of a, you know, necessary but not sufficient step to helping improve the staffing at those facilities.

And to Heidi's point, you can think about

disparities in different ways about just sort of making sure people get the level of care they need, but the idea was that of all the various things Medicaid payment could maybe be most effective at reducing the disparity of -- you know, if Medicaid payment is sufficient, then perhaps high-Medicaid facilities would no longer have such worse outcomes compared to other facilities in the state.

COMMISSIONER HERRERA SCOTT: I guess I'm thinking about it a little too granular. So I'm also thinking about the bed type. So, if I think about the payer mix that you had, fee-for-service versus managed care, I'm thinking institutional versus acute rehab or some acute setting, and at the very least, could we start thinking about that? Is the staffing ratio related to the institutional care versus the acute care and thinking on the acute side readmissions, things like that? So that maybe I'm getting too much in the weeds, but that's how I was trying to define the quality issue, because there is a difference, right? And the acuity and the quality of that care, how are we doing there? But then, certainly, on the institutional setting, as we saw with COVID, what are the long-term implications for that as well?

So I don't know if that needs to be differentiated based on the -- at least on the pie chart you provided on the payer mix. I mean, it's all Medicaid, but MCO versus fee-for-service, et cetera.

MR. NELB: Yeah. We can take that back and look at that.

I do want to note the star ratings are adjusted for acuity, but there is, I think, a valid point to note that, you know, residents who are long-stay at a nursing facility have different care needs than short-stay patients. And so this is where some of the new staffing studies and things could help.

And I guess in terms of thinking about what an appropriate benchmark or target for -- you know, in terms of reducing disparities, you know, it may be best to focus on comparing high Medicaid, long-stay populations with maybe a private pay, you know, facilities that have more of that but long-stay versus comparing it to short-stay facilities, which are more covered by Medicare, so--

COMMISSIONER HERRERA SCOTT: Right, exactly. That's where I'm going, because you're not going to see long-term institutional by care commercial necessarily. So

is it apples to apples?

MR. NELB: Yeah.

COMMISSIONER HERRERA SCOTT: Okay. Thank you.

CHAIR BELLA: Jenny.

COMMISSIONER GERSTORFF: So I have a couple of comments. One, it explicitly says Medicaid payments here in Recommendation 1, and I think that collecting the non-Medicaid payments as well, it doesn't have to be by payer but in aggregate is useful to understanding the Medicaid situation.

And then you said the hope for asking for a format that enables analyses is that we'd be able to connect different things, but I just think that's very important, and we may want to be more explicit about that analysis, being able to connect these reports with quality measures, with cost reports and that sort of thing.

CHAIR BELLA: That makes sense to me to look at that for the other sources, not just Medicaid. Do you have a thought on that?

MR. NELB: Well, I guess we want to point out that on Medicare costs, we do have data on total revenue for the facilities and their margins. So we thought that

the biggest gap was the Medicaid payment, and that's where we've been focusing.

In terms of that aggregate look at facilities, I think we sort of have it, but the point, I think, when we talk about connecting with other data sources, it's sort of making sure that everything is reported based on that Medicare cost report number, that then we can link to that source to understand the overall finances, that we can link with nursing home, compare, and then these other future databases once they come out about chain ownership and things.

COMMISSIONER GERSTORFF: Yeah. And I was just thinking reconciliation and validation. So, if you have the total revenue in this report and then you connect it to the cost reports, that's kind of another validation step. And you don't necessarily have to connect them to have the information for analysis, which can be a barrier, collecting multiple sources of information and connecting them, so just easier analysis that way.

CHAIR BELLA: Okay. There are several things to take back. I think the biggest one is that our recommendation focuses the expansion of number one for the

cost aspect and the related parties.

And then we can -- if you could take a look at Heidi's comment about further elaborating on the statutory goals, to try to at least signal the importance of quality and our other principles, access all those things. That would be really helpful.

In addition, we didn't talk about it much. It was referenced in the work, but I do want to keep top of mind that for duals, there are a million duals in nursing homes at any given time. And so we may not be ready to recommend any payment models to CMMI but sort of keeping that population and some payment enhancements, building on what's been done on the past, I think is something that we should have -- it can be on a parking lot, but let's not totally lose that we want to revisit that periodically to see if there's opportunities to try to advance in that arena for that population in particular.

Okay. Any last comments?

[No response.]

CHAIR BELLA: Do you guys need anything else from us?

[No response.]

CHAIR BELLA: You have more than enough to -- okay.

So you'll bring this back in January. We'll take a look at the revised recommendation, and we'll tee it up for a vote. Is that right? Yep.

Okay. Thank you very much. Great work.

All right. So we will move into our last session before lunch, which is our annual analysis of DSH. Like magic, there's Aaron.

[Pause.]

CHAIR BELLA: You know this is what we wait for every December. I know. I know. Welcome, both of you. We'll turn it to you to get us started.

REQUIRED ANNUAL ANALYSIS OF DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS

* MR. MI: Thanks, Melanie.

Today Aaron and I will be presenting our statutorily required analysis of disproportionate share hospital, or DSH allotments.

As a reminder, we do this analysis every year as part of our statutory mandate, and this work is separate from Rob and Aaron's work on structuring DSH allotments

during economic crises. They will be returning with that work in a future meeting.

So I'll start with a little bit of background on DSH policy and then move to our statutorily required analyses, which look at the relationship of federal DSH allotments and three measures of need.

I will present on the rates and levels of the uninsured, and before handing it off to Aaron, to present the amounts and sources of uncompensated care within each state and the number of hospitals with high levels of uncompensated care that provide essential community service.

Aaron will then discuss the upcoming DSH allotment reductions beginning next October and end by summarizing the key chapter points and next steps.

I just wanted to note that this current report, which will be published in 2023, is the penultimate DSH report required by Congress. We welcome both comments on this report as well as any additional analyses that you may like to see for the 2024 report.

So some background on DSH. As a reminder, under the Medicaid statute, states are required to make

supplemental payments to hospitals that treat a high proportion of Medicaid and low-income patients. These supplemental payments are known as disproportionate share hospital, or DSH payments.

DSH payments are limited by state DSH allotments, which vary widely by state. Allotments for these payments are based on DSH spending in 1992 and adjusted for inflation. During the COVID-19 PHE, ARPA increased federal DSH allotments through an enhanced federal medical assistance percentage for DSH payments. States have a wide latitude to distribute DSH payments to virtually any hospital in the state, but total DSH payments to a hospital cannot exceed certain types of uncompensated care that the hospital provides.

The federal DSH allotment reductions are scheduled to begin in fiscal year 2024, which starts on October 1st of 2023. This year's DSH report will be the last one before these reductions are scheduled to begin.

And now to move on to our statutorily required analyses. According to the Census Bureau, 27 million people, or 8.3 percent of the United States population, were uninsured in 2021, a significant decrease of 0.3

percentage points from 2020.

The uninsured rate in 2021 was highest in adults below age 65, individuals of Hispanic origin, individuals with incomes below the federal poverty level, and individuals in states that have not expanded Medicaid.

As part of the PHE, CMS implemented a continuous coverage requirement, which prohibited states from disenrolling Medicaid beneficiaries, thereby decreasing the uninsured rate.

HHS has estimated that approximately 15 million Medicaid beneficiaries, including 5.3 million children, could lose coverage when the PHE ends.

Now I'll hand it over to Aaron.

* MR. PERVIN: Thanks, Jerry.

Okay. Hospitals can receive DSH payments up to their levels of uncompensated care. DSH uncompensated care is defined as unpaid cost of care for the uninsured and also Medicaid shortfall.

The most recent available data on uncompensated care for all hospitals comes from the 2020 Medicare cost reports, which defines uncompensated care as charity care plus bad debt, and some of this data is reported for

uninsured individuals.

Hospitals reported a total of 42 billion in charity care and bad debt in FY 2020, which represents 4.1 percent of hospital operating expenses. Fifty-one percent of this amount is charity care for the uninsured. Sixteen percent is for charity care for the insured, while bad debt is 34 percent, though this data is reported for both insured and also uninsured individuals.

We also looked at how this varies by state that have expanded Medicaid, and on average, states that have expanded Medicaid have half the levels of charity care and bad debt compared to non-expansion states.

The other component of DSH uncompensated care is Medicaid shortfall. Medicaid shortfall is the difference between a hospital's cost of care for Medicaid-enrolled patients and the total payments it receives for those services.

Medicare cost reports do not include reliable information on shortfall, and for this reason, we use the annual American Hospital Association survey for a national estimate. The latest AHA survey indicates that Medicaid shortfall totaled $25 billion in 2020 and a payment-to-cost

ratio of 88 percent, which is largely unchanged from prior years.

We can reliably estimate Medicaid shortfall for specifically DSH hospitals, but this is with a significant data lag, using Medicaid DSH audit data from 2018. This is actually the first year in a while that we have had accurate data on shortfall that can be comparable across states within our DSH audit data.

Among DSH hospitals, Medicaid-based payment rates paid 78 percent of Medicaid costs. Non-DSH supplementals paid 8 percent of costs, and DSH payments paid 9 percent of costs, though it should be noted that this varied extensively by states, with many states paying over a hundred percent of Medicaid costs for specifically DSH hospitals.

To show this variation by state, we bucketed states to the extent to which they pay hospitals as a percentage of cost for Medicaid beneficiaries. On the left, you'll see that 12 states that have the smallest payments as a percentage of costs, and so after accounting for DSH, these states pay on average 85 percent of cost.

On the right, you see the 12 highest-paying

states. These states pay on average 12 percent over cost for Medicaid beneficiaries. However, it should be noted that this chart does not account for various things. These payments do not account for provider financing and Medicaid payments, for example. Many states use intergovernmental transfers and provider taxes to fund DSH payments and other types of supplementals, which means that these amounts are likely larger than net payments that these hospitals received after accounting for the provider contribution.

This year, we also looked at hospital measure -- or hospital margins in FY 2020, which includes the first six months of the COVID-19 pandemic. We also looked at margin data for all hospitals and then also specifically deemed DSH hospitals. Deemed DSH are DSH hospitals with high Medicaid or low-income utilization. These hospitals are statutorily required to receive Medicaid DSH payments, and depending on how you want to look at hospital finances, there are two mildly different stories. Operating margins, which specifically looks at costs and revenue associated with strictly patient care were negative for all hospitals and deemed DSH, negative 4 percent and also negative 7.4 percent respectively.

While on the other hand, total margins, which includes other income and critically for 2020 also includes Health and Human Services' provider relief funding that was authorized as part of the 2020 stimulus. These margins were positive. After accounting for DSH and provider relief fundings, total margins for both all hospitals and deemed DSH hospitals were around 7 percent.

MACPAC and other stakeholders previously raised concern that the initial provider relief distributions did not adequately target safety-net hospitals. While subsequent funding was targeted to safety-net hospitals, this issue ended up raising questions around what is a safety-net hospital.

Organizations are currently trying to develop a common definition for a safety-net provider, and this is something that we plan on monitoring in the coming year.

For the final statutory requirement, we used data from the Medicare cost report and the AHA annual survey to report on deemed DSH hospitals that will provide essential community services, while MACPAC defines -- which MACPAC defines as things like inpatient psych, burn services, and whether or not a hospital is a critical access hospital.

When using Medicaid DSH audit data, we found that 749 hospitals met the deemed DSH criteria in 2018. Ninety-three percent of these hospitals provided at least one essential community service. All 56 percent provided three or more, compared to 34 percent of non-deemed DSH hospitals.

Now I'm going to move on to our estimates of the DSH allotment reductions.

So, in our analysis of DSH allotment reductions, which again are scheduled to be implemented on October 1st, 2023, that means that this is actually the last report before those reductions are scheduled to take effect. So there's going to be $8 billion in reductions each year between 2024 and 2027.

Reductions are going to affect states differently and are going to range from a 6.1 percent reduction to a 90 percent reduction for FY 2024.

We should also note that there's a possibility that the COVID-19 public health emergency will end in fiscal year 2023. Should this happen, the increased federal allotments that were provided to states under ARPA will also expire on October 1st, 2023. Should this occur,

FY 2024 federal allotments will decline by an additional $1.2 billion.

Lastly, we find -- and consistent with prior years, we find that both reduced and unreduced DSH allotments share no meaningful relationship with different measures of need that Congress has asked us to consider.

So, as next steps, this DSH report will be published in our March report. We're going to continue to monitor congressional action on DSH, should anything change.

Furthermore, staff -- Rob and I specifically, we're going to return in a future meeting with a set of recommendations for countercyclical adjustment to DSH allotments.

Finally, I should point out that we are starting the work plan for our next DSH report, which is our final DSH report, and this summer, we're going to start working on that final report. And we're looking for feedback on what kind of analyses the Commission would like for this final report. For example, a key takeaway staff have had in doing these reports for several years is that DSH payments should be considered in conjunction with all other

supplemental and also base payments that a hospital may receive. Staff could try to do an analysis that looks at all these types of payments as opposed to just narrowly focusing on DSH.

Other ideas could include revisiting how DSH payments are targeted to different safety net hospitals. Also, research has come out recently which discuss how DSH is targeted and how that is related to measurements of equity. This is also something we could try to quantify in future DSH reports.

And so, with that, I turn it over to you all and looking forward your questions and feedback.

CHAIR BELLA: You just jinxed that it's going to be in the end of your package, that this has to continue for another 10 years.

Thank you very much. I'll open it up for Commissioner comment. Tricia?

COMMISSIONER BROOKS: So, recently, SHADAC released a report indicating that the undercount in Medicaid on the uninsured data had doubled in 2021, which is the most recent Census data. How does that -- what impact does that have? Because we know the variation is

different from state to state, and just curious what you think about that.

MR. PERVIN: So our results are actually -- and, Jerry, you could jump in too if you want to. But our results show the uninsured rate nationally. It's using the Census data, and if there is a chance that the uninsured numbers are actually being undercounted, then that means that the uninsured rate is actually higher than it should appear.

And I think that the big implication that this would have is for DSH allotment reductions. So DSH allotment reductions are based on different measures, one of which is the level of uninsured within each state, and states with higher rates of uninsured or -- sorry -- lower rates of uninsured have larger DSH allotment reductions. So I would say that when it comes to the uninsured levels as it pertains to the DSH report, the really large implications are how those allotment reductions are structured and then distributed by states.

COMMISSIONER BROOKS: I don't know if there's more that you can research to figure out what the impact is and make a statement on that, but I do think it was

shockingly high, and certainly, it challenges everyone's assumptions about what was going to happen with uninsurance with the continuous coverage protection in place. And other surveys contradict that uninsured rate.

CHAIR BELLA: Thank you, Tricia.

Comments on -- Fred?

COMMISSIONER CERISE: So the punchline continues to be the same, right, that there's no association between the factors that you would think DSH was designed for and then in the actual distribution.

I've heard someone refer to them as "proportionate share payments," and not "disproportionate share payments." But specifically, I am intrigued by some of your thoughts about looking at targeting DSH payments and trying to correlate that with some measures of equity.

The concern that I have still is about the targeting of DSH payments and how we can account for that accurately, and because it's so convoluted and we have such difficulty identifying net DSH payments, net of IGTs, that it's very difficult to see how states target those payments.

I've talked about this in the past. The figure

you have of all the states, that shows the share of DSH payments and compared to the percentage of those payments received by deemed hospitals shows the states all over the place. But I would expect that there is a cluster in that left upper quadrant that seems to indicate states are targeting those payments.

But I'd be interested to know, particularly in that quadrant or the ones that you have higher DSH payments for those deemed hospitals, how many of those states rely on IGT vehicles to make those payments? Because it's going to be -- you know, I know in a number of instances, it's going to be substantial.

I can tell you an example of one county in Texas where the payment may show up as a $220 million payment, but the IGT is $140 million IGT. And so what you'll see is a $220 million payment, but the net payment is really an $80 million payment. because the state will use those IGTs to pay all providers. I know that's probably very difficult to tease, but that chart, you've got a footnote there that describes it. But the footnote is the story, and I just don't think those dots on the grid are -- I think they could be misleading.

MR. PERVIN: Yeah. So what Fred is talking about is we do find -- no, but we have -- so we don't have provider contributions or provider-based financing on DSH. We don't have this data at the hospital level. However, the GAO did release a report that specifically looked at 2018 and tried to get a sense at the extent to which both supplemental payments, then also DSH payments are financed through these provider taxes and also these IGTs. So, while we couldn't look specifically at the facility level, we did do kind of a very basic analysis at the state level.

And Fred is largely correct. States that rely on intergovernmental transfers to fund those DSH payments, those DSH payments do proportionate -- those DSH payments or those states do primarily target DSH to publicly owned providers. So the way the DSH payment is financed, it has a large influence on which hospitals then receive those payments.

But we can try to kind of flesh out that footnote a little bit more in the chapter narrative for this report and then also think about how to account for that, I guess, in the next report.

COMMISSIONER CERISE: Or perhaps we could go in

depth with a couple of -- a few states where you can get more granular data and make the -- you know, show the story or provide some examples.

CHAIR BELLA: Thank you, Fred.

Other comments? How about going to what Aaron teed up at the end, other things that we'd like to look at?

Heidi.

COMMISSIONER ALLEN: I just wanted to say that I thought that the three things you mentioned all sounded really good.

CHAIR BELLA: So can we talk a little bit more? If we were looking at all payments together, can you just say a little bit more about what will -- I mean, that is a common theme for us, right? So I'm very supportive of doing that. What are we still going to be -- feels like we always are -- that there's always something missing, and I just want to make sure I understand like how far we can get with that because I think it's valuable for sure.

MR. PERVIN: Sure. One thing that should be coming out soon is CMS is -- or Congress has required CMS to report on supplemental payments within the CMS 64 system. That system is not completely up and running yet,

but it's supposed to be reporting payments starting for, I believe, FY 2020.

On top of that, we also have the directed payment preprints that we could kind of see if there's a way to combine that information with also other payments that a hospital -- or if there's a way that we could combine that with other payment data that we also have.

Next year, we're expected to have the 2019 Medicaid DSH audit. So that would help us with kind of the DSH piece.

And then we also have at least base payment rates within T-MSIS, and of course, we'd have to do some kind of validation to see if we could really report out that information properly. But that looks promising from that vantage point.

I would say the big area that we would still be missing is really the provider contribution piece. That information really is still state level. We don't have really that information at the provider level, though, like Fred said, we can investigate to see if there's certain states where that information is more readily available at the facility basis.

CHAIR BELLA: That's helpful. Thank you.

Other comments? Fred, anything else?

[No response.]

CHAIR BELLA: You got to give us your list now.

COMMISSIONER CERISE: I know.

CHAIR BELLA: I mean, this is like --

COMMISSIONER CERISE: No, it's good. And I think that the reference to other payments -- because, you know, DSH has become just one of many now, right? I mean, you can talk about the acronyms of supplemental payments, and it's much less -- you know, I don't want to say less critical, but states have come up with so many other payments, and so it's important to look at the total package now.

CHAIR BELLA: Any other comments? Looking at the screen, I don't see any.

Anything else you need from us?

MR. PERVIN: No, I think that's good. We'll take your advice on next year's report. We're in the work planning process. We're really going to start digging into that soon, and so we'll take that back, and staff will start to brainstorm how we can improve upon this for next

year.

CHAIR BELLA: Do we have any crystal ball about whether the reductions are actually going to go into effect?

MR. PERVIN: I would not say that I have a crystal ball. However, I will note that the DSH allotment reductions have been delayed several times between, gosh, 2016 now. The most recent time that they were delayed was during COVID with the Consolidated Appropriations Act of 2020. So we'll be on the lookout for whether or not those are delayed further but no crystal ball on our end.

CHAIR BELLA: All right. We may take a vote offline.

All right. Thank you very much for this work. Well done.

We will open it up to public comment now on any of our morning sessions. If you would like to make a comment, please use the hand icon, introduce yourself, your organization, and I'd ask that you keep your comments to three minutes or less, please.

[Pause.]

CHAIR BELLA: Well, I see no hands. We'll give it just a couple more.

There is. Great. Excellent.

So, Len, welcome, Len. It looks like we need to unmute or he can unmute. Okay. If you can unmute, then we're ready for you to make your comment, please.

PUBLIC COMMENT

* MR. KIRSCHNER: Okay. I think I'm unmuted.

CHAIR BELLA: Here you are. Yep.

MR. KIRSCHNER: Good morning. It seems like this discussion has been going on now for 30-plus years, and it is quite amazing that we're still arguing about how DSH is distributed and how it is funded and how the other supplemental payments play into this.

You and I have been talking about this going back to the 1980s, and it is staggering that we are still having this conversation as to what DSH really does, how it's disproportionately shared, and how it is financed, and government transfers.

It is truly frustrating that after all these decades, we still are at this point in the conversation about this important policy.

A comment. Really not a question.

CHAIR BELLA: Well, thank you. And just so we have it for the transcript, would you please introduce yourself and the organization? Because, obviously, I know you, but the others may not.

MR. KIRSCHNER: Yeah. Leonard Kirschner. I was the Medicaid director in Arizona, AHCCCS, decades ago, 1987 to 1993, on the State Medicaid Advisory Committee, and still deal with Jami Snyder and the Medicaid agency in Arizona.

CHAIR BELLA: Thank you, Len. We're all ears for any solutions you have. Otherwise, I think we'll keep talking about it and try to make progress, but appreciate the comment.

Okay. I don't see anyone else. So we will go ahead and break. We will be back at 12:45 Eastern for a conversation about transitions in coverage. So thank you all for this morning, and we'll see you back here at 12:45.

* [Whereupon, at 11:45 a.m., the meeting was recessed, to reconvene at 12:45 p.m., this same day.]

AFTERNOON SESSION

[12:46 p.m.]

CHAIR BELLA: Welcome back to the afternoon session of MACPAC. Thank you everyone for joining us.

We are going to turn it to Linn and Rob to kick us off. Welcome.

TRANSITIONS IN COVERAGE BETWEEN MEDICAID AND OTHER INSURANCE AFFORDABILITY PROGRAMS

* MX. JENNINGS: Great. Thank you. So good afternoon, Commissioners. Today Rob and I are presenting on policy issues that affect transitions and coverage between Medicaid and other insurance affordability programs, and this work follows up our previous work examining transitions in coverage and continues the Commission's ongoing discussion on how states are preparing for the unwinding of the PHE.

Today we'll provide some background on the unwinding of the PHE, transition requirements, and an overview of steps involved in transitioning between insurance affordability programs. We'll also present some of the challenges and policy issues related to each step, the monitoring efforts, and potential next steps.

So, currently, the PHE is authorized through January 11th, 2023, but it's expected to be extended. And the Commission has been monitoring the unwinding of the PHE in anticipation of states resuming routine eligibility redeterminations.

And this month we're discussing transitions from Medicaid to other insurance affordability programs, which include CHIP, the Basic Health Program, BHP, and the health insurance exchange.

ASPE has estimated that about a third of Medicaid beneficiaries who may lose coverage at the end of the PHE could be eligible for subsidized coverage on the health insurance exchange, and many others may be eligible for other insurance affordability programs.

States and federal government operate multiple insurance affordability programs for families and individuals at different income levels, and for each program, the state establishes specific eligibility policies within federal rules and manages the eligibility determination and redetermination process.

The exchanges are a little different in that states have the option to use the federally facilitated

marketplace, or FFM, which uses the federal exchange eligibility and enrollment platform, or they have the option to develop a state-based exchange.

States with the state-based exchange can choose whether to use the federal platform for eligibility enrollment functions or develop their own exchange platform, and in this case, this allows for states to have more flexibility with their eligibility enrollment processes.

A few states with state-based exchanges have opted to use the federal platform, but most have developed their own, and many of these states have fully integrated their exchange with the other insurance affordability programs.

The ACA included several provisions intended to ease transitions between these programs, including a provision to standardize procedures for transferring eligibility data between programs. However, individuals may experience challenges with this process, which can lead to a gap or loss in coverage. And before the pandemic in a prior MACPAC analysis, we found that only 3 percent of individuals who dis-enrolled from Medicaid in 2018 enrolled

in exchange coverage within a year.

So, in order to help guide our discussion about the transition process, these are the steps that are often required to complete the transition from Medicaid to another program, so beginning with the Medicaid agency, transferring account information for any individual who is determined ineligible, and then the other insurance affordability along with the Medicaid agencies will send a notice. If the other insurance affordability program requires additional information prior to determining eligibility, they will also include that in the notice. And so then the beneficiary -- or the individual at that point would submit additional information, and then at that point, the program can determine eligibility. The individual would then select a plan, if they need to, pay a premium, which isn't always required, and then that would effectuate coverage.

And so to inform our work on this process, we reviewed available literature and guidance on coverage transitions and conducted interviews with states, state exchange officials, CMS, consumer advocates, and other experts.

In the next slides, we'll go through each step of the process, explain some of the challenges and policy issues related to each of these steps.

So, to begin with the account transfer, if an individual is determined ineligible for Medicaid and is potentially eligible for another insurance affordability program, the state Medicaid agency is required to transfer the individual's account information to the appropriate program, and so states with fully integrated eligibility systems for the state Medicaid and exchange don't have to transfer account information because they're stored in one system.

States without integrated systems or those that use the federal exchange platform have challenges sending and receiving complete information. For example, the federal exchange can only accept the individual's name and contact information, and CMS has noted that it's not feasible for the federal exchange to improve the account transfer process before the unwinding of the PHE.

States without integrated systems also have similar challenges with sending complete information and often exchanges aren't receiving the critical information

to determine eligibility. So the individual will have to submit additional information.

Then once the account has been transferred, the other insurance affordability program will send a notice with additional steps and actions for the individual.

During our interviews, we heard that states and exchanges may have challenges reaching individuals if the contact information is outdated, and for those who do receive the notices, they may receive inconsistent information from the Medicaid agency and the other insurance affordability program, which may lead to confusion about -- for individuals trying to navigate this process.

CMS has published guidance to states and exchanges, encouraging these insurance affordability programs to improve outreach, to update contact information in advance of the unwinding, and to update notices to provide individuals with consistent and clear next steps.

Next, after the individual receives the notice, they need to respond to continue the transition process, and they may have challenges responding in the designated enrollment period if the notice doesn't provide clear next

steps or if they have outdated information and don't receive the notice.

For transitions from Medicaid to the exchange, individuals generally have to apply within 60 days following the loss of coverage in order to qualify for the special enrollment period. However, beginning in March of 2022, the federal exchange added a special enrollment period for individuals with incomes up to 150 percent FPL so they can enroll at any time. And some states with state-based exchanges have also implemented this SEP, and in our interview with Washington, they shared that they have expanded the low-income SEP to include in individuals with incomes up to 250 percent FPL.

HHS and CMS are also implementing other approaches to improve assistance provided to individuals transitioning to the exchange, including investing in funding to navigator organizations and launching a pilot program to connect individuals to a navigator if they've had their account transferred to the FFM.

And now I'm going to hand it over to Rob.

* MR. NELB: Thanks, Linn.

So the next step in the process is determining

applicant eligibility using the information submitted. During our interviews, we heard about some challenges that some beneficiaries may face because of program-specific differences in how income is counted and verified. Although all programs used the modified adjusted gross income, or MAGI methods, Medicaid, CHIP, and the Basic Health Program determined income at a point in time. Whereas, the exchange determines income on an annual basis.

In addition, different programs sometimes use different electronic sources for verifying income, which can create challenges for applicants.

The stakeholders we interviewed also noted some of the unique challenges involved in determining availability of employer-sponsored insurance, which affects eligibility for exchange coverage. In particular, there have been challenges for individuals who have an affordable offer of ESI for themselves but not for their whole family, which has been referred to as the "family glitch."

The Biden administration recently addressed this issue through new IRS regulations that were finalized in October, and so hopefully, it won't be as much of a barrier for the unwinding of the PHE.

After being determined eligible, beneficiaries must select a plan, which can be challenging, especially on the exchange where there are a large number of plans available.

To help beneficiaries who don't select a plan, some states we spoke with have been exploring auto-enrollment policies, similar to the rules that exist in Medicaid and CHIP.

However, because enrolling in exchange subsidies creates a potential tax liability for individuals, current IRS rules require people to opt in to auto-enrollment for exchange coverage.

It appears that at least one state, Rhode Island, has figured out a way to work around this limitation, but the other exchange officials we spoke to were still trying to figure out how to make it work, given existing rules, and weren't ready to have a policy in place for the unwinding of the PHE.

In many states, Medicaid managed care plans also offer plans on health insurance exchanges, and so we heard during our interviews about efforts to engage these plans to help beneficiaries enroll.

The next step in the process is paying premiums, if applicable, in order to effectuate enrollment. During our interviews, we heard about a number of steps that states in the federal government are taking to reduce or eliminate premiums, since they're known to be a barrier for enrollment.

First, Congress recently expanded federal exchange subsidies through 2025, and as a result, HHS estimates that about 62 percent of individuals moving from Medicaid to the exchange during the PHE unwinding may be eligible for zero-dollar premiums.

Some states who spoke to, such as Washington State, also have state-funded programs that help lower exchange premiums further.

Yet another approach we heard about in New Mexico is having the state pay the first month's premium so that an individual can be enrolled more quickly.

Once a plan is selected and a premium is paid, the other insurance program sets the start date of coverage. Here, again, program-specific differences can result in gaps in coverage between the loss of Medicaid and the start of the new program.

Some of the state-based exchanges we spoke with were working to set earlier effective dates to help smooth transitions, and states with an integrated eligibility system, it was easier to coordinate the end of Medicaid coverage with the start of the other program.

So now that we've talked through the various steps of the transition process, I'm going to finish by discussing plans to monitor transitions during the unwinding of the PHE.

As you discussed in the October meeting, CMS is collecting a lot of information about Medicaid redeterminations, but in our review, we didn't find much information that CMS is planning to report about coverage transitions.

For example, as part of the Medicaid performance indicators, states are required to submit information about the number of account transfers from Medicaid to other programs, but there aren't any plans in place to report whether individuals who are transferred ultimately end up being enrolled in another program.

When we spoke with CMS, they mentioned that they were exploring ways to better link data from multiple

programs to better understand these transitions, but these efforts were in the early stages of development. And there were concerns about data quality. So they weren't sure whether they'd be able to report information publicly during the unwinding.

The state exchanges that we spoke with did note that they do collect data internally, tracking, for example, whether individuals complete the various steps of the process. But many states were still exploring how to best share that information with their state Medicaid agencies to help track these transfers.

Some states we spoke with, such as New York, were in the process of developing dashboards to help track these transitions, but again, it wasn't clear how much of this information was going to be made available publicly.

So, in an ideal world, many of the stakeholders we spoke with noted the value of collecting data on the extent to which individuals complete each step of the enrollment process in order to better track coverage transitions and understand where the biggest challenges might be.

To help illustrate what might be learned by

looking at the process step by step, this figure shows the number of individuals who completed each step of the exchange enrollment process during the 2019 open enrollment season. As you can see, many of the individuals who applied were not eligible, but I think what's perhaps more interesting is the fact that of the 14.8 million eligible individuals, only 11.4 million selected a plan and only 10.6 million individuals paid their first month's premium, which confirms a lot of what we heard during the interviews about how some of these steps may be barriers to enrollment.

So that concludes our presentation for today. Commissioner feedback on the issues we talked about in this presentation will help inform our future work. We are planning to continue to monitor the unwinding of the PHE, but the limited information that's available will limit our ability to say much in a timely manner.

Also, if Commissioners are interested, we can do further work, examining long-term policy changes to help smooth transitions between coverage sources. Of course, in doing so, we'd want to focus on the Medicaid and CHIP policy levers that are within the Commission's purview.

So, with that, I'll open it up for questions.

CHAIR BELLA: Thank you both.

Tricia?

COMMISSIONER BROOKS: Okay. I'll try not to monopolize the conversation, but I have several points I'd like to make.

But, first, a question on your slide 14 on the data. When you say they were determined eligible, does that mean eligible at any income level or eligible only for PTCs?

MR. NELB: So this is data from the open enrollment period, and we can go back and check. I believe they were just at least eligible to --

COMMISSIONER BROOKS: Enroll at all.

MR. NELB: -- enroll.

COMMISSIONER BROOKS: Okay.

So one thing that you highlighted on this slide about monitoring is that we know CCIIO releases pretty good timely enrollment data during open enrollment, but then we have radio silence. So I really think CMS should be encouraged to ensure that we can parallel, look at declining Medicaid enrollment and increasing exchange

enrollment, won't be during open enrollment, so majority of folks moving might be coming from Medicaid and help us get a sense of whether people are falling into the gap. So I think that's an important point.

The other thing is, not surprisingly, I want to talk about kids, because I didn't hear a lot about Medicaid to CHIP. Your prior churn research shows that 22 percent of kids have a gap moving from Medicaid to CHIP, and we also know that prior uninsured data, although it came down a little bit in this last Census report, would indicate that moderate-income kids, you know, are at greater risk for being uninsured. So I think we need to dig much more into why these gaps occur.

As we know, two-thirds of the kids who are expected to lose coverage during the unwinding should be eligible for CHIP, and yet, you know, if there's a gap or if 72 percent are disenrolled for procedural reasons, as ASPE projects, then we could see the number of uninsured children in this country double.

And just as a reminder, over half of the children in the country are on Medicaid and CHIP, compared to less than 25 percent of adults. So, to me, we've really got to

concentrate a little more on the kids.

The other point I wanted to make -- oh, actually two. So, first of all, I don't think the SEP is high enough at 150 for the unwinding. During normal times, maybe so. But if people -- you know, you're talking about a three-year time period. They could go over 150 percent, and it does nothing for kids, because Medicaid and CHIP cover kids above 150 percent at every state. So, even if there was a separate SEP for kids losing Medicaid or CHIP that goes to higher-income levels, I think it would be really helpful.

The other thing I'm a little concerned about is when states implement the new FPLs with inflation. The way that it is, I would expect there to be a pretty significant change in the dollar equivalence of the FPL levels, and states have -- generally have those in by April, but if they're preparing for the unwinding at the same time, if they don't get those FPL levels in prior to the unwinding, then we're going to be disenrolling kids who actually remain eligible simply because of that bump.

So thank you for your tolerance. I think that's it for now.

CHAIR BELLA: Thank you, Tricia.

Did you want to say anything on -- particularly on anything related to CHIP?

MR. NELB: Great points that I think we can continue to explore work we can do in that area. The Medicaid-to-CHIP transitions are sort of more within the Commission's purview, right, sometimes than the Medicaid to exchange.

I think as Martha, I think, presented in October, the recent proposed eligibility rule did include some measures to help improve those transfers between Medicaid and CHIP, we could see what ends up being finalized and think about if there's ways to go further in that area.

COMMISSIONER BROOKS: Am I on? I think that would be longer term. I don't think those rules are going to be finalized or are put into place prior to that, and I would go back to a point that I've made previously, and that is that if we simply required the grace period in CHIP to be applied for the first month's premium, that could be a big help.

But while you're talking about further work, 17 percent of kids losing CHIP have a gap to get to Medicaid.

There is no reason that that should be happening at all, and that's another area that we should focus on. It's not so much during the unwinding, but it certainly is longer term.

CHAIR BELLA: Thank you, Tricia.

Martha?

COMMISSIONER CARTER: I was just curious about actually a table that you had in our materials that weren't in the slides that showed a percentage of the people who -- in this coverage transition who were disenrolled from Medicaid or CHIP, but there was no transition to other insurance identified. And I was just curious how good that information really is. Are there linkages to employer-based insurance? People's situations change so much. They go into the military or they're incarcerated. How much do we know? How much are we able to know? Are people really losing coverage or just we don't know or some of both?

MR. NELB: Yeah. So I think you're referring to the figure that was in that issue brief that we published over the summer. Yes. And one of the limitations of that analysis is we don't have much information about people with other sources of -- with no other source of insurance

identified.

It is likely that a large number do maybe move to employer insurance or other sources, but some may become uninsured. And this maybe gets at why -- you know, one of the limitations too is we're looking at people -- all people who were disenrolled, but we didn't have reason codes to know, you know, whether they were disenrolled for procedural reasons or whether they were disenrolled for changes in income or other reasons.

COMMISSIONER CARTER: So there's no way to link systems to say this person actually is now covered here or went into the military and they're covered there or whatever?

MX. JENNINGS: Well, I think it's something that they're looking into, how to link those sources.

But I just wanted to note the Urban Institute released an updated report in the last week or so or a couple of weeks and with that had new estimates of where people might go after the coverage transitions. And with that, I think about half were expected to transition to ESI.

And then in terms of those who would become newly

uninsured, they expected about 40 percent to potentially be eligible for subsidized exchange coverage, but they would end up in the uninsured group, so if they have some estimates on kind of where people may be going.

COMMISSIONER BROOKS: But they also estimated that children shouldn't have a problem getting from Medicaid to CHIP, and that's just not accurate.

CHAIR BELLA: Thank you.

Laura.

COMMISSIONER HERRERA SCOTT: So keeping with this theme, has there been any discussion with the states? So, given that the number of MCOs that are part of national entities that also have products in the exchange -- so whether or not the payer could track the movement of a member, because it's in their best interest to keep the member within their universe of products that they offer -- has there been any discussion in states that have national payers with products on the exchange, coordinating with them for that information?

MR. NELB: I think so. As we noted, there's been guidance in allowing the plans to help coordinate the enrollment process.

I think actually the transitions from Medicaid to exchange, we do have that data. There's a lag from when we can get it, but they are able to track that.

The gap we have is if someone doesn't go to the exchange but maybe goes to employer coverage, which I guess could still be with the same health plan but could be with a different one.

As Linn mentioned, there are some other databases that people are exploring ways to link it, but there's not -- whereas we do have good administrative data on Medicaid and exchange enrollment, there isn't like a national database of enrollment and employer coverage.

COMMISSIONER ALLEN: Heidi.

COMMISSIONER ALLEN: I was just curious about what happens when the difference between point-in-time estimates versus annual estimates. What happens if a person -- I'm thinking about seasonal workers and how they avoid fluctuations and income over the year, and depending on what time of year they start, they're reupped. What happens if they make too much money for Medicaid in a point-in-time estimate, but their annual income puts them below eligibility for the exchange? Do you know?

MR. NELB: Yeah. So there -- we can get back to you, and Tricia may know more of the specifics of how it works, but there is a -- because of that difference, there is a chance that someone could get ping-ponged between Medicaid and the exchange.

Some states have -- the way they count income could try to help smooth out for those seasonal workers, but it varies a little bit by state, and it is definitely a potential reason for some challenges for people in that situation.

COMMISSIONER BROOKS: Yeah. So it's called the "gap-filling rule," and if exchange determines that you're not of sufficient income to be eligible for PTCs, they send you back to Medicaid. But I think that's another data point that we have no information on as how many people get ping-ponged.

I know that the advocacy community has indicated that -- you know, particularly early on, that was a real concern that states had not actually effectuated that well, but we still don't have the data to know what happens.

And at that point, Medicaid is supposed to enroll them based on the annual income that was calculated that

made them ineligible for PTCs.

CHAIR BELLA: Can we go back to the monitoring slide, please?

As we think about PHE and what the role -- what MACPAC's role should be, we've centered around data transparency and monitoring and all of those things. Is there anything that we need to shine a greater light on that came out?

Tricia mentioned CCIIO and sharing data on here we have about states, stuff that isn't regularly shared with Medicaid agencies. Hone in for us, if you will, on anything else that you discovered through this that we should be paying more attention to that we may not have -- we may not have already addressed.

MR. NELB: Yeah. So I think the -- again, sort of the step what happens after the account transfer seems to be sort of the biggest gap in our knowledge, and I guess it's maybe worth noting, in these interviews, we mostly focused on the state-based exchanges because they weren't part of -- our previous analysis was looking at states with federal exchange or whether they moved from one source to another.

But my understanding at least, the states with the federal exchange, the state maybe doesn't always get that data from the federal exchange about whether someone successfully transferred or not. So, in addition to maybe better reporting for the public, there could be maybe opportunities to share information with states to help coordinate those efforts.

CHAIR BELLA: Do we know why that doesn't happen today?

MR. NELB: We can, yeah, look into it a little bit more. I know when we got the -- for our own analysis of the exchange data, there's certain privacy rules and stuff, so we could only report on it in the aggregate. But presumably, states should be able to use that data.

But, again, we have two different entities administering these programs that just, I guess, are challenges sometimes with sharing information from one to the other, but --

CHAIR BELLA: I guess where my head is, we're talking about sending a letter to the administration about the importance of data transparency, and if there's anything else that we would want to include in there

relative to additional areas of transparency that will help people retain coverage ultimately at the end of the day, then that would be a good opportunity to do that. So we'll just plant that seed. We don't have to make a decision on that.

And then I would also like to endorse what Tricia is saying about really making sure we're doing all we can be doing on the kids' coverage and transitions. You're educating me about already what the problems were for kids that are transitioning between CHIP and Medicaid that are just going to be exacerbated. So I don't know where that can fit into some of our future work, but I would put a plus-one next to that because that's -- if that is one of the things that's supposed to be working fairly easily in the system and it's not, then I think we need to take another look at that.

Other comments?

COMMISSIONER BROOKS: I just want to add on to that comment I made about FPLs. In the eleven non-expansion states, I believe either nine or ten rely on dollar thresholds that are not updated with the FPL. Parents who are just going over their dollar limit, if it

was an FPL-equivalent eligibility level, they wouldn't lose coverage, but they will because that FPL equivalence erodes over time if you're not adjusting those dollar thresholds. We're going to see a lot of parents losing coverage in the non-expansion states.

I also would suggest that those states, the big states like Georgia, Texas, Florida, examining the CHIP transfers there are really important.

I was on an unwinding webinar with Florida stakeholders, and the executive director of the Healthy Kids program said they need a minimum of 45 days to move a kid from Medicaid to CHIP, and there's just no reason it should be that way.

CHAIR BELLA: Thank you, Tricia.

Dennis?

COMMISSIONER HEAPHY: Thanks.

You guys list a lot of really good best practices that states are employing. I'm wondering is there anything you can do to build on that to make recommendations, or is that beyond the scope of the work in terms of putting them together and say here are some recommendations we make based on what we've seen in X, Y, and Z states, depending

on how they pan out? You've got New Mexico. You've got Rhode Island, and I think something in New York.

MR. NELB: Yeah. There certainly were a lot of promising practices we heard. I think the intent of this presentation is sort of more informational to learn what's happening.

It's sort of unclear when the unwinding will actually happen, but if it does happen in the spring, there's probably not much time for states to make major systems changes or things, but hopefully, we'll have a chance to learn from the unwinding about how well some of these practices worked and can help inform our future work which could lead to recommendations about long-term changes.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: Other comments or questions?

[No response.]

CHAIR BELLA: All right. Why don't I open it up for public comment, just because we're a little bit ahead of schedule. So we haven't had much active public comment today, but we'll see. If anyone would like to make a comment, please use your hand icon, introduce yourself and

your organization, and we ask that you keep your comments to three minutes or less.

We have one. I think if you unmute yourself, you should be good to go.

PUBLIC COMMENT

* MS. SOMMERS: Hi. Can you hear me now?

CHAIR BELLA: Yes. Welcome.

MS. SOMMERS: Great. Thank you.

My name is Anna Sommers. I'm a health services researcher, but I'm not speaking today in that capacity or on behalf of any organization. I'm speaking to you today about my own family's experience with the California's marketplace.

I have a family member living in California who was enrolled in Medi-Cal for a time and then landed a job that increased her income, making them ineligible for Medicaid. At the time of her transition, she called the Medi-Cal office and her Medicaid plan and alerted them to her change in income, and they affirmed that she would need to enroll in a marketplace plan. They told her that her eligibility for Medicaid would expire at the end of the month, September 30th.

Before then, she began her new job. In the short window she had to obtain coverage before her Medicaid coverage ended, my sister and I helped her select a marketplace plan and apply for the premium subsidy so that she could begin that coverage the first of the month; that is, October 1st. She submitted an application to enroll and was contacted by this marketplace plan with the following notice. Her enrollment in the plan could not take place on October 1st because the Medicaid managed care plan she was enrolled in would not unlock her membership until October 30th. That would mean that she would have no coverage for one month.

We made several calls to try to resolve this, without success. As far as I could tell -- and I couldn't confirm this anywhere -- this inability to unlock her membership could have had to do with her application submission date, which occurred within a few business days at the end of the month. So perhaps the Medicaid plan had already locked her in to the next month of coverage.

However, we confirmed with the Medicaid plan that she was nonetheless ineligible to receive treatment covered by their plan for the month of October. So, during the

month, she was without coverage, she needed an appointment with her psychiatrist and new prescriptions. Paying out of pocket for these expenses would cost her over $1,000, money she did not have.

Our family covered those expenses, and she was fortunate in that respect. But I was shocked that this gap in coverage could occur when a person did everything as instructed. This experience suggests to me that further investigation is needed to understand if coverage glitches occur due to the implementation of notifications between health plans and the timing of lock-in of enrollment in relation to eligibility determinations. Even if the state's Medicaid or marketplace protocols protect beneficiaries from gaps in coverage, it's possible the plans are not following these protocols to the letter, and beneficiaries are bearing the burden.

The prevalence of such experiences, I think, is best uncovered by interviewing beneficiaries themselves and would not likely be uncovered by simply examining documentation.

Thank you.

CHAIR BELLA: Thank you very much. I'm not sure

if you can see us, but there's a lot of puzzled looks. We're looking at each other, curious how this can happen, and a lot of nodding heads about looking into this further and the importance of hearing from the source. So thank you very much for sharing that.

It would be really helpful to do some follow-up there and understand what that issue is and if there's something that needs to happen on the plan side in other states as well.

Any other comments from Commissioners?

[No response.]

CHAIR BELLA: Okay. Thank you both. We appreciate this information.

We will go into our next session, which is an update for Commissioners on developments in recent 1115 waiver approvals, and there are some important things in there that have implications on future policy. And so I thought it was important to put that in front of you, and Moira is going to lead us through this.

Welcome, Moira.

MS. FORBES: Hi, Melanie. And you all can hear me?

CHAIR BELLA: Yes.

MS. FORBES: Okay. And, Joanne, you're ready with the slides?

CHAIR BELLA: Yes.

MS. FORBES: Okay.

RECENT DEVELOPMENTS IN SECTION 1115 DEMONSTRATION WAIVERS AND IMPLICATIONS FOR FUTURE POLICY

* MS. FORBES: So, yes, as Melanie just said, the Centers for Medicare and Medicaid Services have recently approved several large-scale Section 1115 demonstration waivers that allow states to test the efficacy of new approaches to delivering Medicaid services and improving population health.

These include changes to eligibility rules, coverage of additional benefits, and measures to address the social determinants of health, which CMS refers to in these waivers as health-related social needs. The waivers also include changes to policies on financing, payment, and budget neutrality. Next slide.

So, in this session, I will go over some background on Section 1115 waiver authority, give a summary of the main features of some of the recent waivers that

have been approved, and then go over some specific policy issues that are being tested in multiple waivers.

There aren't any specific actions for the Commission to take at this time. A lot of the policies we're presenting today are still in the early stages of implementation, but we wanted to talk about them because they relate to many topics that the Commission has been discussing, including specific policy objectives, such as continuous eligibility; how to address the social determinants of health; and Medicaid's role in supporting capacity development, infrastructure, and delivery system transformation. So this is really just information for you, and then we will continue to monitor what goes on in these states as they roll out the new initiatives and report back as we learn more. Next slide.

State Medicaid programs must comply with, obviously, federal requirements in statute and regulation, but states seeking additional flexibility can apply for formal waivers of some of these requirements. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are likely to assist

in promoting the objectives of the Medicaid program. These waivers have been used to make changes to eligibility, benefits, cost sharing, delivery systems, and supplemental payments.

As demonstration projects, they are generally intended to test new approaches, and in exchange for this flexibility, states must contract with independent evaluators to conduct periodic evaluations of the waiver outcomes.

In the past, a number of flexibilities that states have tested through Section 1115 authority have been turned into state plan options through congressional action. These include coverage of additional eligibility groups, including the adult expansion group and the limited family planning group. Next slide.

Demonstration waivers must meet several requirements, some of which are in regulation and some of which are customized for each waiver in state-specific terms and conditions. They must be budget neutral. There's a requirement for public input before and after the waiver is submitted. The state must provide periodic reports and evaluations, and there's a lot of

characteristics of 1115 waivers that are particular to them. They could be granted for five years. They can be renewed or amended. A lot of states with 1115s have extended them, sometimes multiple times.

Unlike other waiver authorities, Section 1115 waivers can be used to allow states to use federal funds to cover services and populations that would not otherwise be eligible for federal match, as long as the waiver as a whole is budget neutral, and states can use the savings generated by one initiative to pay for other changes in the waiver, again, such as eligibility expansions, as long as the waiver as a whole is budget neutral. Next slide.

Almost every state has at least one Section 1115 waiver and many have multiple waivers. As of the beginning of November, there were 65 approved waivers across 47 states, and there were another 33 pending. CMS has already approved at least seven comprehensive demonstrations in 2022. That number might already be out of date--I didn't check it this week. They may have approved something this week.

Today I'll be using examples from three that included several innovative practices to improve the

delivery of Medicaid services and population health, as well as new or revised policies on financing, payment, and budget neutrality. These are the MassHealth and Oregon Health Plan demonstrations that were renewed with amendments in September, and the Arizona Health Care Cost Containment System, which they call AHCCCS, which was renewed with amendments in October.

There was another comprehensive waiver approved in November in Arkansas that included some of these same kinds of policies. We did not have a chance to go through it in the same level of detail, so today we're just going to give examples from Massachusetts, Oregon, and Arizona. But, just to be clear, there's a lot of activity going on in states, renewing or creating these comprehensive waivers with a lot of innovative policies right now. So there's a lot of initiative going on at the state level.

And we did look at provisions from some other waivers that have been approved during the last few years. Some of them didn't include all of these provisions but may have touched on some of them. So we did look at the California CalAIM waiver, North Carolina's Health Opportunities Pilots, and Tennessee's TennCare program,

just to see the evolution of some of these things. Next slide.

The way demonstrations are developed is the state starts the process. It develops a waiver application. For most of these comprehensive waivers, it's very state-specific. They're very idiosyncratic.

The state has to put that out for public comment before it submits it to CMS, but it will submit its waiver, which can take anywhere from a couple months to even years to develop what that request is going to look like, and submits it. There's then no specific timeline for CMS to review the 1115 waiver application other than the requirement that CMS has to put it out for public comment. That has a timeline.

But other than that, there's a negotiation between CMS and the state. They work the parameters of the state's request, the flexibilities that were requested, the financing arrangements, the spending projections, the reporting, the evaluation requirements, and eventually the state and CMS will get to agreement. Not always. Some waivers eventually, you know, they decide not to go forward with. But generally, the state and CMS will come to

agreement. That agreement is documented in the waiver terms and conditions, and then we can see--the public. These are all posted on CMS's website. Based on what state requests have been approved or denied and how they've been negotiated and how they're recorded, we can infer the direction of federal policy. Next slide.

These next couple of slides, I'll go through some of what we're seeing from reviewing these.

As I said before, it's longstanding CMS policy that waivers have to be budget neutral. Budget neutrality spending limits are based on projections of federal spending that would have happened in the absence of the demonstration, so based on forecast and reasonable projections. And then they compare that to the projected spending for the proposed demonstration.

So deciding what spending would have been without the waiver, which is what lets you figure out how much, quote/unquote, "budget savings" you have under budget neutrality can take a lot of negotiation between the state and CMS and policy decisions by CMS in terms of what counts.

That amount -- those amounts are especially

important when states are requesting authority for costs not otherwise matchable, for example, to cover services in populations that would not otherwise be eligible for federal match.

States with long-term demonstrations are trending those "without waiver" baseline estimates forward over long periods, which now can allow them estimates of substantial savings.

In 2018, CMS amended its budget neutrality guidance to reduce the amount of savings that could be carried forward. Oregon, Massachusetts, and Arizona are all states that have long-term 1115 waivers. So they were all affected by this guidance.

When they submitted their waiver renewal applications last year and earlier this year, they followed that 2018 guidance. What was interesting was in the terms and conditions, CMS responded by modifying its own guidance and allowing the states to carry forward more savings and also stated -- it has stated that these modifications that it's just made to its budget neutrality approach that it said in 2018 and applied to these three states, it will likely apply to other states going forward.

Another point under budget neutrality is that CMS can designate some expenditures as hypothetical spending that's largely exempt from budget neutrality requirements, and states have submitted some expenditures as hypothetical. For example, Oregon asked the costs associated with extended continuous eligibility for children as hypothetical costs or certain social determinants of health expenditures as hypothetical. Usually, those can be approved, but they'll have spending caps applied to them. Next slide.

Section 1115 authority does not allow the Secretary to change the federal matching percentage, but it does allow expenditure authority for costs that are not otherwise matchable. Beginning in 2005, CMS authorized states to use federal matching funds for designated state health programs, which we refer to as DSHP, which are existing state funding programs that didn't otherwise qualify for Medicaid match. This effectively frees up state funds that could be used to support demonstration expenditures, which increases the state's effective FMAP.

In 2017, CMS indicated that it would no longer allow demonstrations to fund demonstration initiatives

through the DSHP mechanism. Massachusetts and Oregon had used DSHP funding in prior waivers, and when they submitted their most recent waiver applications, they requested extensions of these sources of funding. The prior MassHealth waiver had used DSHP authority to allow the state to obtain federal match for premium assistance and cost sharing for health exchange subsidies, partly to reduce federal exchange premiums, and they requested extension of this authority in their renewal.

Oregon Health Plan had used DSHP funding since 2012 to help fund investments in health system transformation, and they asked for new uses of these funds to support future investments as part of its new waiver application.

CMS, despite this guidance from a few years ago, did allow the states to use DSHP funding to support state funding of specific initiatives outlined in the new waivers, and in October, it published a notice that was rescinding its 2017 guidance regarding the phaseout of DSHP expenditure authority. Next slide.

Medicaid covers a small number of services that address the social determinants of health, SDOH, such as

transportation and case management. But it doesn't cover many other services such as food or housing assistance or other social services that could address social needs.

Many states have used Section 1115 demonstrations to finance and test new SDOH models via pilot programs or as part of delivery system reform efforts or through enhanced Medicaid benefit packages, and a lot of these have provided broader access to support and connecting services for all members who are identified as being affected by the social determinants of health.

What we've seen in reviewing some of the newer waivers is that CMS is approving initiatives that allow states to address more intense services. They address food insecurity and housing instability but for more targeted high-need populations that meet specified health and social risk criteria. So, for example, Massachusetts will provide time-limited housing supports, clinical nutrition education, and medically tailored food assistance services for specific at-risk populations like postpartum individuals and households where there are children or pregnant women with special clinical needs. And Oregon will expand its SDOH coverage for certain food assistance

and housing supports and other medically appropriate interventions for individuals who are in certain transitions, such as individuals who are homeless or at risk of homelessness.

CMS's rationale for approving these states' requests is that health-related social needs are a driver of access to health services. Coverage of these services and supports assists in promoting the objectives of Medicaid, which is a requirement of 1115 demonstrations. By helping individuals stay connected to coverage and access health care, the coverage of targeted clinically appropriate health-related service needs services provides a regular source of needed care that can improve health outcomes and the use of other clinical services and so on.

Each state has to develop an implementation plan, report specifically on HRSN service metrics, and develop an evaluation plan that specifically evaluates the extent to which the state is achieving those goals. The costs associated with providing these services are not otherwise matchable. They're going to be funded using DSHP and other sources of state funding, and so they are separately capped under budget neutrality. Next slide.

Housing is a subcategory of health-related social needs, or SDOH. Medicaid programs can pay for housing-related services that promote health and community integration, such as assistance in finding and securing housing or home modifications when individuals transition from an institution to the community. But Medicaid can't pay for rent or room and board except when people are in certain kinds of institutions.

Several states have already used Section 1115 demonstration authority to cover housing-related activities or services for Medicaid beneficiaries. What we saw in these waivers again are some targeted initiatives. Oregon requested authority to provide a variety of interventions to support stable housing in order to avoid triggering, destabilizing transitional events associated with homelessness and the subsequent higher health costs and poor health outcomes.

Arizona requested authority to help members experiencing homelessness or chronic housing instability to attain self-housing and integrated services to end their housing crises in order to achieve improved health outcomes.

CMS approved these requests and is allowing states to provide these housing-related interventions to support stable housing for these specific populations at risk for homelessness and housing instability or who are experiencing transitions, because they're expected to stabilize the housing situations of eligible Medicaid enrollees and increase the likelihood that they'll be able to access other Medicaid covered services.

The states are going to have to assess the effectiveness of these services in mitigating the identified needs of beneficiaries. For example, Arizona is required to specifically show the impacts of the housing support program on beneficiary health outcomes. It's also going to have to show whether and how local investments and housing supports change in response to the influx of new Medicaid funding towards those services. Next slide.

So a little change of focus here. Since 1997, states have had the option to allow 12-month continuous eligibility for children enrolled in Medicaid and CHIP, and to date, 23 states have implemented this in Medicaid and 25 in separate CHIP. Despite the coverage option, children can still lose coverage if they age out, move out of state,

voluntarily withdraw, or don't make premium payments in CHIP. For other groups, of course, states have to redetermine eligibility at least every 12 months, and as we just talked about in the last session, we know that disruptions in coverage can result in unnecessary administrative costs and delays in care for beneficiaries.

States have long used 1115 waivers to expand coverage for populations for whom there's not a statutory coverage option, and we're seeing in a lot of these recent applications that what states are looking to do is to expand continuous eligibility.

Oregon was already providing 12 months of continuous eligibility under the statutory option for children in Medicaid and CHIP. What they're asking for--or what they're getting in their new waiver--is they're going to provide continuous enrollment for children through age six and continuous for everyone six and older, for two years.

Massachusetts is taking a much more focused approach. They're addressing continuous eligibility as part of advancing health equity for health-related social needs and justice-involved populations. They're going to

provide 12 months of continuous eligibility for members who are recently released from a correctional institution and 24 months for members experiencing homelessness.

CMS approved these. They're only allowable under demonstration authority. They otherwise haven't been tested in Medicaid. Obviously, they're very clearly intended to mitigate coverage gaps and churn, maintain continuity of access, and improve health outcomes. States are still going to be required to maintain the eligibility safeguards, like taking action when mail is returned or if they find out someone has moved out of state, and they will be required to conduct monitoring and evaluate the effects of these provisions. Next slide.

Another sort of different thing that these waivers are doing: generally, state Medicaid programs can only use federal funds to provide medical services or to administer themselves. They can't use federal funds for provider capacity development unless it's specifically earmarked, like in 2009 when Congress gave $20 billion to encourage providers to adopt electronic health records, that was a specific thing.

But states have been using Section 1115 waivers

to support delivery system reform investments, especially in integrated care, payment reform, and primary care capacity. We've talked a lot in the past about delivery system reform incentive payment or DSRIP waivers.

States continue to request waiver expenditure authority for investments in provider capacity development, but what we're seeing now are requests targeted at specific investments related to current priorities that the states have, like health-related social needs and behavioral health and addressing health equity.

For example, Massachusetts requested waiver authority to fund a new performance-based incentive program for some of its private hospitals that's intended to reduce health inequities by strengthening and improving quality and health outcomes.

And Oregon requested waiver authority to help support its psychiatric residential treatment services facilities, specifically in serving youth in foster care or child welfare custody. That's a step-down behavioral health service where there's low capacity, and they're trying to help improve -- support those providers to help avoid inappropriate placements.

Arizona also requested an extension of its existing waiver authority to provide resources to providers to support integration of behavioral and physical health care at the point of service.

CMS approved a lot of these requests, although, again, with specific spending caps and requirements for states to report on specific performance metrics. Next slide.

So I've mentioned along the way a couple of reporting requirements and things like that. But here's sort of -- I'll get into the real strings. The Social Security Act -- we've talked about this a lot of times -- 1902(a)(30)(A) requires provider payments to be sufficient to enlist enough providers so that care and services are available under Medicaid at least to the extent that such care and services are available to the general population.

States have not generally been required to meet a specific payment level to demonstrate compliance with this requirement before. Apart from enforcement of specific statutory payment provisions, like the Boren amendment when it was in effect, CMS has never enforced a payment rate floor when it does its regular provider rate reviews or

more recently through the review of Access Monitoring Review Plans.

But we saw in the Massachusetts, Oregon, and Arizona waiver approvals, CMS is now requiring them to increase the Medicaid provider payment rates for primary care, behavioral health, and obstetrics to at least 80 percent of the Medicare fee-for-service rate, and they have to increase Medicaid provider payment rates on both the fee-for-service and managed care side. So, if they aren't already paying that, they need to raise their Medicaid payment rates as a condition of receiving approval for federal financial investments, like all the ones I've been mentioning before, like health system improvements and social determinants of health services, and if they want to use DSHP or other state sources of funding. Those 80 percent levels must be maintained for the duration of the waiver. The states are going to have to submit provider rate data for the three service categories, code sets, and all the other data used to calculate the ratio. So that is a new piece of policy that we're just seeing for the first time. Next slide.

In addition to the payment adequacy requirements,

which is a new thing, CMS always has a lot of terms and conditions. We're seeing a lot of detail in the terms and conditions tied to all of these new initiatives and the spending and financing agreements in these waivers. States have to develop implementation, spending and reporting plans for each of the new initiatives. These have to be submitted to and approved by CMS before they can go forward. States have to develop evaluation plans that address the specific goals in the new initiatives.

For example, the terms and conditions for the Arizona, Oregon, and Massachusetts waiver specify that the states must assess the effectiveness of each approach in meeting demonstration goals, addressing beneficiary health outcomes, and affecting spending and related programs. Next slide.

These monitoring and evaluation findings are intended to inform decision-making at the state and federal levels. The annual and quarterly monitoring reports can provide ongoing updates on implementations. We'll get data on process and outcome measures, which may help identify whether mid-course corrections are needed, and evaluation information, there will be an evaluation design that states

will submit within six months. Then there will be an interim evaluation that's due before the end of the demonstration and summative reports due at the end.

So MACPAC will collect and review these monitoring and evaluation reports to learn more about state activities and findings and identify opportunities for future MACPAC discussion.

So that's it. I'm happy to answer questions. Please don't ask anything too detailed on the financing and the budget neutrality policy, because it gets very, very intricate. Well, go ahead and ask your questions. I will probably say that we'll follow up, but go ahead and ask. But I'm happy to do what I can now and take notes on anything else and get back to you. Thanks.

CHAIR BELLA: Thank you, Moira.

Heidi and then Angelo.

COMMISSIONER ALLEN: Thank you so much, Moira.

I just have a clarifying question. For Oregon's waiver and continuous eligibility, it says it was framed as children, that there's the ability to have continuous eligibility for children, but in the materials and on this slide, it says for people six and over two years of

continuous eligibility. And I wasn't quite sure if you were including adults in that as well.

MS. FORBES: Yes. Yeah.

COMMISSIONER ALLEN: Okay. Very cool. Wow. That's a big deal. It's huge.

MS. FORBES: Yeah. No, that's right. It's the MAGI population over age six.

CHAIR BELLA: Anything else, Heidi?

[No response.]

CHAIR BELLA: Okay. Angelo and then Tricia and then Bill.

COMMISSIONER GIARDINO: Thank you, Moira.

I really was intrigued by Slide 13 because that's the first time I've seen that wording where there's some sense that to get the right number of providers, you have to have some competitive pricing and whatnot. So I'm just wondering if maybe future work could address how that's measured -- and it was Slide 13 -- how that's measured so that we could see if there is some recommendation someday around enforcing that payment adequacy. We'd have to understand what's measured and how strong that measurement is.

MS. FORBES: Yes. We will definitely be watching that.

COMMISSIONER GIARDINO: Great. Thank you.

CHAIR BELLA: Thank you, Angelo.

Tricia.

COMMISSIONER BROOKS: So one thing interesting about the Oregon waiver, I think, that we should keep an eye on is the fact that the details have not been worked out, but they're going to allow the state to track kids that probably would have moved from Medicaid to CHIP during that period of time, so under six, so that the state can go back and claim some of the CHIP-enhanced match. It would be a proxy similar to what CMS has approved in the two states and now I think just one that offer continuous coverage for adults, as you somehow discount the match rate a little bit.

But it's going to be interesting to follow that because, of note, eight of the states that have continuous coverage for kids in CHIP do not provide it in Medicaid, even though there are rules in CHIP that say you should not treat higher-income kids any better than lower-income kids. But states want that enhanced match. So I really think we

ought to follow this, and maybe there's some future recommendations around that, because I think that is the barrier for -- one of the barriers for continuous coverage in Medicaid for kids.

The other thing is just that while we're talking about continuous eligibility is that we really need a SPA option for states to do it for adults. The idea that you have to go through 1115 waiver to give adults one year continuous coverage, which is consistent with how private insurance works, is just -- it's kind of sad. If it's an option, the state gets to decide whether to do that or not, as opposed to it being mandated.

Thank you.

CHAIR BELLA: It seems logical.

Bill.

COMMISSIONER SCANLON: Yeah. My question relates to Slide 13 as well, and it's the last bullet there. I'm not sure I'm understanding this. Is the requirement that the managed care provider rates be 80 percent of the fee-for-service rates within the same state, or is there an external benchmark that the payment rates within a state have to meet?

CHAIR BELLA: I think the Medicaid on the second to last line is supposed to be Medicare.

COMMISSIONER SCANLON: Okay. That's very different, because that's an external benchmark.

CHAIR BELLA: Yep.

COMMISSIONER SCANLON: Okay. I'm sorry.

CHAIR BELLA: Yep.

COMMISSIONER SCANLON: All right. I missed that.

CHAIR BELLA: Jenny.

COMMISSIONER GERSTORFF: I have a few questions, Moira, that you may not know right now, but maybe we can look into them or keep track of them.

Also for slide 13 here where they're requiring 80 percent of the Medicare rates, I see it says that in their evaluation plan, states will have to submit code sets and utilization at the code level for these services. Do you know if the definition of those service categories will be defined by states or if that will be more standard defined by CMS and whether those are defined by provider type or provider -- or service type? I'll stop there.

MS. FORBES: I can get that for you. They have some information in the waivers. There is a periodic

comparison of Medicaid fee-for-service rates across states to Medicare fee-for-service rates that is done and published -- I want to say by the Urban Institute. And CMS suggests that states use the same method and the same codes, but they can use a different method if they want. And so that's all spelled out in the terms and conditions, and we can get that to you, but they suggest that they use the same methods like for consistency.

COMMISSIONER GERSTORFF: Great. That makes sense.

Are the evaluation plans public materials? Are those posted along with the waivers on the Medicaid website?

MS. FORBES: Yes, they should be.

COMMISSIONER GERSTORFF: And then specific to the behavioral health category, there are several behavioral health services that are not covered by Medicare. Has there been any indication how that will be handled?

MS. FORBES: I can go back and look. There was actually a fair amount of detail in the terms and conditions about how they wanted to handle all of that, and so I can go back and look. They had definitely thought

through how they wanted those comparisons to be done.

COMMISSIONER GERSTORFF: That's great. Thank you.

CHAIR BELLA: Thanks, Jenny.

Fred?

COMMISSIONER CERISE: Thanks, Moira. I have a couple of questions, kind of a technical question, and then I have a couple other comments.

When you say like the food insecurity, housing supports, those types of things are separately capped under budget neutrality, does that mean that there's a set amount that you can spend in those categories, but they still count against total budget neutrality, or it's a separate amount outside of budget neutrality?

MS. FORBES: I might get this wrong.

COMMISSIONER CERISE: I asked that because you said don't ask technical finance questions.

MS. FORBES: I know. It's a separate -- I believe it's a separate amount, and it is separately capped.

COMMISSIONER CERISE: So I have a couple of other questions. One, on the measurements, because of those

things like housing supports that you want to be able to demonstrate at least cost neutral or savings in the program, oftentimes those things are not cost savings, but they have a positive impact on care. And I'm thinking, let's say, tailored meals for a pregnant person and then the time beyond pregnancy for someone who had diabetes during pregnancy. It may be a good thing to do. It might not show up in an ROI, financial ROI right away. And so things like that or housing supports for people who are using the ED frequently or maybe not even using ED frequently, but are there -- in the measurement systems, are there well-being measures or other measures of benefit that are not purely financial, that get considered in whether or not the program has been successful?

And I have one other question.

MS. FORBES: That's a good question. I mean, we haven't seen the monitoring plans or the evaluation plans yet. They're not required yet.

There was a lot in the terms and conditions that instructed the states. I mean, we have yet to see how they're going to do this, but the states were asked to find a way to track both the costs associated with those

initiatives and the offsets in a way that could inform future policymaking, because this is the piece where we always get stuck.

We don't know how much covered services were really offsetting. We don't know what those downstream effects really are, and we also don't know how much it really costs to do some of these things.

It's difficult when you're doing so many of these different initiatives to be able to really attribute.

COMMISSIONER CERISE: Right.

MS. FORBES: But there is definitely a lot of language in the terms and conditions intended to make an effort to do a much more rigorous and intentional job of that. So, hopefully, they will do that.

There was also a lot about trying to get, as I think -- actually, I guess it was a commenter who said this, like beneficiary perspectives and so on, incorporating that into evaluations, to do focus groups and to do interviews and to do things like that, and to make sure that information was being collected as part of the evaluations. And so that's a piece of information that would be included. In addition to the quantitative

information, there was a lot of different kinds of qualitative information, that they're expected to be factored in.

So they are definitely -- you know, this Commission has made recommendations in the past about improving evaluations and improving how that information gets used. CMS had already been taking steps in that direction. And, definitely, there was a lot of that written into the terms and conditions.

I think one of the things for this Commission to do will be, as these evaluation plans come out, to see how much that is being reflected in the actual plans.

COMMISSIONER CERISE: Thanks for that.

And then, finally, have you seen in these waivers or others how CMS is treating budget neutrality in terms of states under approved waivers that are increasing rates? For instance, they recognize they need to increase rates for personal care attendants or nursing home staff, things we talked about already. Or is CMS adjusting budget neutrality to account for those increases, or does that become a deterrent for states to address some of those other needs through improved rates?

MS. FORBES: I remember thinking to myself, reading the part where states have to increase their rates to that 80 percent of Medicare threshold: what does this mean for budget neutrality? And now I can't remember if I ever found out the answer, but I feel like that's the same question. So that's a good question. We'll get back to you.

COMMISSIONER CERISE: Okay. Thanks.

COMMISSIONER ALLEN: This is Heidi. You've pretty much answered or addressed my question, but I would just like to say that it would be very interesting to see what the evaluation plans for these and have a little bit more detail on how they plan to track it and especially as it relates to consumer voice, which is something that we've talked about a lot in here and needing more. But since I've been on the Commission, we haven't done the work looking at evaluation plans, and it seems like now would be -- with these very interesting social determinants of health initiatives, it would be a good time to kind of have an issue brief or a presentation or some way of looking across states to see how they're meeting the challenges of evaluation and if it has more rigor and more consumer voice

than prior evaluation plans have.

MS. FORBES: Yeah. We will definitely be watching for those.

CHAIR BELLA: Dennis?

COMMISSIONER HEAPHY: Fred and Heidi asked most of my questions, and I'm still confused over budget neutrality. It seems I'm not the only one. I hope I'm not the only one.

But my question was actually about the 80 percent, and it wasn't clear to me. It applies to the state but not necessarily to MCOs? So we don't know what the rates are that MCOs are paying?

MS. FORBES: The state will have to demonstrate to CMS that the assumption -- that the amounts going into the capitation rates are assuming 80 percent of Medicare. There would have to be a directed payment arrangement. I believe if they were going to enforce that down to the provider level, I would have to go back and look and see if there's a requirement that states also have a directed payment arrangement to make sure that providers get paid that amount. But that may be a condition of the waiver as well. I can go back and check.

COMMISSIONER HEAPHY: Okay. And someone said that there's a clarification that it was 80 percent of Medicare rate, not Medicaid, right?

MS. FORBES: Yes. I committed the most embarrassing mistake for a MACPAC employee to make.

COMMISSIONER HEAPHY: No, no, no. That's fine. The reason I ask is because access to providers is so challenging, and they're always talking about a lot of it is because of rates, and is 80 percent enough? Would it make a difference if it was raised higher? Is there differences in states that have 1115 waivers, and do they pay more than 80 percent, or they pay 85 percent? Are there any variations in that regard?

MS. FORBES: There was -- CMS cited justification for raising the rate but not for how they got to 80 percent.

COMMISSIONER HEAPHY: Okay. All right. Thank you.

CHAIR BELLA: Thank you, Dennis.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: Moira, thank you.

Just a couple closing comments. It's going to be

really interesting to watch how CMS uses the waiver authority, particularly for some of the social determinant-type services, and we heard at the panel -- last time? I can't remember when it was, when we were talking about workforce issues and we were talking about things like childcare subsidies, and I think some states are starting to ask for that. I don't think those have been approved.

But this notion of cost avoidance, Fred, that you were getting at and trying to prove that there's value, I feel it is starting to be -- I mean, the more that these get approved, the more it shines attention on those things. And so I think if there's a way that we can be sure that we're on top of that in helping do anything to demonstrate the relationship between some of those services and traditional medical costs, that's going to be beneficial.

I also would love to -- you can clarify this offline. In my head I was thinking that it would all have to count toward the budget neutrality thing, which I think might be a little bit different than what you and Fred had talked about. So I would love clarification on that, because I can't imagine they're approving these things and allowing them outside of budget neutrality. But if you

could let us know that offline, that would be wonderful.

Okay. Thank you. This is a perfect segue into the next session, which is about in-lieu-of services. So, Sean, we'll have you kick us off.

[Pause.]

CHAIR BELLA: You have to admit this teed you up perfectly, right? Yes.

IN-LIEU-OF SERVICES AND VALUE-ADDED BENEFITS: IMPLICATIONS FOR MANAGED CARE RATE SETTING

* MR. DUNBAR: It was great. In fact, I'll try not to repeat things that Moira said.

All right. Thank you, Melanie. Good afternoon, Commissioners. It's a pleasure to continue our discussion around managed care rate setting, this time taking a little bit of a closer look at in-lieu-of services and value-added benefits and how they factor into the process.

Oh, great. So today I'm going to walk through a few different things. First, I'll provide a brief overview of what we've done so far on rate setting. I'll walk through some of the background on the state flexibility around in-lieu-of services, the role that value-added

benefits play, as well as some state efforts to pursue some of this through 1115 waiver flexibility.

We'll review some findings from our prior work and then spend some time getting your feedback on potential areas for consideration that can help inform a response to anticipated rulemaking.

All right. At the September and October meetings, the Commission engaged in detailed discussions focused on managed care rate setting. The discussions are based on findings from an expert roundtable on risk mitigation that MACPAC conducted, a rate-setting study that also looked at actuarial soundness, research into managed care directed payments, as well as follow-up work that staff had done to look into some areas where the Commission had indicated they had some interest.

We also highlighted anticipated rulemaking from CMS that should address several areas where we've done some other rate-setting work, such as access, directed payments, and in-lieu-of services. We don't know what the specific policy options will be that the administration might propose, but Commissioners were interested in examining several of these areas in more detail.

You may recall that in October, we talked in more detail about access and state-directed payments to a degree, and today we'll focus specifically on in-lieu-of services.

All right. To set up today's discussion, I'll provide some context on the key pieces we'll be covering. Medicaid rate development rules provide the states with flexibilities not available in fee-for-service. One of these is the ability of MCOs to offer medically appropriate, cost-effective substitutes in-lieu-of state plan services.

In-lieu-of services must be authorized in the MCO contract, optional for plans to provide, and optional for beneficiaries to use. Because in-lieu-of services are authorized in federal managed care regulations, a waiver is not required to implement them.

In-lieu-of services can be medical or non-medical in nature. For example, a state may authorize MCOs to offer in-home visits as an alternative to office visits. Non-medical in-lieu-of services typically address SDOH-related needs, such as providing medically tailored meals or offering housing supports.

Utilization and costs associated with in-lieu-of services are considered in capitation rate development and included in the numerator of the MLR calculation.

In 2016, CMS created an exception to the in-lieu-of services flexibility for stays in IMDs of up to 15 days, which is otherwise not a covered state plan service. Unlike other in-lieu-of services, however, the cost of IMDs cannot be used in the rate setting. The anticipated utilization must be repriced to reflect what the cost would have been if the same services were delivered through providers covered under the state plan.

Since then, stakeholders have been interested in states using the flexibility to provide services and supports addressing SDOH, given the links between SDOH, health care spending, and outcomes. However, there are certain challenges related to non-medical in-lieu-of services that we'll discuss.

Managed care also provides states and health plans with the flexibility of value-added benefits, which are services that MCOs may provide in addition to covered Medicaid services. These are generally non-medical and can include wellness incentives, such as gift cards for

attending preventive care visits. These can also include services designed to address SDOH, like transportation services not covered under the state plan or transitional housing for individuals experiencing homelessness.

VABs are typically funded by an MCO's administrative costs, and the cost of providing these services is not specifically factored into capitation rate setting. However, the cost of VABs can be counted in the numerator of the MLR if they're activities that improve health care quality.

Since VABs are offered outside of the capitation rate, there's usually no requirements for what an MCO must provide, if anything. These can vary by plan, by beneficiary group, or even by region within a state. As a result, beneficiaries may have access to different VABs based on which plan they choose, where they live, or what their needs are. But some states are increasingly asking plans to offer VABs, with some getting more prescriptive in their RFPs, and asking plans to commit to providing certain VABs to Medicaid beneficiaries.

Section 1115 waiver flexibilities is another emerging area where states, with the support of CMS, are

pursuing in-lieu-of services and other SDOH-related services. One of the most notable recent examples of this is California's CalAIM waiver, which establishes a number of in-lieu-of services to improve housing-related supports. Some of the examples California included were housing navigation services, housing deposits, and short-term post-hospitalization housing.

You just heard from Moira about CMS approval of several 1115 waivers in recent months that continue to bolster SDOH-related service offerings. I won't repeat what you heard from her but wanted to flag this as one of the ways in which states and CMS are engaging more on SDOH, which oftentimes is addressed through non-medical in-lieu-of services.

Using an 1115 waiver to establish a framework of non-medical in-lieu-of services can provide states and MCOs with a pre-approved list of substitutes that can be implemented by plans.

So MACPAC's interviews with states, actuaries, health plans, and CMS identified a few key themes related to in-lieu-of services, especially as it relates to the rate-setting process.

Our first finding focuses on the extent to which in-lieu-of services is covered in federal and professional actuarial guidance, which can be limited. The CMS Annual Rate Development Guide describes reimbursement for in-lieu-of services, in particular, as it relates to the IMD exception that CMS passed as part of the managed care rule.

The Actuarial Standards of Practice describe how actuaries should reflect covered services, including in-lieu-of services, but the resources don't specify which services may or may not qualify as an in-lieu-of service for the purposes of rate development.

Interviewees noted that this is primarily a challenge for non-medical in-lieu-of services that a state may want to pursue, since actuaries may not know which particular non-medical services CMS may approve.

Another finding is that limitations in the definition of what constitutes an in-lieu-of service can pose challenges for state efforts to address population health. The in-lieu-of service flexibility for IMDs has been well received by states. A survey by the Kaiser Family Foundation found that 35 states have implemented this flexibility. However, most states do not take

advantage of the in-lieu-of service flexibility allowed under current rate-setting rules to cover services that address SDOH.

A MACPAC review of capitation rate certifications found that few of them mentioned SDOH-related in-lieu-of services.

MACPAC did find in its research that states may induce plans to cover SDOH outside of the capitation rate as value-added benefits or as investments of excess profits to reduce MLR remittances. For example, one state recently required plans to commit to covering specific VABs for the full five-year contract in its recent RFP. Several other MCO contracts reviewed by MACPAC required plans to offer VABs, while some others only encouraged it but didn't require it.

Stakeholders we spoke to commented that it would be helpful if CMS provided clarity on which VABs may be reasonable substitutes for state plan services as non-medical in-lieu-of services so that they can be captured in rate development.

We also found in our research that it's unclear how much flexibility that states have under actuarial

soundness to pursue in-lieu-of services; in particular, the non-medical type.

A number of states have used flexibilities available under managed care and actuarial soundness to add benefits, increase provider payments, and make investments in activities related to SDOH.

States have required MCOs to invest a percentage of revenue or profit into certain activities, cover specific benefits as VABs, or to direct additional payments to providers. By including them in the capitation rates and certification of actuarial soundness, these payments and services are not subject to separate review or limit as they might be if they're pursued through a waiver. However, interviewees weren't sure how CMS might respond in the future to concerns that state efforts to promote program objectives could be consistent with the actuarial soundness requirement.

MACPAC also heard in its interviews that states and other stakeholders would like more guidance on what can or cannot be included in rate calculations when it comes to in-lieu-of services and other SDOH-related supports. In particular, states appear interested in considering more

non-traditional services.

There was some sentiment among interviewees that guidance from CMS indicating which types of in-lieu-of services that could be quickly approved would be helpful. For example, this guidance could take the form of a preprint indicating which services are substitutes for others.

Given the growing efforts to address SDOH through non-medical in-lieu-of services and value-added benefits, stakeholders spoke about the discretion that states have to determine the components of its MLR. For example, one state that MACPAC reviewed counts SDOH investments in the MLR numerator for remittance payment calculations to incentivize these investments by the plans. Another state that requires MCOs to offer specific VABs limits the amount of profits that plans can retain but includes a higher than typical underwriting gain assumption in their managed care rates.

Stakeholders we interviewed did note particular challenges that states may face when encouraging or requiring MCOs to invest in addressing SDOH. For one, because beneficiaries can change MCOs as often as every

month, a plan may not ultimately benefit from the reduced spending that results from improved population health. Some thought this concern could be buffered to a degree by the fact that MCOs can include VABs in the numerator if they improve health care quality or that these investments may also help plans achieve any quality-related financial incentives or bonuses that a state offers.

Another potential concern is the effect of these investments on capitation rates over time. One state, in particular, noted that it covers SDOH-related services through a payment approach in its 1115 waiver, expressing concern if they tried to cover these in the capitation rate, plans would not support investments in SDOH in the long run because improvements would result in lower capitation rates.

There's a handful of discussion questions I wanted to highlight for you today that can help with the thinking around any potential rulemaking from the administration.

Our research has shown that states continue to have questions regarding which in-lieu-of services can and cannot be included in capitation rates. In particular,

staff heard that states are interested in counting a broader set of non-traditional services, like housing, as non-medical in-lieu-of services. However, current rate-setting rules typically limit these types of services as value-added benefits funded through MCO administrative dollars.

Commissioners could consider whether CMS should provide new guidance on what distinguishes a service as in-lieu-of services or as a value-added benefit for the purposes of CMS approval, which could help states and their actuaries structure the capitation rates. More specificity could reduce the amount of time that states and CMS spend addressing questions on the rate certification.

Commissioners could consider whether it would be beneficial for CMS to publish guidance indicating which types of non-medical in-lieu-of services could be quickly approved.

Commissioners could discuss any concerns regarding the widespread availability of in-lieu-of services. As we discussed earlier, there's no federal requirement that plans have to offer all available in-lieu-of services. So variation may exist depending on the plan

a beneficiary chooses. The same goes for value-added benefits, which can vary by plan, by population, or perhaps even by region.

Commissioners could share their perspective on the treatment of non-medical in-lieu-of services and value-added benefits in the MLRs. States would like additional direction from CMS on how to factor costs associated with SDOH-related services in the MLR when developing rates or when reporting to CMS. For example, CMS could provide more explicit guidance on what type of SDOH-related services count as activities that improve health care quality.

The Commission could also consider whether CMS should be more proactive in providing guidance on how non-medical in-lieu-of services should be accounted for in rate development. Doing so could better align rate-setting guidance with state and federal program priorities.

The Commission could also think about ways in which CMS can support state efforts to implement non-medical in-lieu-of services based on how the state prefers to operate its Medicaid program. For example, a state may not want to undertake a new broader 1115 waiver to do so. Given the extent of interest states have demonstrated for

implementing the in-lieu-of services flexibility for IMD, should CMS offer similar specificity for a core set of non-medical in-lieu-of services that may be broadly appealing?

So, in terms of next steps, I look forward to getting your input on the content that we presented today, where you think there may be some other areas to do some additional digging in advance of any rulemaking coming out. We'll use your takeaways to prepare a draft response to any potential proposed rule that comes out.

And remember the exercise here is to sort of help the Commission think about where it may be interested in commenting on in-lieu-of services. You don't need to take any position on any particular issue until a proposed rule is released, and once the rule is released, we'll come back to you with the draft comment letter, informed by what we've talked about the last few meetings. Also, none of this precludes the Commission from thinking about other recommendations that it may want to pursue in this report cycle or in a future report cycle.

So, with that said, Melanie, I can pass it back to you and other Commissioners, and I will put all those questions up in case it's helpful.

CHAIR BELLA: It's very helpful. Thank you for teeing those up.

I'll start with Martha.

COMMISSIONER CARTER: Thank you, Sean, and it does seem that additional clarification and guidance would be really helpful. Thanks for pointing that out. It seems like there's a lot of missed opportunities because the states just don't know what's possible.

Another point that I would like for us to pay attention to -- and you probably can guess I'm going to say this -- is to what extent are states including or not including the FQHCs especially in value-added services around social determinants of health.

We've talked about how it's complicated. The PPS rate, the perspective payment system rate, makes things more complicated for payment to the health centers, but that shouldn't mean that the states don't include it or the MCOs don't include the health centers, and then how do they get paid those additional services? And I think we need to pay attention to this.

You've heard me say almost 50 percent of the health center patients are Medicaid and CHIP, which is 14

million people. Half of their caseload is. It's 14 million people. So there's a lot of potential for the health centers to do work in the SDOH arena. So we just need to pay attention to where they're getting included.

CHAIR BELLA: Thank you, Martha.

Jenny, then Fred, then Angelo, then Sonja.

COMMISSIONER GERSTORFF: Okay. I have several questions for us to all think about and talk about. Fantastic job on the materials, really compiling so much information and synthesizing it down for us very clearly, and it got my brain going in a lot of different directions.

But I think there are three kind of groups of topics and questions we can think about under this. One is capitation rates and the capitation rate setting. One is the MLR, MLR reporting and remittances, and then the other is financial reporting, so when the states -- or not states, but the health plans are doing their audited financial statements and how that information is reported to NAIC and state insurance commissions.

So, on the rate side, I think a lot of times when we encounter in-lieu-of services in practice, it ends up being a very small volume of dollars, and so then you end

up doing a lot of administrative work for a very small amount. So where are states using these that there are material expenses, and is there a way to structure the benefits, kind of like California is doing, to really support MCO flexibility to employ whatever options are best for beneficiaries but in a way that scales so that there will be material, enough volume to consider in capitation rate setting?

And then for guidance from CMS, I think I'd like to see how the cost of in-lieu-of services should be considered and how that should be documented in certifications. Should it be included in our base data? Should it be included in trend assumptions, other adjustments, that sort of thing?

And when should they be considered for capitation rates? How material is that?

And then, also, who can provide in-lieu-of services or value-added benefits, or are there services that are in-lieu-of services when they're provided by FQHCs or other providers but they, when they're provided by the health plan, are not -- you know, maybe they're just administrative costs or state plan services? So better

definition around that would be helpful.

And then how we should collect data on this to be used in capitation rate settings. So, usually, these value-added benefits or in-lieu-of services are not collected in claims data, and there is no standard format or standard data store for that currently. So it's a lot of ad hoc reporting, data collection. It's going to vary from state to state. The quality is going to vary. So guidance there would be helpful.

And also how states should validate then what's being reported. So, with claims data and HIPAA and all kinds of laws and requirements, we have a good handle on how to validate medical expenses, but these other services are much more difficult.

I still have my financial reporting and MLR questions. Do you want me to go through those, or do you want me to give a chance for other Commissioners to chime in?

MR. DUNBAR: [Speaking off microphone.]

COMMISSIONER GERSTORFF: Okay. So, on the financial reporting side, I think right now there's limited accountability for how value-added benefits are reported in

statutory financial statements. So, if the costs for the value-added benefits don't meet the definition of health care quality improvement, then they could be buried in other administrative costs. And then those total administrative costs are intended to be used in capitation rate setting as base data, and if they do meet the definition of health care quality improvement under the federal regulations, then it seems like they should be eligible for inclusion in the capitation rates. So that feels unclear in the financial reporting.

So how should states and actuaries account for those costs in an administrative load, the non-benefit load for capitation rates, and how should we be evaluating financial reports?

And then for the MLR calculations and remittances, what sort of documentation should be required from health plans or states for proving the basis of their expenses? And if value-added benefits are covered as part of a value-based purchasing contract with providers, can those be covered through incentive payments where certain quality measures are being met, and so the provider receives incentive payments? And, really, that's covering

value-added benefits. Is that allowable? Is that something we should encourage, and then how should they be reported?

And my last question is, what tools states can use to evaluate if incentive payments under value-based purchasing contracts are appropriate?

CHAIR BELLA: And I'm sure we will come back to you and ask you maybe to package some of those up again.

Fred, you have to follow that. Good luck.

Thank you, Jenny.

COMMISSIONER CERISE: Great. So I'm going to follow up with a stupid question. I do have a question and then a comment.

My question is if you can help explain that instead of the gymnastics of that IMD rate setting and what's counted -- do you count it for utilization but not rate setting?

And then I do have another, just a comment, to address the questions raised. I mean, they're all geared towards should there be more clarity on the front end, and I think it's an emerging area. There's going to be a lot of activity in this space, and so to the extent possible,

being able to define, okay, what qualifies as an in-lieu-of service for capitation rate setting, what's a value-added service that you can count for MLR purposes but not for capitation purposes, I think those would be helpful.

And then some of the tricks are going to be how do you define what those are. So, if you say you can do in-lieu-of, you can do a hospital at home or home visits or video visits or phone visits, email visits, they'll need some definition around what qualifies there, so those don't get abused, right? But I think the more clarity that you can give on the front end, rather than sort of doing it on a state-by-state, waiver-by-waiver, state plan request by state plan request is going to be more helpful.

So now my IMD question -- because that's a great example of in-lieu-of service that I think that sounds like states have taken advantage.

MR. DUNBAR: I may start backwards, if that's okay.

I think everything you said and what I think was your second question or point was pretty consistent with what we've heard. I think with respect to MLRs and what constitutes as something that improves health care, I think

the last time CMS provided some guidance on that, they essentially sort of deferred to the states to sort of figure out what constituted that threshold, right? And so it does create that situation where you may not know, and then you kind of go back and forth, and it sort of, you know, spins some wheels in the rate development process.

And we heard -- the idea of California came up, where we've got that list of a dozen or 14 or so, like those pre-approved services. People said, well, you know, CMS could just put out a list that we know we can kind of pick and choose from, like a menu. So, yeah, that's very consistent with what we heard in our stakeholders with our interviews.

As for the IMD question, it's an interesting one. My understanding is that when they put this out in the 2016 managed care rule, they were concerned that between Medicaid expansion and then increased coverage through exchanges that there may be a shortage of inpatient psych and SUD services. And so they wanted to provide states with some flexibility to still provide the same level of services, but given potential capacity issues that were a concern, using other -- or using IMDs for other providers

who may be at max. But I think they also didn't want to layer in the cost of IMDs relative to what the other state plan providers were. So they let you use the anticipated utilization for the services, but they didn't want the cost of IMDs to be used. They just kind of reversed it to keep the cost that you would have paid for those other provider types.

Jenny, I think, you have a --

COMMISSIONER GERSTORFF: I just want to clarify there, because I do that calculation, and it's kind of counterintuitive. So we take the utilization for those inpatient stays, and we do price it at the state plan provider rate. That's usually an increase, because to be in an in-lieu-of service, it has to be cost effective, which means at or lower than the cost of the state plan service. And so it really is an increase over what was actually paid. So the cost is in there.

COMMISSIONER CERISE: It's captured.

COMMISSIONER GERSTORFF: Yeah.

COMMISSIONER CERISE: Interesting.

COMMISSIONER GERSTORFF: It's repriced to the state plan cost, which is more than what the actual IMD

cost is.

CHAIR BELLA: It makes perfect sense. Yes, yes.

Clear? Yeah.

[Laughter.]

CHAIR BELLA: Okay. Thank you.

Angelo, then Sonja, then Darin.

COMMISSIONER GIARDINO: Thank you.

Certainly, I'll preface this with stating my bias, which is I certainly want to see more attention to social determinants of health and whatnot. So I wonder if you could comment on if you think there's evidence or what the quality of the evidence is that would suggest that allowing the in-lieu-of services to be in the MLR will have a positive impact, because obviously I have a bias. I would like to say yes, have CMS promote that, but is there any evidence that supports that, or do you have any thoughts on that?

MR. DUNBAR: That's a good question. I'll start by saying I'd have to go back and would want to go back and look at the literature before giving a really conclusive answer, but I think the general sense is that I think, in particular, a lot of the non-medical in-lieu-of services

tend to be what's used to address social determinants of health. And I think there has certainly been research that shows that cost-effective care that addresses health-related social needs can have a positive effect from a cost and a health outcomes perspective. So I think that's what I would look to and to address your question of is there value in including it within the MLR or rate. So I think there is literature to support it.

COMMISSIONER GIARDINO: Okay, great. Because certainly in the population health world, operationally, we think so. So I would love to see some evidence that we could make a really strong recommendation, so thank you.

MR. DUNBAR: Good question. Thanks.

CHAIR BELLA: Thank you. Sonja?

COMMISSIONER BJORK: Well, what an exciting time in Medicaid that we have these new tools that we can work with, these tools that are not traditional Medicaid benefits, and so those who are in California and other states that are engaging in this experiment are just very, very busy trying to figure out a lot of the mechanics and the details that have been brought up so far. So I think we're going to have a lot to base our learnings on, and

some of the questions will get answered over time.

But I did want to maybe just add to some of the things Jennifer brought up about the difficulty in measuring and some of the challenges. The thing I'm the biggest proponent of is let's set this up or let's advise CMS to set this up so that states want to do this, not that it's so hard that nobody's willing to take it on and so as much advice as we can give ahead of time about what works and how you can set things up for good measurement and other details related.

So, in California, there are, indeed, 14 in-lieu-of services, and I'm saying "services" on purpose because they're not added as a Medi-Cal benefit. They're services, and that means that the different health plans, they have the option of adding them. They can add one, two. They can add all 14.

And the reason the state wanted to do that was to encourage the experimentation and also give time for the take-up, because some of these services take quite a bit of effort to get into place, and that's for several reasons. One is that they are services that are provided by non-traditional providers, and by non-traditional, I mean they

don't usually work with Medicaid. And so a housing service provider or a navigation provider, they may be working on grants or county funding, and now we're asking them to engage with Medicaid. And that entails probably getting enrolled with Medicaid and understanding how you interact with health plans and how you get paid, and that can take a very long time.

We did get information from the state with some CPT codes for all 14 of these -- not CPT -- HCPCS codes, Jennifer, HCPCS and modifiers. So those are all laid out, and they set that up so that this could be measurable as we start to provide the services and report them.

So I want to advocate for -- knowing how small the sample size is and that it takes time for take-up, I wanted to advocate for patients, as it does take a long time to stand these up, and for some of the benefits, you can't tell right away what was the value added, did it really help. So, on some of the benefits, how obvious can you get that it is wonderful to get someone out of the hospital, out of an acute care setting, into medical respite? You can show that right away. Just look at the cost of the hospital day. Compare it to how much cheaper

it was and much better for the patient to be in medical respite.

Some of the other benefits, my goodness, it will take a long time to see how that impacted the cost of their health care. So housing navigation, many of us in many states, there is a severe lack of affordable housing. So navigation could go on and on before somebody actually gets in a home and gets stable. Many, many places are struggling with workforce, so not just health care facilities but all the community-based organizations, they have workforce issues right now. So it's hard for them to take on a new project, a new benefit, a new way of working with a health plan.

So all of these, I believe, speak to a long ramp-up, and I really do want to get a good sample size before we start doing different types of analyses.

When California was deciding to do this, I am very certain that the conversations with CMS involved each and every one of those 14. There had to be some scientific evidence or pointing to other pilot projects that showed that these worked. They didn't just say okay on all of these 14. So I think we can learn a lot from California

and from the other states that are currently doing experiments.

But I really would like us to look into how we can advise to set this up for easy take-up for states and easy take-up for health plans. I'm oversimplifying because it will never be easy, but smooth or, you know, using lessons learned. But I can't express enough how exciting it is to be able to offer these things to people, the medically tailored meals, respite for folks who are taking care of loved ones at home, but they need a break so that they don't have to turn to a more institutional setting. Even home improvements, asthma remediation, I mean, it's just the list is wonderful, and so I'm a big proponent of figuring this out and giving good advice.

Thank you.

CHAIR BELLA: Thank you. It will be very helpful to tap into your expertise on being on the plan side of doing this in California, so thank you very much.

Darin and then Dennis.

COMMISSIONER GORDON: So, going back to the discussion about whether or not CMS should identify a list of those things that qualify, I think that's reasonable,

but I'd put a caveat that I would hate that that be the end of that list, because they were very much in a discovery phase. And some of the things that -- you know, I think back in Tennessee. Prior to in-lieu-of, we had cost-effective alternatives in our waiver back in 1994, and some of the things that providers and plans were doing, like go back to the one that we've all heard in different states, but buying the air conditioner for chronically ill patients that were having exacerbations in the heat of summer, you know, we wouldn't have thought of that. And we probably wouldn't have included it and spelled it out in our waiver, but it avoided serious exacerbations in that particular situation.

So I just want to go back to where there was the discussion about that. I think it's helpful for states to understand some of the things that they have approved and that they would quickly approve, but that we wouldn't look for them to define everything, because I think it's going to just inhibit some of the innovation that's out there, so having a path or a process to do others.

Which leads to something that Jenny brought up that I think is a big issue, not only as we talk about in-

lieu-of services but also as we talk about value-based purchasing -- and I've been saying this for a while -- is the capturing of the data. So I don't know, to Jenny's point, how you deal with this, how you get it in T-MSIS data because it's not coming in on a claim, but how you can do some of the analysis to understand some of the benefits or some of the creativity that's happening here. And so it just makes that piece even more important as we continue, because I think we're starting to roll down a hill on this.

And, again, I think there's a lot of great opportunity here in unleashing some of the innovation, not only for the plans, but the providers as well will be great. But it will all be for naught if we're not capturing the information and understanding what things work and what things didn't work, and I think that's equally as important.

And I've had some folks say, well, in trying to capture all those types of things, that's just going to be too burdensome or too onerous. We probably won't be perfect at it, but I think we have to at least start launching down the process. It's going to be a lot easier on the front end to think about how we try to capture the

big things than if we look back after the fact and then try to re-create that. So I think it needs to be a key element here.

But it is exciting. I think there's a lot of great opportunity. Let's just help make it more accessible for some kind of analysis of other states that are exploring or looking to go down that path, you know, have some evidence base for which to pursue it.

Thank you.

CHAIR BELLA: Sonja, is your comment to Darin's?

COMMISSIONER BJORK: Mm-hmm.

CHAIR BELLA: Okay. Sonja, then Dennis, then Laura.

COMMISSIONER BJORK: It is. So these HCPCS codes with modifiers are the way that we can send in data. Some of the community-based organizations, they never even heard of that before. So, in California, they're allowed to send in an invoice, and it's the health plan's problem to convert that into something that we can send in to the state. They wanted to make it as least burdensome as possible to these small agencies that don't bill usually.

And then, beyond that, I totally agree with Darin

that I have heard from a lot of community-based organizations, please don't make it so hard for us with too many data points that we have to send in for every single customer, or you make the administrative burden too hard, and we'd have to hire staff just to do that. So think about them out in the field. Maybe they have an iPad, and they're trying to talk to somebody who's very challenged. They can't answer 45 questions, so creating a balance between what data is really needed in order to do the analysis and really relying a lot on the HCPCS codes and the modifiers and putting the burden on the health plan to send in that information.

CHAIR BELLA: Thank you. Very helpful.

Dennis, then Laura.

COMMISSIONER HEAPHY: There's a lot of stuff, exciting stuff happening in Massachusetts. So, as Sonja was talking, I was nodding my head.

But I also think it's important, one thing about navigators for housing, and it's important to get the consumer's perspective on why is it taking so long to get housing. Is it because of the cost or those navigators actually doing their job? And so to understand what's

working, what's not working in these in-lieu-of services, having the consumer perspective is going to be really important, is going to be really important, and not to just jump to ROI, because we've got some really good data that shows there are direct dollar savings that are being achieved in certain situations. But sometimes medically tailored meals just make sense, even if they're not going to achieve that direct ROI.

And, Sonja, you're nodding your head. So I'm glad I'm not saying anything that's not making sense to you.

But sometimes that just makes sense to do, and it's not going to achieve the savings right away.

CHAIR BELLA: Thank you, Dennis.

Laura?

COMMISSIONER HERRERA SCOTT: Sonja said what I was going to say, just many of the in-lieu-of services are provided by community-based organizations, which just don't have the infrastructure, not only to sign some of the BAAs and DUAs that they're asked to sign, because they don't have the legal team to review these 40-page documents, but the data collection and everything else is problematic.

And then to the point that you made about in-lieu-of services, oftentimes the 'N' is so small, right? And it's for a particular population serving 25, 40, 50 people, but should there at least be some thresholds? I don't know. I think you used 2,000 for actuarial soundness, and maybe that's too much, but what is the number before you start considering whether or not to capture a service like that in the rates because -- or else it will be a lot of work for you for a small end, which really, financially, and even quite frankly even from an outcomes, except for maybe the people actually getting that service, the 'N' is so small to be able to extrapolate it for a population.

CHAIR BELLA: Dennis, did you have another comment? No.

Heidi.

COMMISSIONER ALLEN: So this is totally random, but it's going through my mind, and something that I think would be interesting to keep an eye on is that in January, Oregon is starting to do psilocybin-assisted therapy, and they have licensed their providers. They're licensing the products, all this through the Oregon Health Authority.

And this month, the article came out in New England Journal of Medicine of an international multi-site study of psilocybin and treatment-resistant depression that found that it led to significant improvements on day one that persisted for 12 weeks, and that's the FDA route for psilocybin, which probably wouldn't be approved until 2026.

But then, in November, Colorado just passed a law that's similar to Oregon. So, in the next couple years, we might see all of these states providing therapy outside of the health care system but for mental health conditions that are very common. And I'm very curious if this will be paid for by managed care companies through in-lieu-of services, and if so, would it be considered clinical or nonclinical? Because it is clinical inasmuch as it is licensed through the Oregon Health Authority with trained providers in a substance that is regulated, and it is for treating specific health conditions directly. But it's completely outside of what we think of as traditional health care.

So I just think it's really interesting. I just don't know what's going to happen with it, and I'm kind of just curious if that's the route they'll take.

CHAIR BELLA: All right. We'll put a pin in that one, keep an eye on that one.

And Jenny for the last comment.

COMMISSIONER GERSTORFF: Yeah. So, as Darren was talking about the data, I feel like a good follow-up for a future meeting could be an environmental scan of what barriers there are to collecting data, so identifying what those are, and maybe that helps us focus on how to resolve them.

And I want to highlight, well, maybe a couple more things. When we're talking about the in-lieu-of services and capitation rate setting, in particular, there's a disconnect in when the services are happening versus when you're paying for them, right? So, if you have some inpatient hospital stays that are avoided this year, that data for this year won't be used until calendar year '25 premiums, for example. And so, in 2025, when we're setting these rates, we're using this cost from 2022, and it starts to feel a little bit disconnected.

I don't know how we consider that, but I feel like it's an important thing to be thinking about, because for MLR, what happened last year, you're being measured on

that. But for capitation rates, you're projecting forward, and I think that kind of goes along with the premium slide that you included in the materials.

We hear from health plans a lot as a state rate-setting actuary. MCOs don't always want to invest in something that they're not certain will be in the capitation rate in the future. So that kind of limits innovation, and what are ways that we can address that, or is that real, and how real is that? And how can we quantify?

I don't think we talked about it during the presentation. So the premium slide, when we're hearing from providers or MCOs that we're going to reduce cost in the future, which means you're going to pay us less, but we don't want you to pay us less, so keep paying us the same, but we're going to pay less. They don't want to reduce their future of payments. So how do we resolve that?

CHAIR BELLA: So data collection, thinking more about data collection, you're bringing up an important point about lag and timing and incentives for spending on some of these and the impact on the future rates.

You're all making my brain hurt a little bit. We

should have had this session at the start of the day.

I think there's a lot more to do here, and it feels like it's great that we're getting primed for the rule and we'll be prepared to comment, but there's so much work that we could be doing in this space, and kind of keeping an active list of that, I think, is going to be really important.

I think of all the things on your list here, anything that is more clarity, I think there was a strong endorsement by the Commissioners. I didn't hear any -- bullet point two, I didn't hear anybody expressing concerns. I mean, we have some questions for some clarifications, but I think mostly the focus is on clarity and transparency and then the 25 things that Jenny mentioned. If you could get those done by, you know, end of year, that would be great.

[Laughter.]

CHAIR BELLA: All right. Any other comments from Commissioners?

[No response.]

CHAIR BELLA: Sean, I'm going to guess you have more than enough. Do you need anything else from us?

MR. DUNBAR: This is a good amount. I appreciate all the ideas, and I'm just glad there's a transcript I can go back and refresh my brain.

CHAIR BELLA: Okay, perfect.

MR. DUNBAR: Thank you.

CHAIR BELLA: Thank you very much.

We'll open it up to public comment quickly and then take a break. If anyone in the audience would like to make a comment, please use your hand icon, introduce yourself and your organization, and we ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I am not seeing any hands, and there will be one more opportunity for comment at the end of the meeting as well.

So thank you again, Sean. We'll go ahead and take a break, and we'll reconvene at three o'clock. Thank you.

* [Recess.]

CHAIR BELLA: All right. Welcome back, everyone.

I am thrilled to introduce our next session,

which is about MMP transition, and I'll let you guys go into the acronyms and all those fun things. But welcome, Kirstin and Drew, and we'll turn it over to you.

MEDICARE-MEDICAID PLAN DEMONSTRATION TRANSITION UPDATES AND MONITORING

* MR. GERBER: Thank you. Good afternoon, Commissioners.

I'll be providing an update today on the initial stages of the transition process from Medicare-Medicaid plans, or MMPs, to integrated Medicare Advantage dual-eligible special needs plans, or D-SNPs, by states participating in the Financial Alignment Initiative demonstration.

To begin, I'll cover some background about the MMPs and D-SNPs before diving into recent rulemaking from the Centers for Medicare and Medicaid Services that set an end date for the MMP demonstration.

I'll then highlight themes that arose from our interviews with state and federal officials about the transition process so far and our framework for monitoring the transition as it proceeds.

The Financial Alignment Initiative kicked off

demonstrations in 13 states back in 2013, offering three models to choose from: the capitated MMPs, a managed fee-for-service model, or an alternative model. We'll be focusing exclusively on the nine states that have MMPs today, as it's the model addressed by the CMS final rule.

MMPs feature three-way contracts between state Medicaid agencies, the managed care entity, and CMS. These contracts allow for passive enrollment, integrated member materials, and the possibility for states to share in savings to Medicare that may result from integrated care.

Evaluations of these demonstrations, which we've cataloged in an inventory available online, have had mixed findings. Overall, enrollment in the MMPs was lower than initially expected. Improvements in outcomes, such as reduced emergency department visits or long-stay nursing facilities, were limited, and none of the MMPs realized savings to Medicare or Medicaid during the life of the demonstration.

The MMPs did receive high ratings from beneficiaries, and evaluations showed that stakeholders were supportive of the demonstration overall.

Another integrated model is the D-SNP. These

Medicare Advantage plans only enroll dually eligible beneficiaries and are designed to meet their specific needs. D-SNPs offer varying levels of integration including highly integrated dual-eligible special needs plans, or HIDE SNPs, which cover long-term services and supports, behavioral health, or both, and fully integrated dual-eligible special needs plans, or FIDE SNPs. They're typically responsible for all Medicaid and Medicare benefits.

Compared to the MMPs, D-SNPs are widely available. D-SNP products are present in 46 states and the District of Columbia and enroll more than 3 million beneficiaries as of this year. The D-SNP model received permanent authorization in 2018, and recent rulemaking and guidance have made greater level of integration in the model possible.

D-SNPs have separate contracts with CMS and state Medicaid agencies, and states can further integrate coverage in their D-SNPs by maximizing existing authorities for contracting, which the Commission described in prior work last year.

In January, CMS issued a notice of proposed

rulemaking that included regulatory changes that increased D-SNP integration, in part, by adopting elements of the MMP in addition to setting the sunset date for the MMP demonstration.

Those changes include expanded requirements for integrated appeals and grievance processes and service area alignment for FIDE SNPs and HIDE SNPs with their companion Medicaid plans.

In March, the Commission commented in support of the rule's move toward greater integration, and CMS finalized the rule in May.

The CMS final rule says that MMPs must end by the end of calendar year 2025 at the latest, though states are not required to transition to an integrated D-SNP model. Those that plan to do so were required to submit transition plans to CMS by October 1st of this year, which included how they'll maximize integration throughout the transition, sustain the ombudsman program without federal funding, and engage stakeholders in the process.

States were also asked to identify policy and operational steps needed to achieve these goals as part of establishing a tentative timeline.

There are some elements of the MMPs that do not transfer over to these integrated D-SNPs, such as a mechanism for states to share in savings to Medicare.

And now I'll move over to some updates, what we heard from speaking with state and federal officials.

In preparation for this briefing, we spoke with officials representing five states as well as federal officials and subject-matter experts. All states have requested the extension to 2025 for their programs, excluding California, which had already opted to end its demonstration prior to publication of the rule. California has been working closely with CMS to transition to aligned D-SNPs. That will take effect in the coming months.

Most states expressed confidence in their ability to successfully transition their demonstrations into aligned D-SNP products by the end of 2025, and several emphasized that they'll be taking an incremental approach to this.

States told us that they're in the early stages of planning in the transition. The plans submitted in October are drafts that states expect to refine along the process of receiving feedback from stakeholder groups.

Some states are in the process of developing those stakeholder communications, outreach strategies, as we speak, whereas others have already begun sharing their plans publicly.

Massachusetts, for example, has its One Care Implementation Council, the consumer-led working group that has provided feedback to the state regarding the MMP. The state said it will work closely with the council among other stakeholders as it finalizes policy and operational details.

Some, if not all, states will need to undergo Medicaid managed care procurement. Given the length of time needed for procurement, typically 18 to 24 months, this is one of the more pressing decisions of the transition. State officials are in early discussions about procurement, and some have identified other state action needed to proceed.

For example, South Carolina does not currently enroll dually eligible beneficiaries in Medicaid managed care, and it will need time to receive approval for changes to its state plan to allow those beneficiaries to be enrolled.

For some states, not all of their existing Medicaid managed care plans offer companion D-SNP products in the same service area.

We did hear from state and federal officials that the substance of the MMP contract could largely be lifted to form the state contracts with the D-SNP, which would help preserve certain requirements such as single ID cards or care coordination requirements.

Another timeline consideration that arose from interviews regard information technology system changes. These upgrades may take significant time, and delays are not uncommon. Changes to IT systems may be needed as states take on a greater role in the enrollment process and will need to facilitate data sharing with health plans.

We also identified enrollment as a potential area of concern. During the demonstration, a number of states relied upon a third-party enrollment broker to manage enrollment, and for states that lack experience enrolling dually eligible beneficiaries into coverage, this transition could become a heavier lift.

We also heard one state voice concern that marketing to beneficiaries could become less person-

centered, and that member materials may be less integrated than they were under the demonstration as things move forward.

CMS has provided states with technical assistance and feedback during the transition planning process, and it will be continuing that support as states begin to implement their plans. In our interviews, CMS described its positive experience assisting California with its transition and noted it anticipates using that process as a template for its technical assistance with the remaining MMP states.

During our interviews, state officials said they were greatly satisfied with the level and quality of technical assistance received thus far. States also uniformly expressed appreciation for the contract management team model implemented under MMP, which comprised regular calls between the states, CMS, and health plans.

While not explicitly mentioned in the final rule, it's expected this type of support can continue for states interested in doing so.

All states we spoke with plan on a smooth

transition for beneficiaries and acknowledge the importance of minimizing disruptions. States plan to transition their enrollees of -- their MMP enrollees into D-SNPs with exclusively aligned enrollment, which means that only enrollees of an affiliated Medicaid managed care plan may enroll in its FIDE SNP.

A few states we spoke with also mentioned that they plan to use default enrollment where states can approve D-SNPs to automatically enroll a Medicaid member becoming eligible for Medicare if the D-SNP is of the same parent company as that member's Medicaid plan. As we noted earlier, some elements of the MMP do not transfer over to the D-SNP.

But we heard in our interviews that some would have preferred to keep tools like passive enrollment, which states found very effective in increasing enrollment in the MMP, or shared savings. None expressed much concern or frustration that they won't be available going forward, and it did not sound as if it made up a substantial part of conversations with CMS.

One element that will continue -- the ombudsman program will no longer receive the federal funding it did

under the demonstration. States told us they plan to continue the programs as required, although sourcing state-only dollars is under discussion. For some states, ombudsman services for dually eligible beneficiaries will transition to existing long-term care ombudsman offices.

Now moving on to our framework for monitoring, the transition processes continue through 2025. The primary areas we've identified to monitor from our interviews to sort of bring out the takeaways and based upon their complexity and amount of time needed to complete or potential cause for disruption for beneficiaries include the areas of stakeholder engagement, Medicaid managed care procurement, system changes, and enrollment processes.

Looking at next steps, states told us to anticipate completing their initial rounds of stakeholder engagement in the spring of 2023. Of the eight states undergoing the transition to integrated D-SNPs, excluding California, two states have published transition plans that they've submitted to CMS. We plan to continue to review these as more are released, and we also plan to stay apprised of state actions on procurement and plans for enrolling eligible beneficiaries as they take shape by

following up with interviews.

We look forward to any questions Commissioners may have about what we heard in our interviews or feedback on the elements we should monitor going forward.

Thank you.

CHAIR BELLA: Thank you very much.

I'm actually going to start off with a couple of comments and then go to Dennis next for comments.

I appreciate the focus on monitoring and thinking about and talking to the states directly. I would encourage us to continue to do so as that period shrinks, and it's good to hear that the states, by and large, didn't seem concerned.

I would say one state, at least in their public plan, Massachusetts, does not seem particularly excited to be transitioning to this, and there is a feeling, I think, that some of this is moving backwards, because in some features, the MMP was more integrated and the D-SNP is a different platform. So, at the end of the day, it doesn't matter which acronym it is. It matters like what is better for dual eligibles, and if we can keep that lens and make sure that as part of the transition and the ultimate

options available to states that people aren't losing access to some things, I think that's going to be really important.

And I would just give an example. There's a state now, a big state with a lot of duals, that the misalignment between the state contracts and the CMS SMAC -- so that's the state Medicaid agency contract -- is such that like they can't get them aligned, and so the SMAC has to be in, in order for the plan to start enrolling beneficiaries in Medicare open enrollment. The SMAC hasn't been approved. So the plan can't start marketing and doing enrollment, and it's an integrated product.

And meanwhile, all the non-integrated products that don't have to go through that step can be out there. Like, marketing and brokers can be using their commissions, and so it undermines efforts. And that happens because we have to deal with two separate -- two completely separate programs, right, the Medicaid agency and the Medicare agency. And you didn't have that with the MMPs.

And so full cards on the table, obviously, like I was at CMS when MMPs were birthed, so I have a little bit of a soft spot for them. But making -- like, watching for

procedural things as well that take away from beneficiaries getting integrated care and kind of allow non-integrated models to proliferate, I think, is something that I would like us to keep an eye on as well.

But overall, very appreciative of this work and always love it when we hear from states.

MS. BLOM: If I could just make one comment, Melanie.

So, just to reiterate, we didn't actually talk to all of the states, reach out to all the states. But we know that there are some states that we weren't able to talk to that might be having different experiences.

And, also, the levels of integration in some of these MMPs were different. Like, Massachusetts is a far-ahead-of-the-game state, I would say, and we did hear some concerns from them about sort of a little bit of a backward step. So we're trying to keep our eye on those variations.

MR. GERBER: Yeah. I would say speaking to the plan that they publicly released, I know Massachusetts had voiced interest in things such as Leavitt proposal, I think indicating an openness to more integrated options in the future, but from what we heard from them and other states

was there seems to be acceptance that this is the plan going forward. And making it work through their conversations with CMS, there wasn't what sounded like any major conversations going on, either trying to bring over elements from the MMP that aren't transferring or any concerns about integration in D-SNPs that don't -- that states are unsure that they'll be able to address.

CHAIR BELLA: I think it will be interesting to watch as we get closer, kind of what those feelings are, and as other -- you know, there's great amount of interest in Congress, several pieces of legislation floating around about duals. So it's all good, so appreciate that. We'll be keeping an eye on it.

Dennis, I'm going to go to you next.

COMMISSIONER HEAPHY: Sure. So I'm Massachusetts dual eligible, and I benefitted from the MMP model. And I think two things central to the MMP model which are important to consider, one is the single three-way contract, the Medicaid, Medicare -- or CMS, the state, the state Medicaid office, and the plans were in a single contract. And now we're going to have two separate contracts, one, the plan of a contract with CMS, which will

oversee the Medicare part of the contract, and then you'll have the SMAC, which will be the Medicaid part of the contract. And so we're going from a single contract to two separate contracts.

And, as we all know, one of the biggest barriers to integration of services for people is that lack of alignment between Medicare and Medicaid, and so, as much as folks are -- don't seem very concerned about what this means for the finances, advocates in the state are and advocates are nationally, I think, somewhat concerned about what does this mean.

And so one of the concerns we have is that this will be a cost shift for -- a cost shift to the states, and that rather than the emphasis which had been an MMP or rebalancing spending to LTSS and LTSS reducing hospitalizations, that, you know, Medicare is going to -- Medicare will reap the financial savings, apart from the financial alignment, and that this is going to really affect the bottom line of a MassHealth and what it will be able to do, not only for dual eligibles but for all Medicaid recipients in the state.

Again, confusion about the total financing, and

under the misaligned contract, the plan will have separate MLR ratios, and so one for Medicaid and the other for Medicare. How will actuarial soundness be assured if the state and CMS reconcile MLR separately, using differing actuarial analysis? Will CMS and then -- and Medicaid, different Medicaid offices around the country, contract requirements include definitions of actuarial soundness that require plans to provide actuarial utilization account to data rather than -- rather than just predictions? How will directed payments work? Complications around quality measurement, like, how will we actually measure the quality of this new configuration?

And every state works differently in how it oversees the plans. MassHealth is more of a hands-off state and other states more hands-on, and so we're looking at should MassHealth require MA plans to participate in the state-directed BP initiatives and develop value-based purchasing strategies within state-specified guidelines, because other states do have that. And, Darin, you talk about that a lot.

When plans do not meet MLR requirements, should MassHealth always require MLR remittance to MassHealth?

Can we be more creative around MLR remittance so that it's actually used for -- to reinvest in the D-SNPs.

I know I'm a little bit all over the place, but we're just trying to figure things out. I do think it does require oversight, not only just the transition from the MMP to the D-SNP, but even if you heard at the start that they didn't make the financial savings that they had hoped. They also used -- CMS is also using the MMP as -- practices from the MMP to guide the D-SNP development. And so, as it's being used to guide D-SNP development, we need to make sure that the mistakes that were made in the MMP don't follow through in the D-SNP development.

I think one of the things we need to look at really closely is what is the definition of care coordination. Is it defined by -- differently in every state, or we're going to have a clear definition of what care coordination is based on outcomes and encounter data, and what's that actually going to look like? And I think that's -- there's a great opportunity there. There's also a chance for a lot of risk there in terms of managed care organizations not providing adequate or appropriate care coordination for high-need populations.

I think that's it. I don't know if there's anything else, Melanie, you thought I should share.

CHAIR BELLA: You and I could probably go on forever. Everybody else is getting a little glazed-eyes, Dennis.

But, Martha, did you have a comment?

Thank you, Dennis.

COMMISSIONER HEAPHY: I'd like just to say the reason why I think it's really important that the -- we're talking like it's not the largest percent of population, but it's the highest cost in the cost drivers in the country. So focusing on ensuring that this population -- we're looking at reducing costs and quality of care, I think it's really important for the Commission to look at, even as our glazed eyes glaze over.

[Laughter.]

CHAIR BELLA: Martha.

COMMISSIONER CARTER: Thank you. Dennis, that perspective is really helpful.

I was taking a step back. and I couldn't help wondering if there was -- if it would make the states leery to start programs like this. How often does it happen that

they get ended? I know PACE was -- wasn't PACE defunded for a while? And so, you know, there were only eight or nine states that participated in this, and is there uncertainty in the minds of state officials when they think about joining one of these programs that it might not continue? I just wondered how often that happens, and is it -- does it have a chilling effect on what states -- willingness to participate?

CHAIR BELLA: This is really going to make your eyes glaze over, but just for context -- and I'm going to oversimplify all of this -- these demonstrations were done under the Innovation Center authority, and so there are requirements about impact on cost and quality that have to be certified by the Office of the Actuary. And the evaluation results are not -- my understanding is part of the reason these need to transition is the evaluation results aren't allowing those tests to be met, and so the -- but, also, the evaluation is of the entire eligible population in a given state, and you've seen some of the participation rates. Because proper evaluation design is to do it that way, that's the way the evaluation was done, but it doesn't tell us of those who were engaged, was there

a cost savings and what the impact was on those that were engaged. And so, in some of the states, in particular, where the participation rate is so low, you can imagine that there's no way it could overcome that.

So I would say that if you consider the evaluation design, you might say that the results are somewhat inconclusive, because, again, it's the right way to do the design, but it's difficult when you're not just looking at the people that are engaged. And so it's -- some of the results about the experience of beneficiaries, I think, are really important, and those were very positive on this. So I don't know.

But what I was going to tell you is that the Massachusetts used to have -- in the early days, there were three states that had a demonstration well before D-SNPs, and Massachusetts was one of them. And they had one contract, and they were required to transition into D-SNPs when D-SNPs came along. And then they got to do this demonstration, and now they're going to be required to transition into D-SNPs again. So it's interesting.

I don't think that they usually go away as much, Martha, as they're -- not impermanent, but they’re

demonstrations for a while. D-SNPs weren't permanent for a very long time, and it was frustrating for states and for plans to know, like, should we keep investing in this. So I think it's a valid point.

If the next demonstration comes out for duals, maybe states are going to be reluctant because there's not much permanence.

That was very long winded.

Laura.

COMMISSIONER HERRERA SCOTT: So just a follow-up question to what you just said, given what we know about D-SNPs, though, so maybe the MMP didn't pass the test, but then the default to the D-SNP, the evidence there is not great either, in fact, maybe by some accounts worse. How does that get taken into consideration, or is it yes/no, you pass the test, and then the default is --

COMMISSIONER GORDON: It wasn't under that.

COMMISSIONER HERRERA SCOTT: Okay.

CHAIR BELLA: Yeah. D-SNPs don't have the innovation center sort of litmus test --

COMMISSIONER HERRERA SCOTT: Got it. Okay.

CHAIR BELLA: -- that this one did. What's

that? PACE doesn't either, no. No. Those are all -- PACE and D-SNPs are now permanent, permanent program offerings, and this one has continued in demonstration status.

I think CMS is doing what -- they're following the protocol, and they're doing a nice job of working with states. I think it's our job to continue to think about how do we get truly integrated options to everyone across the country and support states in doing it, not to -- myself included, not to get hung up on what acronym vehicle that is.

So do you have any other questions? Comments?

COMMISSIONER GERSTORFF: Well, it just seems, even if it's a different authority, what are the options versus just stopping the program altogether and to everything that Dennis described, one contract, two contracts, care coordination, and what we know about managing two payers, right, on behalf of a member patient, that there would be -- I don't know. It's wishful thinking, Pollyannaish, and like you said, regardless of the letters that you're calling it, but some other option for consideration, even if the authorities were different, based on the intent of MMP and tweaking of it before

saying, "Nope, you failed the test. You have to go to this option."

CHAIR BELLA: And that's sort of the flavor of, I think -- Massachusetts' letter, for example, contains some of that, sort of like I wish we could do something different, else, evolution. Yeah.

All right. You guys definitely -- you knew you would get a lot from me, so thank you. I appreciate this work and look forward to continued updates on it.

MS. BLOM: Great. Thanks, guys.

CHAIR BELLA: All right. Going to move into a session on Medicaid coverage of drugs and a continued discussion of the relationship to Medicare coverage decisions, and Chris is going to join us.

[Pause.]

CHAIR BELLA: Welcome, Chris.

MEDICAID COVERAGE BASED ON MEDICARE NATIONAL COVERAGE DETERMINATION: MOVING TOWARDS RECOMMENDATIONS

* MR. PARK: Thank you.

At the September meeting, staff presented on the potential implications of antiamyloid monoclonal antibodies

for the treatment of Alzheimer's disease, such as Aduhelm, on the Medicaid program. As part of the discussion, Commissioners express interest in a potential policy option to allow states to implement coverage requirements following a Medicare national coverage determination. So today we'll continue that discussion in moving toward a potential recommendation.

First, I'll provide a quick refresher on the different drug coverage standards under Medicaid and Medicare Part B.

Next, I'll discuss the option to allow states to restrict or exclude coverage of a particular drug based on a Medicare national coverage determination. This includes a draft recommendation for statutory change, the rationale for this policy, as well as implications for different stakeholder groups.

In order for any recommendation to be included in the March report, the Commission must reach a decision on the recommendations so staff can draft the chapter and specific recommendation language to be voted on at the January public meeting.

Outpatient prescription drugs in Medicaid are an

optional benefit that all states have chosen to provide. Medicaid drug coverage is governed by the Medicaid Drug Rebate Program under Section 1927 of Social Security Act. Under the Medicaid Drug Rebate Program, or MDRP, drug manufacturers must provide rebates in order for their products to be recognized for federal match. In exchange, states must cover all of a participating manufacturers' products. States may limit the use of particular drugs through utilization management tools, such as prior authorization or preferred drug lists, but at the end of the day, a state cannot outright exclude coverage of a drug.

Physician-administered drugs, those that are administered by a health care provider in a physician's office or other clinical setting, are unique in that their inclusion in the MDRP can depend on how the state pays for the drug. If a state makes a direct payment for the drug separately from the service, they can claim the statutory rebate.

Under the MDRP, a state is generally required to cover all of a participating manufacturer's products as soon as they're approved by the FDA and enter the market.

This requirement makes the Medicaid program unique among payers, and generally, plans sold on health insurance exchanges and Medicare Part D have minimum requirements for drug coverage, but they are allowed to exclude coverage for some drugs. Additionally, exchange plans and Medicare Part D plans are allowed a period of 90 to 180 days to make coverage decisions once a drug hits the market.

Medicare Part B covers drugs that are not usually self-administered by the patient and furnished as part of a physician services in an outpatient setting. So these are generally the same as the physician-administered drugs in a Medicaid program.

Medicare Part B must cover services that are reasonable and necessary for drugs. This means that Part B generally covers FDA-approved drugs for on-label indications and other uses supported in CMS-approved compendia.

CMS can develop coverage determinations for items and services that apply nationwide through a national coverage determination, or NCD. CMS can initiate an NCD internally, or one can be initiated at a stakeholder's request.

Under certain circumstances, CMS can link coverage of an item or service to participation in an approved clinical study or collection of additional clinical data. This policy is referred to as "coverage with evidence development," or CED. CED is used when there are outstanding questions about the service's health benefit in the Medicare population and allows CMS to gather additional data that would further clarify the effect of these items and services on the health of Medicare beneficiaries.

CMS has rarely used CED for prescription drugs. The most recent example of a CED was for the antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease.

In April of 2022, CMS finalized an NCD with CED policy for these Alzheimer's drugs. Coverage is limited to participation in a clinical trial or other approved comparative study, depending on the pathway under which the FDA approved the drug. If the drug was approved under accelerated approval based on a surrogate endpoint, it must be in a randomized controlled trial. If the drug was traditionally approved based on direct measure of clinical

benefit, then coverage can be in a CMS-approved prospective comparative study.

States may implement prior authorization or use a PDL to manage the use of prescription drugs. However, it is not clear to what extent states can use these tools to limit use.

In the recent case of the Aduhelm, the National Association of Medicaid Directors asked CMS for the flexibility to apply the same coverage requirements as Medicare; that is, limit use to participation in a clinical trial comparative study.

Because the MDRP coverage requirements are in statute, CMS does not explicitly have the authority to allow states to restrict coverage similar to a Medicare NCD. A beneficiary or drug manufacturer may challenge the state's coverage criteria, and the extent to which states can restrict coverage of a particular drug covered under the MDRP may ultimately be decided by the courts. A statutory change would be needed to ensure states could implement coverage criteria based on Medicare NCD, including any CED requirements.

The Commission can make the following

recommendation for a statutory change. The draft recommendation reads: "Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on a Medicare national coverage determination, including any coverage with evidence development requirements."

Under the NCD, CMS has gone through a formal process to review the evidence and seek external comments to determine what they consider to be reasonable and necessary. This recommendation would give states the flexibility to align their coverage criteria with Medicare and use that federal determination of reasonable and necessary coverage.

This would be in line with previous Commission recommendations to align Medicaid policy with other federal programs.

In its June 2019 report, the Commission made a recommendation to align Medicaid's time frame for making drug coverage decisions with the federal standards governing Medicare Part D and exchange plan formularies.

It is important to note that this policy would

not be a national coverage decision for Medicaid. States would have the option to follow the Medicare NCD, but nothing in this recommendation would prohibit a state from providing broader coverage than the Medicare NCD.

Allowing states to follow a requirement to link coverage of a particular drug to participation in a clinical trial or the collection of additional clinical data would be a helpful tool in addressing state concerns of covering prescription drugs that have not yet demonstrated a clinical benefit. Such a policy would allow for an additional collection of data on the clinical benefits of a drug in the Medicaid population, which may reflect a different mix of health status, demographic, or other socioeconomic characteristics than found in either the original clinical trial or Medicare populations.

Additionally, states could link CED requirements to an outcomes-based contract to obtain larger rebates when the drug does not provide the expected clinical benefit.

Finally, the Medicare NCD process includes periods for public comment. So stakeholders have several opportunities to express their concerns during the process. CMS has demonstrated a willingness to alter its proposed

criteria in response to concerns. For example, in 2019, CMS proposed to apply CED in its decision for CAR-T therapy. However, in response to concerns over beneficiary access, it ultimately removed the CED requirement.

This allowance is unlikely to affect many drugs in Medicaid. Because NCDs are a Part B provision, this policy would only apply to physician-administered drugs.

Additionally, this process has rarely been used for drugs. To date, the more restrictive CED requirements have only been used three times on prescription drugs, and CMS has indicated that it does not expect to use CED frequently for drugs in the future.

CMS is unlikely to evaluate or implement CED policies for drugs that are not significant to the Medicare population. As such, this recommendation likely would not address concerns for many drugs that are significant to Medicaid; for example, treatments for conditions prevalent in childhood such as cystic fibrosis. Even so, drugs for which Medicare is a primary payer still could create significant expenditures and corresponding budget pressures for states.

For example, the analysis we presented in

September showed that gross spending on Alzheimer's drugs before rebates could reach as high as 1 to $3 billion a year, depending on the breadth of label indication, uptake, and the price of the drugs. For context, that spending range would be similar to the annual gross spending on hepatitis C drugs.

Allowing states to follow a Medicare NCD would likely reduce federal spending on those drugs. In particular, if CED requirements were implemented, they would likely reduce utilization for those drugs, and thus, spending would also decrease.

We have requested a score from the Congressional Budget Office, which we plan to provide at the January meeting.

Given CMS's history of using CED and its statements about rarely using it in the future, it is likely this recommendation would not result in a large amount of savings.

In a similar manner, state spending would likely decrease as utilization of drugs under CED requirements decreased.

Generally, beneficiaries have been opposed to CED

requirements proposed under Medicare NCDs and are likely to oppose this policy to the extent that it could reduce access to particular drugs.

Similarly, manufacturers also oppose such policies and argue that the CED requirements significantly restrict access and that Medicaid coverage should not be restricted any further than currently allowed under the MDRP.

However, a Medicare NCD could provide some benefit to beneficiaries by ensuring that the drug is delivered under appropriate guidelines and monitoring. Many specialty drugs have serious safety risks, such as brain swelling or brain bleeding. The collection of data under CEDs could provide important information on the occurrences of these adverse events and provide additional information about the potential benefits and risk of treatment in specific subpopulations.

CED requirements could also change manufacturer decisions about the pathway under which they seek FDA approval. For example, the CED requirements applied to the Alzheimer's drugs, it could provide an incentive to seek traditional approval, because the prospective study

requirement allows for broader coverage than the randomized clinical trial requirement under accelerated approval.

As I mentioned previously, there are opportunities for stakeholders to voice their concerns during the Medicare NCD process, and CMS always has the ability to revise an NCD as more information becomes available.

Finally, providers could face an administrative burden in the collection and reporting of data required under a Medicare NCD. To the extent that these providers also serve Medicare beneficiaries, then they would already need to have their procedures in place to collect and report these data, including Medicaid beneficiaries in the data collection and reporting process may not be a substantial burden.

To wrap up, at this meeting, Commissioners need to decide whether or not to move forward with this particular recommendation. We would appreciate feedback on the draft recommendation language and the rationale. Staff will then draft the final recommendation language to be voted on at the January 2023 meeting and also include a chapter for inclusion in the March 2023 report.

And, with that I'll turn it over to the Commission for any questions or comments.

CHAIR BELLA: Thank you, Chris.

Who would like to kick us off? Heidi.

COMMISSIONER ALLEN: Thank you, Chris. This is very helpful, and the materials have been helpful. And I understand that MACPAC has done a lot of work in this area before my time, and so there's elements of this that I may not totally understand.

But I would say based on what I've read and what was presented that I would not support a recommendation moving forward, and the reason for that is I'm not a big fan of workarounds, patching things. And one thing that is very clear is that a lot of the concerns that face the Medicaid population are not addressed by this policy. So it's a limited policy with a limited scope and doesn't really address the bigger issue of how does Medicaid control drug costs and how do we have drugs that are of high benefit to enrollees and ways for states to manage costs.

I think there are notable differences in the Medicare population and the Medicaid population, and I

think that those differences could become really important, not necessarily with when we're talking about Aduhelm but in other drugs that Medicare may make a national coverage decision on.

And it relies -- you know, when I'm reading through the materials, there's a lot of inferences that are about a CMS that cares about access. So, you know, it's noted that CMS indicated that they don't plan to use this often. Well, that's not super reassuring to me.

The second thing is that CMS can change their mind if beneficiaries and advocates say this doesn't work. Well, maybe they will and maybe they won't, but I don't think that's -- I don't feel so confident in either of those things that I would feel super inclined.

Low-income people are often excluded from clinical trials and studies based on comorbidities or circumstances, even financial circumstances, that make them not an ideal candidate for a research study, like being able to have transportation back and forth and somebody to care for you. I mean, there's a whole list of it, but you can -- definitely, there's a large literature to suggest that low-income people are underrepresented in clinical

trials and research. And they're a population that have been harmed historically by research. So, even if they were included through the studies, they may be less likely to participate, particularly African Americans and people who have been harmed by research in the past.

Another thing that bothers me is that if a statutory change is required to do this, why wouldn't we pursue a statutory change that's specific to Medicaid? I understand the benefit of aligning federal programs, but Medicare is concerned about peoples 65 and above and people with disabilities, and their focus is still on those populations. And our focus should be on our population, and if we're making -- if we're asking Congress to make a change, why wouldn't we make it for Medicaid specifically?

And MACPAC is not even allowed to comment or make anything about related to Medicaid -- Medicare. So, if this were causing, down the road, a harm to Medicaid enrollees, we couldn't say anything about it. We couldn't say, "Hey, MedPAC, like we have concerns. Why don't you change this?" That's not our business, according to statutory authority. So that is, to me, a problem.

And then some of the language in the chapter, I

found a little patronizing when talking about the potential, like, stakeholder response. It's not our job to make sure that drugs that are offered on the market are safe and effective, and so we don't make coverage decisions to try to protect people from risks that they might have from taking that medication. And so there is a potential impact to beneficiaries that is not listed in our talking about this at this point where, like, maybe they won't get access to something that could have benefitted them.

I think just saying like, "Oh, we will prevent them having side effects from a drug that maybe isn't fully tested," that's just -- that's one side of a coin, but the other side of the coin is maybe we will prevent them from having access to something that could have benefitted them, and I think that that needs to be included as well.

That's it for me. Thanks.

CHAIR BELLA: Thanks, Heidi.

Just to clarify one thing, we're amending the -- I mean, it is a Medicaid statute amendment. We're not doing anything with regard to Medicare.

COMMISSIONER ALLEN: But we would be aligning our decisions to Medicare, and Medicare has the decision-making

power about that. So we couldn't -- if we aligned it, correct, by changing the Medicaid statute, then if we had concerns later with the decision that Medicare made in a national coverage decision, we could not comment on that because then it's a Medicare decision and not ours?

CHAIR BELLA: Except this is always a state option, and so the state has -- and I would say that, you know, if we didn't have these two titles with a bunch of dual eligibles and Part D and sort of the difficulty and the relationship between Medicare and Medicaid and Part D, I think it might make this conversation different, but they are -- they are inextricably linked.

COMMISSIONER ALLEN: For one population, right, but not for the other, the entire Medicaid and CHIP population, and that's the part that could be affected by this, inadvertently, by trying to focus on this narrow subset that has the duals.

If we were talking about just aligning it for duals, I would be more inclined.

CHAIR BELLA: I think his point is the drugs we're talking about, like they're not -- well, I'm not going to argue that.

COMMISSIONER ALLEN: Yeah, yeah. No. I'm interested in your thoughts.

CHAIR BELLA: And we have lots of people in line to talk, but I appreciate those comments. It tees us up well.

Martha, then Angelo.

COMMISSIONER SCANLON: Hold on.

Do you want to go, Bill? Go ahead.

COMMISSIONER SCANLON: I guess, in part, I mean, I feel like part of this is that -- and I'm particularly sort of affected by this -- are the particular circumstances we're dealing with here, Aduhelm. Okay. And how this came about where we had an almost unanimous vote by the FDA Scientific Advisory Panel saying do not approve this drug yet. The evidence is too thin.

Medicare could have said we're not going to cover this at all. Instead, what they said is we're going to try and gather more evidence, which I think is beneficial to everyone involved.

But it's also protective of everyone involved. We don't want this to go on forever without evidence, and you've talked about, Chris, in other sessions about the

problems with accelerated-approval drugs. And we've come in and weighed in on that, that we need to have the incentives, that if we're going to have accelerated approval, we've got to get the evidence as rapidly as possible to know whether these drugs are safe. And that is what I think is the essence here.

I feel like there's enough, both tradition and also guardrails here, that this is a safe recommendation. And, as Melanie pointed out, this is only about allowing states. It's not saying states must. States can take your perspective and say we're going to cover it because there may be somebody that's going to benefit. But I think it's more important to be saying we're going to work to make sure we get enough evidence, that we have the science to say this is a safe and effective treatment.

And I really find it unfortunate that we recommend -- we talk about budget at all in this context. I don't care whether it's going to cost more or cost less. I care about do we have the science to say that these drugs are safe and effective. In fact, if it's going to cost more to get the evidence, we should spend more to get the evidence. That's my perspective.

CHAIR BELLA: Thank you, Bill.

Martha and then Angelo and then Fred.

COMMISSIONER CARTER: I just have a point of clarification, Chris, just as I'm thinking about this. Is the formulary for 340B the same as the formulary for the MDRP? Would this affect 340B, or would it be completely separate?

MR. PARK: The formulary is determined by the payer, so the health plan, Medicaid, Medicare. That's just how, if and when, they're going to cover a particular drug.

The 340B program is tied to the Medicaid drug rebate program in terms of the calculations of the rebates. So the 340B price is essentially the same as getting the Medicaid net -- the net price up front. And so there's a lot of definitions in terms of what's a covered outpatient drug. That 340B definition is tied to the Medicaid program's definition.

So this recommendation wouldn't affect that because these drugs would still be considered covered outpatient drugs in the Medicaid rebate program as long as the manufacturer has that rebate agreement, and so therefore, they would still -- they would be covered under

the 340B program as well.

What we're talking about here is to what extent that a state or a Medicaid health plan could exclude coverage of a particular drug or restrict coverage to certain circumstances, and so there's this -- there's a gray area because those situations are not well defined as this is acceptable and this is not. And this recommendation is trying to say that CMS has made a federal determination of what they consider reasonable and necessary, and so we would allow states to use that determination if they want to. It's a state option in terms of where they would place their restrictions.

COMMISSIONER CARTER: So, theoretically, a covered entity under the 340B program could make the same choice?

MR. PARK: I guess if they were the particular payer, if it was like an FQHC-sponsored health plan where they are making the coverage decisions, yes.

COMMISSIONER CARTER: Yeah. We do.

MR. PARK: I guess if they were -- as the provider, they would have to -- like, depending on what -- like, if the Medicaid beneficiary was at an FQHC, then they

would need to follow the procedures to collect the data.

For an uninsured beneficiary, then I guess it's up to -- it would be up to the -- how they would want to cover that particular product for a particular person.

COMMISSIONER CARTER: I think I get it. Thank you.

CHAIR BELLA: Darin, you had a clarifying question?

COMMISSIONER GORDON: Yeah.

Just something you said, Chris, was not my understanding of the recommendation, and I'll come back with my comments on the recommendation.

But, when answering that question, you said that it was the state or a plan making that decision. It's actually a state, as I understand, making a decision on whether or not to follow the Medicare approach to the coverage decision. The plan cannot do that in the absence of the state making that decision.

MR. PARK: I think it depends on how the state has set up their program, because if this is a statutory -- like, regardless if it's a state or a plan, coverage has to be according to what is allowed under the MDRP.

Based on the 2016 covered outpatient drug rule, you know, plans can make their own formulary decisions, but if they are not covering it to the extent that it should be under the MDRP, the state has to kind of wrap around that coverage and provide it.

So a lot of states potentially have requirements on the plans to either follow the same formulary or they may do it on a particular class, like the hepatitis C drugs or HIV drugs, where they say in the contract that the states must provide a certain level of coverage.

But if this is a statutory change and depending on if the state allows plans to make their own coverage determinations and have their own separate formularies -- because it would now be allowed under the MDRP to follow the Medicare NCD, then a plan could do that, irrespective of what the state --

CHAIR BELLA: How is that -- how does that --

COMMISSIONER GORDON: Yeah.

CHAIR BELLA: I thought definitely -- a plan in Pennsylvania, Pennsylvania Medicaid doesn't elect the option, but one of the MCOs in Pennsylvania could?

MR. PARK: Because it would be allowed under the

MDRP, then technically, the plan could because they would be still providing coverage.

CHAIR BELLA: But how is it allowed if the state hasn't chosen to elect --

MR. PARK: The state -- I mean, the state could simply tell the plans they must follow, you know, what they want to do in this particular class. But, if the state does not do that, then I think the plan would be allowed to -- and this is the case for all prescription drugs. Like, they could have greater restrictions on a certain class of drugs, like antipsychotics, than what the state has on their PDL, but the state can always require the plans through their contracts to follow the state's PDL.

COMMISSIONER GORDON: Yeah. I think I look at a PDL different than whether or not you have to cover a drug or not. So I think that's maybe we're splitting hairs, but just reading a recommendation to allow states to exclude or otherwise restrict coverage of a covered outpatient drug, the way that I understand the recommendation and that I'm comfortable with the recommendation is allowing a state to do it. I think it gets a little bit more challenging if it is -- because then it's going to be a bit of an odd

patchwork if you have different entities making that decision.

And, usually, for -- I think about it in the context like of benefit, Chris, rightfully or wrongfully. The plan has to do what the state is saying is a covered benefit or isn't a covered benefit, and maybe I'm oversimplifying. But, in this case, saying the state has to make that decision, I think I have comfort in that. I think if you're allowing a lot of different entities to make their own independent decision, I think that gets a little bit more -- I get a little uneasy with that or that doesn't feel as right to me, I guess.

CHAIR BELLA: Okay. We may have to come back to that.

Patiently waiting, I'm going to Angelo.

COMMISSIONER GIARDINO: Thank you, Melanie.

I would just say, as a general principle, I'm somewhat compelled by allowing states to use something like a national coverage determination in their thought process. I don't think that's a trivial decision-making process, a national coverage decision. I see it akin to an expert panel kind of consensus and there's an opportunity for

public comment. So I think that's a lever that state Medicaid programs should have if they want to use that national coverage. It is voluntary. The recommendation says "allow states."

And I also don't think it's a great thing, just in general, to say the right decision is always to allow everyone to have everything. In public health, sometimes people say, well, what's the problem if you just allow X? Well, it may allow people to get something that's not beneficial, so that's a big problem. So I think connecting or allowing states to connect their decision-making to collecting more evidence to see if something really is beneficial is an appropriate approach to some of these really complicated decisions.

So I'm inclined to support this recommendation.

CHAIR BELLA: Thank you, Angelo.

Fred and then Tricia, and then, Martha, do you have your hand up again? Okay. Oh, thank you.

COMMISSIONER CERISE: Thanks, Chris, for the work.

I'm also in support of the recommendation. As you mentioned, states already have the option to include

outpatient drugs. All states do it. But it's an optional program. Right now, I think states don't have individual drug decisions driven by the rebate program, right?

MR. PARK: There's some flexibility in how they can manage it, but at the end of the day, there needs to be a process in which a beneficiary can appeal and have access.

COMMISSIONER CERISE: But it's all or none.

MR. PARK: Right. That's right.

COMMISSIONER CERISE: They can't pick and choose, and so those decisions are not based on individual drugs and what's best for the patient. But, I mean, you're either in or you're not in.

MR. PARK: Right.

COMMISSIONER CERISE: So it's not as if they're able to make individual drug decisions based on what they think might be in the best interest of a group of patients or what have you.

We've heard work that you've presented about the accelerated approval program and drugs that have been approved through that pathway without strong evidence of clinical benefit, maybe have intermediate endpoints and

things like that but without the strong evidence of clinical benefit where the manufacturers may actually have a disincentive to produce that that definitive evidence. And so they drag their feet, and some of the discussion -- which leads to some of the discussion we had earlier about whether we have different time frames for making those decisions around drugs approved through that accelerated pathway.

Again, that approval and their inclusion then may actually be a disincentive for them to complete those final -- of the definitive clinical studies.

So I do think this is a very limited, narrow recommendation around a national coverage determination. Doing this through the spectrum of coverage with evidence development seems absolutely reasonable and, in fact, beneficial. So I would support what you've got.

CHAIR BELLA: Thank you, Fred.

Tricia, then Laura.

COMMISSIONER BROOKS: I think Fred clarified part of my question, but I just really want to confirm that we're talking about a limited number of drugs that have not yet shown the efficacy that they need to show. So Medicare

can make a determination.

So, for example, infusion drugs for children with SMA, which costs a million dollars, wouldn't be affected because Medicare would not necessarily be making that determination.

Do we have any idea how many drugs currently are under the CED?

MR. PARK: There are three drugs currently in the history according to what MedPAC has reported.

COMMISSIONER BROOKS: Okay.

MR. PARK: And this most recent case for the Alzheimer's drugs is probably the most significant one. The others were in more limited circumstances.

COMMISSIONER BROOKS: So I was really persuaded by Bill's comments. I could be in support of this recommendation.

CHAIR BELLA: Thank you, Tricia.

Heidi, question?

COMMISSIONER ALLEN: Yeah. I have a point of clarification. So, up there, the recommendation is talking about national coverage determinations of which the CED is a subset, right? And are we talking about just limiting it

to the subset, or are we talking about linking it to all national coverage decisions?

MR. PARK: I think it would -- and granted, we can always revise it, but basically, the CED is a subset. And that's usually where Medicare would put more requirements on coverage. The other national coverage determinations on drugs, which there's still very few where they do that, is usually more aligned with clarifying the FDA label indications and that they will cover it under those particular situations. And where they might restrict it is more on some of the off-label indications.

So, generally, I think -- I'll go back and check, but I think for all the other NCDs on prescription drugs, it's pretty much aligned with what the FDA label indications are.

COMMISSIONER ALLEN: But then that excludes off-label indications?

MR. PARK: I think that's where they usually would try to put some more evidence requirements. One of the other cases where they had a CED was for certain off-label indications, to make sure that they collected evidence on what the benefit was for those off-label

indications.

COMMISSIONER ALLEN: But the recommendation we're making would link it as an optional for any national coverage determination.

MR. PARK: Yes.

COMMISSIONER ALLEN: So that is bigger than what we're talking about when we're talking about Aduhelm.

MR. PARK: Potentially, yes.

CHAIR BELLA: I think the point you're making is don't rely on the fact that there's only three times this has happened for CED, because we're talking about something broader. Is that what you're saying, Heidi?

COMMISSIONER ALLEN: Well, we're not saying that we're going to align it with national coverage decisions that involve a CED. We're saying we're going to align it with national coverage decisions, which are much broader, and the CED is much narrower and fewer. I would be more comfortable that something that was attached to the CED than I would just the broad -- because I don't -- I just don't even know the whole bank of things that are decided in a national coverage decision for Medicare and how that could impact access and Medicaid.

And I appreciate that it's optional, but this is why we have so many disparities in Medicaid, because states -- you know, not all states are generous in certain benefits. And then you'll have a person in one state who has better access than a person in another state.

And so I have concerns about it being so broad, and I have concerns about it being linked to decisions that Medicare is making on behalf of Medicare, not thinking about Medicaid, though, hopefully, they would be thinking about duals.

CHAIR BELLA: Do you need a clarifying question or a comment?

COMMISSIONER BROOKS: Yes.

CHAIR BELLA: Okay.

COMMISSIONER BROOKS: I mean, I got the distinct impression from my question from Chris that the national coverage determinations aren't hugely broad either, or is that not the case?

MR. PARK: I will go back and check to see how many times they've done it on drugs. I think they are usually done more on some of the other technologies and not -- I think, generally speaking, for Part B, they usually

say anything that's approved by the FDA or in one of those CMS-approved compendia is covered. But I can double-check to see how many times just the general NCD was applied to drugs.

Generally, when they're more restrictive than like the FDA requirement, that's where the CED comes into play is to say we need more evidence, and so we are going to limit it to these certain situations. But, again, I will review, try to see how many times the, just general, NCD process was used for drugs and what types of outcomes in terms of coverage and restrictions that they applied to it.

COMMISSIONER ALLEN: We're not voting on this until January, correct?

CHAIR BELLA: We're not.

COMMISSIONER BROOKS: So I think it would be helpful to get a grasp on whether that's hugely broad or simply somewhat broader, that isn't necessarily going to have much more of an impact.

COMMISSIONER ALLEN: It would be helpful for me to know, too, in the cases where these have been determined and more evidence has been collected, are low-income people

represented in these studies, and when it affects a population that is not just above 65, are people under -- or do we have good -- like, are we seeing a Medicaid population in these studies? Because if we aren't and there's no requirement that they do, then it just would basically mean that Medicare recipients would still have an avenue to get these drugs by participating in these clinical trials or additional studies, but Medicaid recipients would not have as equal of access.

CHAIR BELLA: I hate to be to beat a -- I mean, but it is mostly going to be the duals we're talking about who are Medicare and Medicaid. That's who it -- so it's fair to say are the under-65 duals represented. That's fair. But most of what we're talking about are going to be drugs that are going to a Medicare population. That is, the Medicaid piece of that is their dual status.

COMMISSIONER ALLEN: But how so when Medicare makes decisions for adults? Right? Like, there's a lot of drugs that are adult specific but not age-65-and-above specific.

MR. PARK: So let's take the example of the CAR-T cancer therapies. That would be a broader population than

over 65. Granted, they removed the CED requirement, but in that situation, under the current environment, only the Medicare beneficiaries would be required to have some kind of follow-up data collection.

So we would not necessarily have information on a 20-year-old who got the same treatment, because that requirement wouldn't be in place.

Another point, I guess, it also depends on the level of data requirement that CMS requires. So, for the Alzheimer's drug example, if it was through accelerated approval, they want it in a randomized controlled trial, because they definitely want more information on the clinical benefit.

When it was traditionally -- if it's traditionally approved where the manufacturer has submitted that evidence of the clinical benefit for the FDA and gotten traditional approval, then it's a much lower standard of evidence collection. So it can be a prospective study. It can be in a registry, and you don't necessarily need that control population. And so that's a much broader population who would be able to access the drug. And so it kind of depends on how CMS structures that

as to like how many people may or may not get into the coverage pool.

So, under that prospective comparative study, that's where it would be more likely that low-income populations would be able to get in, because it's not as small as a randomized controlled trial in terms of minority groups or other subpopulations. In the Alzheimer's decision, they specifically said they wanted to see broad representation of different groups in those studies, and so I think CMS is conscious of trying to make sure that they are collecting information on everyone.

One potential benefit, if this was applied to Medicaid, is that we would be certain, at the state option, that they would start collecting information on the Medicaid beneficiaries. So we would start getting more outcome information on the low-income populations or racial and ethnic subgroups that may be more prevalent in Medicaid than in Medicare. So that would be one potential use of this is to make sure that for a particular drug that we are getting that additional information for the Medicaid-specific population.

CHAIR BELLA: Okay. I'm going to take a timeout

and say three things for sure, we've asked for, right? One is more information on NCD, the prevalence and the scope. Two is, I think, clarifying the state plan question. Three is thinking about how you would make sure that Medicaid populations are represented in the collection of additional evidence. So those are at least -- I'm hearing those things that we would like to have come back.

Do you have one to add to the -- this is not exhaustive. I just want to keep moving to the other folks.

COMMISSIONER CARTER: I think we've -- I think we're sort of tripped off over the terms. I think a national coverage determination is just a determination. It's a yes or no, or yes with conditions, and that we really want to put in here what we're concerned about is this coverage with evidence development, the CED.

So I think that we might be okay with it if we said based on a Medicare national coverage determination of coverage with evidence development.

CHAIR BELLA: That might make some people comfortable. I don't think that was the original intent. So let's come back to the recommendation.

COMMISSIONER CARTER: Okay. Well, I think we

need to --

CHAIR BELLA: I'm going to go to Laura.

COMMISSIONER CARTER: We need to define national coverage determination, because I think we're using it interchangeably with CED, and I don't think that --

CHAIR BELLA: I mean, that's the reason why we definitely asked him to come back with information on the NCD, Martha, to see what does that look like.

Laura and then Verlon, then Angelo, then Dennis, and maybe back to Martha. Or you may have just gotten your comment done. Okay.

Laura.

COMMISSIONER HERRERA SCOTT: So that's where I was going. So, you know, the clinical benefits were not demonstrated, which is why the scientific community was so upset by the decision. Even the uptake by prescribers has been low, because they're not comfortable doing it and which is unfortunate, because now we've put the physicians as the gatekeeper for this drug because of where we're at.

And it's not benign. So there have been complications related to the drug, including cerebral lipedema, and there have been deaths. And we could

probably get that data from the adverse reporting system that the FDA has. So it's not benign.

So, to Martha's point, it's really related to the coverage with evidence development requirements. This was put in place because of the concerns related to the drug, not only by the scientific community and the physicians but just because also some of the side-effect profile related to the drug. And if they're concerned for the Medicare beneficiaries, I don't know why we wouldn't also be concerned for the Medicaid beneficiaries that could be exposed to this drug.

To echo Bill and Angelo and Fred, I am in support of a recommendation, but because of the confusion, Martha -- and I think you said it well -- whether we're equating CED with NCD, maybe it's just tweaking the recommendation, outpatient drug based on Medicare national coverage determination, with coverage, with evidence development requirements. So then it's really those drugs that we're concerned about where the clinical benefits have not been proven and quite frankly do no harm. Where there is demonstrated harm, we're not sure outweighs the risk of the drug as far as the benefits to the patient, then that might

make it at least clearer on which drugs would fall into this category.

CHAIR BELLA: Thank you, Laura.

Verlon.

COMMISSIONER JOHNSON: Actually, Laura and Martha were very helpful I think, in some of the questions or thoughts that I had.

I just want to say I really appreciate the work, Chris, that you've done on this, and I have to say to my fellow Commissioners, thank you for all your questions and your insights because I have had a hard time wrapping my head around this for sure. And, really, as I think about everything that we do, I always think about will it get us closer to providing more access in coverage, will it provide savings, will it move the needle on health equity, and so I appreciate all the comments around that.

Ultimately, I think with the way we're going to go back and narrow the -- not narrow the scope, but provide more clarity, it will be helpful. But I feel like we've got to do something for the same reasons, right, do no harm, but let's really figure out a solution around this.

So I just wanted to say thanks for that, but

again, I appreciate the remarks that Laura just made because that really was helpful for me.

CHAIR BELLA: Thank you, Verlon.

Dennis?

COMMISSIONER HEAPHY: I'm going to pass because I was going to say that a while back. Heidi, thank you for it, because I would have just voted for this until -- it does have to be narrowed down. So I appreciate this conversation. It was really helpful.

CHAIR BELLA: Other comments?

[No response.]

CHAIR BELLA: So it sounds like the will of the group is to make it clear that we're talking about CED. I think you could bring it -- I'm still interested to understand just the NCD environment, and maybe there's something there that we want to take a look at too. But I think the comfort leaving this room -- and it may or may not be comfort still, Heidi, but there is greater comfort with a narrower CED lens. And then let's bring back the additional information you can find about NCD and just see what we can understand about that.

And then you've written down all the other things

that we've talked about too.

MR. PARK: Yep.

CHAIR BELLA: Anyone who we did not hear from who wants to sort of yea/nay where we're landing? Everybody good? Kathy? Sonja? Jenny? Darin, do you have any other comments? No? Okay. Thank you for starting us off.

Chris, do you need anything else from us?

MR. PARK: Nope. That's it.

CHAIR BELLA: Boy, we actually ended this session two minutes early. I was thinking we were going to keep on going.

All right. Thank you very much for your work here.

All right. So we're going to have the last session of the day, which is to highlight MACStats. Jerry. And Chris is going to stay.

[Pause.]

HIGHLIGHTS FROM MACSTATS 2022

* MR. MI: Hi. Just wanted to say that MACStats is scheduled for release next Thursday, December 15th. For members of the public, we'll have MACStats both compiled as the published book and separated into individual tables on

our website. Most of the tables have both the Excel and PDF versions for your convenience.

So MACStats is a regularly updated, end-of-year publication that compiles a broad range of Medicaid and CHIP statistics from multiple data sources, including the Census enrollment survey and national- and state-level administrative data.

Listed on the slide are six sections of MACStats.

This year's addition of MACStats includes two new tables on access to and experience of care among non-institutionalized individuals using data from the Medical Expenditure Panel Survey, or MEPS.

In addition, Exhibit 12 has been updated with both 2019 and 2020 data. The exhibit was not updated last year due to a delay in the release of health care spending projections from the National Health Expenditure Accounts.

One more thing to note is that due to a delay in the release of the 2020 National Health Interview Survey, or NHIS, we opted to update the data to the most recent year, 2021, and skip the use of 2020 data.

Key statistics of this year's MACStats show similar results to last year. These key statistics focus

on Medicaid and CHIP enrollment and spending compared to other payers, Medicaid's share of state budgets and more.

In fiscal year 2021, almost 30 percent of the U.S. was enrolled in Medicaid or CHIP at some point during the year. Looking at the state-funded portion of state budgets, Medicaid was a smaller proportion than elementary and secondary education, and Medicaid and CHIP combined were a smaller share of national health expenditures when compared to Medicare.

So, getting into the trends of the data, over the last eight years, Medicaid and CHIP enrollment has increased by about 57 percent. Most of this change happened in the first initial years after the bulk of ACA expansion. Most recently, enrollment and Medicaid and CHIP increased by about 7.2 percent from July 2021 to July 2022. This follows a 10.4 percent increase in Medicaid and CHIP enrollment from July 2020 to July 2021. Much of this increase since July 2019 is attributable to the economic downturn created by the COVID-19 pandemic and the continuous coverage requirement attached to the federal medical assistance percentage increase under the Families First Coronavirus Response Act. Enrollment increased in

all states.

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

In this graph, spending for health programs are compared with spending for other components of the federal budget for fiscal years 1965 through 2021. In general, the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965.

In 2021, CHIP was 0.2 percent of the total federal outlays a decrease from 0.3 percent in 2020. Medicaid share slightly -- Medicaid share increased slightly from 2020 to 7.6 percent of total federal outlays, which is still less than Medicare share at about 10 percent.

Since 2020, both Medicaid's and Medicare's share of the federal budget have been lower than in prior years because of a large increase in other mandatory program spending for pandemic-related relief such as unemployment

compensation, coronavirus tax relief, economic impact payments, and other housing credits.

In fiscal year 2020, we see that over 70 percent of enrollee are enrolled in comprehensive managed care, and this accounts for over 50 percent of Medicaid benefit spending. LTSS users accounted for only 5.3 percent of Medicaid enrollee but almost one-third of all Medicaid spending. That is $197 billion was spent on services for these 4.4 million enrollees.

Note that this estimate only includes enrollees using at least one LTSS service under a fee-for-service arrangement and does not include those receiving LTSS under a managed care arrangement.

For fiscal year 2021, DSH upper payment limit and other types of supplemental payments accounted for over half of fee-for-service payments to hospitals.

Total spending per full-year equivalent enrollee across all service categories ranged from $3,495 for children to $23,123 for the disabled eligibility group. Spending for managed care capitation payments was the largest service category across all eligibility groups.

In 2021, 35 percent of Medicaid enrollees had

annual incomes less than a hundred percent of the federal poverty level, and 53 percent had incomes below 138 percent of the federal poverty level. As of July 2022, 38 states and D.C. are now covering the new adult group.

MACStats also reports on beneficiary health, service use, and access to care us using survey data from the NHIS and the MEPs. In 2021, children and adults with Medicaid or CHIP coverage were less likely to be in excellent or very good health than those who have private coverage. Children with Medicaid or CHIP coverage were as likely to report seeing a doctor or having a wellness visit within the past year as those with private coverage and more likely than those who were uninsured.

While most children and adults with Medicaid or CHIP coverage had a usual source of care, they were less likely to have one compared to those with private insurance. Children and adults with Medicaid or CHIP coverage are more likely to report having a more difficult time reaching their usual medical provider compared to those with private coverage.

Thank you.

CHAIR BELLA: I was looking at the last piece.

Okay.

Open it up for comments or questions? Heidi, I heard a little gasp from you over here.

COMMISSIONER ALLEN: Oh, I was just surprised at how much the DSH and directed payments made up out of the fee-for-service, like 50 percent.

MR. MI: So I wanted to mention that directed payments, I think, are made under managed care, and that our factoid with the 54 percent is specifically for fee-for-service payments.

And this, I think this percentage has been fairly consistent within the past couple of years.

COMMISSIONER ALLEN: And it's just so, I mean -- and that's the black box, right, that we have such a hard time knowing where the money's going? Interesting.

CHAIR BELLA: Anything that the two of you found surprising?

MR. MI: I think this year, we have a couple new exhibits. We have two using MEPs data, and several NHIS exhibits have new fields. But I think what I found most surprising was in Exhibit 24 of our MACStats data book, that's the data book exhibit on supplemental payments under

fee-for-service, and in fiscal year 2021 compared to fiscal year 2020, basically there were approximately 4.5 billion less dollars spent under Section 1115 waiver demonstrations compared to fiscal year 2020. There are many reasons for it, and we didn't really take a deep dive in, but they might be because of a shift towards directed payments or the expiration of several DSRIP programs.

CHAIR BELLA: Tricia. Oh, and Angelo next.

COMMISSIONER BROOKS: I assume that you still have Exhibit 32, which is ever enrolled and that we see a bigger jump in the Medicaid, the M-CHIP enrollment or Medicaid overall compared to CHIP or a separate CHIP?

MR. MI: Exhibit 32 is still in the data book, although I don't have the -- I can pull the exact numbers, but I --

COMMISSIONER BROOKS: I can probably wait until it gets --

MR. MI: I can bring the data book, but yes, Exhibit 32 is still in there.

COMMISSIONER BROOKS: Okay. Yeah. I would suggest footnoting, you know, that the impact of the continuous coverage protection, if you were trending that

out, it's going to have a bump there that's going to recede at some point.

Thank you.

CHAIR BELLA: I'm going to make myself a note to look at Exhibit 32 on December 15th.

Angelo.

COMMISSIONER GIARDINO: Thank you.

I'm looking at Slide 9, and as a pediatrician, I just would like to call everyone's attention to what a wonderful investment it is to help children. Look at that number, on average, the 3,495. So kids are a great investment. My suspicion is that they're the largest enrollment group in Medicaid.

So the factoid that I usually get asked is, what percentage of the nation's population of children are covered by Medicaid and CHIP? So is that in the MACStats data set?

MR. PARK: Not specific to children. Exhibit 1, which actually I think the stat is up here, does have it for the overall Medicaid and CHIP population. And so, in 2021, it was almost 30 percent of the U.S. population was in Medicaid or CHIP for at least part of the year. But we

don't necessarily do that specific to children.

COMMISSIONER GIARDINO: Yeah. I would just ask, if it's possible, to consider that. That is the one fact that pediatricians and child-serving professionals are always interested in, that specific number. Usually, we have to do some mental gymnastics to figure that out, so thank you.

MR. PARK: Yeah. It's not the exact same measurement, and it might be underreported, but we do have some of that information in the survey tables that's reported in NHIS. And I feel like it's 30-ish percent.

COMMISSIONER GIARDINO: You have the booklet.

MR. MI: I could actually pull up the number right now, but the numbers should be available under Exhibit 2.

COMMISSIONER GIARDINO: Okay.

MR. MI: Which is total. Yeah. So, in our Exhibit 2 of this year's MACStats report which uses the NHIS, it says that 38 percent of all children are enrolled in Medicaid of CHIP.

COMMISSIONER GIARDINO: Great. Thank you. And, again, kids are a great bargain. They're a wonderful

investment, and I'm just really glad to see the numbers.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: That's interesting, because if you look at child enrollment in Medicaid and you look at the total child population in the United States, you will find that about 52 percent of children are enrolled in Medicaid or CHIP.

Now, part of the problem in making that calculation is that some states -- like, Florida only covers up to age 18 in Medicaid. So states have that choice of 18, 19, 20. So you have to sort of parse it out a little bit on a state-level basis in order to get to the national, but that 52 percent, I think is pretty, pretty close.

UNIDENTIFIED SPEAKER: Is that ever enrolled versus point in time, or what is what?

COMMISSIONER BROOKS: That is point in time. I mean, that would be based on current enrollment looking at the last population numbers that we have.

CHAIR BELLA: I want you all to look at the book and pick a table that you look for every year.

Angelo, your hand is still up. Do you have

another comment?

COMMISSIONER GIARDINO: No, no. I just keep looking at Slide No. 9, and I'm just so happy. The kids are a great investment.

[Laughter.]

CHAIR BELLA: All right. Well, that will be your future table.

Okay. Any other comments from Commissioner?

[No response.]

CHAIR BELLA: Thank you for the update. We'll look forward to seeing that come out, and I think we're done with this session.

We have time left now for any public comment from anyone on any of the sessions that we have done this afternoon. So same spiel as always. If you'd like to make a comment, please introduce yourself and your organization, and please keep your comments to three minutes or less. If you would like to do, please use your hand icon.

Okay. Candace, I think you need to -- yep.

PUBLIC COMMENT

* MS. DeMATTEIS: Okay. Can you hear me?

CHAIR BELLA: Yes.

MS. DeMATTEIS: Okay. Good afternoon, and thank you so much for allowing me an opportunity to comment. My comments are directed to the discussion around Medicare, NCDs and with CEDS and applying that to Medicaid.

A couple of comments. First, safety and efficacy is an FDA decision. It's not CMS, be it Medicare or Medicaid. Accelerated approval was mentioned several times. The safety standards FDA applies for accelerated approval are the same as those applied to traditional approval.

Efficacy is also the same standard, but it is applied to a different clinical endpoint, an earlier clinical endpoint, and it seemed a couple of times I heard things that maybe didn't align with that.

The NCD process for Medicare does involve public comment. It is specific to Medicare. It is not comments from the Medicaid population or how would this apply to the Medicaid population. So I think it's a little bit of an incorrect assumption to say that people have plenty of public comment, as if this would apply to Medicaid as well. I think that would require and should require much more robust discussion and comment.

Equity issues are huge. Disparities are a huge problem in Medicaid, and setting up a clinical -- or an NCD requirement would essentially be no access. If you've ever participated in a clinical trial, you would know that it requires a great deal of health literacy. It requires reliable transportation. There's a pretty high bar to participating. You have to show up within a certain time period, or the data is not useful. And that would create significant restrictions for a Medicaid population that I did not hear discussed today or considered.

Also not discussed was what happens with the removal of the NCD or changes at the Medicare level. How is that going to filter down within states who have made the decision to adopt this policy, or as was discussed, potentially individual plans? So not only would there be differences amongst the states but within the specific plans.

There are also significant ethical implications that were raised as part of the Medicare NCD process about requiring people to be randomized to placebo for an FDA-approved treatment. I did not hear any discussion about that as well, which I would think would have significant

implications for a Medicaid population, particularly one where there's a lot of distrust in the system, for good reasons, around clinical research in the past.

So I know my time is running short, but there's a lot of unanswered questions in addition to the ones that were raised today. So we would strongly urge you to consider those and vote no on this when it comes up in December.

Thank you.

CHAIR BELLA: Thank you, Candace.

For the record, can you please state the organization you're representing?

MS. DeMATTEIS: Yes. Thank you for asking. Candace DeMatteis. I'm with the Partnership to Fight to Chronic Disease.

CHAIR BELLA: Thank you very much for your comments.

Sue? If you could introduce yourself and your organization before you could start. Thank you.

MS. PESCHIN: Hi. Can you hear me?

CHAIR BELLA: Yes.

MS. PESCHIN: Terrific. Thank you.

Hi, everyone. I'm Sue Peschin, and I serve as president and CEO at the Alliance for Aging Research.

And over the past several years, my organization has developed subject-matter expertise on CMS's use of coverage with evidence development, or CED, and under CED, Medicare only covers an FDA-approved medical treatment on an extremely limited basis and under the condition that beneficiaries have to enroll in a clinical trial or a patient registry.

It's mostly been used for devices, and we worked on it for heart valve disease, for less invasive technology that was created in Medicare beneficiaries for heart valve disease. And the decisions in general are very politicized, and it's mostly because of the economic impact on payers and specialty providers and hospitals and health systems, but they are really little league compared to what's been going on in Alzheimer's disease and coverage for monoclonal antibodies targeting amyloid.

And the reason behind that is, using Aduhelm as a test case, CMS was able to make this sweeping change, because they had tried it with CAR-T a few years ago, but they hadn't been able to cross over the finish line with

regard to drugs or biologics. And they did it here. So it's setting a precedent for them to be using it for Medicare beneficiaries with any disease, so any types of new treatments that come out.

And I know you've heard they're not planning on using it, and we'll see how that goes. But the idea that it's a temporary determination while they collect more evidence really is kind of a ruse.

And Candace said this about CMS being a payer, not a biomedical science agency like the FDA, and what we mean by that is that this serves as an extreme form of utilization management for millions of Medicare beneficiaries.

There was a study that was published in April of this year in the American Journal of Managed Care on the CED process, and of the 27 CEDs that have been initiated over the past 15 to 20 years, less than 20 percent have ever concluded. And several actually never resulted in a study at all. So a lot of new treatments and technologies continue to be severely limited without ongoing justification, and there's bipartisan uproar about this.

Nanette Barragan -- Representative Nanette

Barragan, Barbara Lee, Brett Guthrie, and Representative Miller-Meeks all wrote a bipartisan letter signed by 40 lawmakers really imploring CMS to reconsider it due to equity and access concerns.

Now MACPAC is considering this policy recommendation that's going to give state Medicaid programs the option of adopting Medicare national coverage determinations requiring CED, and what this would do is it would amend current law, requiring states to cover all drugs when manufacturers agree to provide the mandatory rebates that are established by the Medicaid Drug Rebate Program.

So the comments from Dr. Allen, you guys should take notice of. We share her concerns. This is going to be a lot more sweeping. I don't know why there's been some equivocation on this, but the MDRP requires a drug manufacturer to enter into a national drug rebate agreement with the Secretary of HHS in exchange for state Medicare coverage of most of the manufacturer's drugs. So, if you're -- if they adopt, they say, "Okay. We want to take this coverage policy on this one drug," so they're rejecting Aduhelm from Biogen, then they're also rejecting,

for the rebate program, Biogen's drugs for MS and SMA. So this can go beyond, you know, to the cancer rare diseases to old people, to kids.

So please pursue the concerns that this is much more sweeping than it's been presented. This is all about cutting patient access to save Medicare costs, full stop. And we're not against, you know, saving Medicaid costs, but this has very far-reaching effects on patient access, and it's going to have negative impacts on people of all ages in Medicaid. It's going to exacerbate health equity problems, and it's just -- overall, it's morally heartless.

So please dig in. Don't vote until you're crystal clear about what this recommendation would actually do.

Thank you.

CHAIR BELLA: Thank you, Sue.

I don't see any other comments.

Any additional comments from Commissioners? Any questions on anything?

[No response.]

CHAIR BELLA: Kate, anything?

[No response.]

CHAIR BELLA: Okay. We are starting tomorrow at 9:30. We'll start off with a panel and so look forward to seeing everyone then. Thank you for a great first day. Have a nice evening.

* [Whereupon, at 4:37 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, December 9, 2022.]

PUBLIC MEETING

Ronald Reagan Building and International Trade Center
Hemisphere A Room
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Thursday, June 9, 2022
9:31 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
KISHA DAVIS, MD, MPH, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
MARTHA CARTER, DHSC, MBA, APRN, CNM
ROBERT DUNCAN, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
VERLON JOHNSON, MPA
WILLIAM SCANLON, PHD
LAURA HERRERA SCOTT, MD, MPH
KATHY WENO, DDS, JD

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:31 a.m.]

CHAIR BELLA: Good morning. Welcome to Day 2 of our December meeting. We are thrilled to kick off the day with a panel for outcomes for adult leaving incarceration.

So, Melinda, I'm going to turn it to you and say thank you in advance to the panelists, and we're really looking forward to this discussion.

PANEL ON THE ROLE OF MEDICAID IN IMPROVING OUTCOMES FOR ADULTS LEAVING INCARCERATION

* MS. BECKER ROACH: Great. Thank you.

Good morning, Commissioners, and thank you to our expert panel for joining this discussion on Medicaid's role in improving outcomes for adults leaving incarceration.

This is a follow-on to the October meeting where Lesley and I provided background information on adults with criminal justice involvement and the inmate exclusion which prohibits the use of Medicaid funds while an individual is incarcerated, with the exception of certain inpatient stays.

At that meeting, we also presented state approaches for facilitating Medicaid coverage and access to

care for adults upon release, including state-funded services to support Medicaid enrollment and connections to community providers.

Twelve states are also seeking approval for Section 1115 demonstrations to waive the inmate exclusion and provide pre-release Medicaid services.

CMS is expected to be approving some of these demonstrations soon. CMS is also expected to soon release a report on best practices for improving health care transitions for individuals during reentry, followed by Section 1115 guidance on providing pre-release Medicaid services, both of which are required by the SUPPORT act.

In this session, the Commission will further examine state efforts to improve outcomes for adults leaving incarceration as well as considerations for implementing pre-release Medicaid services. The unprecedented nature of these demonstrations raises important policy and operational issues that will be part of the discussion today.

Our distinguished panel brings a range of perspectives from Medicaid, corrections, and the experience of individuals who have made the transition from

incarceration to the community. Their names and titles are on the screen, and their full bios are available in your meeting materials.

Moving now to our moderated panel discussion. The first question is directed to all four panelists. Why is it important that we're talking about Medicaid's role in improving outcomes for people leaving incarceration, and what are some of the factors that have brought this population into focus in recent years?

And I thought, Vikki, maybe you'd like to kick us off.

* MS. WACHINO: Sure. Thanks, Melinda, and thanks so much to the Commissioners for addressing this really critical issue.

The United States has the highest incarceration rates in the world, and as a result, the population of people who experience incarceration is large and touches a broad swath of society. Two million people each year are either in prison or in jail. 500,000 people leave prison every year. Ten million people cycle through jails every year. So it's a large population, and the population, as MACPAC saw in October, has significant health care needs,

higher rates of almost every major physical condition; asthma, diabetes, hypertension; higher rates of infectious diseases including HIV, tuberculosis, and hepatitis C, not to mention COVID; and higher rates of mental health conditions and substance use disorder.

And, if you look overall at the population, I think MACPAC saw some data to this effect at your last meeting, vast racial disproportionality in who we incarcerate with people who are Black five times more likely than people who are white to be incarcerated, significantly higher rates for Indigenous populations. And incarceration correlates with poverty significantly. So it's a very low-income population and disproportionately people of color, yet we have very poor health outcomes for this population.

Mortality is very high from a multitude of causes. The standout is opioid use disorder and overdose, where estimates are that the death rate from overdose in the few weeks following release is somewhere between 40 to 120 times higher than the general population.

In addition, there are very high rates of emergency room use for people in the period post-

incarceration, yet as a nation, we do very little to support the health needs of people. You're going to hear from my fellow panelists about some of the cutting-edge work that's being done in some places in the country, but by and large, we have no system for helping people meet their health needs at release. We leave people to fend for themselves, and this is why we get the results that we do.

I think overall, the health care system is going to struggle, and the Medicaid program is going to struggle to meet some of the goals that are commonly agreed upon with regard to health.

I think we're going to have a hard time, given the size of the population and the prevalence rates for some of these, very significant conditions, meeting national goals around public health, population health, mental health, and addiction without redesigning how we provide these services to people as they're being released and after they're being released. And that's what we're talking about now with the SUPPORT Act requirements and the potential for waiver approvals from CMS is how do we build continuity and access to quality services and build a bridge for people as they're being released, and that

bridge would for the first time start before someone is released by providing Medicaid coverage of those services and continue through the community services, building on some efforts in some states and some places that have taken place since the Affordable Care Act was implemented.

The implementation challenges to doing this are not small, and this is why I'm thrilled that MACPAC is having this conversation, because the success of these new policies is going to rest on how they're executed. And the challenges, as we'll talk about this morning, are significant, and this is a reason that it's great that MACPAC is having this conversation. It's the reason that I, together with my partners at the Council on Criminal Justice and Waxman Strategies, created earlier this year, the Health and Reentry Project, where we gather diverse stakeholders from the criminal justice system, the health care system, as well as social justice advocates, and people with direct experience of incarceration to explore together whether we could identify common elements of how are we going to make this work for people as they're leaving incarceration. And it's the results of that work that I'll be happy to share with you as we go through the

panel.

MS. BECKER ROACH: Thanks so much, Vikki.

Maybe we'll turn to DeAnna and then to David and Jami as well.

* MS. HOSKINS: Thank you. Thank you for having me today.

I actually come to this conversation not only as an individual who has worked in criminal justice for the last 22 years, but as a formerly incarcerated individual who has successfully reintegrated back into society.

One of the biggest things that we talk about that always amazes me is that we remove people from the community to actually pay for a mistake that they made and then once upon release go home and be rehabilitated and be a productive member of society. But we don't give them the basic human needs or tools to be able to do that.

Working inside of a department of correction as a case manager, the hardest thing that I saw, which is why this population is being more prevalent, is the disconnect from incarceration to community. Incarceration closes the fence behind them. It is now on the community's responsibility. Community doesn't have the resources.

One of the biggest things with incarceration is psychotropic medication. People are on psychotropic medication, what we call a "K code," while they're incarcerated. Without a connection to the community, those psychotropic medications are stopped, once the person reenters our community, and there is no connection to services. There is no connection to benefits to continue on to be a productive member.

When we talk about the rate of incarceration or recidivism within the first 90 days, we see that break. We see people leaving incarceration, struggling to reintegrate, and from whatever stabilization they had while they were incarcerated has just totally been disrupted as they reenter back into our community.

But one of the biggest things that we really don't pay attention to is incarceration is traumatic within itself, and typically, people who have made mistakes or made a decision who are incarcerated experience trauma prior to incarceration. So now I'm walking into incarceration with a traumatic experience. I'm entering a new traumatic experience that has never been addressed, and the department of corrections medicate me to stabilize me

until my release, and then again, it's disrupted.

So, when we talk about the need of people being productive members of society, talking about a population that we have basically dehumanized in some kind of way as not having access to basic human needs of survival for what they need. Vikki talked about the disproportionality. Most of our communities that are filling up our prison systems are communities where community health centers have been removed. There's no investment in those community centers. Emergency room is the doctor of choice because of that disconnect. So, as we'll talk about -- and I'm sure I'll have a chance, opportunity to talk, is what have states done?

I'm from Ohio. We have been very unique to ensure that the continuation of medication and continuation of access happens from incarceration to community, but it took sitting down and making a decision to have a hard conversation of not only do we -- must do this, we have a responsibility to do this if we're going to talk about public safety, because who are we truly trying to keep safe in that environment when we use those words?

So I'll stop there.

MS. BECKER ROACH: Thank you.

Jami or David, would you like to jump in and talk a little bit about your focus on this population?

* MS. SNYDER: Certainly, I'm happy to start. I mean, think Vikki and DeAnna captured it really nicely from a data perspective and from a lived experience perspective.

I think within the Medicaid agency in Arizona, we don't see our work around justice-involved populations as sort of peripheral to the work that we do day to day. We really see it as aligned with our overarching strategic priorities around enhancing the quality and continuity of care offered to AHCCCS members. Around our priority related to bending the cost curve, we know there are benefits in that regard when we focus energy and effort in serving justice-involved populations, in advancing the state's public safety goals, as DeAnna mentioned, and really more recently in addressing issues of health equity and social drivers of health. And I'll talk a little bit more about it in a moment in terms of the specific initiatives that we've carried out, but recently, in October, we received approval on an 1115 demonstration waiver request, our housing and health opportunities waiver

request. And it's going to allow the state to fund up to six months of transitional housing, and we're specifically focusing on populations that are leaving institutional placements for the effort initially.

And we feel like that's really important, in particular, for justice-involved individuals, that they have an opportunity to transition into a housing environment where we can offer some level of stability from a clinical perspective, connect individuals to critical social service supports before they transition ultimately into a permanent supportive housing with wraparound Medicaid compensable supports.

And I know we're going to talk again in a moment about specific initiatives, but we really see this work as central to the work that we're doing around health equity and social drivers of health.

* MR. RYAN: Good morning. On behalf of Sheriff Koutoujian, I just wanted to thank the Commission for the opportunity to kind of give you our perspective on this work. Sheriff Koutoujian is also a member of HARP because he's very committed to addressing this issue and really sees this as a continuity of care issue for the individuals

that are in our custody, because we're looking at the studies that show that if folks have insurance coverage, Medicaid as well as access to the care upon reentry, this is a public safety issue because it's going to impact recidivism.

But the sheriff's background before becoming sheriff, he was in the state legislature and chair of public health as well as health care and really kind of came in as sheriff over 10 years ago with sort of a unique lens into this issue. So, in the post-ACA world, we worked very hard to identify opportunities for our population from things from enrollment to suspension versus termination of Medicaid benefits as well as the inpatient exception, and now all moving towards trying to increase access behind the wall for individuals, because we really feel like this is going to improve the health outcomes of our population, which is increasingly -- we're seeing individuals entering our custody with increased but unaddressed behavioral health issues.

I mean, on average, around 37 percent of our population is diagnosed with an SUD, and of that population, 92 percent also have a diagnosed mental

illness. We were not built, designed, or intended to be de facto treatment centers, but that's what we've become. We're the largest mental health provider in our county. So we want to find a way to be able to -- for folks that are reentering, be able to connect them to the services that they need so that they can stay in the community and not have to come back to jail. So thank you for this opportunity to present today.

MS. BECKER ROACH: Thanks so much.

I want to turn to DeAnna. Could you describe reentry from your experience and the experience of others you've worked with? What are some of the factors that affected your ability to access care post-incarceration?

MS. HOSKINS: Thank you. So one of the things I always say is that reentry is not always a removal from the community. A lot of times people are convicted and sentenced to post-community supervision, but the trajectory of their life has changed because now they have that felony conviction and different things, so understanding that is really the conviction of the criminal, the criminal crime that has happened.

But, for myself, I've dealt with a substance

abuse issue. I was removed from the community, committed a crime, and part of it was not even having the opportunity for substance abuse treatment default. It was incarceration to address the behavior. No one went to the root cause of why I was acting out in that way.

But upon reintegration back into the community, there was no continuation. I was lucky enough to do a behavior modification program in my community, but there was no continuation of the services that I had received. I had to actually seek out that type of assistance myself but without any type of coverage. I didn't know where to get coverage, to be able to pay for those services. It was actually other individuals who had some access knowledge who had experienced it themselves that were able to help me.

But, again, when we talk about leaving incarceration back into the community and that disruption, I was just lucky enough to be able to tap into other people to help guide me. But what I saw from working inside department of corrections, I was a case manager in Pendleton Correctional Facility in Indiana. I knew nothing about the Indiana correctional system. I knew nothing

about Indiana communities.

So you had individuals leaving incarceration, going back to different communities, and a case manager whose only job was to do a release plan to actually prepare you but not actually release connections. I was not aware of the community resources. I wasn't aware of the housing situations. What I knew is that by law, this is your end date, and you have to be released from this facility, whether that's to a homeless shelter, whether that's to the streets of Indiana in any kind of way. The department of corrections and correctional facilities do not hold accountable what happens once you walk out of that door.

Again, my experience and just the connection, I came home and I had children, and I always tell the joke of when I came home, of course, my family wanted to give me my children back immediately, but upon taking my children back, it was not only my health care, but it was the health care of my children because my family was taking care of them. They received services. Now I was the primary caregiver, and actually those services for my children who were in counseling because of my substance abuse or because of my absence from their life was now disrupted again

because of that lack of continuation of me as the parental parent, custodial parent having access to those resources to not only continue mine but to continue those.

One of the things we know about incarceration is that they talk about children of incarcerated parents have a higher rate of being incarcerated themselves, and I felt part of my responsibility was how do I disrupt to ensure this doesn't happen to my children. And part of that was getting access to counseling, getting access to some of that treatment that they could start to deal with that parental separation that they had experienced. But, again, coming out, me not being eligible while I was incarcerated, was disrupted. Coming back out into the community, I had to start all over from scratch, which took a six-month actual opportunity to connect to that again.

And I did deal with some behavior issues from my son at the time but trying to get him access to those treatment services. So, when we talk about reentry, especially for women who are primary caregivers, women are a higher incarceration rate. The rate of women being incarcerated is going up, but women also are primary caregivers, and typically, when we are released, we are

actually absorbing a family again, that actually not only do our mental health and things have to be addressed, sometimes addressing the trauma of what we went through for our children that disrupted is important as well. But that disruption actually stops it, not only for the mother, but for the family as a whole as well.

MS. BECKER: ROACH: Thank you, DeAnna.

Jami and David, before we talk about your state's pending Section 1115 demonstration requests, could you explain some of the efforts that Arizona and the Middlesex County Sheriff's Office have undertaken to improve health outcomes for adults leaving incarceration?

MS. SNYDER: Certainly. I'd be happy to.

And exactly to DeAnna's point. The work that we've done in Arizona is really focused on ensuring that individuals are connected quickly to care upon their departure from that correctional setting and that they have the resources they need once they leave the correctional setting to more successfully integrate back out into the community.

So a couple of efforts that we have pursued over the course of the last five or six years or so, similar to

I think some work that's going on in other states around the country, we did in 2017 implement an enrollment suspension effort. We exchanged data with our Department of Corrections, our Department of Juvenile Corrections in five of our fifteen county jail systems so that we can effectively suspend enrollment when an individual leaves a correctional setting and reinstate that enrollment quickly prior to their departure so that they're able to access care upon departure from that correctional environment.

I mentioned that we are currently exchanging data with five of our fifteen counties. That includes our two most populous counties. So that includes Maricopa and Pima County. So it covers approximately 90 percent of inmates in county jail settings.

In addition, for those individuals that aren't enrolled in Medicaid but are going to be released from a correctional environment, we work with correctional facilities to assist the member in applying for benefits prior to their departure and have done a lot of coordination in that respect. Our approval rate for those pre-release applications sits at about 94 percent, so pretty pleased with where things sit in that regard.

In addition, we have very specific requirements for our contracted managed care organizations. I think you all know in Arizona, we're a managed care state, and we have specific requirements around reach-in work. And, in particular, for individuals with chronic or complex needs, the expectation of our managed care organizations is that they will connect with the individual prior to their departure from that correctional setting and begin to coordinate care so they're able to access care quickly upon release.

In addition, we do require our managed organizations to maintain justice system liaisons, and they actually are that hub of activity around the reach-in work, and that's been really successful. And we have a justice system team within the agency too that coordinates with the liaisons.

Over six years ago now, we initiated what's called our targeted investments program, where we provide incentive funding to providers in our network that are interested in partnering with us in integrating care at the point of service. Part of that effort has been standing up 13 collocated justice clinic sites around the state of

Arizona, and those justice clinic sites, in addition to offering the full continuum of clinical care, including physical or acute care services, behavioral health services, connecting individuals to community-based supports, they're charged with maintaining parole and probation services on-site at the clinic location. It's been incredibly successful. They also offer medication-assisted treatment, employment support, support around food issues, or food insecurity, peer and family support, to DeAnna's point, making sure that we're attending not only to the individual's needs but to the needs of the whole family. And approximately 4,600 members have been served through those justice clinic locations since the inception in 2017.

In addition, I mentioned earlier something I'm really excited about, our recent waiver approval around transitional housing, being able to reimburse for up to six months of transitional housing as well as outreach to homeless populations. But the transitional housing piece, we think is really essential to our work around integrated care and extending that understanding of integrated care to include social drivers of health.

And, as I mentioned, the population that we're specifically targeting for the provision of transitional housing are individuals that are leaving an institutional placement, whether that's a long-term inpatient stay or a correctional setting, understanding that the risks are greater for those populations in terms of a stability post-institutional stay, and so really excited to stand up that benefit over the course of the next year. We have a lot of work ahead of us, but we were thrilled to get that approval, although I know, as we'll talk about in a moment, we're still waiting on approval for our reach-in requests, but again, we'll revisit that in a few moments.

MR. RYAN: So my boss always likes to say that we have a unique window of opportunity for the folks that are entering our custody. There, we have a short window. On the sentence side, on average, folks are with us for probably eight to nine months. On the jail side, we're probably looking at around 60 days. And just to provide like a little bit of background, like our census right now is around 262 on the sentence side and about 375 on the pre-trial side. We are different and apart from the state DOC prison. We are a jail and house of correction. There

are 14 in Massachusetts, and we're one. The sheriffs are independently elected. We're obviously -- our state DOC reports to the governor. So that's a little bit different.

But the sheriff also likes to say that reentry begins on day one, so very focused on that time that we have with them but making sure that we are providing individuals with the glidepath back into the community by trying to connect them to all the social determinants of health as well as community supports upon reentry.

Two areas of focus for the sheriff have been one on medication-assisted treatment. We offer all three forms of FDA-approved medication-assisted treatment, but what I think is a little bit unique about the program that the sheriff provides is that that also comes with post-release navigation for navigators, which is also peer-led, that are helping folks transition back into that community. So, at that end of stay, they are with that person and staying connected to that individual as they are looking to kind of navigate and connect through all the different services they need to, you know, whether that be housing or a job or family reintegration, to DeAnna's point, or, you know, continuing their education.

We also you know, obviously provide educational opportunities and more so in the postsecondary area, because we have a lot of folks that are actually coming into our custody that already have their high school diplomas and GEDs. So we're sort of focusing in that area.

And then an additional program that's actually run out of our office of Medicaid, that came through a recommendation of the Council on State Governments to really kind of focus on the behavioral health needs of the justice-involved that are in our custody. As I cited earlier, those numbers are extremely high.

So what the state did is they actually put dollars to allow for a behavioral health provider to come in and do individual service plans with folks, and that includes obviously Medicaid enrollment and making sure that that's part of that, but then, again, it's that post-release navigation and, again, trying to connect them all to those, you know, community supports.

We were a pilot site for it. It's now actually commonwealth-wide here in Massachusetts. It's a very exciting piece of it, and we're seeing some of the early evaluation come back that this is actually having an impact

in the way that we were hoping that folks were going to remain housing stable and remain in their jobs. So we're excited about the path forward for that program as well.

MS. BECKER ROACH: Thank you.

Vikki, as we look ahead to approval of state Section 1115 requests to provide pre-release services, can you discuss key considerations for implementing these new demonstrations? What are the main challenges or concerns you've heard in your work with stakeholders?

MS. WACHINO: The criminal justice system is not a monolith. There are 2,000 prisons, state and federal, nearly 3,000 jails, 1,500 juvenile justice facilities. So it's extremely fragmented. One struggles to really find the words for how diverse it is.

They're all managed in different ways. Jails are local. They contract for their health care services on their own. They're highly autonomous.

In addition, the services that are provided within prisons and jails have very little transparency and do not generally, although there are exceptions, follow the same rules of the road as community services. There's not necessarily billing or claiming. There's not standard

structures of accountability, and those services are generally provided to in service of correctional needs rather than clinical needs.

Correctional environments are highly hierarchical. You can think of them as paramilitary structures, and their primary concern is safety and security. And so part of the challenge is the diversity of setting. Part of the challenge is how do we start to think about bringing a community standard of care into a correctional system.

As we engaged stakeholders -- and I'll say we talked to 70 stakeholders earlier this year. Also, the work of the Health and Reentry Project, or HARP, was also informed by 11 cross-sector leaders on our advisory committee, including Sheriff Koutoujian. The recommendation of the stakeholders was to establish -- to navigate all of this complexity by establishing a North Star of implementation, and that North Star was a care model that's designed specifically around the needs of the person leaving prison or jail. And what that looks like is a strong connection to primary care services linked as strongly as possible to behavioral health services, with a

very strong patient navigation support, because as DeAnna said, when people are leaving, they're left on their own.

We had one person on our advisory committee with direct experience of incarceration who said, "When I left prison, I was homeless, and so I relied on other homeless people as my navigators," and we need to switch that.

And then, again, as you've already heard, there are very high rates of trauma, both for people before they enter, and for many people, incarceration itself is a deeply traumatizing experience. So trauma-informed care is also part of the solution set as well as connections to social support. So that's the North Star, and that's what I will offer to the Commission and other policymakers as something to build towards.

Along with that, there are very significant implementation challenges that need to be navigated, and I think the way we start navigating them is by convening across sectors. There are very limited touchpoints right now between most criminal justice entities and most health care entities and most state Medicaid programs, but for these policies to be successful, they all need to be at the table. They need to start speaking each other's language.

They need to start talking about their goals and where they're complementary and where they're not, and I do think there's a lot of complementarity around public health and public safety.

So we've got an opportunity here to get our oars in the water and pulling in this, in this similar direction, but we also have to acknowledge some of the really big differences between community settings and clinical settings.

And, on that point, one thing we heard very clearly from our stakeholders was the need to prioritize clinical, evidence-based services that meet a community standard of care. There is very little trust among beneficiaries who are in the justice system, in the services that they are receiving.

There's not always, in all candor, great trust in the health community, health care services among this population either, but I think part of the challenge to address is how do we start moving services to a community standard of care. That includes infrastructure, like claims and billing and electronic records, and that includes bringing -- making sure that the services, the

providers are meeting a community standard of care. And it's very hard to gauge how big a lift that is, because there's not a lot of information out there.

Clearly, systems, as you've heard from Jami, are a key part of this. How do we connect information systems and data systems that underpin the ability to share and transfer information so that Medicaid programs can actually manage the health of the population, and so that we know when someone is released or about to be released? And, in too many places in the country, that infrastructure has yet to be built. So I think that's a key element of it.

And I'll just end with, you know, three additional considerations, again, that we heard from the 70 stakeholders we spoke with. One was we need to build community services. Looking at correctional environments in and of themselves isn't going to move the needle because too often people are coming to prison and jail with significant unmet need. And for reentry to be successful, the community providers need to play a bigger role and to be supported in growing into that role.

Underpinning all of this is making sure that as Medicaid starts paying for these services, as with any

other area of Medicaid where the federal government is now starting to fund something that's traditionally been a state and local responsibility, how do we make sure this is not just a refinance of what is already going on? And that's where I think making some of these investments to support leaders like David and Sheriff Koutoujian, like how do we start investing money to build a stronger clinical health care system at release.

And, finally, the need for people with direct experience to engage in policymaking and implementation, these services and what happens in correctional environments is walled off from the rest of society intentionally. So very few policymakers, including former policymakers like myself, really have any idea what is going on in those environments and what the needs of people as they are released are. And I have found it incredibly valuable to hear from people who have experienced it, to get their insights. And I think that they should play a role in policymaking and monitoring and ensuring accountability.

And I think that's actually the real final element I will emphasize is the need post-approval for

having ongoing accountability for what's going to happen with these services.

MS. BECKER ROACH: Thank you.

Jami and David, what are some of the policy and operational issues related to implementation of pre-release Medicaid services that you're working through in anticipation of your demonstrations moving forward?

MS. SNYDER: You know, I think Vikki really captured it.

So, clearly, we've been doing -- and we have expectations, rather, of our managed care organizations in terms of reach and activity. We are looking to CMS to approve our request to be able to reimburse for that activity, but the conversation doesn't end there, right? It really is around that care model and ensuring that we are attending to the needs of each individual and their family as they leave that correctional environment.

And a few things that we've been thinking about in Arizona as we prepare or hopefully prepare for approval from CMS for our request is really the need to tailor our supports to individuals, looking at individuals who may be living with a serious mental illness and ensuring that

we're doing some pre-release screening for those individuals so we can establish their eligibility or that designation upon their departure from a correctional environment.

In addition to offering basic, like, case management, care coordination services, really looking at the kind of range of social service factors or issues that may be an area of need for individuals, whether we need to sit down with those that we serve and develop a housing plan and develop a plan for pre-tenancy wraparound services, so thinking about what that looks like, especially given our new benefits offering up to six months of transitional housing, looking at life skills training and support, so really preparing for independent community living, ensuring that individuals, when it comes to housing -- this is a huge issue for us is ensuring that individuals are document-ready, that they have the documentation needed to successfully rent an apartment, and so looking at various ways to collect that documentation and house it easily in one place for individuals as they leave those correctional environments, also looking at the provision of employment support services, and so really a much more

robust kind of engagement with individuals than we've been able to offer to date, with our very straightforward requirements, our managed care organizations.

And so, again, I think we have a lot of work to do. I think the key is really tailoring the work that we do to the needs of the individual.

And, Vikki, to your last point, I think that's absolutely essential and something that we feel very strongly about in Arizona is having individuals with lived experience at the table informing the care model that we establish. So, over the course of the next year, the agency is really committed to engaging with community stakeholders but most notably those with lived experience so that they can inform the benefit that we stand up ultimately.

MR. RYAN: Yeah. In Massachusetts, we've been working for over 18 months in preparation to implement this, if we were to get approval, by coming to the table. I mean, Massachusetts has really done a lot of work on sort of that intersection of public health and criminal justice. But, you know, first coming to the table, we're kind of speaking different languages. Like, there's a bit of a

learning curve on what's the difference between an ACO and an MCO, what's the difference between sentence and pre-trial, and so I thought it was really helpful that we started this work early.

And I think, you know, one of the things that we've really been focused on, you know, to Vikki's point, is that care coordination that we're going to need. And I do believe that there's probably going to be a need for some additional provider education in and around the needs of this population because it's the chronic illness, it's unaddressed behavioral health issues, but also individuals with criminogenic issues as well.

You know, they're leaving our custody after eight or nine months. Those issues still need to be addressed, and, you know, one of the things we're also looking at here in Massachusetts is workforce, to, you know, really be able to respond to the needs of those individuals coming in but, on the front end, obviously identifying what those issues are, so the assessment that's going to have to occur upon intake so that we're making sure that we are developing a service package, if you will, that's going to meet the needs of these individuals.

Other things that we're hoping to utilize is telehealth, right, as part of this to be able to kind of connect with providers. Ideally, we would like for them to come in, right, and meet with individuals prior to release, but seeing ways that we can identify opportunities for telehealth. Also, to Vikki's point, the billing structure, we don't do that now. So, again, that's going to take staffing resources that we're going to need to be able to put the guts of that, if you will, in place in any one sort of correctional facility and how that's going to be able to work. You know, luckily, we have certified application counselors that help us do this process of enrollment, but that we're going to need additional, I think, resources, staffing resources for that as that sort of grows behind the wall.

And then the last piece would be that we anticipate additional transportation outside the facility, and so just for an example, anytime anyone goes out of our facility for an outpatient appointment, there's two officers that are assigned to that individual. In an environment where recruitment and retention continues to be challenging, that is going to pose, again, a staffing

challenge for us. And there's also the security side of that, because anytime anyone steps outside the facility, there's a heightened concern in and around security because they're outside the facility.

So, you know, all these issues, we've been able to, you know, touch on through our work over the last 18 months, and we feel like we're well positioned. But, you know, there's still a lot of work to do on the implementation side. But I do feel like we have identified the various pain points and issues that we're going to have to address moving forward.

MS. SNYDER: And, Melinda, can I chime in really quickly --

MS. BECKER ROACH: Sure.

MS. SNYDER: -- with one additional item that Vikki mentioned and I alluded to earlier? And that's around data exchange. I mentioned that we -- in our suspension effort, we exchanged data with five counties, five of the fifteen in Arizona, but ten counties, most of which are rural and remote and frontier areas, were currently unable to exchange data primarily due to kind of system limitations on the county jail side of things. And

so part of the conversation going forward needs to be how do we support those county jail systems to effectively exchange data and make those system improvements so that we can do so, because we know that individuals leaving county jail systems in those more rural and remote areas already face huge challenges in terms of being able to access services and supports. And so we really need to be able to break through that challenge, and so we've had a lot of conversation with the 10 counties that we're not currently exchanging data with about how we could better support them so that they can effectively work with us in that effort.

MS. BECKER ROACH: Thank you.

DeAnna, what do you think should be top of mind as states begin to implement prerelease Medicaid services? What factors will shape their ability to improve outcomes for individuals leaving incarceration?

MS. HOSKINS: Thank you for that. Over the years, having worked in this field, one of the things that I really paid attention to was that in every discipline -- substance abuse, mental health, homelessness, women's services -- we've always established peer-to-peer support, understanding that we're dealing with a population that is

very distrusting. For some reason, the criminal justice system is very reluctant to establish peer-to-peer models. In actuality, some of the laws around probation and parole prevent you from connecting, actually fraternizing with an individual who may have a criminal conviction as well, right? But when we're talking about a country with 70 million individuals that have been impacted by the criminal justice system, it's almost going to be impossible. So we're working on probation and parole from that side.

But from the Medicaid side, the biggest issue with even accessing medical services is the trust of the system. We're talking about a population that has been totally distrusting of corrections, police, health care, of anything. In fact, a lot of individuals don't even access health care until they're incarcerated. Something happens while they're on the inside that forces them to connect with the correctional health care.

But also, secondly, it's not only establishing that, but actually building those systems in our communities as trusting partners, building those systems within partnership and not to -- all so often within the criminal justice system, we've treated this as a person

problem and not a system problem.

Recidivism, we've always focused on what the person doesn't do right versus has the system even built the infrastructure if you want to actually become a productive member of society.

So Vikki and others have talked about the importance of people with lived experience at the table. This is very different for the criminal justice system, because typically, when a person commits a crime, we kind of write them off. They're a person who has -- are an ex-felon, an ex-convict.

And I'll say JustLeadership was established because we realized that those closest to the problem were closest to the solution but typically furthest from resource and power to do anything about it. So we invest in the leadership of formerly incarcerated people to elevate their voice, empower them, and educate, to sit at tables to have our voices heard as well.

We don't want to be defined by the worst mistake we've ever made in society. We want the opportunity to rehabilitate in some kind of way, and a lot of times, that's inclusive of access to health care, which is a basic

human need. I'll keep coming back to that, which is a basic human need.

So, when we start talking about how do we implement this, how do we connect, it's definitely centering the voices of those most impacted in those conversations, centering those voices in how does accessibility actually benefit you and your community.

But, also, what we heard today too is this isn't a silo issue of just health. It's around employment. It's around housing. It's around breaking the economic mobility, creating -- closing the economic wealth gap as well. I always say if I can feel good, if my mental health is stable, I can become a productive member on my job. I'll become a productive member in my community. That actually starts to increase the public safety.

Again, I'll close with this. When we talk about public safety and public health, are we being inclusive of everyone, or are we excluding some based on a mistake they've made? And, currently, to this point, we've been very exclusive of certain populations when we actually start to identify those words.

MS. BECKER ROACH: Thank you.

This final question is for all panelists, and that is, what could Congress and the administration do to improve health outcomes for adults involved in the criminal justice system, particularly during the critical transition from incarceration to the community? What, if any, additional flexibility or support do states need to successfully implement pre-release Medicaid services? I don't know if anyone wants to take that first.

MS. HOSKINS: I'll kind of share what Ohio did that I think can be very much replicated actually. We passed legislation in the state of Ohio that required individuals leaving the department of corrections to actually have a 90-day prescription to our pharmacies across the country, whether it was Walgreens, the community pharmacy, but it was a system that mandated that everyone leaving prison, if they were on some type of psychotropic or health care medicine, there is a prescription in the community for at least 90 days while you try to connect to a primary care or a mental health. That began to really close the gap.

But, also, additionally, we enroll people in Medicaid 90 days before release. Although it can't be

active while they're serving time, the day they leave, their case manager, as they're closing out their file, can hit submit, and they are automatically emergency accepted as an individual in the community would access the Medicaid so they can immediately go to that pharmacy and pick up their medication.

So it was just testing out little things of that nature, and what we found with the high rate of mental illness in our communities, that our legislators in Ohio actually legislated that. We didn't want to do it as a pilot anymore. We wanted to make this a way of business that the state of Ohio operated with people returning to our communities.

And, also, now we're pushing the state of Ohio, and I think North Carolina has already, where a community health worker -- actually, we're looking at a Justice Navigator model where it becomes Medicaid reimbursable for those community providers who are actually providing that community health worker, and they're starting to have access to the Department of Corrections prior to release. I think it's very important, and I'll stop there.

MS. WACHINO: I think there are a few things that

Congress could consider doing in order to expedite progress in this area and make changes successful. DOJ plays a big leadership role in driving policy and perceptions and action at all levels, even though their authorities don't reach to the local level.

Having a DOJ-CMS collaboration on implementing changes to health at reentry, I think, would be extremely valuable. They do similar work now, largely focused with SAMHSA, on behavioral health, but something that convenes cross-sector actors at the state and local level and develops best practices for some of the major implementation issues. How do we have people leave with their drugs in hand, their prescription drugs in hand, and get to a pharmacy? How do we build infrastructure?

So collaboration, best practices, convening on an ongoing basis across HHS, and in particular, CMS and DOJ, I think, would be a worthwhile investment.

Looking at how we can support providers, community providers, perhaps particularly health centers, but also reentry service providers, that could be through new grant money. It could be through examining how current grant funds are spent and are they encouraging investments

in reentry capacity or are they not. We're at what I perceive to be a high watermark in terms of some of the grant funding that's gone out over the past few years post-COVID. This has a lot of flexible uses, and I think some encouragement to the field to really make some investments in provider capacity.

Being a reentry service provider is really hard. We heard from reentry service providers that they would try to find out what services were available to connect people to, and there was no information. They go and they google and try to figure out what's available. So building the capacity of those types of entities as well as community health care providers, I think, would be extremely helpful.

Both of those ideas are really directed to the state level, but at the federal level, I think CMS has a really strong interest in working in these areas as we've seen. And that's what's gotten us to this point of really contemplating these changes. It's a heavy lift for them.

So my own lived experiences as a former federal official -- and I will say because there is this divide between the criminal justice system and the health care system, CMS has a lot of learning to do. I did not, in all

candor, understand these issues when I led CMCS. It is in the six intervening years since I left government that I have come to understand them, and I think CMS could use some support in taking on these issues, and so that we're really resourcing the issues and the capacity in line with the importance and the potential value of these services for the health system.

Additionally, I think evaluation and monitoring, and evaluation is easy to say, but in a way, the monitoring in this is going to be more important. This is not an area where we can do an evaluation five years from now and see how it worked. We are going to have to monitor over time, and although I see great potential in these changes to improve health, we are not going to overcome the divides between corrections and criminal justice and health in a year.

We should level-set expectations and expect to learn as we go and to get data and input from communities that have experienced incarceration in disproportionate ways, in people who've experienced it, to create accountability structures to oversee the work.

My last suggestion is actually not for Congress

but for MACPAC. Over your 12-year history, you've made an enormous difference in improving understanding of issues for policymakers, and I think it's fantastic that you are taking on this issue. I am looking forward to your June report. I will be the first person to read it.

But I really encourage you to make an ongoing commitment to analysis on these issues. I think policymaking really struggles in this area for lack of analysis and data. In all candor, some of the data I shared with you earlier is 10 years old. I cite it because it is easily the best available, but we need to understand what's going on. We need to look at what people are experiencing during transitions. We need to look at how the ideology of the substance use epidemic has changed and is changing. And so I'd really encourage MACPAC to make an ongoing commitment to analysis on these issues.

MS. BECKER ROACH: Jami?

MS. SNYDER: And I would -- yeah, I would echo David's earlier sentiment and Vikki's sentiment around the need to see some level of collaboration at the federal level, because in fact, we do -- correctional officials and Medicaid officials speak different languages. So, if we

could facilitate that coordination at the federal level between DOJ and CMS and they could issue a set of best practices, offer technical assistance to states. We're doing a lot of that work sort of organically on the ground in states, but really to have that federal-level commitment to ensuring that the communication is happening, to ensuring that states understand what's available to them in serving justice-involved populations, I think is really critical.

The other piece, I know, Vikki, you mentioned support for community-based providers, community health centers. I would also say support for community-based organizations. That's still a group of folks that Medicaid programs are trying to get their hands around in terms of how do we as Medicaid programs support CBOs that have no interest, at least in Arizona, in enrolling with the Medicaid program and billing for services, but they're critical to our success in serving justice-involved populations, and so what does it look like for Medicaid programs to provide support to those CBOs so that they can be a real partner in this effort.

And I do really -- I agree with you

wholeheartedly, Vikki, around the need for evaluation and monitoring. I think some of the challenges really still lie in data exchange across systems and making sure that we're bringing all of the data that's really going to sort of paint the picture of how successful we've been together. And so we continue to work with our state universities and philanthropic organizations to figure out how we can bring resources into the Medicaid program that will allow us to take a deeper dive into the data and look at whether we've been successful with our suspension efforts, our pre-application efforts, our reach-in efforts to date.

And so I think that's going to be an important piece of the equation in supporting CMS too, right? Going forward, if they're going to, in fact, approve reach-in activities, the reimbursement for reimbursement -- reach-in activities, rather, we're going to have to be able to demonstrate that there's merits to that work. And they've been great partners to date.

Yeah. My final plea to CMS, of course, would be to approve the 11 -- or no -- 12, right? Now 12 reach-in requests that are on the table. We understand that it's likely right around the corner, hopefully any day that

they'll approve the first one, but we're eager to get started, as I know the other states are.

MR. RYAN: My boss, Sheriff Koutoujian, likes to say as well that the best reentry sometimes is no entry. So I think additional supports from Congress and the administration in crisis response reform, I think, would be really helpful, because what we're hearing -- because we have 54 police chiefs and 1.6 million people in Middlesex County. And what the sheriff hears from police chiefs is that there's someone to call, someone to respond, but not somewhere to go.

So we're trying to stand up a crisis diversion facility in Middlesex County so that -- you know, so many folks are coming into our custody with unaddressed behavioral health issues. There's probably a lot of examples of folks that probably don't need to be in jail that could receive that treatment in the community. So I think that that's certainly one.

And then, on the reentry side of things, certainly bolstering the community supports that are available for folks upon reentry, because if we don't have things like housing, it's going to really be challenging

for folks that are reentering if they don't have somewhere to put their head at night, so looking at those.

And, as far as flexibility is concerned, the pre-release period, it takes a while to get the planning in place for individuals, and the biggest ramp-up period that we can get on that in access to Medicaid, like 90 days, would be really helpful to make sure, because oftentimes -- like right now, providers won't talk to us because folks don't have access to the benefit. And that's a real challenge, right, because we want to make sure those appointments are locked in before they go, and so as much of a ramp-up period that we can get prior to release is really going to help us on the continuity of care side of things.

MS. BECKER ROACH: Thank you so much to our panelists.

I will turn it back now to the Chair to kick off the discussion.

CHAIR BELLA: Thank you very much.

Let me first, just on a process question. I think we asked you all to be with us until 10:45. Is it possible for you to stay until 11:00 if we have those

questions? Is that -- okay. Thank you very much. I can anticipate that my fellow Commissioners are going to want to talk to you for more than 15 minutes, so thank you.

Who would like to kick us off? Tricia?

COMMISSIONER BROOKS: So thank you. This was really excellent, and David made a point that was circling in my head when Vikki had talked about evaluation and monitoring is that, if we do a good job of this, perhaps we can demonstrate that if we move it upstream and provide these services prior to incarceration, that we can -- you know, that's where we talk about upstream and savings across the board, right? Certainly, I think that that evaluation is really critical.

My question is -- and by the way, DeAnna, I love your mission statement on your website. I heard you repeat one of those sentences that really stood out to me. But my question is I think more specific to Vikki.

Vikki, you made the comment that CMS needs support. Can you be more specific about what that would look like? Dollars are probably part of it.

MS. WACHINO: Yeah. I think resources or staff resources and financial resources. I mean, this is a

larger issue, but CMS does not get generous increases in administrative funding over time, yet we ask them to do a lot. And they're being asked to do a lot right now on the end to the public health emergency, which is, I think, an imperative for them.

They're being asked to address equity, to address behavioral health, many, many things. So I think it's worth thinking about how are we really supporting the agency in doing its work.

I've seen some growth on Congress's part in this area, in the Bipartisan Safer Communities Act, the establishment of the Technical Assistance Center for Schools, and for the EPSDT reviews. I think it's promising, and you could use that model and combine it with DOJ. But I also think like having some people resources is helpful.

CMS is -- everyone is operating in this environment of significant workforce challenges, right? So whoever you talk to as an employer, they're dealing with very significant turnover, right? They're dealing with the move to a virtual environment, and at the federal level across agencies, they're dealing with retirements, right?

And so I just think we need to think a little bit about capacity of the organization.

And then, as I said, in this particular area, there's a learning curve that the CMS team has to go through in understanding these issues, and I think from the little bit I've seen, they're doing a great job of it. But it's a lift of work to understand these issues.

So that's what I envision, and I know MACPAC has probably thought about these issues of administrative capacity before. I know they're not easy to grapple with, but it's worth giving some thought to how we're supporting it. There are great people there who are really, really dedicated, and how are we supporting their efforts in this and other areas?

COMMISSIONER BROOKS: So, DeAnna, you touched on a point that is close to my heart, and that is children's mental health. For many years, a lot of people have been in denial that young children have mental health issues, and we certainly know that there's a lack of capacity in providing services to children. What more can we do to educate policymakers and thought leaders about that?

When you talked about your family was ready,

"Hey, here are your kids. You know, good luck," what more can we do to really elevate that and help people understand that? If we are really focused on children having a healthy start, which breaks the cycle, what more can we do to elevate that?

MS. HOSKINS: Thank you for that. One of the biggest things that I discovered personally that happened again with my incarceration, again, my removal for my children, my children were in school, and that disconnect as well, where especially in urban areas, inner cities, there are more police officers than there are social workers and counselors to deal with the children and the issues that the children are coming with.

Behaviorals that show up in school are typically responded to in a criminal activity versus what is going on with this child at home. This child's parent has been removed. They're in another caregiver's home. What is going on in those things?

So, when we talk about it, I think actually looking at focusing on children of incarcerated parents, that even when the health -- a caregiver steps up who may be employed and they may not be receiving Medicaid, does

Medicaid follow that child so that that child has access to counseling and resources in the community to help address it versus putting that responsibility on a new caregiver who may have stepped up and have an additional cost as well?

So I think. for me, no one, when I was incarcerated, ever asked me did I have children. It was all about the crime that I did and different things of that focused on punishing me without understanding the punishment.

And I think, again, we can't continue to operate in a silo, that we're making a decision. I'm not saying that I wasn't to be held accountable for what I did. Definitely, but also, in my sickness and illness of my substance abuse disorder at the time, didn't pay attention to the harm I was causing towards my children. So the system as well didn't pay attention to that, and how do we disrupt the trauma that these kids were now experiencing as well? Which becomes a cause to our system as well if we don't.

MS. WACHINO: Can I just add on to that, Tricia? There's so much emphasis right now on maternal mortality

and infant mortality, and incarcerated women deliver babies in prison and jail, and then that baby is removed from them. And both parts of those processes are very traumatic to the mom and the infant. So, again, it's another place where we're trying to move towards these national goals, and if we exclude this population from the conversation and from the policy interventions, I think we're going to hold ourselves back from really reaching the potential.

CHAIR BELLA: Thank you both.

Angelo, then Sonja, then Laura, then Darin, then Martha. Quite a list.

COMMISSIONER GIARDINO: I really wanted to thank the panelists. This has been really informative.

I have a couple questions. One is, are the concepts and approaches you're talking about applicable to the adolescents who are in the juvenile justice system? And then if you could comment on any unique elements for those adolescents that you'd want to focus some attention on. And then, third, are the 1115 waivers that you're all involved in, do they include the adolescents who are in the juvenile justice system?

Thank you.

MS. HOSKINS: I can start talking about with the adolescents. I'm not about the waivers, but a lot of times when we talk about access to medical, it's inclusive of those adolescents in incarceration, and I think -- thank you for bringing that up, because that is an area where mental health behavior issues and different things are actually being demonstrated. We're seeing a younger population being more incarcerated without the issues that were driving the behavior being addressed.

So, again, being in those situations, one of the biggest things I know we are pushing for is how do we create health centers that are correctional centers, how do people actually get addressed with the traumas that they're walking into those situations with, but again, that very inclusiveness and separation of correctional health care at this time is totally contracted out. It's very private of what happens. There's no continuation into the community.

So I think looking at it from an adolescent perspective, because a lot of those children are actually sitting in those correctional facilities without access to that care, and again, once they enter community, it is disrupted if they did receive any.

COMMISSIONER GIARDINO: Thank you.

MS. SNYDER: I can certainly speak to Arizona's request. I think our activity to date with adolescents has been somewhat limited, but our waiver requests specific to reach-in work does include serving the adolescent population. So we're really excited to be able to use that waiver approval ultimately to better serve children and adolescents in correctional environments.

MR. RYAN: And our waiver requests includes DOYS as well.

COMMISSIONER GIARDINO: Great. Thank you so much.

CHAIR BELLA: Thank you.

Sonja? You might be on mute. We can't hear you.

COMMISSIONER BJORK: Sorry. I had the double mute.

When DeAnna mentioned the Justice Navigators, I sure perked up. And then I wondered about how they're being used. You mentioned community health workers. So is it a community health worker that acts as a Justice Navigator?

And then I was wondering, are these folks that

work --they're employees of the jail, or are they outside? Are they employees of outside community-based organizations that help with the navigation?

And then after you answer, I wanted to ask Mr. Ryan, is it better to have the services provided by people that already work at the jail? If there was a Justice Navigator, is it very, very difficult to have outsiders who work at community-based organizations be able to come in and meet with those who are in custody?

You mentioned telehealth, but I just am wondering how to operationalize the wonderful idea that DeAnna mentioned of people being assigned a navigator to help them with the multitude of things that we've all been talking about.

MS. HOSKINS: Thank you. In North Carolina what happens is it's a cross-pollination. Community health workers or recovery coaches have been dealing with around substance abuse and mental health, it's the same population. They're finding out that people have had justice-impacted contact. So how do we continue to move and focus on there? We have not moved to a system that distinctly says these are community health workers for

people who have been impacted by the correctional system. It's the understanding that those populations are cross-pollinating, and they're the same individual. So it definitely has not.

One of the things, Vikki brought up something very important that when I served as senior policy advisor over the Second Chance portfolio, we invest a lot of money in innovative ideas that actually come out in reports and different things. Then we put them on the shelf, and they get dust.

And there was a report or a project that came out of Georgetown University, and it was focused on probation and probation officers of how they could guide people through the system. And my immediate response was probation officers have a caseload of 300. There's no way they could do this.

But we could operationalize peer to peer with this curriculum you have developed, that individuals who have already navigated almost like AA/NA model when people -- if you're in recovery -- I have been in recovery 24 years. When you're in recovery, you find a sponsor that helps navigate you through this system. But, again, for

some reason in the criminal justice system, we're very reluctant to that.

And it's the same way of how do I navigate this new world in this new life. When you're working in criminal justice and you're working with people from oppressed and marginalized communities -- I'll never forget working in gang violence. And the fact that I was starting to work with gang members who wanted to move into pro-social life and never even had an ID to understand their Social Security number at the age of 25, right, because they never had a need for it. Police always knew their identification, who they were, but we were actually navigating them into a new lifestyle of responsibility. And we had to walk them through that, that you should have a state ID. You should be able to identify who you are. This is how you show up for work on a constant basis.

I think we, in society, take for granted that everybody understands things that we've been privileged to. I just happened to be privileged to come from a home and made some decisions, but what I found out is a lot of people don't have access to the role models or things that were established in my household that happened in their

household.

So, when we talk about Justice Navigators, my biggest advocacy is people have been harmed by the criminal justice system, giving them access back into the system. And I don't know for the sheriff and your department, but when I worked under Second Chance, that was the biggest pushback from Department of Corrections and jails was giving people, who had been formerly incarcerated, access to their system to work with the people who are ready to come home.

MS. SNYDER: And I would just echo the sentiment around the power of peer support. That's something that we've heard often from individuals that we serve, and in fact, we have a peer support academy, and we've developed a second-level certification specific to forensic peer support which has been really valuable in terms of serving individuals with any level of justice involvement.

MR. RYAN: At the Middlesex Sheriff's Office, we utilize both models for the MATADOR, the Medication-Assisted Treatment. We have Middlesex Sheriff's Office employees who are also peers, who sort of help in that post-release navigation.

And then for the behavioral health justice-involved initiative that we're part of, that's run by our Office of Medicaid, that's an outside provider that comes in and does the individual service plans and then the post-release navigation. That also utilizes peers for that program as well.

But, to your point, anyone who is coming in from the outside into a correctional facility and meeting with folks, there's the level of staff interaction with command staff. There's that piece of it, but then it's also coming in. And some folks may not have the experience of actually working in a jail. It's a different environment. So you have to get used to that piece of it.

But the biggest thing is the trust, right? So, for the folks that actually work at the Middlesex Sheriff's Office, the justice-involved individuals in our custody see them every day, so they know them. And so the folks that are coming in from the outside -- and sometimes there's turnover with navigators, like who is this, why are they meeting with me, and so that does take a little bit of time to establish that trust with the individual before they're willing to work with folks on their reentry plan. So

that's something that we certainly recognize.

But I will say for the model that we utilize for the MAT program, it is a little bit easier because they can see them every day and interact with them on a daily basis as opposed to three times a month to have someone coming in.

But that's true with, honestly, any vendor that comes in to do anything in a jail, that it is a challenge to have folks coming in from the outside but one that we've addressed in the past.

COMMISSIONER BJORK: I appreciate you emphasizing those factors because as those of us who work in Medicaid try to meet with people who work at -- who are sheriffs or who work in the jails, being able to understand their challenges. You know, we think we're offering, "Oh, we're going to come in 20 times a month," and to the people we're meeting with, they think, "Oh, boy. Thanks a lot. How are we going to handle that?" And so there are so many logistics to work out, and this really helps promote that understanding, so thank you.

CHAIR BELLA: Thank you.

Laura, then Martha, Dennis, and Verlon.

COMMISSIONER HERRERA SCOTT: Mine is more of a question and clearly because my lack of understanding, the role of the jails and the prisons, given that they have dollars to hire these contractors. What policy levers do they have to say if you're going to provide this health care, these are the expectations, and this is the data we'd like to see? So I think it was DeAnna or Vikki -- I'm not sure -- focusing on the security and the safety but not on addressing the clinical care of the inmates while they're there. Can you talk a little bit about that side and any policy levers on that side to get them to move to more of a whole health approach, not just the security safety?

MS. WACHINO: It's a great question. I think that prisons and jails have the levers. They also have a lot of autonomy in how they act.

On the prison side, let's just take state prisons. They contract on their own. They're accountable to the governor's office. So I think there's an ability for state leaders beyond state DOCs to get the right people across the state cabinet to the table, and those right people are documents, other public safety agencies, public health, and Medicaid, to start to align them around a

common vision and to identify the commonalities in their work and where they are complementing and where they are doing each other a disservice through the way they are doing things.

I will say it's very hard to know how that is working now, even if you just put aside the multisector approach, what's actually going on in contracting. There are a few places, Pew Charitable Trusts, for example, that have tried to look at contracts in prisons and jails. It's very hard. There is not a lot of information there. So, Laura, it's hard to answer your question in anything but a hypothetical way, because the reality is so obscured from view.

On the jail side, it's a different -- it's even harder, because every jail is locally autonomous, and I think this is one area where there's going to be challenges in terms of state Medicaid programs, advancing services there, because states generally don't have any authority over jails. And so how do you, first of all, bring sheriffs and wardens and staff along in the conversation?

MS. HOSKINS: And I'll just follow up with that. My experience, when I was the director of reentry for

Hamilton County in Ohio and we were moving into Medicaid expansion -- and I remember the local jail's medical contract was up for reassignment, and I could not get in any word into this contract. Actually, the vendor who was the current vendor contractor wrote the grant that they were applying for, which totally blew me away, and I remember just asking for a clause to be put in there at the end, that if the needs of the county and the sheriff change, this contract will be revisited.

A year later, Medicaid expansion happened. We were able to revisit it. We wanted to call a meeting with the correctional provider, which was out of Vegas, huge provider across the country. They were telling us what they weren't going to do. We brought in a health commissioner, and we really had to have a sit-down conversation, which totally to me was obscured. But then I understood how much power that they had, and it was very limited on what they were going to communicate with.

I think there was an issue where an individual was taken from the jail to the hospital and came back, and the information that the sheriff needed, medical was not given to the sheriff. And I had no understanding.

And I think Vikki was in office when I'm calling CMS and saying, "Okay. There's this law that for some reason correctional vendors think they're in control, when in reality you are a contractor of the sheriff. So whatever you know goes to the sheriff because that is your employer," right? And they were actually throwing out all these HIPAA laws and different things. The sheriff, being two different worlds, didn't understand and thought had to be followed. So, again, it was this communication, this education that had to take place.

But the county commissioners were the purse strings, and we had to push our county commissioners to say how those medical contracts should be written. But, again, it always had been a siloed issue. County commissioners -- the sheriff is elected. The commissioner controls the budget, but the sheriff controlled everything that happened at the jail. He doesn't know medical. So, again, the medical vendor was writing their own contracts as to what they were going to provide, which was very minimum.

So it was really this -- we have to bring entities together to actually have the impact we want.

MS. WACHINO: And just one. So it goes without

saying that we don't even know what that costs. Okay.

CHAIR BELLA: Thank you.

Martha and then Dennis.

COMMISSIONER CARTER: Thank you for this really thought-provoking presentation.

I find it really troubling -- or lots of it was really troubling, but troubling that there isn't a community standard of care for health care in our prisons and jails, and I have to think, well, why is that? It's the historical -- what's the background for why people aren't eligible for Medicaid when they're incarcerated?

And so I realize all the struggles that you guys are doing to try to just get in-reach and pre-discharge eligibility, but here I'm thinking naively. Shouldn't we be just working toward making sure that people either keep their Medicaid coverage when they're incarcerated or are able to gain Medicaid coverage while they're incarcerated? And that should just be part of our health care system, just like anybody who's anywhere else. So I'm sure that's a naive point. So tell me why that doesn't work. I mean, what would have to change for this to be a unified system?

MS. HOSKINS: I just want to say thank you.

That's the issue we, as formerly incarcerated people, talk about. Let's talk about the pink elephant in the room, why the correctional system even exists, right? It was built on the abolishment of slavery as a way to continue to enslave free labor from certain individuals. So we utilized corrections, and I think Michelle Alexander wrote about it. We used the criminal justice system, having contact with the criminal justice system, to still entrench some of those things that a person can't have access to, right? There's laws that say where you can't work. In Florida, people who have a felony conviction just got back their voting rights.

So the system was built with that establishment and looking at -- you know, I'm learning, as I do more research, prisons and jails really -- if we talk about when they changed their name to rehabilitation was focused on rehabilitation. But we moved more to a punitive concept, and what we're seeing is even the medical care is in a punitive way.

I do think the lack of inability of not having Medicaid access inside a correctional system, because it will change and have to bring up a standard of care that is

delivered inside those correctional facilities.

And I'll stop there because I know me and Vikki have had this conversation a while back.

MS. WACHINO: Martha, I connect your question to the larger efforts that are underway to move away from policies that punish someone over the course of their lifetime, right, not just prison and jail or during their -- for their period of incarceration. So the Pell restoration, the voting rights restoration, like there is -- we are at a time in society where we are kind of rethinking some of the things that are kind of collateral and consequences, and one of them is losing Medicaid coverage of prisons and jails.

This is an implementation conversation. So I'll approach your question from an implementation perspective, which is that's a heavy lift to bring what's going on in corrections up to a community standard.

It's probably very different now. It's hard to say with any confidence because we don't have data, but bringing everything that's happening in a prison and jail up to a community standard is going to take some time.

There are different views on how fast you can do

that, right? There are proposals on the Hill to totally repeal the inmate exclusion. So, clearly, there's some people who are just like, "Let's be done with this. It's punitive. We need to do better immediately."

There is the Medicaid Reentry Act also on the Hill, which would apply Medicaid coverage in the 30 days prior to services all across the board. That's a somewhat more incremental strategy.

And then there's the waivers which are an even more incremental strategy. You could view the waivers as the first step, and this is very consistent, I think, with Medicaid's history of using waivers is how do we start to grapple with these issues, how do we learn as we go, and is there an opportunity here to inform larger policymaking. Again, if you're willing to take a somewhat slower, more incremental road, which I recognize not everyone is, there are people who are really -- who really view this as a key impediment to achieving equity and social justice in the country, which I respect, but I do think that there's operational implementation issues that would need to be thought through as we do that.

MS. SNYDER: But, Vikki, may I ask, isn't it

truly at its core a financing issue?

MS. WACHINO: Yes. I mean, everyone in this room, because you're all Medicaid experts, gets this, right?

I don't know how many levers we have as a society to advance correctional health. Litigation has been the historic tool and with mixed success, shall we say. Federal authorities don't reach too many of these environments, right? So there's only so much, for example, that DOJ can do.

Medicaid is a very powerful lever for change, and so as you think of it as a financing question, it's also a question of, okay, if this is going to be -- if Medicaid is a primary lever, potentially forgetting, Martha, to the vision you outline of let's bring all of these services up to a community standard to promote health and fairness, what's the play? Right? How are we going to leverage the ability of federal financing, which for most people will be 90 percent, in order to actually move the needle of what's happening there?

CHAIR BELLA: Thank you.

We have --

MS. WACHINO: Jami, did you want to -- I'm sorry. Did you want to build on that on the financing question?

MS. SNYDER: No. No, no, no. You captured it, but I just go back to the inmate exclusion at its inception in 1965 with the inception of the program. It really was to ship the cost to the states, correct?

MS. WACHINO: It was to maintain the cost that the state and local governments was already bearing. So it was a decision --

MS. SNYDER: Yeah.

MS. WACHINO: I believe a decision on Congress's part to retain control at the -- and money at the state and federal level. And, of course, there'd be federal budgetary implications that you also want to consider in changing course.

MS. SNYDER: Exactly.

CHAIR BELLA: Okay. We have Dennis and Verlon, and we have about two minutes left, to be respectful of time, so just keep that in mind.

Dennis.

COMMISSIONER HEAPHY: Sure. So two quick questions. One is, what are the specific levers that you

think Medicaid offices need from CMS to bring this to their states? Because Medicaid offices are so overwhelmed as it is.

And then in contract with MCOs and ACOs, what are the contracting barriers that you guys face? Are there best practices in contact with MCOs and ACOs that can actually make this work?

That's for anybody.

MS. WACHINO: Jami, I think you're very well equipped to answer this question.

MS. SNYDER: Yeah, sure.

Do you mind repeating your first question? I just want to make sure.

COMMISSIONER HEAPHY: Sure. What do Medicaid offices need? What leverage do they need from CMS to actually implement these programs beyond 1115 waivers? Is there anything that can be done beyond 1115 waivers to enable state Medicaid offices to actually implement these types of programs?

MS. SNYDER: Yeah. Beyond waivers, I think it goes back to that discussion around -- and we always -- you know, we work in partnership with CMS, both Medicaid

programs and the National Association of Medicaid Directors, to develop toolkits and resources for states to capitalize on best practices. And that's, I think, really critical that CMS invests some time and resources into that.

I'm going to go back to Vikki's earlier statement, though, about the challenges that CMS faces from a staffing standpoint. That's real. That challenge is real, even in terms of waiver approval. So, asking CMS to come to the table with more, I think, is a bit of a long shot, and so there's a question there that I think needs to be answered.

Now, remind me of your second question?

COMMISSIONER HEAPHY: What are the barriers to contracting with ACOs and MCOs that Medicaid offices face? Because they're also overworked. Medicaid offices face the same barriers, if not more, than the CMS offices face.

MS. SNYDER: Yeah. I mean, I think there are a number of states that have integrated very specific requirements in their managed care contracts around care coordination, case management, reach-in activities for justice-involved populations. Arizona is just one of them.

I don't see any real barrier to moving forward with those sorts of requirements and expectations of managed care organizations.

I think the key, though, is holding them accountable once you insert those expectations in the contract, really ensuring that they are doing the work that you expect them to do in terms of assisting individuals in a correctional setting as they move back out into the community, and going back to DeAnna's earlier point, not just focusing those efforts on the individual but really the individual and their family.

CHAIR BELLA: Thank you.

Verlon.

COMMISSIONER JOHNSON: All right. Well, as luck would have it, my question was very similar to the last one, Dennis's. But what I will say, though, is thank you for this opportunity to hear what you all have to say.

As someone who has an uncle who did not have that bridge that he needed and actually passed away, this means -- very special to me that we are taking this up as a policy for future discussions. So I just want to say thank you for that, and that I am really looking forward to us

being able to have the opportunity as MACPAC Commissioners to really move the needle in health care equity in this forum. So I really appreciate it. So thank you so much.

CHAIR BELLA: All right. I am going to try to squeeze one, my own question, in which is, Jami, you mentioned dedicated resources, I think. So are other teams -- are you talking about with other states about how to have teams dedicated to this, and is there anything -- if we think about best practices, is there anything in that regard that we should be highlighting?

And then if either of you, Jami or David, want to give two seconds on like where -- what kind of questions CMS seem to have mostly on the waivers, because I think we're interested to understand like what the hang-up might be, but also if you do need to drop, you are welcome to drop.

MS. SNYDER: Melanie, I can take the first question.

I think as a Medicaid agency, as we ventured into the social determinants, social drivers of health space, it's become really apparent to us that we needed to have resources within our organization and within our managed

care organizations that have expertise around those topic areas, whether it's housing, criminal justice, and it's made an incredible difference, because as was mentioned earlier, there are huge translation and language barriers between corrections and Medicaid programs. And so to have individuals with that expertise within the organization and to require managed care organizations to have individuals with that level of expertise, that type of expertise, it has been really helpful to us, not only in supporting the work that we're currently doing but also advancing some of the work that we have on the horizon related to social drivers of health. So I can't say enough about bringing folks into your organization that actually have experience in the corrections, housing, food insecurity space.

And I don't know, David, if you want to take the other one.

CHAIR BELLA: I think you might be on mute, David.

MR. RYAN: Oh, I'm sorry.

CHAIR BELLA: No, you're good. Thank you.

MR. RYAN: I think that we recognized early on the sort of need to assemble the stakeholders in order to

start to prepare for this possible implementation. But our history of interfacing with the Office of Medicaid goes back to, you know, post-ACA, right, because we were beefing up our enrollment activities. We then passed the law around suspension versus termination. We were looking to utilize the inpatient exception. So we, luckily, have had a good period of time for both agencies, if you will, who are doing somewhat siloed work to be at the table. So I feel fortunate that we've had this time, and again, there's more work that needs to be done.

Again, on the waiver side of things, my understanding is that CMS did not want to hold up the entire waiver process. So putting the MIEP request to the side while they kind of proceeded forward on that -- one thing that was included that, which we're really excited about, is 12 months of continuous coverage post-release, because not to get too much in the weeds on this, but once someone leaves, we really don't want them to have to be monitoring their mailbox for a redetermination letter. So the fact that folks are having a bit of a glidepath back in continuous coverage for a year to see that in the waiver approval is really exciting, and we look forward to working

with CMS on this.

But we're also monitoring very closely what's happening in California in talking with them about what you're doing as far as preparation is concerned and who you're assembling, so certainly happy to steal any good ideas they might have.

MS. SNYDER: And I do think you're right about CMS's decision to kick the can down the road a little bit with these reach-in requests because states had overarching 1115 renewal requests that they were trying to get through the process.

I also am hearing with the reach-in requests as well as requests around things like traditional healing, there's an interest on CMS's part, understandably, in creating some consistency in regard to guardrails around the benefit across states. And so I think it's helpful to them to be able to look across the -- I guess it's 12 requests that are out there and ensure that they are approaching their approvals in a consistent manner.

CHAIR BELLA: Thank you. That's very helpful. We really will stop asking you questions now, although I think we could go on forever.

We always ask people, like, if you had a magic wand, what would you have us do? You've kind of all said that, but that question is an open-ended question for us. And so we won't hesitate to be asking you for input, and we hope that you will let us know as you come across things or you have additional thoughts, because this is an area that you can tell we have a significant amount of interest in.

So thank you very much to the four of you. We really appreciate the time and the expertise and the candor you shared with us today. Thank you very much.

MS. SNYDER: Thanks so much.

MR. RYAN: Thank you.

FURTHER DISCUSSION BY THE COMMISSION

* CHAIR BELLA: All right. We have time for Commissioner discussion, and, Darin, you wanted to kick us off.

COMMISSIONER GORDON: Yeah, I couldn't help to think, as we're hearing from everyone, we have a real obvious parallel from my perspective. Like when we thought about the duals where we had two systems, two programs, they don't talk well -- they don't understand the other one well, and it's doing a disservice for the people they serve

or that are eligible for their services. And I see -- as everyone's talking, and we talked about the steps we took for duals about, you know, supporting states of bringing in some of those resources, to coming up with a plan, you know, what are you doing in this space? I see that as a path worth exploring for us, because as you consistently heard, bringing people together, building that expertise within the Medicaid agency, being important, learning from one another, that's going to take some capacity building and support, and I think that's maybe a framework for us to think about as this work continues.

CHAIR BELLA: Thank you. Other comments? Heidi.

COMMISSIONER ALLEN: So I'm just reflecting back on the issue brief that we had on this topic, or the presentation maybe is what I'm thinking about, but the fact that jails had an average of 28 days stay, and to me it doesn't even make sense why you would discontinue Medicaid for such short periods of time. And it feels like -- and telehealth was mentioned today, but it feels like with telehealth, with the short times that people are spending in jails, and with incentives to get these contracted providers to provide higher-quality services, it seems like

even if you could get permission for people in jail to have no disruption of their coverage and then you could get permission for vendors to bill Medicaid, that would -- that just the incentive of being able to get that money might help them put the systems in place to do claims and billing and also might rate the standard of care, and also potentially provide an avenue for providers, particularly specialty providers who are caring for people who are briefly incarcerated, to continue to be able to see those providers while they're in jail, because I'm imagining a system where you go into jail; by the time they get even your medical records to know what to give you, there's been all sorts of disruption, and then how good are they at, you know, communicating with your providers what they did while they were in jail.

I just wonder, you know, what the possibilities for a model like that would look like. It's not quite as far as any of the waivers have gone or it's not as specific as any of the waivers have gone, which makes me wonder why. And maybe there's something I just haven't thought about in that area. Like why wouldn't you say, okay, if people are only here for 28 days, let's have them -- you know, when

you think about some of the waivers that go 60 days previously, just if that would be something that they could do or if that inmate exclusion means that that's just not even possible. Anyway, thinking out loud.

CHAIR BELLA: Melinda, do you have any line of sight into that? If not, it's something we can take back.

MS. ROACH: I would just note that -- I'm just sort of pulling out my cheat sheet here. I know at least one state -- I think it's Oregon -- is proposing to provide Medicaid coverage throughout incarceration for people in jails as well as youth. So -- and I think sort of at a national level, you know, there are conversations about sort of starting with jails in terms of any rollback of the inmate exclusion. So I think it's something that's on people's radar.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: Just a quick comment, not so much specific to providing coverage to the incarcerated or upon reentry but about 1115 evaluations. I'm just not sure that they in the past have been as strong as they need to be or, you know, I think it was David or somebody who said something about, you know, you do -- you have a brief

or whatever; it goes on a shelf, and nobody ever looks at it again. And I think as we -- when we have opportunities that, you know, include 1115s, always emphasizing the importance of a robust, timely, and well-distributed evaluation is really key.

CHAIR BELLA: Thank you. Other comments? Laura.

COMMISSIONER HERRERA SCOTT: This is a question. So to that point, with the 1115 waivers, when they are evaluated, is that shared with other states in case they want to do something very similar when there's evidence to support whatever the waiver did for that state?

CHAIR BELLA: They're publicly available. Is that what you -- I mean, but there's often such a lag.

COMMISSIONER HERRERA SCOTT: Okay.

CHAIR BELLA: But they are publicly --

COMMISSIONER HERRERA SCOTT: But there's nothing proactive -- other than putting them on a website, so somebody actively has to go to the website to see if there's something that is something they might want to do, but it's not pushed out as a potential best practice for --

CHAIR BELLA: It might be pushed out. I mean, you know, CMS -- and I'm going to overgeneralize, and,

Verlon, you should -- like if there's an area of interest, you know, they'll oftentimes make a template or like a model waiver where they're, you know, kind of guiding the states to practices that have been approved or requested by multiple states, which I think is a really good way to push it out. Agree?

COMMISSIONER JOHNSON: Yeah, no, I definitely agree with that. The idea behind 1115s is to learn from them, and so they really want to make sure people are [off microphone].

CHAIR BELLA: Sonja.

COMMISSIONER BJORK: I wanted to follow up with Darin's comment about how there are similarities with duals work which is so difficult, but no one has given up yet, and I feel like this is an area that's rich with opportunity for us, for research, and for coming up with recommendations on framework, recommendations on tools. You know, the rule about incarceration, you know, the exclusion for incarceration, I heard a couple different ideas. You know, one plan is -- one of the 1115 waiver plans wants to allow Medicaid eligibility 30 days before release, and then I heard the comment about let's have

continuous enrollment in Medicaid after someone is incarcerated. These things could -- these are areas that we could really look into and see what happened during these demonstrations and are there other pilots where we can look into what the research shows, because they seem very important.

And then, finally, the difficulty of these systems working together, just one of the examples is that use of community health workers, or if you'd like to call them "justice navigators" or "peer-supported folks," allowing those types of providers to be reimbursed through Medicaid helps a lot because now there's a payment source. And so perhaps even if they were jail employees, it could be a reimbursable benefit or service type provider. So just looking into the use of that and how that helps make this a good program.

CHAIR BELLA: Thank you, Sonja.

So, Melinda, this is going to be a chapter. It's going to be part descriptive. It's going to let us know the key themes, what states have asked for, what has been approved. But it will also sort of lay a foundation for us to continue looking for areas that might be worthy of

recommendations, either to CMS or to Congress. Is that how you're seeing this evolve?

MS. ROACH: I think so, and I know a lot of ideas have come up in the conversation today, and we would just sort of continue to look for Commissioner input in terms of what are the specific areas of follow-on work you may be interested in doing. I know there was sort of a clear message in October that kids is an area of interest, so that's something we're thinking about now in work planning. But if there are other areas, it would be helpful to identify them and maybe sort of come to some agreement on that.

CHAIR BELLA: Dennis?

COMMISSIONER HEAPHY: I looked at a map, and there's ten states that 25 to 50 percent of folks are duals, and then a large percentage of states have at least 10 to 25 percent are duals. And so I'm wondering with the D-SNPs what's happening at CMS, if there wasn't something that couldn't be done in terms of injecting a requirement or looking at including incarcerated folks somehow in the requirement for D-SNPs in the coverage they provide.

CHAIR BELLA: On the Medicare side?

COMMISSIONER HEAPHY: Yeah.

CHAIR BELLA: Okay. We can -- I think that would be hard for us to recommend since it's Medicare coverage.

COMMISSIONER HEAPHY: I'm sorry. Medicaid side, because --

CHAIR BELLA: Part of the SMAC?

COMMISSIONER HEAPHY: Correct, as part of the SMAC, because the system's still broken because Medicare and Medicaid don't speak.

CHAIR BELLA: Yes. Yes, it is. Thank you, Dennis.

Kisha, do you have any comments you want to close this out, any words of wisdom?

VICE CHAIR DAVIS: No words of wisdom. Nothing additional. I do want to echo some of Verlon's comments about the importance of this work and from an equity perspective how, you know, justice and law folks are a very much marginalized and forgotten people, even within Medicaid, even more so than some of the other folks that we think about. And I love the direction that we're taking. I think some of these ideas on how we can really bring some attention and shine a bright light, I think it was Jami or

maybe Vikki who said the analysis is helpful, and so the more attention that we can bring, you know, highlighting the chapter, not letting it die, continuing to bring up the information and the statistics on it, and I think pushing other organizations to update that information and statistics is going to be really important in driving the work forward.

And I would encourage us to also think about how we can expand out of the box, some of these things that Heidi was mentioning, right? We are in a system that has created inequity, and are there ways that we can start to break out of that system, thinking about continuous coverage, thinking about, you know, how that changes how we pay for things, and really starting to bring some of the humanity back to folks.

So I just, you know, really want to thank Melinda and thank the panel. This has been just such a robust conversation, and I think what I'm hearing is everybody is really excited to continue this work. So I'm glad to see that we are doing it.

CHAIR BELLA: Thank you, Kisha. Yes, you know we love panels. This was a remarkable panel. Thank you. It

doesn't happen by accident, so thank you very much.

I think one of the things that -- and to dare kicking this off about different parts of the systems that don't work well together, but also just like us, like we want to be touching everything, the states want to, CMS wants to, and nobody has the bandwidth to be able to do all these things. And so making sure that we carry that theme about support for CMS and states as part of this I think is going to be really important. But thank you very much.

We're going to take -- you might want to sit there just for a little bit longer to see if we have any public comment. So we'll turn to the audience to see if there's any public comment. If you would like to speak, please raise your hand, introduce yourself and the organization you're representing, and we ask you to keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: All right, Melinda. You're off the hook. No comments. I think everybody was probably blown away by the panel, as we were. So thank you again very much, and we'll call up Kirstin for our last session.

[Pause.]

CHAIR BELLA: Yes.

Kirstin, welcome. You have the exciting task of being the last speaker for us today about an RFI, of all things, so have at it.

CONGRESSIONAL REQUEST FOR INFORMATION ON DATA AND RECOMMENDATIONS TO IMPROVE CARE FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. BLOM: Thank you. This will be very exciting.

Well, so I'm here to talk about a request for information. This is a congressional one, on data and recommendations to improve care for the dually eligible population. And as I think Kate mentioned this morning, this came out right before Thanksgiving, so we've been spending some quality time looking at it since then.

I'm going to walk through what's in the RFI and then three areas where I think MACPAC could comment, based on our prior work. Our prior work would inform the comments on the RFI, which is already sort of our typical way of addressing these.

These are the three areas that are relevant to

the RFI: requiring state strategies to integrate care, which is a recommendation we made earlier this year; state capacity to integrate care; and then considerations for a unified program. And then lastly, we'll talk about next steps.

So the RFI came out on November 23rd from Senator Cassidy, and a bipartisan group of five other Senators, and asked a series of questions about coverage for the dually eligible population that is informed by three principles identified by the Senators, and they are listed here: the diversity of the needs of the population, the range of state capacity to support care for duals, and the financial incentives that might drive outcomes and efficiencies. The RFI is seeking a legislative solution based on these three principles.

There are several areas where we could comment, where prior work overlaps with questions raised in the RFI. These areas are our most recent work on requiring state strategies to integrate care, state capacity to integrate care, a topic that the Commission has emphasized in a lot of our work on integration for duals, and then finally, considerations for a unified program, which came up because

of our thinking around the inherent limitations of trying to actually integrate two distinct programs. This is an idea that we would create a brand-new program that would be just for duals, designed for them, outside of Titles 18 and 19.

So the state strategies, in the RFI the Senators asked for policy recommendations to improve integration between Medicare and Medicaid. The Commission has approached integration in sort of three areas, broad buckets: increasing enrollment in integrated coverage, making it more widely available, and increasing the levels of integration that are available. So in thinking about all of those buckets we came up with a question around how do states approach this from a first step, and that led us to this discussion, this idea and recommendation around requiring all states to develop a strategy for how they plan to integrate care for their dually eligible populations, including things like their approach, who would be eligible, and benefits that would be covered.

We made this recommendation in our June report, and we also wanted to address the issue of state capacity to do this, so we included the idea in that recommendation

of additional federal funding to support states.

State capacity is the third area. The RFI acknowledges that there are varying levels of capacity to integrate care across states, and it's looking for proposed reforms, in the words of the RFI, to be grounded in reasonable expectations for what states have the desire and capacity to do.

We have heard from states directly about the barriers that they face, through roundtables and through interviews with states. States talked to us about competing priorities, limited capacity to take on new responsibilities. We all know that states are operating with limited resources, but states have also emphasized to us their limited expertise on the Medicare program.

We understand that there is wide state variation in Medicaid programs, and of course, states are at very different stages of integrating care. Some states are already offering fully integrated options. Other states are not offering any integrated options as of yet for their beneficiaries. And those states, and particularly the ones that are at the lower levels of integration, I think are looking for a place to start, and that's been driving a lot

of our work, especially around things like the strategy.

Finally, the third area where we could potentially comment is around a unified program. So the congressional RFI asks about the need for a new, unified system, because again, their acknowledgment as well of the limitations of trying to integrate care across these two programs. The RFI is looking for insights into what that should look like.

In our March 2021 report, we examined some of the policy and design issues that would need to be considered in establishing a unified program. We discussed, as a first step, for example, that policymakers would need to think about the overarching goals of such a program and take into account the different perspectives on that. For example, beneficiaries might be looking primarily for access to services or ability to make choices about their coverage, whereas states and the federal government might be primarily concerned about improving care and containing costs.

Other areas for potential comment would include decisions around administration of the program, including whether CMS or the states or a combination of the two would

administer it. Another important consideration is state flexibility and whether states will have the option to participate, as they do currently under the Medicaid program.

So in summary, as you guys know, MACPAC has an extensive body of work to draw on for potential comment, as I've laid out here today and as is reflected in your materials. The Commission could, based on your feedback today, express general support for the Senators bipartisan efforts to improve coverage for duals, highlighting our prior work on this topic that might be informative for them. We could also offer to be available to them as a resource, to the Senators, as they work toward a legislative solution to reforming coverage for this population.

So we are interested in your feedback today. With that I'll draft a comment letter for review by a subset of Commissioners interested in looking at that, and then we'll get comments out to the Senators, due by January 13th.

I will turn it back to Melanie.

CHAIR BELLA: Thank you, Kirstin. Comments or

questions? Darin, I'm going to have you start us off.

COMMISSIONER GORDON: Funny because I didn't have any questions, but I will. No, I thought all of what you're suggesting, leveraging our body of work here.

The one that, if you could remind me, I read through that RFI but when you were talking about the new program, the new title, was something they asked about in the RFI or is that just a suggestion to consider for integrating?

MS. BLOM: So yeah, they asked about whether or not this is doable within the current system and whether we kind of need to look to something new.

COMMISSIONER GORDON: Okay.

MS. BLOM: So there are a lot of questions, and they're very open-ended, but I think sort of the general tone is maybe what we've been trying to do isn't working out like we had liked.

COMMISSIONER GORDON: Yeah. Well, the only other thing I'll say is how you said we would approach it makes total sense, but also that letting them know that we are continuing work in this section. So it's like, yes, we'll help you, but we're continuing to focus on this area

because of the importance of it from our perspective as well, just reminding them of that so that they can just follow us more closely.

CHAIR BELLA: Thank you, Darin. Martha, then Sonja, then Laura.

COMMISSIONER CARTER: Thanks. I continue to be worried that these new models might be developed that bypass the community health centers, because it's so difficult to figure out a rate setting that complies with the other federal regulations around PPS.

But as we've said, in previous meetings, health centers have a fairly large population of duals, and that population is growing as the people that are currently in Medicaid, and our patients at health centers are aging into Medicare, and they're likely to stay as low-income duals. I don't know what the will of the Commission is on that but it's certainly a strong interest of mine, to make sure that health centers are included in new models.

CHAIR BELLA: Thank you, Martha. Sonja?

COMMISSIONER BJORK: I like the approach that we're taking and especially referring to the body of work that's already done. But there are probably developments

every week and month, and so I'm wondering, does any updated information need to appear in the response to the RFI or do we just reference that we will provide updated and current information? And what I'm thinking of is some states, California is one, they are already requiring all the Medicaid managed care plans to create and operate D-SNPs by 2026, and some even earlier. So that work is already in process and can be mentioned or built upon as a possible model. And that's ongoing work, and some of the announcements happened after our last paper on it.

So how do we get information to them on ongoing or updated efforts? What's the best way?

MS. BLOM: Yeah.

CHAIR BELLA: I do think, Sonja, because part of the MMP transition work, for example, what California is doing has been covered by the Commission, and so I think where Kirstin has laid it out is we're not necessarily trying to pick favorites of models. We're trying to kind of endorse the need that the states need capacity and support. Because without the state capacity and support, none of this stuff, honestly, matters if they can't do it. And then I think the nod to the unified program, they did

actually use that phrase, "unified program," and that's how our chapter had set out.

So I think that our opportunity is to tee up the policy issues that would need to be deliberated as we go forward.

We can try to be as current as possible in our response, but I don't think that -- my personal opinion is we don't need to resay what everybody else is going to say about how hard it is for these two programs to work together. We need to pick our themes. But it is a good point about continuing to be a living, breathing resource for them. Because the good thing is it has bipartisan support, this area. I think we know there's been a lot of activity this year, and this is signaling there will be activity next year.

So I think positioning ourselves to constantly be that source of what's happening on the ground, that is a good reminder for us, so thank you.

COMMISSIONER BJORK: That's what I was getting at. Will they come back to us or do we specifically mention that we're here on an ongoing basis, or something like that? Because I think there is going to be big action

over the next couple of years in this area.

CHAIR BELLA: Yeah. I hope you're right. Yes. We can also just bug them, proactively, right?

Laura and then Tricia.

COMMISSIONER HERRERA SCOTT: So of all the topics that you mentioned if there's some way just to call out how administratively and operationally complex we've made it for states to implement. I don't know -- they kind of allude to it in some of the areas, but we don't call out just the complexity, even to what you were describing the other day, Melanie, with open enrollment going on, the SMAC not approved yet. So we've already done a disservice for the intent of the program by delaying the approval of the SMAC, and then hearing Dennis talk about, as a patient or consumer, just some of the complexities that he deals with, with the two payers. And even if you were to present it from a system agency and then a member perspective.

But I think that's a drum that we could be or should be beating, because whatever they think about in this RFI process, and whatever they get back, simplifying all of it has to be at the top of the list.

CHAIR BELLA: Thank you, Laura. Tricia, then

Dennis.

COMMISSIONER BROOKS: So we keep hearing CMS and state capacity come up over and over again, right, in every regard, so I wholeheartedly believe that we have to emphasize that.

But this goes to the question I was going to ask earlier, and that is you mentioned that CMS is doing an internal workforce capacity study, or am I making that up? Did somebody mention this, that CMS was looking at their staffing?

Okay. Well then, I misconstrued that. But what I worry about, and you see it at the state level as well as at the federal -- well, not so much at the federal level recently -- that we burn out our good people and we lose the institutional knowledge. And I think we should think more about what we can do to try to boost and advocate for having the adequate capacity to get the job done well.

COMMISSIONER HERRERA SCOTT: Thank you, Tricia. Dennis?

COMMISSIONER HEAPHY: Is there enough evidence so this will actually simplify things for states and reduce burden? I don't know if the evidence is there or not, but

it seems to me that it would simplify things, given the experience with the MMPs, and everything they had to do to try to get service integrated.

And then the other is really protecting consumer rights, that it may be easier for states to just create a one-size-fits-all, which will take away consumer choice and access to service and providers that they require. And to give you an example that we've seen within the managed care system is that people lose access to their specialist in a field, and then they have to choose between the specialist or the hospital, as opposed to having access to both the specialist and the hospital, who are able to provide the needs for their specific diagnosis. And so how do we make sure that's not a one-size-fits-all? I don't really like to use examples like that but just to say that there has to be, at the forefront of this, that choice and innovation need to be there, like we saw in Oregon. They're very excited again. And how do we make sure this is an opportunity for innovation and not just a status quo way of delivering services?

CHAIR BELLA: Thank you, Dennis. Other comments?

Martha, I'll just say, I guess you know I have a

special passion for this. Like I don't think their goal is ever to not have FQHCs as part of these models. And so I think that they are recognized as an important contributor.

COMMISSIONER CARTER: Yeah. I didn't get the sense that there was a goal to not include but just that it's been difficult to wrap everybody's brains around -- design a new system and on top of that figuring out how to include the FQHCs with their unique reimbursement system. And when we had presentations there was no discussion of how the FQHCs would be involved, and I just think we need to highlight that, that we don't want to have a system designed and then, oh, by the way, let's bring the FQHCs in. That won't work.

CHAIR BELLA: Thank you. Any other comments? Darin.

COMMISSIONER GORDON: I don't know if it's worth -- well, I think it's worth it or I wouldn't bring it up. I just don't know if it's going to fit well. But bringing up the issue of the challenge that with the dissolving of the MMPs that there is a big, gaping hole in that shared savings component, that could be a hindrance for furthering more states progressing in this direction.

CHAIR BELLA: I think there is a plan to work that in, right, Kirstin, as some of the factors that are important to states?

MS. BLOM: Yeah. We've got a mention of it.

CHAIR BELLA: I think we're constantly mentioning that. Yeah, I'll just say on that thank you for putting those three areas up. I would just like to remind Commissioners, we're trying to make sure every dual in every state, regardless of the delivery system of that state, has access to integrated products that are consumer friendly and differentiated and all those things. So I think it's particularly helpful for us to tee up some of the policy questions as we get more work in this space.

And I would also remind folks the recommendation to have states create a strategy is now legislation. We don't know where it goes but that's an important foundational piece for all this work, if we can support states in doing that. We'll see what happens in 2023 with these RFI responses and everything else.

Do you need anything else from us, Kirstin?

MS. BLOM: No. I think I'm good. Thank you, guys.

CHAIR BELLA: Okay. Thank you very much.

Any last comments or questions from Commissioners? Kate, anything? That was a fast no. Anybody else with anything?

Our next meeting -- let me just make sure I have that -- January 26 and 27. So thank you all in the room and those of you virtually. Thanks for the engagement.

CHAIR BELLA: Yes, I do want to ask for public comment. Speaking of those of you virtually, if anyone would like to make a public comment, please raise your hand icon and introduce yourself and your organization.

Yes, we have Nataki. Please introduce yourself and your organization, and just a quick reminder that your comments are three minutes or less. You can go ahead and unmute yourself, Nataki and speak. Thank you.

PUBLIC COMMENT

* DR. MacMURRAY: You would think after three years of Zoom I would know how to unmute myself. I apologize.

Good afternoon, Everyone. My name is Dr. Nataki MacMurray. I'm with the Office of National Drug Control Policy. I certainly thank MACPAC for this discussion the last day and a half and particular this last panel.

I'm very intrigued and interested in the conversations around the need for building a capacity for treatment services or for young people with, especially substance use and mental health services for young people affiliated with the juvenile justice system or the criminal justice system, and I would love to hear more about some ideas of how we can actually expand the workforce. That's part of the problem, that does not seem to be an appealing profession for a number of reasons, and so I would love to hear more about what CMS could do as well as what our advocates would suggest as other platforms or programs to increase the capacity or build the workforce, rather, so that we have an increased capacity to provide effective substance use treatment and mental health treatment for adolescents that are often part of this system, the juvenile justice and criminal justice system. Thank you.

CHAIR BELLA: Thank you very much, and we appreciate your continued attendance at our meetings and your comments.

Anyone else like to speak?

It doesn't look like it.

Kirstin, thank you. Thanks to the tech team.

Thank you to the MACPAC team. Thank you to Anne and the Commissioners. I hope you all have happy holidays and we'll see you back in January.

We are adjourned.

* [Whereupon, at 11:43 a.m., the meeting was adjourned.]

1