PUBLIC MEETING

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COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Good morning, everybody. We will give others a few seconds or a little bit longer to join us.

[Pause.]

CHAIR BELLA: All right. Let's go ahead and get started. Welcome, everyone, to the April MACPAC meeting. Thank you for joining us, and welcome to all the Commissioners.

We are going to start with our session on high-cost specialty drugs. Chris is going to lead us through an overview of the chapter and our recommendation. So Chris, welcome, and I will turn it to you.

HIGH-COST SPECIALTY DRUGS: REVIEW OF DRAFT CHAPTER AND RECOMMENDATIONS

* MR. PARK: Thank you. Okay. So I don't see the slides right now, so let me wait until they pop up. Okay. Okay. Thank you.

Today I'll provide a quick overview of the draft chapter and go over the draft recommendations on accelerated approval drugs prior to tomorrow. The chapter

includes discussion on high-cost specialty drugs, including a summary of the work the Commission has done over the past year with a technical advisory panel to develop new models to address the challenges of high-cost specialty drugs.

The chapter will also include a section on accelerated approval drugs and the Commission's recommendations, which will be the focus of most of this presentation. It also discusses design options and considerations for a new benefit for cell and gene therapies that was identified by the advisory panel. As a reminder, we are not making any recommendations on cell and gene therapies at this time.

For the draft recommendations on accelerated approval drugs I will go through the rationale for the recommendations and the potential implications on various stakeholders. If you have minor comments or edits on the text of the recommendation you can send us those later so that we can incorporate them for tomorrow's votes. But if there are things that you think need to be added or clarified in the chapter feel free to raise those today.

The first section of the chapter provides background on Medicaid spending on high-cost specialty

drugs and how the shift in spending towards these drugs creates challenges for states. From 2010 to 2015, net spending on specialty drugs in Medicaid almost doubled from $4.8 billion to $9.9 billion. Specialty drugs have also been the main driver of recent drug spending growth. For example, from 2018 to 2019, Medicaid fee-for-service net cost per claim for traditional drugs fell 0.4 percent while the net cost per claim for specialty drugs increased 8.6 percent. Additionally, in 2019, specialty drugs accounted for 48.5 percent of fee-for-service pharmacy spending, but only 1.3 percent of drug utilization.

Over the past few years, the Commission has heard from states about the challenges high-cost specialty drugs present. They have commented that the current utilization management tools are not effective for high-cost specialty drugs and that they need new strategies and models to address the unique challenge of these drugs.

The next section reviews the Commission's ongoing work on high-cost specialty drugs. The Commission has been discussing the issue of high-cost specialty drugs over the past few years and working to identify potential models that can help states address these challenges.

Although states have started to develop some innovative strategies to deal with particular high-cost specialty drugs, such as those to pay for hepatitis C drugs or outcomes-based contracts, the Commission has heard how these models have been administratively challenging to implement. Thus, states have only been able to use these models on a smaller number of drugs. States are seeking new authorities to address high-cost specialty drugs more broadly.

To assist in the Commission's work in examining the effect of high-cost specialty drugs on Medicaid, MACPAC worked with a contractor over the past year to conduct an analysis of the drug pipeline, and convening a technical advisory panel to examine these issues more closely. The advisory panel included drug policy and pricing experts from academia and the private sector, state Medicaid and federal officials, beneficiary advocates, providers, health plans, and drug manufacturers.

The goal of the panel was to bring together a diverse group of experts to help us prioritize which drugs in the pipeline could have a significant effect on Medicaid over the next few years, identify what challenges these

drugs present, and develop new Medicaid payment coverage policies that could help address those challenges.

This slide highlights the findings from the TAP meetings which were presented before the Commission in January, so I won't spend too much time here. The panel prioritized three types of drugs with particular challenges to states, including accelerated approval drugs, cell and gene therapies, and drugs for sensitive populations, which include drugs for conditions such as HIV/AIDS. The panel discussed the pros and cons of several different models for each type of drugs, as shown in the figure, and ultimately identified a differential rebate for accelerated approval drugs and a new national drug benefit for cell and gene therapies as the models with the most potential. The findings from the panel were helpful in informing the work of the Commission. After deliberating on the various policy options and key design considerations from the panel, the Commission ultimately agreed to proceed with recommendations for a differential rebate on accelerated approval drugs. The Commission also agreed that a new drug benefit for cell and gene therapies has potential, but we are not ready to make a recommendation on this model at

this time.

I will quickly skip forward to the new benefit for cell and gene therapies briefly, since we will be going through the accelerated approval drugs recommendations in detail. Building on discussions of the panel, the chapter presents a framework for a new national drug benefit for cell and gene therapies that could help address the high up-front costs, budget volatility, and the uncertainty in the long-term benefits that cell and gene therapies present.

A new benefit could carve cell and gene therapies out of the Medicaid Drug Rebate Program, or MDRP. It would allow for new coverage, payment, or rebate requirements without disrupting the existing structure of the MDRP for other outpatient drugs. The chapter discusses key design options and the potential tradeoffs that would need to be considered when developing such a benefit, including potential implications for certain stakeholders.

So the accelerated approval pathway allows FDA to grant accelerated approval based on whether a drug has an effect on a surrogate endpoint that is reasonably likely to predict a clinical benefit. The surrogate endpoint is a

market that is thought to predict a clinical benefit, but it is not, itself, a measure of a clinical benefit. For example, tumor shrinkage in certain cancer types has been considered to be reasonably likely to predict improvement in overall survival, and is a commonly used surrogate endpoint in accelerated approval of cancer drugs.

The FDA has acknowledged that using surrogate endpoints creates a risk that patients will be exposed to drugs that ultimately will not be shown to provide an actual clinical benefit. It was also noted that the smaller and shorter clinical trials may mean that there is less information about the occurrence of rare or delayed adverse effects. When the FDA approves the drug through an accelerated approval pathway, it requires manufacturers to conduct additional postmarketing studies to verify that the drug achieves a clinical benefit. However, these confirmatory trials are often delayed.

One analysis found that results from confirmatory trials for over half of indications granted accelerated approval, between 2009 and 2013, were not available after a median of five years of follow-up. This means that it takes longer to complete the confirmatory trials for many

of these accelerated approval drugs than the average of one to four years it normally takes for Phase III clinical trials under the traditional pathway. Because of these issues, states are concerned about being required to cover accelerated approval drugs and paying high prices when the clinical benefit has not been verified.

To address these concerns, the Commission is considering two recommendations. Recommendation 1 is to increase the minimum rebate. It reads:

Congress should amend Section 1927(c)(1) of the Social Security Act to increase the minimum rebate percentage on drugs that receive approval from the U.S. Food and Drug Administration (FDA) through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased rebate percentage would apply until the manufacturer has completed the postmarketing confirmatory trial and been granted traditional FDA approval. Once the FDA grants traditional approval, the minimum rebate percentage would revert back to the amount listed under Section 1927(c)(1)(B)(i).

Recommendation 2 would increase the inflationary rebate. It reads:

Congress should amend Section 1927(c)(2) of the Social Security Act to increase the additional inflationary rebate on drugs that receive approval from the U.S. Food and Drug Administration (FDA)through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased inflationary rebate would go into effect if the manufacturer has not yet completed the postmarketing confirmatory trial and been granted traditional FDA approval after a specified number of years. Once the FDA grants traditional approval, the inflationary rebate would revert back to the amount typically calculated under Section 1927(c)(2).

These recommendations do not affect FDA authority or processes. The recommendations do not dispute the FDA's decision to approve a drug and thus require the Medicaid program to cover these drugs. They are merely a pricing policy focused on lowering the cost to Medicaid. Changing the rebates under the Drug Rebate Program strikes a balance between addressing state concerns of paying high prices for products that do not have a verified clinical benefit while maintaining Medicaid coverage for these products.

These recommendations would lower the net price

of these products until the manufacturer completes its confirmatory trial and verifies the clinical benefit of the drug. Increasing the minimum rebate will allow states to pay less until the manufacturer has verified the clinical benefit, to help account for the risk that the product does not achieve the anticipated clinical benefit. Importantly, the Medicaid Drug Rebate Program coverage requirement would remain, and beneficiaries would maintain access to these products. The higher minimum rebate would also create a financial incentive for manufacturers to complete confirmatory trials in a timely manner.

An increase in the inflationary rebate would help mitigate any large increases in list price that may occur before the manufacturer completes the confirmatory trial. This increase would not go into effect until a specified numbers of years, to provide manufacturers a reasonable amount of time to complete the confirmatory trial, but it would further penalize delays. Because this increase is tied to the inflationary rebate, it would not be applied if the manufacturer does not increase the price faster than inflation.

Once the FDA grants traditional approval, the

rebate amounts would revert back to the standard amount calculated under the MDRP. This would effectively serve to increase net price to the manufacturer once they have verified the clinical benefit of the drug.

The Commission is not recommending specific increase in the minimum or inflationary rebate nor the specified number of years after which the increased inflationary rebate would be applied. That will be left to the discretion of Congress. But the Commission notes that they need to be significant enough to provide a meaningful reduction in price which would also provide a strong incentive to encourage completion of the confirmatory trials. For example, most participants on the advisory panel suggested that the minimum rebate increase for accelerated approval drugs should be higher than the 8 percent increase in the minimum rebate provided under the Affordable Care Act.

Manufacturers have commented that they oppose this policy and argue that additional Medicaid rebate may discourage research and development or delay the market availability of drugs for serious conditions that may disproportionately affect Medicaid beneficiaries. This is

a claim that we cannot evaluate with any type of precision. It is important to note that manufacturers take several factors into account, including Medicaid rebates, when making decisions on drug development and product launch. Medicaid is not the sole payer for these drugs, so an increased rebate would not necessarily have a significant influence on a manufacturer's decision to pursue this pathway. For example, the Affordable Care Act increased Medicaid rebates on brand drugs from 15.1 percent of average manufacturer price to 23.1 percent of average manufacturer price. While we do not know whether this caused any manufacturer to forego a particular drug candidate, it does not appear that there was a decline in drug development in the aggregate.

There have been a record number of drugs approved in the last few years. For example, an average of 25.5 new drugs were approved per year between 2000 and 2009, compared to an average of 37.8 new drugs approved per year between 2010 and 2019. Manufacturers do set the price, so it is possible that increasing Medicaid rebates would create an incentive to launch a drug at a higher price or attempt to shift cost to other payers. However, it is

unclear to what extent manufacturers can raise price. Some economists believe that manufacturers already have the incentive to launch at the maximum price the market will bear, regardless of the level of Medicaid rebates.

Finally, manufacturers would still benefit from the accelerated approval pathway as it would provide earlier access to the market and allow the drug to generate revenue and establish market share while the confirmatory trial is underway. That is, manufacturers would need to weigh the cost of the additional rebates and the benefit of early market access, which could allow the manufacturer to establish its product prior to competitors entering the market.

For beneficiaries, coverage of accelerated approval drugs would not change. They would still be required to cover these products once they enter the market. This is in contrast to the closed formulated approach that commercial payers can use and that a few states have recently requested. In the past few years, Massachusetts and Tennessee have requested Section 1115 demonstrations that would allow the states to implement a closed formulary, meaning that the state could choose to

exclude certain drugs. Both of these states specifically highlighted accelerated approval drugs in their requests, because they believe the high price of these drugs do not lead to prudent fiscal administration when the clinical benefit has yet to be verified.

Earlier this year, CMS approved Tennessee's request to implement a closed formulary while still receiving the MDRP rebates. This is the first time it has been allowed. Tennessee's waiver approval could open the door for other states to seek a closed formulary to exclude coverage of accelerated approval drugs. The recommendations are a way to address price without excluding coverage.

Beneficiary advocates have expressed concern that access to innovative therapies could be decreased if manufacturers reduced research and development or delayed the new therapies. However, increasing the rebate on accelerated approval drugs could potentially increase beneficiaries' access to these products once they entered the market. By lowering the net price, states may be more willing to implement less restrictive coverage criteria on these drugs and improve access.

The increased rebate would reduce spending for accelerated approval products. Because the recommendations do not include a specific amount for the rebate increase, the Congressional Budget Office provided estimates assuming a 10-percentage point increase in the minimum rebate and a 20 percent increase in the inflationary rebate if the confirmatory trial had not been completed after five years. Assuming these rebate changes would be implemented in fiscal year 2022, the CBO estimates that these recommendations would decrease federal spending between $0 to $50 million in the first year, and between $0 to $1 billion in the first five years, compared to the current law baseline.

To provide context for these savings, the CBO estimated gross Medicaid spending on accelerated approval drugs that would be affected by these recommendations, and by gross spending we mean before rebates. In fiscal year 2019, it was approximately $1 billion. The $1 billion includes both federal and state spending.

As a reminder, the Commission will take a recorded vote on the final recommendations tomorrow. I am going to go back to the actual draft recommendation

language now.

Recommendation 1 would instruct Congress to increase the minimum rebate amount above the current 23.1 percent of average manufacturer price for accelerated approval drugs . This is the primary recommendation.

Recommendation 2 would increase the inflationary rebate if the confirmatory trial is not completed after a specified number of years.

The Commission should decide whether to proceed with Recommendation 1 only or both Recommendations 1 and 2 for tomorrow's vote. And with that I will turn it back over to the Commission.

CHAIR BELLA: Thank you, Chris. Thank you for taking us through that so thoroughly and for the work you've done on this.

Just to remind folks and to point out on the agenda, we are going to take the next half hour to have comments and questions from the Commissioners, and then we'll take public comment on this session and the next session before we break for lunch, and also to call folks attention to what we recently posted on our website and included with the materials for this meeting, that we're

going to ask people to limit comments to three minutes, and that will allow us to make sure everyone has time to comment. And those of you who know me know that I will not hesitate to cut off, politely, after those three minutes.

So with that, let's get started with Commissioner comments and questions for Chris. Chuck and then Tom, and then Sheldon.

VICE CHAIR MILLIGAN: Thanks, Melanie. I'll try to keep mine to three minutes too and not get cut off.

So Chris, actually, do you mind going back to Slide 8 for a second? Can somebody go back to Slide 8 for a second?

So I want to elaborate on the second bullet, the FDA has acknowledged that surrogate endpoints creates risks. I went back and read the FDA report from 2014 about accelerated approval that was in our meeting materials, and I just want to elaborate on this a little bit, based on what the FDA wrote.

They wrote that accelerated approval, under accelerated approval, and this is a quote, "There generally will be fewer, smaller, or shorter clinical trials than is typical for a drug receiving traditional approval, which

may generally mean there is less information about the occurrence of rare or delayed adverse events," closed quote.

So we can go back to Slide 9. I'm going to be in support of both of these recommendations. I do want to build on what Chris presented. One aspect of it, to me, is we're actually supporting the FDA here rather than taking over their role or undercutting the FDA. I think that by creating an incentive to complete the confirmatory trial we are addressing the fact that accelerated approval, especially for rarer drugs that affect smaller populations, have typically much smaller sample sizes, much shorter clinical trials. And even though they're predictive of a likely clinical benefit in the surrogate endpoint, there isn't enough data yet to demonstrate that, and that's the purpose of the confirmatory trial. So I do think what we're doing here supports the FDA.

I want to make three other quick points, and then I'll stop.

I think that these recommendations set the right balance between access to accelerated approval drugs and creating an incentive to complete those confirmatory

trials. I don't come at this primarily from a financial point of view in terms of the rebate revenue or the effect on state or federal budgets. I primarily don't come at it from that point of view.

I primarily come at it from the point of view of creating an incentive to complete the work, complete the confirmatory trial, build out the larger sample sizes, understand better the rare and delayed consequences from a clinical outcome point of view for the Medicaid beneficiaries.

The second point I want to make is there is no evidence historically in my experience that any of these rebate increases have actually affected the pipeline for drug research and drug approval.

Chris talked about how the pipeline after the passage of the ACA has been more robust than prior to the ACA, in spite of the fact that the rebate went up from 15.1 to 23.1 percent, but even before that, when states about 20 years ago were moving toward a preferred drug list and supplemental rebate programs and negotiating with manufacturers around supplemental rebates, there wasn't any particular impact on the development of drugs. And I think

partly that's because Medicaid isn't the only player in this market, the only purchaser, the only customer of pharmaceuticals for their covered lives, but I think also because manufacturers do continue to receive a healthy margin, in spite of these rebates.

And then the final point I want to make is our recommendation, I think, properly really would leave to Congress the work of setting the rebate level, determining if any particular drugs for whatever reason should be carved out from this increased rebate.

We are doing something that is directionally recommending how Congress act but not specifically making determinations about rebate percentages or any of that, and so I think we're fulfilling our role as an advisory body to Congress. And I think then the heavy lifting would be with Congress around actually putting the details around this.

So I'm in support of these recommendations. I intend to vote in support of both of them tomorrow, and thank you, Melanie. That's all I had to say.

CHAIR BELLA: Thank you, Chuck.

Tom and then Sheldon and then Fred.

COMMISSIONER BARKER: Thanks, Melanie.

And, Chris, I want to start off by saying thank you for the presentation. I really thought this was a very well-done, well-thought-out presentation. I really appreciate the background. So thank you very much for all the work that you've put into it.

I just had a couple of questions and then a comment. The first question is -- and this is really a basic question, and I'm sorry that I don't know the answer to this. Just as a foundational matter, is an accelerated approval drug approved under 505(b)(1) of the Social Security Act? In other words, is it a covered outpatient drug and subject to --

MR. PARK: Yes.

COMMISSIONER BARKER: -- rebates now because base rebates?

MR. PARK: Yes. So CMS has clarified that even though it's going through Section 506(c) initially for approval, they do consider it to be a covered outpatient drug, and so manufacturers are currently paying rebates on these products.

COMMISSIONER BARKER: Okay. You hit on exactly the question that I had which is, is it considered -- are

they considered covered outpatient drugs? Okay. That's what I assumed the answer was, but thank you for clarifying that.

And then my second question -- and I think Chuck just answered this, but I just want to clarify. We are not making a recommendation to Congress as to the amount of the increased rebate under Recommendation 1 or 2, correct? We're just saying that Congress should increase the rebate, but we're leaving to Congress the policy decision as to how much that increase should be.

MR. PARK: That is correct.

COMMISSIONER BARKER: Okay. So just for my comment, I guess I'd say I'm going to come out in the opposite place that Chuck is. I feel I absolutely understand the point that Chuck is making, and I appreciate that point. I just feel that if there is a problem with the accelerated approval process with the FDA, then that's a problem for the FDA to solve, and that that's not a problem that can be solved by changing the Medicaid rebate.

I feel like if the Congress believes that, for example, manufacturers are not doing confirmatory trials when a drug gets approved under the accelerated pathway,

then that's something that something should be changed in the Food, Drug, and Cosmetic Act, and we shouldn't be using the drug rebate program as a surrogate to solve that problem. So that's where I come out.

I absolutely respect the position that Chuck is taking and where the recommendation seems to be going, but that's where I come out on.

Melanie, I'll stop there.

CHAIR BELLA: Thank you, Tom.

Sheldon and then Fred.

COMMISSIONER RETCHIN: Can you hear me okay?

CHAIR BELLA: Yes.

COMMISSIONER RETCHIN: Okay, good.

Yeah. I want to go back on what Chuck said. I'm having a little different take on that same issue that Chuck mentioned, maybe in part, and it's really regarding the rare and orphan drug argument. That's really a concern to me, and I just thought I'd just talk it through a little bit.

It becomes a statistical issue. So I'm not an expert in clinical trials, but it would seem to me that it's especially a concern when it comes to power.

So clinical trials may take longer when effect size will need to be substantially larger to complete clinical trials in a very rare disease, because the occurrence of those disease or -- in terms of prevention or in terms of treatment, it takes a lot longer to accumulate cases, and you might not get there.

And even if the clinical trials are completed and the findings are negative, there could be a large type 2 error, and that might be occurring already. So that's the probability that a positive benefit was missed because of an inadequate sample size.

So I guess my first question is to Chris. Did the technical advisory panel comment on the issue of power? And I support the recommendations. It just seems to me that if there's some sort of -- we could discuss this, but that the Medicaid program might consider an off-ramp appeal if the benefit of the drug was so compelling that the accelerated approval pathway was sufficient at the normal rate and having an off-ramp appeal would provide manufacturers ample incentive to continue to pursue drugs for rare diseases, and I know that's the argument on this.

And maybe statistician -- or maybe it's already

considered, and that's the FDA's role. That would make me even feel better.

But I don't know. Chris, do you want to comment? Also, maybe somebody -- I don't know, Peter, if you have had some experience with this in terms of clinical trials.

Anyway, that's my comment. Thanks.

MR. PARK: Sure. Sheldon, I could address the comment about the panel. They did not discuss any particular type of error that may have occurred during the sample size. They did acknowledge that it might be a valid reason why some of these clinical trials may take several years to complete, but ultimately, I think their opinion would be it's up to the FDA to decide whether or not the evidence that the manufacturer has provided is sufficient enough to verify clinical benefit.

In terms of the off-ramp, the off-ramp for our recommendation is for the FDA to basically confirm that the manufacturer has verified a clinical benefit and granted traditional FDA approval. So I think that's in the FDA's purview as to what type of evidence they will accept and whether they find it compelling or not. So that could be a spot where a manufacturer could work with the FDA to

finalize that kind of confirmation as a clinical benefit.

The challenge still remains that if it does appear to be compelling but it's based on surrogate endpoints, then the clinical benefit has not been verified yet. So I think states still have that concern that they are ultimately paying for a drug and high prices for a drug where, you know, the clinical benefit has yet to be verified. So I think there's still a challenge there even if surrogate endpoints maybe point to a significant improvement and is reasonably likely to predict a significant improvement and a clinical benefit.

CHAIR BELLA: Thank you, Sheldon.

Oh, go ahead, Peter.

COMMISSIONER SZILAGYI: Yeah. I'm not an expert at clinical trials for rare conditions. I do want to say that the confirmatory trials, I think, are really, really important. As a pediatrician who is taking care of a number of children with these rare diseases, including spinal muscular atrophy and others, I would want to know and parents would want to know not just hope or sort of partial evidence about surrogate markers, but evidence from confirmatory trials and not to look for rare side effects,

because confirmatory trials of these rare diseases are not going to demonstrate -- they don't have the power to demonstrate rare side effects, but they're really looking for effectiveness and very common major side effects.

So I'm in favor of these recommendations, personally, but I'm not an expert on these clinical trials.

CHAIR BELLA: Thank you, Peter.

Fred?

COMMISSIONER CERISE: Thanks, Melanie.

Just a couple comments. Chris, I appreciate the work that you've done on this -- and it's a great document -- and appreciate the expert panel. I know you spent a lot of time with a number of experts looking at this, and so I know that it's a set of thoughtful recommendations.

I don't think any of us want to do anything that's going to stifle innovation, and we don't want this to come across as an us-versus-them type of situation.

I was struck by one of your stats. When you mentioned that almost half of the fee-for-service spend is on just over 1 percent of the utilization of the drugs, that situation at some point has to impact the 99 percent. I think we already see that in a number of areas where the

cost of medicine -- not just drugs, but the cost is pricing people out of the market, and people aren't getting access. So it's impossible to ignore the price issue.

It's more complicated than one set of recommendations, but I do think these recommendations are a step towards trying to deal with a complicated situation.

Some of the comments that this is punishment, I don't see this as punishment. I think it's reasonable to expect a greater discount while drugs are still under investigation, and if that can help push people to complete the investigation sooner, then I think that's a good thing.

So I think this is a reasonable step, certainly not a full answer, but I think it should help states, and it's a reasonable step forward.

CHAIR BELLA: Thank you, Fred.

I'm going to go to Darin.

Before I do that, I just want to give all the Commissioners a heads-up. It would be helpful to hear where you all are. You don't have to give a long rationale, particularly if your points have been covered already, but I am going to put all of you on the spot just to get a pulse check of where everybody is.

So we'll go Darin, then Toby, then Kisha.

COMMISSIONER GORDON: Yeah. Thank you. I agree with several of the comments already made, particularly Fred, and I align myself with some of those comments.

But I also want to just, you know, bring forth that perspective from the states. In reviewing, we had a variety of comment letters on both sides of the issue, obviously, but just from a state perspective, I thought there was a couple of points that I think were worth highlighting or quoting.

So, one, quote, "Increased rebates will ensure states are able to afford coverage of the expensive therapies while actual clinical outcomes continue to be assessed and provide incentives for manufacturers to expeditiously complete postmarketing clinical trials for these drugs," end quote. I think that's an important fact. And I think the point -- there's been several points already made to that effect.

But I want to read one more quote that I as a prior state regulator thought was important. Quote, "Because of the MDRP's requirements, states must cover these products, even as their clinical benefits remain

undetermined during the postmarketing trial period. The absence of this data makes setting appropriate prior authorization criteria for these therapies difficult. In some cases, such as Makena, the clinical benefits fail to be determined after years of state coverage and millions of dollars in state and federal expenditure," end quote. I think added to that, a line of thinking is also, you know, some of the risk that's borne by the Medicaid agency, not just financial risk, but also for some of the beneficiaries.

So I do believe the recommendations -- I appreciate, Chris, all the work you've done on this. I believe having the expert panel -- I think the way that we approached this was thoughtful and thorough, and I do align myself with those that are in support of the two recommendations.

CHAIR BELLA: Thank you, Darin.

Toby?

COMMISSIONER DOUGLAS: Thank you.

Great work, Chris, on this, and again, I do align myself with these recommendations.

From a state perspective, I go back. What I fear

from state Medicaid directors -- and when I was in the role is just the position when you face significant budgetary pressures and we have these new drugs come out, there are actions that whether it's other state officials are pressuring on the Medicaid director or the Medicaid director has to go through it to look at ways to control cost and make arbitrary decisions.

What this is actually going to do, I believe, is really improve the access during this period of time because it's increasing revenue, and that's a big issue for the state Medicaid directors, and so we have to look at it through that lens, as we're giving tools back to the state during this time when these drugs are being reviewed. It will, in fact, create an opportunity for improving access rather than arbitrary utilization controls and other approaches that might impede access.

So, again, I align myself with these recommendations.

CHAIR BELLA: Thank you, Toby.

Kisha, then Tricia, then Kit.

COMMISSIONER DAVIS: Thanks.

I want to thank Chris for the panel, but I also

want to call out the TAP, the technical advisory panel that put this together. You have it highlighted in the comments, but really the expertise that was part of the panel that pulled this together, I really do appreciate their recommendations and the thought that went into this. Really, this is a group that is experienced with dealing with these types of issues. So I just want to make sure that this -- you know, recognizing the body of work that had gone into this recommendation, even beyond just the MACPAC staff and Commissioners that are here today.

I want to align myself in support of the recommendations as well. I really come at it also from the provider, you know, from a physician caring for patients.

The accelerated pathway for approval, the fact that the FDA has created this and as Tom mentioned and Chris confirmed, these are covered drugs, and this is creating access for patients in a way that if they had to wait until the confirmed approval, that certainly would delay. And these recommendations go no way to -- in no way impair that.

But when we think about patients, especially those with rare diseases, lots of desperation, we want to

make sure that what we are offering them goes all the way through with really defining those benefits and efficacy and not stopping with preliminary endpoints. I think that these recommendations strike a middle ground in terms of not restricting access, still recognizing the FDA's approval process, the accelerated approval, keeping that available to patients, but encouraging the completion of clinical trials and not burdening states with higher costs for drugs that haven't been completely proven.

And so, for those reasons, I support the recommendations.

CHAIR BELLA: Thank you, Kisha.

Tricia, then Kit, then Bill.

COMMISSIONER BROOKS: Thank you, Melanie, and, Chris, thank you. This is great work.

I think most of the Commissioners know that my colleague, Edwin Park, served on the TAP and is a Medicaid prescription drug expert. We certainly are in favor of both of these recommendations for many of the same reasons you've heard from my fellow Commissioners.

CHAIR BELLA: Thank you, Tricia.

Kit?

COMMISSIONER GORTON: Thanks, Melanie.

So I'm in favor of these recommendations. I made extensive comments in our previous discussion on this topic. I'm not going to repeat them here. They're in the record if people want to see them.

I just want to make a couple quick points. One, sometimes the confirmatory trials do not prove that the drugs are effective, and then FDA, in its process, says the drug should be withdrawn. And people have mentioned Makena. That's a recent example of this.

So I just want to point out to people, we weren't criticizing the FDA's process. Their process says we want to give access early and because it's a promising drug, and our recommendation, I think is fine with that. The question is how you price that early access.

The second thing I wanted to point out is the commercial payers. In fact, they do take a wait-and-see approach, right? So access to Medicaid is better because of the rebate program, which sort of very quickly, automatically with approval from the FDA provides access so the drug. The commercial payers often wait and see; right? And it's because they are waiting for those confirmatory

trials to be completed.

And then the last thing I want to say is I appreciate and respect Tom's point of view about what's the right way to address this, but, respectfully, I think because the other payers do get to wait and see whether they're going to support these early-stage drugs, the playing field is not level. Medicaid is at a disadvantage compared to them, and so for that reason I would believe -- although I completely respect why you would end up in a different place, for that reason I believe that it is appropriate to move forward with the recommendations.

Thank you.

CHAIR BELLA: Thank you, Kit.

Bill, then Stacey, then Martha.

COMMISSIONER SCANLON: Yes, well, thank you, Chris. This was an incredibly well structured and reasoned piece of work. I want to say I do also support the recommendations, and I've heard the concerns about sort of what might be the impact on the pipeline and value of drugs. And I think it's important to recognize the uncertainty about those concerns. There's not strong evidence that they will be realized.

Similar types of concerns have been raised about almost any proposal to try and deal with sort of drug pricing, and as Fred pointed out, the consequences of high drug prices are very real and very consequential in terms of impacts on individuals with respect to the financial burden, but even more important potentially is the issue of sort of when those prices lead to sort of the inability to access needed medicines and the consequences of noncompliance.

So I think at some point we must come to grips with the idea that we have to start to address sort of the cost of drugs and dealing with this uncertainty about sort of what's going to happen to the pipeline is a part of that.

Having worked in the drugs area from many different angles over the years, I think one simple conclusion is that the drug market is incredibly complex. A second conclusion is there are many opportunities for manufacturers to recoup revenue or to increase revenue sort of under different circumstances. And so, therefore, I'm not even convinced that there will not be a response to an increased rebate in terms of manufacturers' prices, launch

prices, and subsequent increases over time that will recoup at least a portion of the additional rebate that's being charged. And the reality, though, the increased rebate will still provide the manufacturers an incentive to complete the research, because even if they are whole from day one sort of when a drug is launched, they will still make more when the research is done. So I think that it's the right type of incentive to have.

In terms of Tom's concern about this being an FDA sort of responsibility, I'm not sure what tools the FDA would be able to use short of not approving an accelerated approval drug or withdrawing approval for such a drug, which may have worse consequences than actually sort of increasing any rebate where I think the concerns are relatively minimal.

I think the accelerated approval pathway is an attempt to balance the risk of uncertainty over the lack of information or due to the lack of information about these drugs with the benefit that comes from potential earlier access to them. But with that sort of balancing, a part of that responsibility is to move as quickly as possible to get the necessary information to make a final sort of

determination. And so I think that the recommendations are moving us in that direction, and in some respects, I think it's important that there be assistance to FDA sort of in this process, and these recommendations would be an assistance of that type.

Thank you.

CHAIR BELLA: Thank you, Bill. Stacey and then Martha.

COMMISSIONER LAMPKIN: Thanks. I also support both of these recommendations, and just to add a couple of things to the conversation that's been going on. To emphasize Kisha's points about the Technical Advisory Panel, I was privileged to get to sit in and listen to their discussion and deliberation on this and the other areas that they considered for us, and it truly was an impressive group of experts coming from a variety of backgrounds in the industry and being very thoughtful. So we appreciate the contributions that they've made to our discussion and recommendation here.

And then also, as I read, you know, some of the written comments that we've gotten from various stakeholders, you know, we've discussed many of those

points here, and I would urge us as we go back and finalize the chapter to make sure that we have addressed any areas that might just represent a misunderstanding of what the Commission is trying to do here and make sure that we've strengthened those areas.

But, also, I just wanted to say a couple of the comment letters -- the relatively small amount of overall Medicaid prescription drug spend that's associated with the accelerated approval drugs almost seemed to imply that because that was a relatively small and stable proportion, that this recommendation is not necessary. So I just wanted to say and make sure that in the chapter we're emphasizing that really nice figure that Chris showed us on the early slide about different kinds of solutions that might apply to different types of specialty drugs, and so by being thoughtful about different solutions applying to different types of drugs, I mean, by definition we're not saying there's a silver bullet solution to address high-cost specialty drugs, that we have to be thoughtful, break it down, consider the kind of drugs and customers and craft solutions that are specific to that. So any one solution may not get an enormous percentage. But I do support both

recommendations, Melanie.

CHAIR BELLA: Thank you, Stacey. And thank you for having been our eyes on the ground for the Technical Advisory Panel. Very helpful, I know, to all of us.

Martha and then, Leanna, I'll go to you next.

COMMISSIONER CARTER: Thank you, Melanie. I came into this meeting unsure about how I felt about these recommendations. I read all the comment letters, and I really thank people for sending those. I wanted to acknowledge the work of the Technical Advisory Panel and the comments from the other Commissioners.

I also want to acknowledge the fear that I think I hear from patients and their families that they might not have access to these drugs that are -- may be, you know, their only hope at improving quality of life, even if it may not extend life.

And I also acknowledge the concerns of Medicaid program directors trying to preserve access in difficult budgetary times, always, and although, as Stacey said, it's a relatively small spend in the Medicaid program for any individual state, it can be a significant expense.

So with balancing all of that, I think I still

come down on preserving access, and I actually believe that these recommendations do the best job that we can do at the moment in attempting to preserve access to patients and families.

CHAIR BELLA: Thank you, Martha. I'm going to go to Leanna, and then I'm going to ask Brian and Kathy for where they stand on this, and then we'll wrap it up and head into the next session.

COMMISSIONER GEORGE: Yeah, I'm in agreement with what I've heard here. The proposals continue to give beneficiaries the right to choose. You don't necessarily, as the beneficiary, have to accept the drug. We can always [inaudible] because that's, you know -- and it expedites the process towards full approval, which is good, so that those people who are on the fence who want to see the full -- can see that. But, yeah, I'm in agreement with this.

CHAIR BELLA: Thank you, Leanna. Brian?

COMMISSIONER BURWELL: I support both these recommendations. I see this primarily as a shared risk situation. Accelerated approval increases risk across the board for all stakeholders, and I think it's fair that the risk be shared between the manufacturers and the payers.

And I see these recommendations as a good middle point for sharing that risk, and, therefore, I approve them.

CHAIR BELLA: Thank you, Brian. Kathy, you get the last word.

COMMISSIONER WENO: Great. I too support both the recommendations, and thank everyone who participated or who wrote a letter and, Chris, who wrote a great report, as well as the TAP panel, because they really educated me on the issue, and I feel comfortable recommending both.

CHAIR BELLA: Thank you, Kathy.

Chris, do you have any final comments based on what you've heard?

MR. PARK: No. Thank you for all your comments, and we'll certainly try to reflect those in the chapter as we move along in the process.

CHAIR BELLA: Okay. I just want to pile on the thanks to you, Chris, as well as to the folks that participated in the panels, as well as to everyone that sent us letters. And we will take public comment following the next session.

So, with that, we will end this session and move into the session on improving integration through D-SNP

contracting, and Kirstin and Ashley are going to lead us through that session. Just as a reminder for folks, there are no recommendations coming out of this body of work. This will be a chapter in the June report that's consistent with our focus on duals, but no specific recommendations that we're discussing at this point in time.

Welcome, and we'll turn it over to you two.

IMPROVING INTEGRATION THROUGH D-SNP CONTRACTING: REVIEW OF DRAFT CHAPTER

* MS. SEMANSKEE: Thank you, Melanie. Good morning, Commissioners. Kirstin and I are here to discuss our draft chapter on strategies for state contracts with dual-eligible special needs plans, or D-SNPs. I think we're just waiting for the slides to come up.

Next slide, please.

This chapter continues our work on integrating care for dually eligible beneficiaries and increasing enrollment in integrated care models. While a number of integrated models exist, this chapter focuses on D-SNPs because they have higher enrollments than other models and are widely available. We hope to get feedback from Commissioners on the draft chapter and next steps for

future work.

Next slide, please.

D-SNPs are available in 44 states and the District of Columbia, and enrollment in D-SNPs is increasing. Of dually eligible beneficiaries in D-SNPs, the majority are in minimally integrated D-SNPs. Highly integrated dual-eligible special needs plans and fully integrated dual-eligible special needs plans provide a higher level of integration by covering Medicaid benefits like behavioral health and long-term services and supports, or LTSS.

States have authority under current law to promote integration and increase enrollment in their contract with D-SNPs. This authority can be a powerful tool, but relatively few states have exercised it fully due to limited experience using managed care for dually eligible beneficiaries and a lack of Medicare expertise.

Next slide, please?

This map shows the most highly integrated D-SNP available in each state as of January 2021. Although D-SNPs are not always available statewide, often due to difficulty contracting with D-SNPs to cover rural areas,

overall 94 percent of dually eligible beneficiaries live in a county where a D-SNP is available in 2021, and 26 percent of dually eligible beneficiaries are enrolled in D-SNPs.

Next slide, please.

D-SNP authority under current law to contract with D-SNPs was defined in the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA, and refined in the Bipartisan Budget Act of 2018. MIPPA requires all D-SNPs to have contracts with the state and meet a minimum set of requirements, but these requirements do not result in fully integrated coverage. States can use their contracting authority to go beyond the minimum requirements, but few have done so. Strengthening the ability of states to leverage these authorities to further integrate care for dually eligible beneficiaries is an important step in promoting integration.

Next slide, please.

Earlier this year, we contracted with Mathematica to explore opportunities for states to maximize their MIPPA contracting authority with D-SNPs. We presented the results of their work in January, which focused on the 13 strategies listed in this table. These strategies are

described in more detail in the chapter, and we presented on them in January. Some can be implemented by all states, while others can only be implemented by states with Medicaid managed care for dually eligible beneficiaries.

Next slide, please.

States' use of MIPPA strategies depends on the unique state contract, and their decisions to implement different strategies are often complex. Some states, including Arizona, Idaho, and Tennessee, have been able to maximize the use of MIPPA authority to require D-SNPs to attain the FIDE SNP designation. Over 20 percent of dually eligible beneficiaries in these states are enrolled in integrated care. Arizona and Tennessee are both Medicaid managed care states, with managed long-term services and supports, or MLTSS, programs, and they both use default enrollment to enroll Medicaid beneficiaries into D-SNPs when they first become eligible for Medicare. In contrast, Idaho does not have a long history of Medicaid managed care, but was able to leverage MIPPA authority to build an integrated care model on its FIDE SNP that provides all Medicare services and most Medicaid services, including LTSS.

Generally, states where D-SNPs are aligned with Medicaid managed care plans are well positioned to use MIPPA authority. When a D-SNP and a Medicaid managed care plan are aligned, meaning they are operated by the same parent company, the beneficiary can receive their Medicaid and Medicare services through the same organization, allowing for higher levels of coordination.

States with D-SNPs aligned with MLTSS plans are best positioned to maximize integration because their Medicaid managed care plans cover long-term services and supports. Our analysis identified 27 states where at least one D-SNP and Medicaid managed care plan are aligned, including 15 states where D-SNPs and MLTSS plans are aligned.

Next slide, please.

This map shows states where D-SNPs are aligned with Medicaid managed care plans as of January 2021. The dark-blue states are states where all D-SNPs are aligned with a Medicaid managed care plan. These states are best positioned to maximize their MIPPA authority. For example, it can require all D-SNPs to use exclusively aligned enrollment to enroll full benefit dually eligible

beneficiaries who receive their Medicaid benefits from the aligned Medicaid managed care plan. This ensures one organization is responsible for both Medicaid and Medicare benefits for all their members, maximizing integration.

The light-blue states on this map are states where D-SNPs are aligned with a Medicaid managed care plan but not all the D-SNPs in the state. And the dark-gray states are states that do not enroll dually eligible individuals in Medicaid managed care, and they cannot use strategies like requiring exclusively aligned enrollment.

Next slide, please.

States without Medicaid managed care have less ability to use MIPPA strategies. These states could use direct contracting with D-SNPs to cover Medicaid benefits for their members, but this strategy requires substantial state resources and investments, especially for states that lack experience with contracting and procurement. States with Medicaid managed care would require large up-front investments to build staff capacity and Medicare expertise necessary to maximize their MIPPA authority.

Finally, states without D-SNPs are starting from scratch, but may actually be able to achieve higher levels

of integration in their initial D-SNP contracts as they do not have to worry about reflecting current enrollee coverage.

Next slide, please.

We should note that several factors may limit states' ability to use D-SNPs as a vehicle for integration. For example, some states carve out certain populations or benefits from Medicaid managed care, including LTSS and behavioral health, so cannot create fully integrated D-SNPs. States may also be hesitant to focus on D-SNPs if they would compete with other integrated models in the state, like Medicare-Medicaid plans, or MMPs. Small or rural states may have trouble attracting D-SNPs if there are too few covered lives to make such plans financially viable. States may also face a tradeoff between further integration in existing products, increasing enrollment in D-SNPs, at least in the short term. Finally, limited state capacity and Medicare expertise prevent states from making full use of MIPPA, causing the Commission to recommend in June 2020 that additional federal funding be made available to states to enhance expertise in Medicare and to implement integrated care models. This need remains important.

Now I will turn it over to Kirstin to discuss future directions on this topic.

* MS. BLOM: Thanks, Ashley, and sorry. The slide movement was a little clunky there. Apologies about that.

So after going through all of the MIPPA strategies in this contract work that we did that Ashley just walked through, we've decided to focus our work in the next cycle on two strategies, and the first of those is limiting enrollment to full-benefit dually eligible beneficiaries.

The purpose of limiting enrollment in this way is to focus state efforts to integrate care on the population that stands to benefit from it the most.

Using this strategy would create uniformity within the D-SNP in terms of things like care coordination and simplifying materials for beneficiaries and around things like benefits covered.

This is a policy that others have considered. As you guys know, organizations like MedPAC have come close but not recommended it, but not all states are using this. So we want to spend some time on understanding better why that is, what the pros and the cons are.

For example, one potential drawback that gets cited, depending on how this is implemented, beneficiaries would have to potentially disenroll from the D-SNP and enroll in an MA plan. That's partial benefit duals, and that could create some disruptions.

As an alternative to limiting enrollments to only full-benefit duals, one interviewee we talked with suggested establishing separate plan benefit packages. So that's something that we want to think about in this next cycle. That would be a separate plan benefit package, depending on the type of dual, so partial or full-benefit dual.

Some states are already doing this, actually, like Pennsylvania using separate plan benefit packages, and this could avoid the problem of having to disenroll a partial bene dual from the D-SNP, instead keep them in, but just have them under a separate plan benefit package.

One way to make this even less disruptive potentially is to establish a crosswalk so that when someone -- when they set this up, they could just crosswalk in and under a more streamlined process rather than being pulled out or having to go without coverage briefly. That

would involve a change in MA rules. So that's something that we would have to think about.

So this is something we need to do additional work on. So our plan is to do that over this next cycle before we would be able to bring something back to you guys. We're planning to let a contract with a vendor to interview some states and some beneficiaries as well as plans to better understand any concerns or barriers that might exist to setting this up.

The vendor will also, hopefully, analyze the movement from partial to full benefit status. This is something that a number of Commissioners have raised in the past and that we don't feel like we have a great handle on. So we're going to try to understand better how often that might be happening and how many people might be affected by it and then what types of issues that might create around administrative burden for plans and beneficiaries.

And then the second piece is going to be requiring that D-SNPs submit marketing materials to the state for review. We think that doing this obviously can ensure accuracy of Medicaid information for beneficiaries across the D-SNP or D-SNPs in the states, making it easier

for them to choose coverage, and this again is something that some states are already doing. But we'd like to, again, understand better why more states aren't doing this, whether there are barriers, whether there's an administrative burden issue or delays that might result from the additional review.

And then, again, as sort of an alternative to just requiring state review, we want to think about the idea of establishing a formal joint review process like the one that is currently in place for the MMPs under the Financial Alignment Initiative. Under that, under the MMPs, they submit materials to CMS and the state for a joint review.

This is also something that the duals office, the Medicare-Medicaid Coordination Office, recommended in their FY2019 report to Congress. So we are planning to spend some time on this in the next meeting cycle, talking to that office and to others who might have information about the applicability of the joint review process under the MMPs to D-SNPs.

So today what we're looking for is feedback from you guys on the draft chapter on the stuff that Ashley

walked through but then also sort of our plans for the next meeting cycle. We appreciate very much the -- a couple, a few Commissioners have already sent us feedback, and that's very helpful. Happy to take any additional feedback today, or you can certainly contact us directly.

And with that, we're happy to take any questions. Thank you.

CHAIR BELLA: Thank you, Kirstin. Thank you, Ashley.

I think I have one point of clarification, and then I'll save comments for the end. While we'll be focusing on two of those that you named, we're not letting go of the other work we've been doing. We'll still be looking at the various levers that are uncovered in this chapter as part of our broader efforts to look at increasing integration, enrollment in integrated products, and increasing the level of integration in existing products. Is that correct?

MS. BLOM: That's right.

CHAIR BELLA: Comments? Kit and then Chuck and then Stacey.

COMMISSIONER GORTON: So I have a couple

questions. The first, you talk about D-SNPs being available in 44 states, and then you cited a CMS report in the draft chapter that said 94 percent of duals live in counties where they have access to a D-SNP. I'm just having trouble understanding all the math.

My personal experience is in a handful of states, but none of those states managed statewide-ness, because of rural issues and other things.

My question is, are you really comfortable about who has access to what? And the reason I have that question is if we're going to get to a place where we're going to start saying, well, this should happen, the Commission has been trending towards a point of view that says duals should be in integrated programs -- and I don't feel like -- from a foundational level, I have a good enough sense about who really has access to one and who doesn't. So I would like to see a little more detail on that to make sure that we're not saying that some -- even if it's a small percentage of people, it should be an integrated program, but none exists, because the impetus there then is to create programs where they don't exist. So I just would like to understand that a little better.

That's one of the things. Because Medicaid operates at a county level and not at a state level, and I think in Medicaid, because of the statewide-ness requirement, we're accustomed to thinking about states as units when, in fact, the Medicare program doesn't operate that way. So that's one piece.

And then the second piece I would like us to -- and I'm not sure how to do this, but I'll just raise the issue/question -- is if you're going to focus on aligned plans, that by necessity, I believe, gets you to a place where you're going to have fewer plans, right? And we talked last time when we talked about this about the multiplicity of choices that people in L.A. County have, for example, and including hundreds of choices is more choice than is useful. But some choice is, in fact, useful, and if we get to limited plans, then sometimes the plans lose their Medicaid contracts. And then there's turnover.

And I'd like to understand the beneficiary disruption from that because -- I think we have examples of what happens, but I think because plans' provider networks don't line up that the potential for disruption -- you

talked about the disruption in terms of the partial beneficiaries and that sort of thing, and I get that, but I'd like to really make sure before we get to a place where we're going to talk about, okay, this is how it should be, if we're going to make a recommendation that it should be straight, I would like to know that when periodically a plan falls out and a new plan comes in, that that's not overly disruptive to beneficiaries' relationships to their treating providers. Does that make sense?

MS. BLOM: Mm-hmm.

COMMISSIONER GORTON: Thanks.

CHAIR BELLA: Thank you, Kit. I think your last comment is in the bucket of let's keep these in mind as we move forward on some of the other tools around D-SNP, not necessarily looking for a response now, but, Kirstin and Ashley, do you have a comment on the math? And if not right now, can we come back to make sure we all do understand where -- actually how available these products are today?

MS. SEMANSKEE: Yes. We can make that clear in the chapter, and also, we've done some other work that is not currently in the chapter to kind of look at the county-

level availability of D-SNPs and MMPs, and we can come back to the Commission with more information on that.

CHAIR BELLA: Okay. Does that work, Kit? We'll bring it back?

[No response.]

CHAIR BELLA: Okay, perfect. Thank you.

Chuck, then Stacey, then Brian.

VICE CHAIR MILLIGAN: Great work.

I'm going to build on Kit's comments. I think one of the things that's going to be helpful for the Commission to understand is the issue of that choice. When I look around the country and I look at how many D-SNPs are three-and-a-half-star plans or three-star plans that don't offer the same supplemental benefits that a regular Medicare Advantage plan, non-D-SNP, non-SNP Medicare Advantage plan offers, because it's a four- or four-and-a-half- or five-star plan in that market, dual eligibles are going to pursue the Medicare product that's in their best interest, including the best benefit packages, the best supplemental benefit packages, the best quality of care.

And I do continue to believe that one of the big challenges to integration is the belief that integration as

a value is so important that people will choose it, the dual eligibles will choose it, in spite of the fact that rationally there might be much better Medicare Advantage options to them, available to them than a D-SNP that is mediocre in their market.

So I think I would encourage, as you look into this, to look at -- and before that, you know, sometimes we talk pejoratively around lookalikes and loopholes in that. I'm talking about something much more fundamental, which is a Medicare Advantage plan that's just better than the D-SNP in that market, from a star rating and supplemental benefit point of view.

So I think as the Commission advances its knowledge and understanding of barriers to integration, I think it's going to be important to get a better understanding of the alternative Medicare Advantage options available.

The one other thing I'll mention about that is as CMS changes the weights of star ratings and increases the weight associated with CAHPS scores, D-SNPs often have really, really poor CAHPS scores, and so you might see three-and-a-half-star D-SNPs this year fall to three or two

and a half, and that will lead to frozen membership on the D-SNP side. CMS won't let them enroll new members, which will create a different kind of barrier because of how the star ratings' programs and sort of the carrot and stick around star ratings play out.

And so I think, all to say, it's going to be really important to keep your acumen up around Medicare Advantage, non-D-SNP dynamics because that implicates D-SNP integration opportunities.

CHAIR BELLA: Thank you, Chuck.

Stacey and then Brian.

COMMISSIONER LAMPKIN: Thank you. I just have a couple of questions. I think they're probably more forward- looking than chapter-looking, but you can tell me if we know more about this already.

First, I think the opportunities that states have to use the tools and the MIPPA toolbox and integrate are really engaging and powerful and exciting to think about. I just want to make sure that we're thinking about all the different angles of some of these options, and so both of my questions have to do with the aligned plans, where we're aligning a D-SNP with the Medicaid managed care plan.

So one question that I have is how these aligned, D-SNP, Medicaid managed care organizations are managing their business internally. Are they really aligned internally, and what triggers that question? It's just a conversation I had with an executive from a managed care organization, probably two or three years ago now, where I was asking questions about their D-SNP, which was supposed to be aligned, but he really didn't know anything about it because it was a different profit center. It was a different product, and so what does that look like on the inside is my question, that alignment.

Then the other one is, do we think that any of these alignment-related strategies have tendrils that affect other parts of the program, unintended consequences like, for example, are there any of these alignment policies that a state could pursue that would be disadvantageous, for example, to smaller regional plans or provider-owned health plans that operate in Medicaid managed care but may not be practical to operate a Medicare Advantage plan or a D-SNP? Is there anything there that we should be concerned about? Maybe not. It's just a question that occurs to me because I know that a lot of the

D-SNPs are the big behemoth players.

So I don't know, Ashley or Kirstin, whether you have anything to say that we know already on either one of those topics, or we could just put it on the list for looking forward.

MS. BLOM: I think that's probably a good one for us to put on the list. I don't know, Ashley, if you have anything to add.

MS. SEMANSKEE: I think we mentioned in the chapter that small regional plans may be less likely to operate both in Medicaid and Medicare. So they might not have an aligned plan and if some strategies like selective contracting that require plans to be aligned may affect those plans.

CHAIR BELLA: Stacey, on your first point, I think as I think about four buckets of work or four themes, one of them is promoting greater integration in the products, which is kind of like getting under the hood and seeing inside the integrated products and are they actually integrated. So I think that's an important reminder for us to keep pushing on that. I don't think it's where we all want to be, and therefore, sometimes I think the

beneficiary isn't experiencing as integrated an experience as would be ideal.

Do you have any further comments, Stacey?

[No response.]

CHAIR BELLA: I'm going to take that as a no.

Okay. Brian and then Darin.

COMMISSIONER BURWELL: So, Ashley and Kirstin, I think this is an excellent chapter. I also think it's a very important chapter, one that we've talked about doing for quite a while is the role of MIPPA and creating integrated products, and I think you do a great job in content.

I think we are at a point in terms of the larger policy landscape that there may be growing interest in doing something about duals and promoting integration. So I would really like to see this chapter be -- you know, it's a complex topic, and the dual policy wonks are going to read this and understand it, but I think there are a lot of people that aren't. And I would like to make this chapter more accessible to the broader policy community.

I submitted a number of comments and ways I think that we can do this with call-out boxes and vignettes. For

example, I think a nice vignette would be how integration, D-SNP integration occurs in some of these more advanced states like Tennessee and Arizona, how the plans are linked, and how that affects consumer choice.

And going back to Kit's question, I know that there have been instances in Arizona at least where the Medicaid MLTSS plan has lost the contract, and a new contractor has come in, and their people have had to be shifted out of that plan and the aligned D-SNP plan as well. So I think a little vignette about how that was managed by Arizona would be a great educational piece for people to read.

I do think that in terms of future products or future directions, one obvious direction is to further strengthen the MIPPA agreement to add more requirements to what has to be in a MIPPA agreement to have it approved. So I think we should include that.

I do think we need kind of more contextual information at the beginning of the chapter about what the MIPPA agreement is, what the process is in terms of having an agreement between a state and a D-SNP, and when the D-SNP comes up for approval every year that they have to have

the MIPPA agreement as part of the application, just a little process-oriented about how this linkage between states and D-SNPs works around the MIPPA agreement.

Finally, I do think we do have a lot of work that we could do around the enrollment process and choice in integrated care products. In the MLTSS states that I have worked in, they have all had an enrollment broker contractor that beneficiaries can use to get information around -- they're assigned to a particular Medicaid plan, what their opportunities are to switch out, and what their opportunities are for enrolling in a D-SNP, whether it's an aligned D-SNP or a non-aligned D-SNP. I think these enrollment processes and how they affect consumer choice are a very important part of the future of the development of integrated care models.

CHAIR BELLA: Thank you, Brian.

Darin?

COMMISSIONER GORDON: My comment will be brief. I think on the topic that was brought up, that Stacey brought up, and Melanie commented on it and Brian did, as well, about what integration looks like within an organization, it just makes me think when we talk about the

different states I do think it's important maybe to highlight how long they've been in that approach or that model. I know where we looked at, you know, the very first year, versus where we were five years into it, it's very different. And I do think there is a bit of an evolution that occurs in that. So, you know, if we are looking at a state, for example, on commenting about what that integration was like at the plan level, I think it's just important that to, I think, provide that context. How long has a state been in that journey, just so that we don't lead to conclusions for someone that maybe just started versus someone that's been doing it for a while.

CHAIR BELLA: Thank you, Darin. Other folks want to comment?

Okay. I have a couple. You guys didn't really think that I would leave without commenting on duals, but I will be brief too. I very much appreciate the work and it's feeling like we're striking a nice balance, this sort of big picture, what should the future look like, and then more technical. But I think if the big picture is the March report, our chapter on what we would have to think about to have a unified program, and then our June chapter

will be much more sort of tactical steps and things states could be doing.

The only comment I would say is the key ingredient for whether it's the big or the more technical is the state's ability to actually do it. And so it does keep harkening back to our recommendation from last year about needing to do what we can to support state capacity, to develop Medicare expertise, to have dedicated resources.

And so I don't want to lose sight of that. If it were up to me we would be reiterating that for Congress every month, and just emphasizing that it's just so critical for our ability to do any of the things that you guys uncover, as potential opportunities.

But that is the last comment, other than to say thank you. Thank you for that work.

So we are going to move into -- well, actually, I'm sorry. Ashley and Kirsten, do you have what you need from us to finalize the chapter and have it ready for the June report?

MS. BLOM: Yes. Thank you guys, and thanks again to the people who have already submitted comments to us. We are working through those now.

CHAIR BELLA: Okay. Wonderful. Thank you.

We are going to move into public comment. We are opening up public comment to the two sessions we've had, so this session and then the one before this session on the recommendation related to accelerated approval. I will remind folks that may not have heard me at the outset that we are asking for people to limit their comments to three minutes so that we can ensure we have time to get through all the comments. I will give you a polite little verbal indicator when you've hit your three minutes, and then I actually do have the ability to turn your sound off, so I will do that if we need to, to keep things moving along.

And I would also ask folks to state their name and the organization they're representing when they do make a public comment. And lastly I would say you are always welcome to submit comments electronically, and the way to do that is to send them to comments@MACPAC.gov.

So if you are in the public, thank you for joining us, and please use your little hand icon in the GoToWebinar and then we will recognize you and unmute you, and you will be able to make your comment. So we will open that up now.

PUBLIC COMMENT

* MS. HUGHES: Kari, you are self-muted. You can unmute yourself and make your comment.

MS. ROSBECK: Hi. Yes, thank you. My name is Kari Rosbeck. I'm the President and CEO of the Tuberous Sclerosis Alliance, a nonprofit dedicated to find a cure for tuberous sclerosis complex, or TSC, while improving the lives of those affected. TSC is a rare genetic disorder that causes tumor growth in all the body's vital organs. Symptoms can include seizures, kidney failure, brain and lung tumors, autism spectrum disorder, and severe learning disabilities. TSC is also the leading genetic cause of both epilepsy and autism.

TSC is a good example of how the accelerated approval pathway can work to get treatments to patients who do not have other safe, effective options. Subependymal giant cell astrocytomas, or SEGA, is a slow-growing tumor that can cause life-threatening complications by blocking cerebral spinal fluid, and remains a major clinical feature of TSC. Not all individuals are surgical candidates, leaving them with fatal complications.

Novartis' Afinitor, a cancer medicine, was

originally introduced in 2009, and granted accelerated access approval for TSC indications in 2010 for SEGA, 2012 for renal angiomyolipomas, and 2018 as adjunctive therapy for partial-onset seizures. Novartis completed the FDA-required studies, submitted data to FDA, and received regular approval.

If the proposed additional rebate had been in place, I believe it is unlikely that they would have used the accelerated approval pathway and maybe even declined to study Afinitor for TSC. The outcome would be individuals would remain without treatment options. Applying the additional rebate to accelerated approval indications and rare diseases would be complex to administer and would penalize manufacturers who are doing everything right. Ultimately, it is the patients who would pay the price.

As the TSC community can attest, this FDA program is vital to providing treatments where previously there was a serious unmet medical need. We encourage you not to place disincentives on manufacturer use of this program and to keep the ultimate beneficiary in mind, the patients who desperately need these medications.

Thank you so much.

CHAIR BELLA: Thank you, Kari.

MS. HUGHES: Kristin, you have been unmuted. You can unmute your line and make your comment.

MS. WHEEDEN: Thank you. Please confirm that you can hear me.

CHAIR BELLA: We can.

MS. WHEEDEN: Thank you. Hi. My name is Kristin Wheeden and I serve as Executive Director of the American Porphyria Foundation, and I'm also a mom to a 15-year-old son named Brady, who lives with a type of porphyria called erythropoietic protoporphyria, or EPP for short.

Porphyria is not a single disease but a group of eight inherited genetic disorders that result in an accumulation of porphyrins and porphyrin precursors in the body. Now I'll not give you an entire lesson or the porphyrias today, because Melanie will be sure to cut me off quickly, but I will share that EPP presents with intolerance to sunlight. Sun and other artificial light causes extreme phototoxicity and burning pain, akin to putting your hand in boiling water. It's something that no one in their lives should feel. And if treatments all are in place, all should have access.

Patients with extremely rare diseases like the porphyrias may never see a treatment developed without working drugs as incentives, and pragmatic approaches to FDA approvals greatly accelerated approval pathway. In fact, the first treatment under the Orphan Drug Act was the 1983 approval for a porphyria treatment called hematin, that is -- you can hear the doorbell ringing -- that is still part of the standard of care to this day.

We are very unfortunate to have three approved therapies and one drug approved -- excuse me -- that is currently in a Phase III clinical trial addressing porphyria subtypes. Each of these treatments received one or more FDA designations designed to provide incentives to encourage and aid the development of drugs for debilitating rare diseases, like the porphyrias.

As a parent, I can assure you that we want robust evidence on whether a new treatment is effective, as well as the risks that are associated with it. Accelerated approval is not a shortcut around safety and efficacy. It is essential in its pragmatism for both patients and manufacturers. We agree that manufacturers securing accelerated approval must follow through with FDA-required

studies, but disagree that failure to do so in ultra-rare conditions is a problem, much less one justifying a penalty on use of the accelerated pathway.

It is a struggle -- and I will put on my professional hat as well as my mom hat -- it is a struggle to find companies interested in and willing to invest in developed treatment for low-prevalence conditions. Please do not follow through with recommendations that can disincentivize and create another barrier to therapy development for people with rare and ultra-rare disease like the porphyrias.

Thank you for listening.

CHAIR BELLA: Thank you, Kristin.

MS. HUGHES: Diane, you've been unmuted. You can unmute yourself and make your comment.

MS. BERRY: Thank you. Can you confirm you can hear me?

CHAIR BELLA: We can.

MS. BERRY: Thanks so much. I'm Diane Berry with Sarepta Therapeutics. Sarepta submitted written comments on this proposed recommendation, which I hope you've had a chance to review. Sarepta is a leader in precision genetic

medicine for rare diseases, including EXONDYS51, which has been raised in MACPAC meetings as an example of what, quote, "may be wrong with accelerated approval."

However, facts and a growing body of evidence tell a different story of how Duchenne and EXONDYS51 in fact exemplify the success of the accelerated approval pathway and that it works as it was intended by Congress and FDA.

Duchenne is a universally fatal, rare, pediatric disease caused by the absence of dystrophin, a protein vital for muscle structure, function, and preservation. With 100 percent certainty, without dystrophin, patients with Duchenne experience progressive muscle deterioration, irreversibly losing the ability to walk, feed, and dress themselves, and breathe unassisted over time, ultimately succumbing to their disease in their mid to late 20s. Time is not on their side.

In utilizing the accelerated approval pathway for Duchenne, FDA recognized the life-threatening and debilitating nature of this disease, the lack of available therapy, and that dystrophin production is a justifiable surrogate endpoint reasonably likely to predict a clinical

benefit, a point recently reinforced by a team of independent clinical researchers.

MACPAC has referenced that manufacturers take too long to complete postmarketing confirmatory studies. It doesn't get any easier to conduct clinical endpoint-driven trials post-approval than it was pre-approval. We cannot will these trials to go faster. Timelines for such trials are necessarily driven by the same disease-specific considerations as well as additional operational factors and regulatory engagement. It is reasonable to expect verification of clinical benefit to take years, particularly for slowly progressing, highly variable diseases like Duchenne, and new therapeutic classes with novel mechanisms of action like EXONDYS51.

Notably, subsequent applications of accelerated approval in Duchenne have gained efficiencies due to learnings applied from the EXONDYS51 experience. Post-approval data generation is far from static. Beyond our commitment to executing postmarketing requirements, we are actively creating opportunities to collect real-world evidence. While not yet reviewed or validated by FDA, the analyses demonstrate that EXONDYS51-treated patients may

experience a delay in loss of ambulation by as much as 3.4 years, and a significant clinically meaningful attenuation of pulmonary function decline.

EXONDYS51's approval enabled Sarepta to reinvest all of its revenue and more back into developing additional and improved innovations for Duchenne patients, and it signaled to the broader industry that a viable regulatory pathway exists for this complex, rare disease. Five years ago, there were no FDA-approved treatments for Duchenne.

CHAIR BELLA: Your time has expired. If you could wrap it up, please.

MS. BERRY: Okay. I would just like to emphasize three points. First, a differential rebate will undermine FDA's accelerated approval pathway, because it will discourage drug developers from utilizing it to pursue development of therapies in otherwise intractable disease areas and will harm patients if treatments are never developed. Second, assessing a higher rebate on accelerated approval drugs could impact slow completion of postmarketing studies. Many rare diseases, including Duchenne --

CHAIR BELLA: I am going to ask you to wrap it

up. If you want to go ahead and get your third point in and then we're going to have to move on. Sorry.

MS. BERRY: The last point is what was recognized during discussion, that targeted accelerated approval drugs is, we feel, misdirected, as it will not yield significant budget savings. They account for less than 1 percent of annual Medicaid spending year after year and is not a key driver of growth in health care spending. Thank you.

CHAIR BELLA: Thank you very much.

MS. HUGHES: Marc has been unmuted. Marc, you can make your comment.

MR. YALE: Thank you so much for allowing me to make a comment today. My name is Mark Yale and I'm the Advocacy and Research Coordinator for the International Pemphigus & Pemphigoid foundation, and I also serve on the board of directors for Haystack Project.

Through my own experience as a rare disease patient living with pemphigoid, as well as my involvement in advocacy for pemphigus and pemphigoid patients, and others living with extremely rare conditions, through Haystack Project, I can tell you that accessing treatment can be an immense undertaking. Pemphigus and pemphigoid

have been treated off-label with a variety of different therapies that have varying degrees of success in helping control our disease, and payers can make getting access to off-label treatments extremely challenging.

We are now one of the handful of ultra-rare conditions with an FDA-approved treatment, Rituxan, now considered first-line therapy for pemphigus vulgaris. There is no question that manufacturer incentives, like the FDA priority review breakthrough therapy designation and orphan drug designation were really vital to getting this therapy as quickly as possible for patients with pemphigus who struggle every day to control their symptoms.

We were fortunate that Rituxan has been on the market since its approval in 1997, and that due to the nature of our condition, clinical trials could be completed without surrogate endpoints. The proposal to create an additional rebate for accelerated approval, though, could be a significant deterrent to developing a new product for pemphigus.

The proposal also raises questions that do not have good answers from a policy perspective. For example, if Rituxan's pemphigus indication were achieved through

accelerated approval, would an additional rebate apply, and would it only apply to that indication? It would seem that the proposal would decrease research rather than encourage postmarket studies, especially when medically accepted off-label uses would be covered without the additional rebate.

Placing a disincentive on the pathway that is designed to encourage early access to promising treatments could have the greatest impact on ultra-rare disease patients like myself, and your proposal today is basically a vote against investment in patients like me.

Thank you again for your time, and I hope you consider my comments.

CHAIR BELLA: Thank you, Marc, and thank you for sharing your personal story.

MS. HUGHES: And Jack has been unmuted. Jack, you can make your comment.

MR. ROLLINS: Good afternoon. Confirming that you are all able to hear me?

CHAIR BELLA: It's a little faint but we can hear you.

MR. ROLLINS: Okay. Hopefully this is better.

I'm Jack Rollins, Director of Federal Policy at

the Association of Medicaid Directors, and I would like to offer some comments in support of the Commission's consideration of the enhanced rebate for drugs approved on the accelerated approval pathway. I'd like to contextualize this support by calling to attention the longstanding challenges of the sustainability of the Medicaid pharmacy benefit imposed by high-cost care and specialized therapies.

While we fully support the development of such therapies and the promise that they represent for particularly vulnerable patients with rare diseases and conditions, we want to recognize that the Medicaid Drug Rebate Program, as currently structured, was not really designed to address the very high entry point costs associated with these products.

Across a number of states, we have seen the pharmacy benefit be a key driver of increased costs of the program, and those costs do come with tradeoffs, as every state is required to operate a balanced budget in every fiscal year in their Medicaid programs and throughout the state budget writ large. So we strongly encourage the Commission to gives states additional tools to manage those

costs in an appropriate manner, and we view this proposal as a step towards that direction.

We also want to call to attention the challenges with focusing on value-based purchasing as the sole path forward for managing these types of drugs. Value-based arrangements often will require some specific negotiations on a per-product or even per-indication basis, that many states do not currently have the clinical and administrative capacity to execute on.

There is also no guarantee that value-based purchasing arrangements would successfully contain costs for these products for the states. We also support value-based purchasing, in principle, but we do not recommend that it be the primary vehicle for managing these types of products.

We have submitted some written comments to this effect as well, which we hope you will all have the opportunity to review, and I appreciate the consideration of perspectives from the state Medicaid agencies on this important topic. Thank you.

CHAIR BELLA: Thank you, Jack.

I see no other hands at the moment. Any last

comments from Commissioners? Oh, it looks like we do have another commenter.

MS. HUGHES: Kara, we have unmuted your line, so you can make your comment.

MS. BERASI: Yes, can you just confirm you can hear me?

CHAIR BELLA: We can.

MS. BERASI: Excellent. Thank you. My name is Kara Berasi. I am a board member of CDG Care, a pharmacist, and also the mother of a child with CDG, or congenital disorder of glycosylation. Glycosylation is a process of adding sugar building blocks called "glycans" to proteins, and all body systems require glycosylation to work normally. Over 400 genes play a role in glycosylation, and over 130 of those genes are known to cause CDG.

There are currently 149 known CDG types with additional types being discovered each year, and to give an idea of how rare these disorders are, the most common form, which is PMM2-CDG, has only about 250 diagnosed patients in the United States.

CDG is usually apparent from infancy. It can be

associated with a broad variety of symptoms and can vary in severity from mild to severe and also can be disabling and even life-threatening. In fact, 20 percent of patients die within their first year of life.

There are currently no FDA-approved treatments, so supportive therapies like physical, occupational, and speech are the only options for the majority of CDG types. There's only one of 149 types that can be treated with oral mannose, but that has not been effective in the other types.

It can be very difficult to get researchers and manufacturers interested in pioneering innovation for extremely rare disorders like this one, especially when there are so many types with similar mechanisms but different body system impacts. So accelerated approval for us is not a shortcut or a pathway with sub-par evidence. It may be the only way a treatment for CDG could become a reality.

So we do not view the additional rebate as a way to help patients by making treatments more affordable; rather, it's a threat to ever getting treatments developed or tested through to approval.

So we want to stand with you and find another way to get the postmarket studies done that seems to be the apparent reason for considering this proposal. The company has done nothing wrong by using this pathway, and yet they're being punished before they defaulted on commitments. So I'm sure it's more administratively burdensome to apply these penalties and rebates after they've defaulted, but what isn't burdensome in the world of health care or even more so in the world of ultra-rare that my son and so many others live in every day as we fight for the attention of these big drug companies and a chance for a more typical life?

Thank you all so much for your time and kind consideration today and giving me the opportunity to speak.

CHAIR BELLA: Thank you, Kara.

MS. HUGHES: Michelle, you have been unmuted to make your comment.

MS. DAVIS: Hello. My name is Michelle Davis. I joined the International Fibrodysplasia Ossificans Progressiva Association, also known as the IFOPA, in 2016 as its executive director. I'm also the mom to a son with an ultra-rare cancer, synovial sarcoma.

I'm here today to talk to you mainly about FOP and the impact on the drugs that are being developed that this policy potentially has. FOP is an extremely rare condition affecting only one in two million people. It is one of the rarest, most disabling genetic conditions known to medicine. An FOP bone forms in muscles, tendons, ligaments, and other connective tissues, and ridges of extra bone develop across joints, progressively restricting movement and forming a second skeleton that imprisons the body in bone.

Babies with this condition will show malformation of the great toes at birth, and the progression rate is unpredictable but appears in a pattern of upper body in childhood and lower body in adolescence. Flareups can occur spontaneously or follow physical trauma such as childhood immunizations, falls, surgery, biopsy, or viral illness. No treatment exists for FOP, but parents do have hope that one of the products in clinical trials will receive approval.

Given the seriousness and rarity of FOP, investigational treatments are eligible for FDA fast-track designation as well as FDA breakthrough therapy and rare

pediatric disease designations. Fast-track designation allows companies to have more engagement opportunities with the FDA and allows them to be eligible for accelerated approval and priority review, all of which will help treatments reach patients faster, especially those with ultra-rare, life-limiting, disabling, life-shortening diseases like FOP.

Please do not disincentivize the development of therapies for rare and ultra-rare disorders like FOP by penalizing an approval pathway that could be the tipping point between companies pursuing and not pursuing research.

We appreciate the need for ensuring Phase 4 postmarketing studies are completed. Our patients will benefit from the information on that more than anyone. We are also on the front line as really rare patients and can tell you how difficult it is to do those studies, how to keep those patients engaged, which is something not always in a company's control. Maybe we should incentivize patients rather than penalize the company.

We need to have more creative than the proposal you are considering today. We need all the incentives we have to date and more in getting companies to study

conditions like FOP.

Thank you.

CHAIR BELLA: Thank you. I think we have one last comment.

MS. HUGHES: Yes, Georgia, you have been unmuted. You may make your comment.

MS. BURKE: Thank you. My name is Georgia Burke. I'm a directing attorney with Justice in Aging, which is a national advocacy organization seeking to improve the lives of older adults, and I guess I'm the only commenter who's talking about the D-SNP chapter.

I wanted to support the value of encouraging and supporting more state expertise in Medicare. Having a state office of Medicare or some other way within the state of having sufficient dedicated staff with responsibility for working specifically on duals issue is really a critical element to the success of integration efforts.

As has been noted, MIPPA does offer an opportunity for very specific requirements in state contracts, but state oversight of the implementation of those contractual requirements and state coordination both with CMS and with the plans and with affected stakeholders

throughout the life of the contract is just as important. And I think one of the real values that we saw with MMPs was the coordination that developed and the relationships that were developed between CMS and the states, and they were so important as ways of being able to address the issues that arose during the introduction of the Financial Alignment Initiative.

There is no doubt about it: Medicare and Medicaid are both extremely complicated programs, and setting up very intentional pathways for exchange of expertise and coordination at the agency level between both CMS and the state is just as important to integration as integration within the plan structure itself.

Thank you.

CHAIR BELLA: Thank you, Georgia.

MS. HUGHES: Okay. Camille, you have been unmuted to make your comment.

MS. DOBSON: Hi, good afternoon. Camille Dobson, deputy executive director of ADvancing States. We represent the aging and disability directors that deliver LTSS to Medicaid and non-Medicaid clients. I also wanted to speak in support of the Commission's work on dual-

eligible integration. It continues to be a large focus for our members. I'm particularly interested in the work around different benefit packages for partial- and full-benefit dual eligibles. I think that would be an interesting research approach as we find a lot of states do not include dual eligibles, partial duals in particular, because they don't really see any value in capitating that benefit to the health plans and the hassle of doing crossover claims and those kinds of things are not sometimes worth the squeeze, so perhaps there's something there.

I also wanted to echo Chuck's note about the value of integration as -- integration as a value in itself and the fact that there may be, in fact, better MA plans Star rated in the service area. We've heard that repeatedly from the SHIP counselors who are on the front lines of helping individuals take their Medicare coverage, and they almost exclusively have told us that they look at the Star ratings. And so without better information about why integration is a good thing for dual eligibles, they're very likely to encourage individuals to pick the highest rated plan and ones that have more robust supplemental

benefits. So I think that's not a small issue to consider.

Again, I know it's a little bit in the weeds, but I think it was a really interesting point and echoes what we've heard.

So I'll just conclude, again, with my gratitude for your ongoing work on this subject and really helping the states focus and provide resources to help them do a better job.

CHAIR BELLA: Thank you, Camille.

All right. I appreciate everyone who has made public comment today, especially those with your personal stories. Thank you very much for taking the time to do that and for those of you who have commented. Additional comments, again, can always be submitted to comments at MACPAC.gov.

With that, we are going to wrap up the morning. Thank you to the Commissioners. We will resume at 1:15, and we will have a session on improving access to behavioral health services for adults. So we'll see you all at 1:15. Thank you.

* [Whereupon, at 12:21 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:15 p.m.]

CHAIR BELLA: All right. Why don't we go ahead and get started. Welcome back, everyone. This afternoon, we're going to focus a lot on behavioral health, starting with a session on access for adults.

I'm going to turn that over to Chuck who is going to lead us through this part of the meeting and say welcome to Erin.

VICE CHAIR MILLIGAN: Thank you, Melanie.

Erin, we look forward to learning about the continuation of this body of work. So it's all yours.

IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR ADULTS: REVIEW OF DRAFT CHAPTER AND RECOMMENDATIONS

* MS. McMULLEN: Thanks, Chuck.

So, over the past several months, the Commission has discussed access to mental health services for adults on several occasions. While Medicaid beneficiaries with mental illness have multiple needs that could be addressed through changes in public policy, in this chapter, we focus in on the role of Medicaid and improving access to care for

individuals in crisis.

Last month, we discussed three policy options aimed at more clearly defining Medicaid's role in supporting state crisis systems. This included offering additional guidance and technical assistance to states; in part, the need for additional guidance for the implementation of 988, a new nationwide three-digit dialing quote for the National Suicide Prevention Lifeline, which takes effect in July 2022.

States and communities are now grappling with how this will affect existing local crisis hotlines and systems needed to engage with individuals who are in crisis or immanent risk of suicide.

Based on your feedback last month, only two of the policy options we discussed were incorporated into draft recommendations for your consideration today. We decided not to move ahead with recommendations focused on improving collaboration between the Substance Abuse and Mental Health Services Administration, or SAMHSA, and the Centers for Medicare and Medicaid Services, or CMS. Rather, a discussion regarding collaboration between these two agencies has been incorporated into the draft chapter.

During the March meeting, Commissioners also raised concerns about the role of other payers, including Medicare and commercial insurance in the provision of crisis services. Given the Commission's statutory authority, the draft chapter does focus on how CMS and SAMHSA can be more effective in supporting Medicaid efforts to improve access to crisis care.

So today we will review a draft chapter for the June report to Congress and discuss the two draft recommendations I mentioned earlier. The draft chapter does cover a number of different areas, many of which we have presented on previously. As such, a lot of my comments today are intended to capture the key findings of the sections listed here rather than the detailed analyses laid out in the chapter.

So, to set the context for the two recommendations and future work on improving access to care for beneficiaries with mental illness, the chapter begins by discussing the prevalence of mental health conditions of the Medicaid beneficiaries and the rates at which they receive treatment, comparing the experience of beneficiaries to those with private coverage.

In this section of the report, several observations are made, and a few key findings are listed here.

Some of you have reached out regarding the prevalence and treatment rates among beneficiaries of color for both this chapter and the chapter on children and youth that Melinda will present after this session.

Generally, we found that beneficiaries of color experience mental health at lower rates than their white counterparts. We also found that beneficiaries with mental illness who are Black, Hispanic, or multiracial were less likely to receive treatment when compared to their White peers.

There is no single answer that can explain these differences, and there likely are different explanations for various ethnic groups. However, we still try to incorporate additional studies into the draft chapter to further examine variations in the prevalence of mental illness among minorities.

While the findings in the previous slide are the result of a number of factors, coverage of mental health services heavily impacts access to care. Last month, we

heard that the Commission wanted to frame recommendations on improving access to crisis services within the broad mental health continuum. As such, the chapter lays out the continuum of care as established by the American Association for Community Psychiatry.

We then go on to summarize state coverage policies for 15 discrete mental health services. We found that many states do not cover a full continuum of mental health care, covering on average 12 out of 15 mental health services. The largest gaps in the continuum are for residential services and supportive services, including supportive employment and skills training and development.

In addition to gaps in service coverage, there are a number of reasons why Medicaid beneficiaries with mental health conditions receive treatment at low rates. The chapter includes analyses of several data sources which point to a provider shortage as well as a severe maldistribution of mental health providers at the state level. Access to mental health services is further affected by the unwillingness of some providers to participate in Medicaid.

I should caution that none of the findings we

present on this slide or in the draft chapter are new. Concerns about access to mental health services have been well documented for over a decade.

The consequences of limited access to mental health treatment are significant. The chapter examines the intersection of mental health, mortality, and rising rates of suicide. We highlight various studies that demonstrate that individuals with mental health conditions often die prematurely, which we'll discuss as well in the chapter on clinical integration.

Suicide is one of the most widely acknowledged contributors to premature mortality among individuals with mental illness. It's the 10th leading cause of death in the United States.

Limited access to treatment has also contributed to the criminalization of mental illness. Law enforcement is often the first to respond when individuals experience mental health crises. As a result, a disproportionate share of individuals with mental illness wind up in jail or prison. Most people with a history of mental illness do not receive treatment while they're incarcerated in prison.

Beneficiaries are also more likely to experience

involvement with the criminal justice system than their privately insured peers. We found that beneficiaries with any mental illness were more than three times as likely to report that they were on parole or probation in the past year compared to those with private coverage.

The chapter then turns to how crisis services can be used to facilitate real-time access to behavioral health care for beneficiaries of all ages. In order to ensure that beneficiaries are receiving appropriate care at the right time, some states have developed crisis systems that provide early intervention when an individual is experiencing a behavioral health crisis.

Crisis systems also triage and assess individuals and connect them with the appropriate level of care. Ultimately, the goal of crisis services is not just to determine the level of care needed for an individual, but to resolve their behavioral health crisis so more intensive services are not needed. Offering such care is a key strategy to reduce inappropriate use of psychiatric hospital beds, decrease boarding in emergency departments, and reduce the need for law enforcement to respond to behavioral health crises.

We discussed two national efforts in the chapter to address rising rates of suicide and to facilitate access to behavioral health care for individuals in crisis, the first of which relates to the implementation of 988, as I mentioned earlier. This takes effect in July of 2022.

The National Lifeline isn't just one call center. It's made up of a network of over 170 state and local crisis hotlines that are linked by a toll-free number that's available 24 hours a day, 7 days a week. Many stakeholders have expressed concern that there will not be sufficient capacity to meet the increased demand when 988 goes live. In part, this is because funding for crisis hotlines is often a state and local responsibility, and that will continue to be the case after 988 is implemented.

There are multiple ways states can finance hotline services, and how Medicaid can support these hotlines will be discussed shortly.

Until recently, the core components of the behavioral health crisis continuum had not been fully defined. In February 2020, SAMHSA did issue national guidelines for crisis care, establishing the three-part elements of a crisis system that are listed on the slide.

We discussed each of these components in detail last month, and the chapter further describes each of these components and how technology, including caller ID and GPS-enabled technology, can be used to coordinate and respond to behavioral health crises in real time.

While most states are using Medicaid to pay for some form of crisis services, many state crisis systems are not fully aligned with SAMHSA's national guidelines. States including Arizona and Georgia are highlighted in the chapter, as Medicaid is playing a growing role in implementing comprehensive crisis care in those states. Even in these states that are considered innovators in the delivery of crisis care, services might not be provided in accordance with SAMHSA's guidelines.

Congress has taken several actions to increase funding for crisis services. Last month, we reported that the Mental Health Services Block Grant included a 5 percent set-aside for crisis services, and Congress has also appropriated an additional $1.5 billion to the Mental Health Services Block Grant.

Finally, the American Rescue Plan offers an enhanced FMAP for certain community mobile-based crisis

intervention services. It also made available additional funding for state planning grants.

Current federal guidance does identify some ways Medicaid can pay for crisis services, but it often falls short of providing enough detail to states or to offer a roadmap to support the three components of a crisis continuum. We reviewed each of these authorities last month. So I'm not going to go into detail describing each one, but I do want to reiterate that throughout the chapter for each of these authorities, we note that states do not have sufficient guidance that addresses how Medicaid can complement other funding sources, including state and local funds or block grant funding to support components of the crisis continuum. This type of guidance is needed, as Medicaid cannot be the sole supporter of state crisis systems.

Improving access to crisis services does require effective communication between CMS and SAMHSA. However, federal programs targeting individuals with mental illness are spread across multiple agencies, and prior studies have documented a lack of coordination at the federal level.

The chapter describes findings from a 2014 report

issued by the U.S. Government Accountability Office, or GAO, that highlighted a lack of coordination among federal programs that serve those with serious mental illness. Ultimately, these GAO fundings promoted congressional action.

The 21st Century Cures Act authorized Interdepartmental Serious Mental Illness Coordinating Committee to enhance coordination across federal agencies, to improve service access as well as care delivery for people with serious mental illness. This committee includes a number of members from various federal agencies and departments, including CMS, and in December of 2017, the committee issued a report to Congress that included various recommendations. Among other things, the committee did recommend that a definition should be established for crisis services, and there should be an implementation of a national standard for crisis care.

The national guidelines that SAMHSA issues, which I discussed on previous slides, were largely informed by this report.

So that brings us to next steps. In the course of our work on this chapter, there are several areas for

further inquiry that have emerged, and our work on crisis services is really just a first step at addressing access to mental health care.

We do expect further work to examine the health care needs of justice-involved beneficiaries. That includes access to behavioral health treatment upon release from correctional settings as well as strategies to ensure Medicaid or CHIP enrollment upon release for eligible individuals.

Given the limited availability of many home- and community-based services, we also plan to further examine how HCBS services for beneficiaries with significant behavioral health conditions are being delivered.

Finally, we also plan on examining access to behavioral health care for beneficiaries that are part of the lesbian, gay, bisexual, and transgender communities.

That brings us to our two draft recommendations. As a reminder, Commissioners will vote on these recommendations tomorrow.

The first recommendation is aimed at providing additional guidance to states. It reads: "The Secretary of the U.S. Department of Health and Human Services should

direct the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration to issue joint sub-regulatory guidance that addresses how Medicaid and the state Children's Health Insurance Program can be used to fund a crisis continuum for beneficiaries experiencing behavioral health crises."

The rationale for that recommendation is listed here, and your chapter goes into greater detail. Sub-regulatory guidance could be used to further clarify how Medicaid and CHIP can be used to pay for the three components of the behavioral health crisis continuum. Specifically, it could further describe how states can use the authorities highlighted on previous slides as well as how to bring funding to pay for different components of the crisis continuum. In developing new guidance, we do know that the Secretary should invite participation of all relevant agencies with a role in implementing the National Lifeline and agencies affecting children and families.

The implications for that recommendation are listed here. We do not foresee that the act of developing this guidance would affect federal spending, but we do think it would assist states in overcoming barriers to

designing and implementing crisis services as envisioned by SAMHSA's national guidelines. It could also enhance access to community-based care for those experiencing behavioral health crises. These gains could be particularly important for beneficiaries of color who are generally less likely to receive mental health treatment than their White counterparts.

Finally, we do not expect this to have a direct effect on plans and providers, but we do note that guidance could assist states in setting clear expectations for providers to facilitate access to crisis care.

The second draft recommendation really builds off the first. It would provide technical assistance and planning support for state crisis continuum. That option reads: "The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use

existing federal funding to support state-level activities to improve the availability of crisis services.

The rationale for that option is listed here. In addition to guidance, states really need technical assistance and dedicated planning to coordinate the multiple state agencies and delivery systems that are involved in the provision of behavioral health services.

As I mentioned earlier, we believe existing funding could be used to support planning and technical assistance efforts. Congress has increased funding for the Mental Health Services Block Grant, and the Secretary could use existing planning requirements under the block grant to support this work. Moreover, Congress has appropriated an additional $15 million to CMS to administer grant funds to plan for mobile crisis provision. As with the first recommendation, we note that the Secretary should work with other relevant agencies as needed.

The implications for Recommendation 2.2 are listed here. I'm not going to go through them, as they are similar as the implications for Recommendation 2.1.

So that concludes my presentation. I'm happy to take any questions in addition to any feedback you have

regarding the contents of the chapter as well as the draft recommendations. Thank you.

VICE CHAIR MILLIGAN: Thank you, Erin.

Let me start by mentioning to members of the public, we have this session and then we have the next session on mental health services for children and adolescents. We will then take comment after that second session.

So, Commissioners interested, if you have questions or comments you'd like to make and if you're able to, at this point, signal your support or concerns about either of the two recommendations that Erin presented. So I see Peter and then Kit and the Kisha.

COMMISSIONER SZILAGYI: Thank you, Chuck.

Erin, thank you for a very clear presentation, as always. I think it is an excellent chapter. I think focusing on major mental health problems in crises is a really good place to start, and as you mentioned, future work needs to sort of go down the continuum or actually go upstream in the continuum.

I do have a generic question, and this relates to both this chapter and the pediatric chapter. This has to

do with the implications for both the recommendations.

If there is better guidance and better -- so one of the problems here is lack of access for appropriate mental health services. If there's better guidance and better technical assistance, wouldn't that increase utilization of mental health services? I don't know whether the implications for cost would be increased or decreased long term, because better utilization at one point might lead to reduced utilization down the road. But wouldn't we expect more use of mental health services, and would that have any financial implications?

MS. McMULLEN: So --

COMMISSIONER SZILAGYI: And are there any modeling studies? And maybe one other question. Sorry to interrupt. Could we estimate what -- if the guidance was followed perfectly across the United States about best use of even existing services, is there any estimate for what might the impact be on improved access to care or use of care? And by increased utilization, that's not a bad thing. I think that's actually often and usually a good thing.

MS. McMULLEN: Yeah. So I'll start with the kind

of first question around utilization.

I do think that one of the kind of goals of a crisis system is to connect people with ongoing community-based and try to avoid higher cost like inpatient or emergency department services if that's appropriate.

I do think SAMHSA's guidance does recognize that some people are going to need inpatient treatment, and that might be appropriate.

Whether or not there's been studies, it is hard to get studies that are specific to Medicaid. There's only a few states that are really close to kind of offering SAMHSA's full kind of -- like the perfect model of what's being offered. There's only a few states we can look at.

The chapter does highlight the experience of one county in Arizona, and it talks about up-front costs and what they saw in terms of savings. We can look and see if there's other studies. I know some other Commissioners emailed me about this as well. So we can look and see.

The experience in Pima County did show that there was substantial savings from implementing these programs, but again, trying to find Medicaid-specific costs related to this is hard. It's especially challenging since we know

that there is a role for SAMHSA block grants and other types of state funding when it comes to the continuum.

And then your question on the modeling, I haven't seen anything that kind of 100 percent estimates like what this would cost and look like, but we can see if we can find some additional information to incorporate into the chapter.

COMMISSIONER SZILAGYI: Great. Thanks. Excellent chapter. Really well done.

VICE CHAIR MILLIGAN: Thanks, Peter. So I have now added Martha, Fred, and Sheldon to the list. But, Kit, you're up next.

COMMISSIONER GORTON: So thanks, Erin, for this ongoing, very important work. I agree with Peter. I'm also pleased that we're focusing on the crisis end of things because I think we often focus on the back end, and I think it's nice to make sure we have the full picture.

So two comments. One to the issue that you mentioned earlier, that some of us raised, in terms of the data suggesting different prevalences by race and ethnicity. It occurred to me, as I have continued to think about that, one hypothesis is at least the data that I saw,

I think I saw in the chapter, were survey data, which means that they're self-reported data. So one of the things we may be seeing is cultural differences in self-reporting, or, similarly, we may be seeing cultural differences in self-identification, so one group more likely to identify themselves as having suffered something than another group.

I think I've seen data, but I may be imagining this, that suggests that in young people, young people of color are less likely to take the same set of symptoms and attach a label of a behavioral health problem to it than young people who are white. So we may be seeing a cultural/reporting difference, and it may be worth poking at that a little bit, just to be able to present a clearer picture to people. So that was one thing.

The second is a very technical thing, and that is some of the data that you presented in the chapter, you're talking about differences in utilization patterns for people who are identified as having a mental health problem. And included there are distinctions in terms of how people of color get more inpatient care and white people get more ambulatory care.

I want to point out where I think you looked at -

- in one part of it, though, you distinguished between clinic care and private therapy care, and I think we need to be careful there, because how providers are enrolled in Medicaid billing systems has nothing to do with do you walk into a building and get escorted to a private room where you sit down with a licensed professional to work? Sometimes that gets billed as a clinic visit and sometimes that gets billed as a private visit, and the service is identical. And so I think we need to be careful about that. Sometimes in hospital-based clinics the motivation for doing that is to get the clinic fee in addition to the professional fee.

So I just think what we want to be looking at there, if we can, and the data may not support this, is actual units of a type of service. Who received counseling, regardless of place of service, and that may be important when we get more into telemedicine as well. Because if talk therapy is, as we believe, at least somewhat efficacious, and may be the most available if you're in rural somewhere, then the fact that you got it, that doesn't mean you had no access to that service. It just means you had access to that service delivered in a

different modality than in a public clinic or in a hospital clinic or in a private therapist's office or whatever. So it's all the same service, rendered by equivalently qualified professionals, just in different settings.

So it seems to me, and maybe that's overly technical, but it seems to me we need to be careful that we don't draw conclusions from place of service codes -- you get my point.

MS. McMULLEN: I will just say that the treatment data in the chapter is also derived from the National Survey on Drug Use and Health, so we're beholden to the different categories of how they map out treatment. I do not want to steal the thunder of Chris Park and Aaron Pervin, because I know they are talking about T-MSIS tomorrow. But I think these are important things that you raise, that we can think about as we start to explore how we can use T-MSIS to look at behavioral health issues. So we will keep that in mind as we kind of move forward and start thinking into this more.

COMMISSIONER GORTON: Yeah, and then we just need to be circumspect in how we characterize it. So if the data don't inform it then we may not be able to draw as

sharp and crisp a conclusion as we would like.

VICE CHAIR MILLIGAN: Thank you, Kit. Kisha.

COMMISSIONER DAVIS: Hi. Thanks, Erin. It was a really good chapter and I really appreciated how much you really brought in the kind of racial perspective and the differences that we see there.

As Kit mentioned earlier, just being really careful about how we talk about experience versus reporting of mental illness in minority communities. We know that black patients are less likely to report, and that doesn't mean that they experience it less. So several times we say they experience, you know, mental illness less, and I would counter that. We can't say that, for sure. We can just say that it's reported less.

And also, you know, I agree with the recommendations. When we're giving the rationale, though, you do such a good job in the chapter of really laying out how this is affecting different communities of color and kind of the detriment that they experience, but we don't talk about that really in the rationale. And we don't give any guidance, you know, creating this continuum to really specifically help address some of these racial differences.

And so saying something in the rationale about encouraging cultural competency and the education of those crisis service providers, and, you know, benefits of outreach to minority communities. That's all throughout the chapter but it's not mentioned at all in the recommendation or rationale, so bringing that in a little bit more.

VICE CHAIR MILLIGAN: Thank you, Kisha. Martha.

COMMISSIONER CARTER: I want to echo the other Commissioners. This is a great chapter and I really appreciate the work you've done on it.

Thinking about the recommendations and which agencies need to play a part, and at the risk of like bringing in the kitchen sink here, I think we want to consider the role of HRSA in behavioral health services. In the adult world, of course, the community health centers are often front line for suicide attempt. You know, I've been there when somebody walks in and says, "I'm going to kill myself and I need help." And when we get to the second chapter, the next chapter on pediatric mental health, the same thing for the school-based health centers. So funding for those programs in the community as a first step to address crises I think is really important.

And the second part that goes along with that is addressing, through HRSA and wherever else the funding comes from, the workforce needs, National Health Service Corps, to make sure that we have the appropriate number of providers in the right places, in the communities that have the highest need. You know, I know that's a congressional funding issue often, but still that these agencies work together to assess the need and to try to direct the resources in the best way possible. So I'd like to consider adding HRSA to that mix.

VICE CHAIR MILLIGAN: We'll come back to that, Martha, before we wrap up this session. Fred, you're up.

COMMISSIONER CERISE: Thanks, Chuck. Erin, I have a quick question and then some thoughts. In this section, and in the other ones too, it stands out that there's an increased prevalence among some of these conditions -- you know, the severe mental illness, co-occurring disorders -- among Medicaid beneficiaries. It's striking when it's worse than the uninsured. And I just wonder, how much of that effect do we see as they get sick and then they become eligible for Medicaid and that's what we're counting? I mean, is there a good way to track, you

know, the fact that it may be weighted towards Medicaid because they become eligible as a result of that condition?

MS. McMULLEN: So unfortunately the survey data we used to do these analyses doesn't include kind of the basis of an individual's Medicaid eligibility. We just know that the individual self-reports that they are on Medicaid. In 2015, we did do, in our report to Congress, a chapter on behavioral health that was based on 2011 MSIS analysis. And in that chapter, throughout it, we looked at people who are eligible for Medicaid on the basis of a disability, to those who were eligible for Medicaid through other pathways. And we did see that most -- I think it was close to half -- of people who were eligible on the basis of a disability had some sort of behavioral health condition.

That data, you know, is ten years old at this point, and we haven't done new analyses. But that's the best data that I have seen on this topic. So I do think that the issue of, you know, if you qualify for SSI on the basis of your disability and you receive Medicaid, it could be possible that there are people with higher acuity when it comes to their mental illness that are in the Medicaid

program. I can't say that with -- you know, I don't have the data to like 100 percent back that up, but I would venture to guess that it's a factor.

COMMISSIONER CERISE: I just wonder how much you see a shift from the uninsured and even the commercial side to Medicaid as a result of the disease, you know.

MS. McMULLEN: We can pull in a little bit more.

COMMISSIONER CERISE: So my comment is, I know we're focused on Medicaid, and that's what we look at. The problem with this is it just crosses all payers, right, and you make a mention of that in some of the rationale there, that it really is impossible to separate this, so who is responsible for setting up the infrastructure? I think the recommendations are right on target, because somebody's got to take the lead to provide the guidance there.

And if you look at, right now my experience is the places that have more complete continuums, it tends to be those big, publicly supported, the local mental health authority or the other districts, that, you know, the state is working with to do everything from the housing to the acute response, the EDs, and that sort of thing. And while Medicaid may be the biggest payer, there are others that

are benefitting from that system, and so how do you pull in the other payers that really have a responsibility. They own a portion. That ED is sitting there for everybody. And so as you set up that infrastructure, how can we pull everyone into that conversation. All the other payers rightfully have some obligation or some responsibility because it is supporting their members as well.

So, anyhow, it's an observation that you can break the federal strains of Medicaid, but there are other payers that are benefitting from that structure, because if you look at the places that tend to have those continuums it's the places that are drawing on public support to set that up, because it's impossible for most places to just independently braid those different funding streams together and put that continuum out there and make it work. So my bid for multi-payer involvement.

VICE CHAIR MILLIGAN: Thanks, Fred. Sheldon?

COMMISSIONER RETCHIN: Yeah, thanks. Can you hear me okay?

VICE CHAIR MILLIGAN: Yes.

COMMISSIONER RETCHIN: Thanks. Thanks, Chuck.

Well, first, Erin, I think this is an outstanding

chapter, but not only that, I think that everything we do at the Commission is important, so I don't want to overshadow everything else that we're doing. But for the mental health crisis that we're facing in the country, this the largest unmet need that I know of, and before the pandemic I felt a sense of momentum, so I'm glad we're getting back to that sense of momentum, and I think it's just in the nick of time.

I'm delighted over the recommendation. I'm delighted with the implementation of the 988 national lifeline. In fact, I predict that the lifeline is going to uncover an even larger unmet need for mental health.

Let me just point out one thing that's sort of an observation. If we were talking about creating a crisis continuum, a national crisis service, for diabetics, because too many diabetics were going into ketoacidosis, I think we would conclude -- and I know this is not exactly a metaphorical, but I think we'd conclude that there's something wrong with access to care for diabetics. So we have something wrong with access to care in mental health, and the crisis continuum is going to unearth that even more.

I do want to add that I appreciated the statement regarding the implication there were communities of color in the impact statements. That wasn't lost on me and I appreciate that add.

I especially applaud the next steps, which is going to include the examination of the intersection of unmet needs of mental health and the criminal justice system, especially for communities of color who are treated differently in our justice system to begin with. This is even more tragic.

And then let me just finally, as you all know, where I would probably end up, and that's on workforce. The participation rates are embarrassing for adult psychiatrists, and they're only moderately better in the commercial, so I understand we've got a real workforce problem. I think we've talked about that a lot.

But I have one question. With all of the variations in pricing and reimbursement, there must be variations in reimbursement we see across states for psychiatrists. Do we know if there is an elasticity there? Is this a payment problem or is it another issue with psychiatrist participation? Erin, do you know?

MS. McMULLEN: No, I think I was able to include one study in the chapter that looked at payment rates across, but it was comparing what Medicaid pays for psychiatrists when compared to primary care physicians for similar services.

COMMISSIONER RETCHIN: For parity.

MS. McMULLEN: Yeah, for parity. And that data is also a few years old. So I haven't seen something that, you know, is specific to Medicaid payment and elasticity for psychiatrists. I do think that through work of some of my colleagues we have shown that if you pay more, providers are more likely to participate. We certainly have seen that happen in Virginia with their substance use waiver. But I haven't seen anything that gets at the exact issue that you're raising.

VICE CHAIR MILLIGAN: And, Fred, were you coming in on this point?

COMMISSIONER CERISE: I'd just comment or just ask you; how much do you think that has to do with -- without a good continuum of care, you're sort of on an island a lot of times. I mean, it's a hard field, because you lack so much system support. Imagine being an

oncologist and I can't get somebody radiated or I can't get surgery or I can't get a line put in to do my chemo, because the rest of the system is not in place. I just wonder how much of it is, it's just hard to work in such a system where you lack a lot of the support to provide the full range of care that people need.

COMMISSIONER RETCHIN: Are you talking, Fred, about just psychiatrist participation rates in Medicaid or across the board?

COMMISSIONER CERISE: Across the board, because we know it's an issue in commercial as well, right, but particularly in Medicaid.

COMMISSIONER RETCHIN: Yeah. I just want to say, though, you know, participation rates do go up from Medicaid to commercial, so money makes a difference. And it's not small. I mean, there's like a 25 percent spread. I don't want to diminish the lack of infrastructure, but with this crisis, when you have 30 percent participation rates in Medicaid, that's a national embarrassment. That's the field. And I don't understand why plans aren't looking at this elasticity to see how much will it take to get some parity.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon, I just want to add here that I think there's been a lot of focus on low Medicaid payment for physician services for a long time, but I don't think anybody's calculated elasticity in demand for any of those services, and so there's obviously a lot of room for improvement, but I don't think there's anything empirical here that will --

COMMISSIONER RETCHIN: Yeah, I agree.

VICE CHAIR MILLIGAN: Okay. Peter, and then I want to kind of bring us in to close this session.

COMMISSIONER SZILAGYI: Just because it's related, this isn't about mental health services, but there was a very nice study in the pediatric world regarding the primary care bump and increased participation by primary care physicians due to the primary care bump. So that's not exactly a test of the elasticity, you know, like a number of different levels of increase of payment, but it certainly is a test of one level of increase of payment, and it did shoe increased primary care participation with Medicaid patients. COMMISSIONER RETCHIN: Exactly.

VICE CHAIR MILLIGAN: Okay. Thank you all. So I want to take two polls among us before we conclude this

session. The first one -- and, Martha, the issue you flagged I'm going to hold for the second poll question, so for awareness. I did not hear anybody opposed or concerned with these recommendations. I heard some support from a few folks, but no opposition or concerns. I just want to -- if you have a concern, could you raise your hand so I can just see if there's anybody who's concerned about these recommendations? Okay, seeing none.

The second poll question is, and, Anne, I invite your participation in this, and Erin as well: Are there any concerns around including HRSA as a carve-out entity for inclusion in these recommendations because of the issues Martha raised around community health centers and National Health Service Corps benefitting from getting some guidance along with SAMHSA and CMS? Are there any concerns about inclusion of HRSA in the recommendation? And if you have concerns, if you could raise your hand or signal it now. Anne?

EXECUTIVE DIRECTOR SCHWARTZ: So I appreciate what Martha is saying about the importance of community health centers and the importance of National Health Service Corps around workforce issues. Fred had also

raised issues around public hospitals. We brought in issues regarding other payers. And all these are important for ultimate solution to this problem.

What I'm concerned about is that the recommendation is meant to be focused and targeted on the actors that are needed right now to help Medicaid programs be more effective in this space. And I think it would be more appropriate to talk about HRSA and others in the text, but keep the recommendation focused on its purpose right here rather than making the recommendation a catch-all for all of the actors that are involved in the system. So I'll just turn it to Erin.

COMMISSIONER CERISE: And since you referenced my comment, Anne, I would agree with that. I agree.

VICE CHAIR MILLIGAN: And so before, Erin, going to you on that, if instead we leave the recommendations as is, but we in the chapter call out HRSA's role in informing the delivery of mental health services, that's, I think, where, Anne, you're directing us. Martha, are you comfortable with that as an approach you could support in the recommendations?

COMMISSIONER CARTER: I can live with it.

VICE CHAIR MILLIGAN: Okay. I'll take it, Martha. Thank you.

Erin, any other comments about any of this? Do you have what you need from us coming out of this session?

MS. McMULLEN: Yeah, I definitely have what I need, and I will definitely take all the feedback you've given today to incorporate some changes into the draft chapter, including the rationale.

VICE CHAIR MILLIGAN: Great. Well, thank you for your excellent work and your ongoing excellent work on this subject matter for us.

So that concludes this session, and we can move into the next session on children and adolescents. And I think Melinda has joined us. Melinda, welcome. We look forward to kind of the continuation of the work that you've been doing on our behalf. It's all yours.

ACCESS TO BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS COVERED BY MEDICAID AND CHIP: REVIEW OF DRAFT CHAPTER AND RECOMMENDATIONS

* MS. ROACH: Great. Thanks, Chuck and good afternoon. In this session, we'll review the draft chapter on access to behavioral health services for children and

adolescents with draft recommendations that we presented last month. The recommendations themselves have not changed, though we've updated the rationale and implications based on your feedback.

This slide lists the main components of the draft chapter preceding the recommendations. The first section brings together the analyses we previously presented to the Commission on prevalence and treatment rates, as well as the availability of behavioral health providers. Where possible, we also examined access among Medicare beneficiaries by race and ethnicity. The chapter then discusses the availability of behavioral health providers serving children and adolescents before turning to the needs of those with significant mental health conditions to further frame the draft recommendations.

The next two slides review highlights from MACPAC's analysis in the 2018 National Survey on Drug Use and Health, which is discussed in more detail in the draft chapter. Most of this data was presented in December with the exception of more recent work we did to look at variations by race and ethnicity.

In 2018, nearly 20 percent of adolescents, age 12

to 17, enrolled in Medicaid reported experiencing a major depressive episode in their lifetime. About 12 percent had suicidal thoughts, and nearly 4 percent had attempted suicide in the past year.

These prevalence rates were similar when comparing Medicaid beneficiaries to youth with private coverage and those who were uninsured. However, there were some differences across racial and ethnic groups enrolled in Medicaid.

Among Medicaid beneficiaries, mental health conditions were more common among white youth when compared to their Black and Hispanic counterparts. Black and Hispanic youth enrolled in Medicaid were also less likely to report having attempted or thought about suicide compared to white beneficiaries.

In 2018, about 4 percent of adolescent Medicaid beneficiaries had experienced a substance use disorder in the past year. The prevalence of past-year SUD was similar when comparing Medicaid beneficiaries to those with private coverage and the uninsured, though the use of alcohol and certain drugs varied by coverage status. Among youth enrolled in Medicaid, non-white beneficiaries were

generally less likely than their white counterparts to report using drugs and alcohol.

This slide revisits data that was previously presented on access to behavioral health treatment, which is discussed in more detail in the draft chapter. The Commission may recall that in 2018, many youth with behavioral health conditions needed but did not receive treatment. This was true for Medicaid beneficiaries as well as youth with private insurance and those who were uninsured. For example, only 54 percent of youth with MDE and 56 percent of youth with MDE with severe role impairment reported receiving any form of mental health treatment in the past year. While youth covered by Medicaid received treatment at similar rates as their peers with private coverage, they were more likely to have received non-specialty services, for instance, from a pediatrician or school counselor, and to have stayed overnight in a hospital or residential facility. Medicaid beneficiaries were also more likely than youth with private coverage and those without insurance to have received services from education sources.

This is one of the newer tables included in the

draft chapter which has mental health treatment rates among youth enrolled in Medicaid by race and ethnicity. As you can see, among all youth in Medicaid, certain racial and ethnic groups were less likely to have received any form of mental health treatment in the past year. Specifically, lower rates of treatment were reported by beneficiaries who are Black, Hispanic, and American Indian or Alaska Native and Hawaiian Native or other Pacific Islander.

Among Medicaid beneficiaries with MDE, youth received treatment at similar rates, regardless of their race or ethnicity. However, there were variations when looking at Medicaid beneficiaries with MDE with severe role impairment. Among Black youth who experienced this condition, only 48 percent received some form of treatment compared to 68 percent of their white peers.

The next section in the chapter uses different data sources to examine the availability of behavioral health providers serving youth in office-based settings, school-based health centers, and behavioral health treatment facilities and finds that the supply of these providers was limited across the country, with particularly acute workforce challenges in rural communities.

One opportunity to expand the behavioral health workforce is through child psychiatry access programs like the one pioneered in Massachusetts. These programs now exist in many states to help pediatric primary care providers manage the mental health needs of their patients through telephone, video, and in-person consultation with behavioral health specialists.

The next part of the chapter focuses on the needs of children and youth with significant mental health conditions who are greatest risk for out-of-home placement and poor outcomes. We discuss factors affecting access to care, including the role of various state and federal agencies, Medicaid and CHIP coverage requirements, and barriers to designing benefits for this people. Access to home and community-based behavioral health services, including intensive care coordination and peer supports, can prevent these children and adolescents from being removed from their homes and communities. Such services have been shown to improve clinical and functional outcomes, school attendance, and other measures. It can also reduce rates of attempted suicide and contacts with law enforcement, yet they're often unavailable or difficult

to access. In numerous class action lawsuits, courts have ruled that states are not meeting their obligations to ensure access to these services under Medicaid's early and periodic screening, diagnostic, and treatment benefit. And as previously noted, adolescents with Medicaid coverage are more likely to be treated in inpatient residential settings when compared to their privately insured peers.

This slide revisits information we presented last month on the multiple federal, state, and local agencies that play a role in serving this population and the need for coordination across these entities.

At the Federal level, this includes CMS and SAMHSA as well as ACF, which administers federal funding for child welfare. Of note, ACF is responsible for overseeing implementation of the Family First Prevention Services Act, which, among other things, expanded the use of federal child welfare funds to include certain behavioral health services that prevent out-of-home foster care placements.

At the state and local level, key partners beyond the Medicaid agency include behavioral health, child welfare, and criminal justice agencies.

While many factors affect access to services, experts have highlighted state capacity as an immediate concern. Specifically, the Commission expressed concern that states face challenges figuring out how to use available Medicaid authorities to structure benefits for children and adolescents with significant mental health conditions. While there are a number of options states can pursue such as 1915(c) waivers and 1915(I) state plan authority, the process can be difficult to navigate, and states have received minimal federal support for their efforts in recent years.

It can also be challenging to engage the multiple federal, state, and local agencies to play a role in expanding services for this population. Stakeholders have noted that while states generally have the federal authority needed to improve access, they often lack the awareness and capacity to use them and can benefit from additional federal guidance and support.

The draft chapter notes that the analytic work just discussed and the recommendations we'll cover shortly are just a first step in addressing access to behavioral health services for children and adolescents. We expect

the Commission's future work to examine access for those in foster care, including concerns about how implementation of the Family First Prevention Services Act may affect access to Medicaid-covered services in certain residential treatment settings. MACPAC is also planning to examine the experience of children and adolescents through future work on access to behavioral health services for justice-involved populations and individuals who identify as lesbian, gay, bisexual, or transgender.

Moving on to the two draft recommendations, as previously noted the recommendation language has not changed since last month, though some of the rationale language and implications have been updated to reflect Commissioner feedback.

The first draft recommendation is focused on additional federal guidance. It reads: "The Secretary of Health and Human Services should direct CMS, SAMHSA, and ACF to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and CHIP.

This slide outlines the rationale. New guidance

is needed to facilitate state adoption of home and community-based behavioral health services that permit children and adolescents with significant mental health conditions to avoid institutional placements. Previous guidance issued by CMS and SAMHSA in 2013 was useful, but is now out of date. Among other things, new guidance should describe additional evidence-based services and state examples, strategies for addressing racial and ethnic disparities, opportunities to reimburse for technology-enabled services, and authorities states can use to pay for home and community-based behavioral health services in Medicaid and CHIP. In developing such guidance, coordination between CMS, SAMHSA, and ACF is needed to address the roles of state Medicaid behavioral health and child welfare agencies.

Similar to the draft recommendations that Erin discussed in the previous section, we don't anticipate that issuing new guidance would have a direct effect on federal spending. Among states, new guidance could spotlight the need for home and community-based behavioral health services and ultimately expand access to such services. We anticipate that the draft recommendation could improve

access to beneficiaries, could be particularly important for those of color given the lower observed rates of behavioral health treatment among certain racial and ethnic minorities. For plans and providers, there would be no direct effect.

The second draft recommendation addresses technical assistance and planning support. It reads: The Secretary of Health and Human Services should direct a coordinated effort by CMS, SAMHSA, and ACF to provide education and technical assistance to states on improving access to home and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and CHIP. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

In addition to subregulatory guidance, technical assistance and planning opportunities are needed to enhance state capacity and jump-start efforts to expand and continue services. Such technical assistance coupled with planning support could help states establish cross-agency partnerships, engage stakeholders, design new Medicaid and

CHIP benefits, and overcome other barriers such as limited state resources and capacity. Existing funding, including recent increases in the Mental Health Services Block Grant, could be used to support planning efforts that bring together state behavioral health authorities with Medicaid agencies and other key stakeholders.

The implications here are largely the same as those associated with the first draft recommendation, though we anticipate more of an effect on state capacity to implement new benefits. We look forward to your discussion and feedback on the draft chapter and the recommendations. Thanks.

VICE CHAIR MILLIGAN: Thank you very much, Melinda.

Commissioners, who would like to start? I see Peter.

COMMISSIONER SZILAGYI: Thank you, Melinda. A very nice presentation. I actually think this is a really outstanding, very comprehensive chapter, and I think it will be used widely, including the graphs and tables, you know, like all MACPAC publications.

First let me say I definitely agree with both

recommendations about guidance and technical assistance. I do have to say that if you look at some of the data like half of youth with a major depression episode received care, 6 percent of youth with substance use disorder received care, adding guidance and technical assistance is not going to -- it's an initial step, obviously, and it's not going to solve the fundamental problems. But it is an initial and a really important step. And we all know that's the way health care gets better, is by steps, not necessarily, you know, major transformations. But I did want to make the point that given the extent of the problems, it's only an initial step.

If you ask pediatricians what's the number one problem they face, it's mental health problems among their patients. If you ask parents what's the number one problem that they face, it's behavioral and mental health concerns. So we're really -- as Sheldon said, we're in a very, very important area.

I do want to make the point that some of the chapter, I think, appropriately focuses on serious mental health problems in children, and we may want to consider another chapter that's more earlier in the continuum

because what pediatricians are seeing is an entire continuum of mental health and behavioral problems in children, and this really addresses more the major depressive episodes, substance use, and more the serious ones.

Just a couple final points. As Sheldon mentioned, workforce is a major problem. We as pediatricians, we can refer children on Medicaid to good mental health services, but they may have to wait four to six months. We can refer them to behavioral health services, but they may have to wait three months, and they can't see a psychologist if they're on Medicaid; they can if they're not on Medicaid. I've had this experience just in the last month. And so workforce and payment, you know, infrastructure is really, really important.

My final point, I think there's new modalities that are really worth highlighting in the future, not for this chapter, tele-behavioral health, which we have covered a little bit. Integrated care -- I'm not talking about EHR integration. I'm talking about collocated integrated care where there's good models in the pediatric world. Mobile health units for children, specifically for children, for

accompanying police, and trauma-focused care.

And, finally, I'm really happy that we're going to -- that future work is going to focus on foster care and families and justice-involved population. So thank you very much.

VICE CHAIR MILLIGAN: Thank you, Peter.

I see Kit and then Fred and then Sheldon and then Tricia.

COMMISSIONER GORTON: Okay. Melinda, thanks for great work and, as Peter said, important work. He said it way more articulately than I do, so what he said.

I was going to suggest that the recommendations might include reference to state and federal and local education agencies, but I will take Anne's feedback about HRSA and apply it to the specific case. But I do think that the chapter is not intentional enough about talking about the role of schools in the lives of children and youth.

And I even think in our summary -- if you look at your slides where you have the -- well, you have a laundry-list slide that says here's everybody who's involved, right? The word "school" doesn't appear on that slide, and

I think that's just a huge oversight. I'm not just talking about school-based clinics who do wonderful, important work, and I don't want to diminish that at all. But the schools themselves provide huge volumes of Medicaid-funded services, and some of them are associated with IEPs. So you have paraprofessionals in schoolrooms.

Some of you know I've started substitute teaching high school science, and half of my classes have para-educators in them, helping kids with mental health and behavioral health issues online. It's an interesting experience, so -- and Medicaid is paying for an awful lot of that.

So it's important to understand how the schools do get integrated or don't get integrated, and I think that might be something, Melinda, to explore in the future is how successful have we been in integrated the health care silo with the education silo. And I would posit that we've been relatively unsuccessful in integrating it.

So I think we need to expand and be more intentional about talking about education. The federal educational authorities don't necessarily contribute all that much, but the state and local departments of

education, local school boards, they contribute a huge amount about whether the schools are open to providing services for kids or not. In some of the more rural communities, the lone school counselor is doing all of this single-handedly and trying to make the referrals that Peter was talking about.

So I think important to amplify a little bit and focus a little bit, the text of this chapter on that, and then I think in the future, I would like to see some more attention -- we've talked about integration of Medicaid and Medicare. I think for children, as important, is integration of education-based health-focused services and health-based, health-focused services, all of which are paid for by Medicaid. So, actually, we own the whole thing.

Thank you.

VICE CHAIR MILLIGAN: Thank you, Kit.

Sheldon -- or excuse me. Fred and then Sheldon.

COMMISSIONER CERISE: Well, a little bit related to Kit's point and to my earlier question as well, Table 3.7 in the chapter, it's striking that the percentage of services among the uninsured compared to Medicaid there,

even in a school setting where you wouldn't necessarily expect to see that, you know, people that have seen a school counselor or a social worker, and so I know it would be helpful to understand that a little bit better if we're going to rely on the schools, as I think it's appropriate, that setting to reach kids. I'd hate to think that that's being filtered by insurance status, whether that's Medicaid or anything else, but, you know, if you look at the chart, that's what it looks like.

VICE CHAIR MILLIGAN: Melinda, did you want to respond to that?

MS. ROACH: I guess I'll just state the points on the role of schools are very well taken, and it's something that we can highlight a bit better in the chapter.

VICE CHAIR MILLIGAN: Okay, great. Thank you.

Sheldon and then Tricia.

COMMISSIONER RETCHIN: Yeah. First of all, Melinda, I think this is just an incredibly important contribution, like Peter said. This extends beyond just with MACPAC. I think it's comprehensive and will be used by policymaker in lots of different areas. So I congratulate you for this, and I'm really delighted that

you and Erin have this continuum, child to adult, because I'm just wondering a little bit about the differences. Maybe you came across -- and I sort of direct some of this, also the question to Peter.

This is just my impression, that with adult SMI, serious mental illness, that a large part of the psychopharmaceutic interventions are delivered by primary care physicians, not necessarily by an adult psychiatrist. So the shortfall there maybe is not as, I guess, catastrophic or influential.

But, on the other hand, on the pediatricians, Peter, I'm venturing that with the same level, very serious mental illness, that child psychiatry is used a bit more than with adults, and that said, maybe you agree with that or not, but I'm really just sort of puzzled by, in this case, the workforce. And you're right. I have a perception that child psychiatrists are still in great demand, and they have a large unmet need. Supply is less than the demand, but then there is this projection that's sitting out there that not only is it meeting demand, but we will have an oversupply of child psychiatrists within a decade. How is that possible?

I mean, Peter, maybe Melinda, what's your reaction to that?

COMMISSIONER SZILAGYI: Melinda, do you want -- I saw that sentence in the chapter, and I was shocked that there might be an oversupply. And I don't know whether that has to do with --

COMMISSIONER RETCHIN: It's out there.

COMMISSIONER SZILAGYI: You know, an oversupply in total numbers but not an oversupply where it's really needed among vulnerable communities, rural areas, and others.

But I think you're right that in the pediatric world, there may be a little bit more dependence on mental health, at least to initiate treatment. Some of the models that Melinda put into the chapter, like the Massachusetts model, is kind of a co-management with perhaps an initial visit with a psychiatrist and then the pediatricians can take over.

Also, in the pediatric world, there is concern that mental health, so even children who present with depression, it may not be depression. It may be trauma, and then they would need a different kind of care, or it

may not even be ADHD. It may be trauma because trauma is so common among children or children who are traumatized, and so there is often, I think, a need for initial mental health care and then co-management.

So I really like the examples that Melinda put into the chapter, but I don't really -- I didn't get under the -- I don't know about the data about the psychiatrists and whether it's a maldistribution.

COMMISSIONER RETCHIN: Melinda, do you know?

MS. ROACH: I think that's a really good point that Peter raises about a maldistribution, but it's certainly something that's not addressed by these HRSA projections. And we can look more closely at the model and sort of other projections out there to sort of understand how they compare.

I think the other thing that the HRSA model doesn't take into account because it was done pre-COVID is the impact on demand that we are already seeing and expect to see into the future for these services. So I think that's another factor that could impact that calculation.

COMMISSIONER RETCHIN: Can I just add, though, Melinda, when you're finishing this off, because you have

the benefit of the adult-child continuum here, to maybe contrast. Readers may not realize the sort of difference in practice where child psychiatry may be playing a very different role commonly, more commonly than with adult psychiatrists, so it exacerbates the workforce need.

MS. ROACH: We can incorporate that. Thanks.

VICE CHAIR MILLIGAN: Thank you, Sheldon.

Tricia?

COMMISSIONER BROOKS: Yes. Thanks, Chuck.

Melinda, great chapter. Overall, I'm really happy to see a focus on children's behavioral health.

But I think we've got to move it upstream. I think we have to talk about very early childhood. I'm glad Peter mentioned trauma because a lot of mental health issues along with other problems start with trauma, and in fact, the Health Policy Institute of Ohio just did some interesting analysis of the cost of trauma for children. And we know that if early on, kids have behavioral issues, they enter school not ready to work. It's just -- you know, it continues on into adulthood.

I would like to see something a little more specific about there being a barrier to behavioral health

for young kids where the pediatrician or other provider is not -- doesn't want to peg the child with a diagnosis. In some states, that interferes with the child being able to get treatment without a diagnosis, and I think that's another piece of the puzzle here that could be clarified in guidance, that it may be early to name a diagnosis for a 2-year-old, but that doesn't mean that that 2-year-old can't benefit from services.

MS. ROACH: That's definitely something that we can work on incorporating. We're familiar with, for example, the example out in California where family services are being provided without a diagnosis. So that's something we can highlight.

COMMISSIONER BROOKS: Thank you.

VICE CHAIR MILLIGAN: Thank you, Melinda.

Martha. And I don't see anybody else after Martha. So if you want to jump on the line, please do so. Martha?

COMMISSIONER CARTER: Yeah. Thanks.

One thing we've sort of talked around but haven't clarified is the difference between school-based behavioral health services and school-based health center services,

and I don't know if there is a way for you to pull that out, but they do provide different types of services. So any clarification you can see that, I think, would be helpful.

VICE CHAIR MILLIGAN: Anybody else?

[No response.]

VICE CHAIR MILLIGAN: I actually did want to follow up on that point too, Melinda.

In terms of the school-based side, I've heard a few different comments. Part of it, I think, is the delivery of school-based health care through -- school-based health centers often FQHC related.

But there's separately this issue of IDEA and individualized education plans and sort of the special ed role, that I don't know the byplay between those programs in terms of delivering behavioral health to children through the school system, either through IDEA or kind of more kind of traditional school-based health center services.

So to the extent that can be integrated into future steps along with some of the other bullets that you have on the slide right before the slide on the screen

right now where you were going to sort of signaling to everybody where you're planning to go, it seems like -- and thank you for pulling it back a little, if we can do that. I think it was the -- yeah, wherever the next steps are. Yeah, thank you.

I think including in this list the relationship of schools and school-based health care and IDEA would probably be an important contribution for children and adolescents.

The other thing I wanted to flag, just based on some of the comments, is about the supply of child psychiatrists. My perception -- anecdotally, but my perception is it tends to be often -- those psychiatrists tend to often be primarily more academic medical center-based, more limited hours, more kind of medication management, less available for crisis, less available after hours, and so I think as we tease out the supply and workforce issues, to whatever extent we can start filling in the details around crisis and the scope of services that are delivered, is it broader than medication management, I think some of those elements really will illuminate where there might be access challenges and where there might not

in terms of services.

Toby, did you want to jump in on this?

COMMISSIONER DOUGLAS: Yeah, just one quick -- and it's what Peter had said earlier. I do want to add on the next steps around technology-enabled solutions as we think about supply or just the limited supply, how is Medicaid facilitating and paying for -- or allowing for benefits of technology approaches. I think that's where a lot of other payers are going, and we need to -- how Medicaid can support our children through approaches that might not be with providers.

VICE CHAIR MILLIGAN: And including tele-behavioral health, presumably, Toby. Is that right?

COMMISSIONER DOUGLAS: Absolutely. I think it's more -- it's clearer, but then I'm getting more even just there are apps and there are other ways that might not be the provider that could support when they can't get an actual visit, whether it's virtually or in person with a provider.

VICE CHAIR MILLIGAN: Okay. Thank you.

Okay. I want to go to the poll question I asked during Erin's session. I haven't heard any concerns raised

by Commissioners regarding the recommendations for this particular topic in this chapter. If you have any concerns, if you could signal by raising your hand.

Okay. Seeing none, I just did want to close that out in terms of preparing for tomorrow and voting.

Melinda, do you have what you need from us from the discussion and otherwise?

MS. ROACH: I do. Thanks for all the comments. We'll take them back and incorporate into the chapter and recommendations.

VICE CHAIR MILLIGAN: Okay, great. Thank you.

So I think we're a little ahead of schedule, and we can go to public comment at this point. And then we'll take a break after that.

Operator, are there any individuals who have raised their hand? Again, we're going to follow the same ground rules that Melanie laid out in the morning session in terms of three-minute time frames for public comment. Do we have any individuals who have signaled an interest in offering a comment for this?

PUBLIC COMMENT

* MS. HUGHES: Yes. Nataki, you've been unmuted.

So you may unmute yourself and make your comment.

MS. MacMURRAY: Good afternoon. Thank you so much.

I really wasn't intrigued about the discussion of -- it really points to issues of capacity. I hear you talking about it in terms of supply, but I think it's also capacity to provide adequate services to young people, especially, and if you could talk a little bit more about how the recommendations of the Commission may help to shape and inform the need to build a capacity, to be able to have not just more routes of access, but more capacity.

You mentioned the Boston and Massachusetts and the work that it's been doing, and I just was on a conference call the other day listening to the fact that Massachusetts incorporated expert into a lot of their school-based services, and they're identifying more youth who have a need for treatment. But, unfortunately, less than 50 percent of them are actually being able to get services, and even when those 50 percent get services, it's three to four months after a diagnosis. And so part of that is access. Part of that is capacity, et cetera.

So I would love to hear the Commission talk a

little bit more about it and include a little bit more information in the chapters to really talk about how your recommendations can push and promote and increasing the capacity to be able to provide services.

Thank you.

VICE CHAIR MILLIGAN: Thank you.

Nataki, I might have missed it. Did you identify --

MS. MacMURRAY: I did not. I'm sorry. I was trying to beat the three-minute clock.

This is Nataki MacMurray from the Office of National Drug Control Policy, your friends at ONDCP. Thank you.

VICE CHAIR MILLIGAN: Thank you. So thank you for that comment, and, Melinda, I will defer to you about how to incorporate that comment into the chapter as we prepare to finalize and release it in June.

Our next individual?

MS. HUGHES: We have Kirsten. Kirsten, you've been unmuted. Please unmute your line.

MS. BERONIO: Hi. This is Kirsten Beronio with the National Association for Behavioral Healthcare.

I just wanted to point out something that may be helpful in thinking about the challenges around workforce and capacity and access to psychiatric services for children, adolescents, and hopefully, you could highlight in your report, programs like the Massachusetts Child Psychiatry Access Project and the HRSA program that kind of builds that out and provides grants to support broader availability of that kind of consultative psychiatric service for pediatricians as a way to just supplement and try to help fill the gap.

There are complications in Medicaid, I think, in paying for some of those consultation services that happen outside of the presence of the beneficiary, but I know of at least one state that has addressed some of those challenges, Rhode Island in a recent 1115 demonstration where they were about to get approval to pay the psychiatric providers directly for those consultation services that can help address some of the challenges there.

So I just wanted to point that out in case it's of interest as a strategy for addressing some of the issues you've been talking about.

VICE CHAIR MILLIGAN: Thank you for that comment.

Operator, I don't see anybody else. Do we have anybody else lined up?

MS. HUGHES: No other hands.

VICE CHAIR MILLIGAN: Okay. Thank you.

So, Melanie, I was going to hand it off to you to kind of wrap us up and take us to break.

CHAIR BELLA: Well, Chuck, that's like the easiest thing I've done all day.

If there are no other comments and we are set on these two sets of recommendations, we are ready to take a break. So we are scheduled to come back at 3:15, and we will talk a little bit more about behavioral health, this time looking at electronic health records, and then following that session, we'll talk about the NEMT reports. And then we'll conclude for the day.

Thank you all, and if you could all be back at 3:15, we will get started again. Thank you.

* [Recess.]

CHAIR BELLA: Okay. Thank you, everyone, for being back on time. I hope you got a little bit of a break. It is still the Chuck show so I'm going to hand it

over to check guide us out on this body of work.

VICE CHAIR MILLIGAN: Thanks, Melanie, and I think it's also the final installment of the Aaron and Erin show for this particular reporting cycle. So welcome both. We look forward to this topic, and I will turn it over to you, whichever one of you will be leading us from the beginning.

ELECTRONIC HEALTH RECORDS AS A TOOL FOR INTEGRATION OF BEHAVIORAL HEALTH SERVICES: REVIEW OF DRAFT CHAPTER

* MS. McMULLEN: Thanks, Chuck. So since the publication of the Commission's 2016 chapter on behavioral health integration, MACPAC has repeatedly commented on the need to improve the integration of clinical care for patients with both behavioral and physical health conditions. We discussed behavioral health integration within the context of the opioid epidemic and as it relates to privacy and confidentiality standards for substance use disorder, commonly known as 42 CFR Part 2. We've also examined how fragmentation between physical and behavioral health systems affect pregnant women with behavioral health needs.

At the December meeting, we continued the Commission's discussion on behavioral health integration, but we focused more narrowly on how increased use of certified electronic health record technology, or CEHRT, can improve integration. We presented the results of an internal analysis that showed behavioral health providers use EHR at lower rates compared to physical health providers. We also provided background information on how states leveraged the Health Information Technology for Economic and Clinical Health Act, or HITECH Act, to make EHR incentive payments to physical health providers.

Next slide please.

Aaron and I totally planned that out.

So today's presentation will include some background information before summarizing the components of the draft chapter. We'll discuss components of clinical integration and rates at which beneficiaries with mental health conditions experience co-occurring disorders. We'll also offer some observations on beneficiary use of the specialty behavioral health system.

Then I'll hand it over to Aaron to discuss health information technology and how it can promote clinical

integration. The material he will present is new and is meant to address questions raised by Commissioners at our December meeting. He will also summarize findings presented at December's meeting and outline barriers to EHR adoption among behavioral health providers. We'll conclude by discussing mechanisms to promote EHR adoption among behavioral health providers. These mechanisms will be examined further in the 2021-2022 meeting cycle.

Next slide.

This chapter is really meant to set the stage for a discussion of policy options to address low rates of EHR adoption among behavioral health providers. It was structured this way based on the Commission's extensive commentary on fragmentation between physical and behavioral health delivery system. Through this work, the Commission has recognized that Medicaid should play a role in promoting integration, and CEHRT adoption could help achieve greater integration, but many behavioral health providers were left out of large-scale efforts to digitize health care records under HITECH.

Next slide.

The chapter opens by describing a framework for

clinical integration that was first used by the Commission in its June 2016 Report to Congress. As you can see on this slide, clinical integration is a term that's used to describe a wide range of activities, designed to provide care to the whole person rather than focusing on specific body systems, diagnoses, or conditions.

The chapter defines each of the components listed on this slide. I'd like to draw your attention to just a few of them, as EHRs can be used to address several of the components listed here.

Obviously, EHRs can facilitate data-sharing. Sharing patient information can help care managers and providers from different disciplines communicate and coordinate care. EHRs can give authorized individuals immediate access to patient data and support knowledge transfer and informed decision-making among providers.

Data-sharing allows providers and systems to exchange information on demographics, type of insurance coverage, hospital admissions, medications, as well as other clinical documentation. This data-sharing could help support other components of clinical integration, including care coordination and screening and referral to treatment.

Next slide.

The chapter then examines the prevalence of co-occurring conditions among adults with mental illness. Here we show some high-level findings that were presented at the September Commission meeting. This chart details lifetime rates of co-occurring conditions among adults with past year mental illness. The draft chapter includes prevalence estimates for specific illnesses as well as rates of co-occurring substance use disorder.

As you can see, in 2018, non-institutionalized adults with any mental illness who were enrolled in Medicaid reported having a higher rate of co-occurring conditions over the course of their lifetime when compared to their peers with private coverage. Beneficiaries also had higher rates of co-occurring conditions when compared to adults who were uninsured. Across all coverage categories, rates of comorbid conditions were higher for adults with serious mental illness when compared to adults with mild to moderate conditions. Generally, beneficiaries with serious mental illness reported higher rates of co-occurring conditions than Medicaid beneficiaries with mild to moderate illness.

Next slide.

So this morning I presented some findings related to the rates at which beneficiaries with mental health conditions receive treatment. Specifically, we found that Medicaid beneficiaries often receive treatment in different settings than those with private coverage. Beneficiaries are more likely to receive treatment in specialty mental health care facilities which tend to specialize in the treatment of serious mental illness. Despite high rates of co-occurring conditions among beneficiaries with mental illness, these settings often fail to provide integrated care.

In this chapter, we reinforce various points on beneficiary use of the specialty behavioral health system. We draw upon prior reports to Congress, where the Commission has commented on the fragmentation between behavioral and physical health providers and their systems. Historically, these systems have been financed separately. This means that Medicaid enrollees with co-occurring conditions often find themselves interacting with multiple public and private agencies, and receive physical and behavioral health care from different sources.

When providers are unable to share information about their patients, this knowledge might lead to conflicting treatment, such as prescribing medications with potentially dangerous or even deadly interactions. Given the high rates of co-occurring disorders among beneficiaries with mental illness, limited data-sharing represents a barrier to clinical integration.

With that I'll hand it over to Aaron.

VICE CHAIR MILLIGAN: Aaron, we can't hear you, if you're having issues on your end.

MR. PERVIN: Can you hear me now?

VICE CHAIR MILLIGAN: Yes.

* MR. PERVIN: Okay, great. Thanks.

Thanks, Erin. A few months ago you heard from Medicaid officials in D.C. and Missouri discuss how integral health IT was to their care coordination efforts. MACPAC has also talked to states, federal health IT officials, and behavioral health provider associations, where we heard from stakeholders that EHR adoption, and specifically certified EHR adoption, is a necessary step to improving clinical integration of behavioral and physical health services. While EHR adoption does not guarantee

effective integration, it is a necessary step for improved clinical information-sharing.

The way that certified EHRs can strengthen integration is multifaceted. Certified EHRs guarantee that behavioral health providers can access state information exchanges. These information exchanges allow for behavioral health providers to have access to critical, real-time patient information, such as when they have been admitted into the emergency room for mental health reasons.

Health information exchanges have been shown to improve health outcomes such as lowering the probability of a hospital readmission, lowering the risk of medication discrepancies, and reducing redundant imaging and lab testing. Certified EHRs also guarantee that behavioral health providers can participate in value-based payment arrangements. In certain value-based contracts, behavioral health providers can be on the hook for quality measures such as following up with a patient after an ED visit for mental illness, alcohol, and other dependence within seven days.

Furthermore, certified EHRs can be built to automatically calculate and submit these scores to state

agencies, whereas manually calculating these scores can often be cost-prohibitive to participation in these value-based contracts.

Furthermore, certified EHR adoption among behavioral health providers can also help states improve their quality reporting. For example, our MACPAC 2020 Report to Congress highlighted the challenges that states face in pulling data from providers for the child and adult core set measures. Oftentimes, these data are stored by the providers in unstructured formats, making data extraction highly difficult. Certified EHRs guarantee that data structure and data transmissions adhere to federal standards. However, specialty behavioral health providers are missing out on much of this value because adoption remains low.

We presented this slide last time in our December presentation, but wanted to highlight it again because it shows the low rates of data-sharing among non-federally owned specialty behavioral health facilities, specifically mental health centers and substance use treatment centers. Among the non-federally owned facilities, only 8.6 percent of mental health centers and 2.7 percent of substance use

treatment centers electronically share patient records with other providers.

This chart also shows the value of federal involvement in health IT adoption. Facilities owned by the Department of Defense have benefitted from federal investments in health IT, and these facilities share data at much higher rates compared to their non-federal counterpart.

In addition to stakeholder interviews, we also spent the last six months reviewing public comment letters on various roles that address behavioral health adoption of EHRs, the most recent one of which was released in January. We found that there are many barriers to certified EHR adoption for the behavioral health community.

However, the principal barrier is cost. Investing in EHRs is expensive. For context, for those eligible under Medicaid's meaningful use program, individual providers are paid as much as $64,000 over five years, and acute care hospitals could be paid up to $12 million over four years for an EHR. Behavioral health providers often have low margins. As such, they lack the capital to invest in the expensive hardware, software, and

staff training that comes with adopting an EHR.

Furthermore, federal standards on certification were designed to comply with the Health Insurance Portability and Accountability Act, or HIPAA. They were not designed to comply with state privacy laws, nor were they designed to comply with 42 CFR Part 2, which governs the disclosure of substance use treatment.

As discussed in many previous presentations, state privacy laws and Part 2 regulations require EHRs to have data privacy requirements that go above federal certification standards.

Finally, there's a large amount of choice of EHRs on the market. However, a small amount of these EHRs are suitable to the needs of behavioral health providers. As such, providers need extensive guidance from health IT experts on what kind of EHRs to purchase. Purchasing an EHR that both meets certification requirements and meets the needs of the practice can be challenging. Federal and state efforts to promote EHR adoption usually have some funding set aside to advise providers on what kind of EHRs are suitable for their practice.

Next steps for this project include evaluating

different mechanisms that can be used to promoted certified EHR adoption among specialty behavioral health providers. These include incentive payments for certified EHR adoption, similar to what occurred under the meaningful use program. We also plan on reviewing Section 1115 behavioral health demonstrations, including those expanding the continuum of care for substance use disorder. These demonstrations require states to develop a behavioral health IT plan.

We will also review 75 and 90 percent federal match that is used by state agencies to upgrade their health IT infrastructure. We want to determine whether this match can be used to promote behavioral health data-sharing.

Finally, the Substance Use Disorder Prevention that Promotes Opioid Recover and Treatment for Patients and Community Act, or SUPPORT Act, authorizes the Center for Medicare and Medicaid Innovation to test behavioral health incentive payments for EHRs in Medicaid. We will investigate CMMI's plan to incorporate this into their models.

Thank you, and we look forward to your comments

and questions.

VICE CHAIR MILLIGAN: Thank you very much, both of you. So any Commissioner who wants to go first. Tricia and then Brian.

COMMISSIONER BROOKS: Sorry. I lost my unmute button.

Thank you for this work. I really appreciate the fact that electronic health records not only need to be integrated between behavioral health but also to make sure that there are those loop-back mechanisms so that there is the exchange of information both ways. And I think that this also sets up potentially functionality that would remove barriers that we find now in early intervention services, or developmental referrals for young children. And I wouldn't want to lose sight of the fact that as changes might be recommended to electronic health records for that coordination, that it be considered more broadly than just for behavioral health.

The other comment I wanted to raise is not necessarily specific to behavioral health but in terms of pediatric-specific electronic health records. I think there are a number of shortcomings in some of the health

records that have not had specific pediatric functionality built into them, and I think those are barriers for providers and others to report on quality metrics. And I would hope that in the future we could spend a little time looking further into that as well.

But thank you for this work on the chapter. I was happy to see it.

VICE CHAIR MILLIGAN: Thank you, Tricia. I have Brian and then Sheldon.

COMMISSIONER BURWELL: So my questions are kind of more around the landscape of this issue. For one, I'd like to kind of have a better context for what kinds of behavioral health providers are adopting electronic health records, or have a high probability. A lot of behavioral health providers are solo practitioners. I can't imagine those, or small group practices, I can't imagine them adopting electronic health records. So I assume we're talking about larger organizations of some kind or another that are behavioral health providers that may have electronic health records and interact with physical health providers around their patient populations. So some context around the market would be of interest to me.

And also, I don't know how much we plan to get into the actual kind of IT nitty-gritty about this, around interoperability and do all certified EHRs have the ability to push and pull data with outside systems, and to what extent is it a two-way process. Because I can see behavioral health providers pulling data off of physical health providers around medical issues, but I could see them not being, because of all the privacy issues, not pushing data out very much, and how those roles of interoperability are operationalized in agreements between different types of providers.

That's kind of a complicated question, but I think it's important to our understanding of this issue.

VICE CHAIR MILLIGAN: Thanks, Brian. Erin or Aaron, did you have anything you wanted to respond to?

MR. PERVIN: Sure, I can answer a couple of those, and then I can kick it back to Erin if she has any additions. So we did look at -- the surveys that we used did also have a piece where you could look at whether or not providers that are affiliated with larger hospital systems adopted EHRs at greater rates, and so that kind of gets to your question about some of the landscape. And

while we did notice that adoption rates are higher if a center was affiliated with a larger organization, the rates of adoption still weren't comparable to providers that were eligible for HITECH incentive payments. But we can definitely do more work on kind of the landscape and market of who is adopting what kind of EHRs, and we can definitely look into that as we continue this work.

On your second question on interoperability and certified EHR technology, so EHRs are quite varied. There's high-quality ones; there's low-quality ones. For the purposes of this presentation, we're focusing very specifically on certified EHRs because they guarantee some of that interoperability. Functions are built into the system. Certified EHRs are supposed to adhere to the interoperability rule that came out recently, and so that's one of the reasons that we're trying to focus on CEHRT because CEHRT offers kind of the bar of where quality -- of EHRs that are equipped to be interoperable with the rest of the system.

VICE CHAIR MILLIGAN: Erin McMullen, did you have anything you wanted to add? Okay. Thank you.

So I did see Kisha and Martha also raise their

hands, but, Sheldon, you're up next.

COMMISSIONER RETCHIN: Thanks, Chuck. Thanks for the piece on electronic health records and how they may be leveraged to improve the integration of physical and mental health with providers who use them. I'm going to just sort of build a little bit on Brian's comment with a little more specificity, and that is, you know, it's not just the large health systems out there that have adopted electronic health records after the Meaningful Use money from the stimulus after the Great Recession, but really just looking at the vendors out there, there are two, maybe three -- but really two very large vendors, Epic and Cerner. And as far as I know, they both have extensive behavioral health modules that are included.

I guess my question is, there is -- and we've now been at this in Meaningful Use for going on 12 years. Is there -- there must be a fair amount of studies, health services research studies that show whether they actually work. And, you know, I don't -- I have to say I've been an advocate of electronic health records my whole career, but I do think we overhype them a bit in terms of actually whether it makes a difference with patient care. But do

you know or do you have any literature review on those two vendors and whether it has actually made a difference in the care of patients who have behavioral health illnesses on physical services and physical illnesses on behavioral health services?

MR. PERVIN: I can take a stab at that. So what we've heard -- in terms of your first question about vendors, so there's a lot of EHRs on the market, but what we've heard from states and also providers is that EHRs that are focused on behavioral health tend not to have a lot of those functionalities built in and also adhere with some of those other interoperability requirements that Brian brought up. That also kind of goes to another point that we brought up, which is that behavioral health providers do need a lot of guidance because of the amount of EHRs that are on the market with the relatively small amount of behavioral health modules that kind of meet their practice needs. But, again, this is something that we can continue to look at in the fall, but that's our understanding of kind of what the market looks like.

Erin, I don't know if you want to speak to some of the integration evidence.

MS. McMULLEN: Sure. I did want to mention that I think one of the challenges when we're talking about EHR adoption with behavioral health providers when comparing them to hospitals or other providers really does -- Part 2 does play a really big role. You know, Aaron in his comments earlier mentioned that EHRs were built to comply with HIPAA. There is no requirement that they comply with Part 2. Even if like a Cerner or other behavioral health module doesn't necessarily mean that Part 2-protected information is being put into the electronic health record. So we've spent some time over the past six months, and with other work we've done on integration, talking to different providers, hospital systems, kind of separate substance use treatment programs, and a lot of the times they have to keep that information out of the electronic health record because it can't be -- there's not appropriate protection systemwide to make sure that people's information isn't disclosed.

So I think part of the struggle when looking at the behavioral health market for EHR vendors -- and it goes back to what Aaron was talking about earlier -- is that the costs are pretty prohibitive. The fact that most

behavioral health providers cannot afford to buy an EHR means that there's not a ton of demand to come up with a solution to share data. We can, you know, certainly look back at our Part 2 chapter and think about how we can integrate some information around some of the benefits of being able to share this information clinically and how that affects patient care. So Aaron and I can look at doing that as we move forward.

COMMISSIONER RETCHIN: Thanks.

VICE CHAIR MILLIGAN: Thank you. Kisha, Martha, and then I saw Brian coming back into line. Kisha?

COMMISSIONER DAVIS: Sure. Thanks, Erin and Aaron, another really good chapter. Two comments.

One, I've had the benefit throughout my career, all of my primary care practice settings have had the benefit of having integrated behavioral health and the benefit of being able to, you know, have access and have that cross-communication with the behavioral health provider is really just essential in trying to provide whole-person health. And so as much as we can facilitate that and encourage that, that's really helpful.

The behavioral health providers have the benefit

of working in a medicalized setting and so have access to that EHR and access to the medical information. But I will say that it was always harder on their end because those EHRs were built to help with more physical medicine, and so trying to adapt what they need and to be able to put that into an EHR format was always difficult when their notes were always clunky and choppy because it just wasn't built for them.

The other comment -- and this goes, Erin, to what you were just saying -- you know, when we have these next steps, the clash that we continue to have between HIPAA and Part 2, until there's better alignment there or we get to a better solution or, you know, really figure out how to be able to share and have that interoperability, then it's really hard to get to the next steps, you know, in promoting further adoption and further integration. I think there's definitely a benefit there. I've seen that. It's beneficial to my patients. But, you know, we keep coming up against this Part 2 barrier and getting to a better solution on that.

So, you know, I would include that in the next steps. It's going to be something that we're going to need

to continue to revisit.

VICE CHAIR MILLIGAN: Thank you, Kisha. Martha?

COMMISSIONER CARTER: I think I'm on the same train about Part 2. I was always confused -- and I suspect many other people are -- about the rules regarding data sharing there a health information exchange when you're looking at HIPAA and Part 2 data. And I think we -- you all referenced HIEs but not specifically any challenges related to whether it's allowed. I mean, I think there was just a lot of confusion there.

And another point about EHRs and behavioral health is that there's a special protection for what's called "psychotherapy notes," and if the behavioral health provider uses psychotherapy notes, those are the notes -- I'm not a behavioral health person, but what they told me was those are the notes they make to themselves, interpretation of what has happened in their session. So they're very private notes, and they have to be -- they have an extra level of protection. They can't be shared. And so an EHR has to be built to sequester those, absolutely not share those. And so there's a lot of mistrust and concern because the behavioral health people

are on this, and they know they can't share this stuff without patient permission. And I think their own psychotherapy notes -- I don't want to speak for them, but I don't think they share them anyhow.

So I think it's -- I can't understate the concern about Part 2 and HIPAA and the whole role of integrating behavioral health and clinical and dental, all the whole-person care kind of notes that we want to do.

MR. PERVIN: Can I just add one thing?

VICE CHAIR MILLIGAN: Yes.

MR. PERVIN: Yeah, so both very good points around Part 2, and I think I just want to -- I think Kisha brought up a very important point, which is that the EHRs were built for physical health providers. They weren't built for behavioral health providers. And until there's a demand from behavioral health providers, until they have, you know, finances that they're able to use to purchase these EHRs, that demand might not really be there. And so I think our belief is that, you know, the EHRs could be built to serve the behavioral health provider's needs, but so far right now they are only being built to -- or they're primarily being built to serve the physical health provider

space, which is why you get -- which is why you get these challenges around data segmentation and EHRs not built to kind of keep that information private.

VICE CHAIR MILLIGAN: Thank you, Aaron. Brian? You're on mute, Brian.

COMMISSIONER BURWELL: Okay. Sorry. I have to believe the trend is for greater adoption of EHRs among behavioral health providers, both just for their own business purposes and also managed care will require more reporting, et cetera.

So if I'm a psychiatrist, I have a group practice in an urban area where I see a lot of Medicaid patients, et cetera, will Epic sell me a module, a behavioral health module? I can't afford the full hospital -- you know, they have 70 percent of the hospital market. So I want to integrate with hospitals and share information. Is there such a thing as a mini-module? I would think that Epic would find that profitable.

MR. PERVIN: Sure, this is something we could look more -- sorry, we could look more into over the summer and the fall. Again, our understanding is that Epic can -- so we haven't done a lot of research on what specific

products are offered by specific vendors, but we can look into that more in the summer and the fall, and then in addition to that, we can determine -- we can investigate whether or not the modules that are being offered by Epic, by Cerner, are really meeting the needs of the behavioral health community.

COMMISSIONER BURWELL: Okay. Thanks.

VICE CHAIR MILLIGAN: Fred?

COMMISSIONER CERISE: There's an issue of scale, too. You know, one fairly large behavioral health provider we've spoken to about this, they're too small for Epic to do a deal with. So they end up not being in that game because, you know, they're not a big system, and so to do these small deals I think is a challenge right now for the -- certainly for Epic. And small practices, they don't have that same access. Even medium size or, you know, behavioral health, moderately sized behavioral health practices that are not associated with a larger system are going to have difficulty there.

VICE CHAIR MILLIGAN: Thanks. Was there anybody I missed who wanted to contribute? Kit.

COMMISSIONER GORTON: So just to follow upon

Fred's last point, I wonder -- again, is this future work, but I wonder if it would be worthwhile to invite the vendors, some of them, to come and talk about what they see as the challenges. You know, are they even thinking about this? Have they tried to solve it in ways that we don't know that they've tried to solve it? Have they run into brick walls somewhere? Are there insurmountable government hurdles? You know, it might be that you guys would talk to them on the phone, and you would hear -- you know, you would hear that they don't have anything to say that's worth taking the Commission's time -- in which case, okay, cool. But it might be that they have some insights into what the barriers are that we're not recognizing because we're Nation technology people, and so I just wonder, just posing a question, whether it might be useful at some point to talk to them and maybe have them talk to us.

VICE CHAIR MILLIGAN: Thanks, Kit. And it looked, Darin, like you wanted to jump in on -- oh, Erin McMullen, did you have something you wanted to mention? Oh. Darin?

COMMISSIONER GORDON: Yeah, just along all these lines that we're talking about, you know, what we heard

when we had moved to integrate the services, we had heard from behavioral health providers, you know, it seems like lot of discussions about some of the more dominant physical health EHRs and then morphing to the behavioral health organizations, I mean, because there are some EHRs out there that are particularly geared toward the behavioral health community. And I heard from those providers; they said they had a great EHR for the behavioral health side, and they talked to their -- you know, the company that provided that, and they wanted to build out some of the functionality for the physical health side, but that wasn't their core competency. And I heard the same argument on the physical health side building on the behavioral. So it was like -- it's not that some of the -- you know, that there aren't some really good tools that are focused on the behavioral health side that are already out there, maybe not -- obviously not broadly, but I just think, you know, if we go down the road Kit's talking about, which I don't think it's a bad road to go down, if we just invite the dominant player on the physical health side to have that conversation, I think we're going to be missing some of the issues that you have expertise in silos on both sides.

The only other thing I want to raise, when we talk about integration -- and I think this is great work, Aaron and Erin, and I think you all should work on more projects together because it's just cool having Aaron and Erin on a project together. It's really around also like edits that may be in place or other processes in place that inhibit from the payers, whether it's the state or the health plans, that inhibit some of this integration as well. We saw that, and, quite frankly, it wasn't intentional. But when you start integrating these services, how you submit claims and, you know, like having two visits in a single day, one on the physical health side and one on the behavioral health side, systems started rejecting them because it looked like it was duplicate services on the same day. I do think there's that whole other component on the integration side that has to be worked through. It's not impossible to work through, but, you know, we didn't hit it head on when we went down that path, but we engaged providers and health plans to have some kind of feedback as we went down that road to try to help our regulations and our edits fall in line with our objective of integration at the clinical level.

VICE CHAIR MILLIGAN: Thanks, Darin.

Kit, and then I'm going to -- Kit and then Martha, your second bites, and then I'm going to have a couple questions, and then I think we need to wrap up this session. Kit?

COMMISSIONER GORTON: So I just want to follow up on what Darin was saying, which I agree with a lot. I also want to point out that many states at the payer level haven't integrated it, right? So Pennsylvania has a behavioral health carve-out. There are different behavioral health plans, right? So it's probably worth looking at the state Medicaid agency, whether or not at the payer level behavioral health and physical health is integrated.

VICE CHAIR MILLIGAN: Thanks, Kit. Martha?

COMMISSIONER CARTER: You would probably do this, but back to our previous comment, if we're going to -- I think it's a great idea to talk to vendors. It's not just Epic and Cerner, though. We would need to look at EHR systems that are used in primary care, in primary behavioral and primary medical care, but the health centers at the CCHPBCs, folks that are already trying to do this

and what systems are they using, probably talk to some providers in those places to, to see what they're challenging.

VICE CHAIR MILLIGAN: Thank you, Martha.

I had a couple of things. One is I did want to go back to the financing piece. I do think it's going to be good to track the innovation center pilots and continue to track where the federal budget discussion goes and some of the rescue plan discussion. I do think there seems to be a groundswell around trying to give behavioral health providers meaningful use-type incentives, and I would just flag that I expect you guys to track that. But I think it's important to keep tracking that as an element of this.

And then the second thing I wanted to mention -- and I wanted to get on the Part 2 train as well -- the CARES Act did make some changes. We're waiting on regulations to come out of those changes. It will move it more in the direction of HIPAA, although not all the way to HIPAA for physical health.

I think it's going to be important to monitor how the regulatory change that is coming out of the CARES Act influence technology and functionality design. So, in

terms of next steps, I would want to make sure that we're tracking how the regulatory framework coming out of the CARES Act gets pulled through the technology roadmaps and functionality work for some of these vendors and some of the providers.

The other thing, I wanted Aaron Pervin – I wanted to just flag. You made a couple of comments in this session that I thought gave me some insights I didn't have coming in.

One is it seems like the vendors and some of the technology have permission to do more than what they do in terms of how they create decision rules, authority, access standards, to comply with a lot of the privacy standards. So it seems like we often talk about the legal and regulatory framework as the barrier, but it seems like the technology companies could go further than they go if they built in various permission rules, access standards about who could see what. And I think it's going to be helpful to track their roadmaps around the permissiveness element compared to the prohibited access issues.

And you mentioned data segmentation. I would put it in the same place, because my sense is more is possible

while still being compliant than is happening, and it may go back to where Fred was talking about scale. It may be that for some of these companies, as they build out their technology roadmaps and their release schedules and all of that, this isn't as high a priority in terms of a customer base or revenue or a business plan. There are rules that could be established that would be compliant that would allow for better data sharing is my sense.

Did anything I just say strike you as incorrect?

MR. PERVIN: No. Everything you said struck me as correct, and I think you put it more articulately than I did, so thank you.

VICE CHAIR MILLIGAN: I would disagree, but thank you.

Erin McMullen, anything you wanted to add to that?

MS. McMULLEN: I don't think so.

I think that the observations that this could be -- that this is possible, segmentation is possible is something that we've been hearing as well. So we will definitely keep our ear to the ground for the NPRM that will come out as a result of the CARES Act and Part 2 and

HIPAA. So we will definitely continue to monitor everything that's going on and how that flows in the EHR work.

VICE CHAIR MILLIGAN: Thank you.

So is there anything else you need from us, Erin or Aaron?

MS. McMULLEN: Not this Erin.

VICE CHAIR MILLIGAN: Okay.

MR. PERVIN: I think we're okay, yeah.

VICE CHAIR MILLIGAN: All right. Well, thank you all very much. We really appreciate the work that you've done this cycle for us.

I'm going to hand it over to Melanie for the next session.

CHAIR BELLA: Thank you, Chuck. Thank you to both Aaron/Erin(s). One Aaron is staying, and Kacey is coming. And we're going to have our final session on NEMT.

Just to remind everybody, this started as a Senate Appropriations request. You've heard about the analysis a few different times, and over the course of that, Congress also took some action. Consider this your last bite at the apple with the chapter that's going in on

this issue, and so this is an opportunity for us just to give any additional feedback to Kacey -- and maybe not, Aaron. I'm sorry. I thought you were both on the agenda.

Always lovely, Kacey, to have you lead us through this. I'm going to turn it over to you.

MANDATED REPORT: NON-EMERGENCY MEDICAL TRANSPORTATION BENEFIT: REVIEW OF DRAFT CHAPTER

* MS. BUDERI: Thank you, Melanie.

So today I'll be reviewing our draft chapter on non-emergency medical transportation, or NEMT, and NEMT is a mandatory Medicaid benefit that provides transportation to and from medical appointments for Medicaid beneficiaries.

Before I start, I'll just note that this work has been ongoing over the last year or so, and the material included in the chapter has already been presented at prior meetings. So I won't be sharing any new information today, but rather, we'll just share how we folded the findings from our study together into the chapter.

Sorry. I'm just having a little difficulty advancing slides.

[Pause.]

MS. BUDERI: There we go. Okay.

So I'll start by reviewing the congressional request. I'll present the key findings from our study, and, Commissioners, you have the draft chapter in front of you, but for the benefit of the public, I'll go over the topics covered in the chapter.

So, in this slide, you see the language of the congressional request. It has no due date and does not require recommendations, and our chapter will serve as our response to the committee, and it does not include any recommendations.

I'll note that since the request was made, Congress acted to include the requirement to provide NEMT into the Social Security Act, which means that the benefit cannot be made optional through regulation alone, as the Trump administration had proposed. So this action changes the context for our study.

So the chapter starts by providing an introduction and listing key findings, which include the following. Although the portion of Medicaid beneficiaries who use NEMT is relatively small, NEMT plays a vital role in facilitating access to care for those who do use NEMT.

The extent to which NEMT programs meet the needs of beneficiaries varies widely across states and within states, with differences based on geographic location, the entity responsible for delivering NEMT, NEMT providers, and other factors.

States and other entities that administer NEMT benefits are currently engaged in a number of efforts to improve program administration, program integrity, and beneficiary experience. These include, for example, adopting new technologies, such as GPS tracking and introducing new transportation network companies, or TNCs, such as Uber and Lyft.

The need for and the way beneficiaries use NEMT may be affected by changes in how beneficiaries are accessing services, including expanding use of telehealth services. However, the long-term effects of such changes on NEMT are unclear and will require additional data than we currently have available. Even so, NEMT is likely to continue to play a central role in helping beneficiaries access care, especially medical care that must be provided in person, including many types of medical care that beneficiaries are using NEMT most often to access, such as

dialysis.

The chapter then provides background information on the origin and evolution of federal NEMT requirements, an over view of current federal requirements and where states have flexibility, and a discussion of past efforts to exclude NEMT from benefit packages, including the Trump administration's proposal to make the benefit optional and states with Section 1115 demonstration authority to waive NEMT.

So, on this slide, I've listed the primary components of MACPAC study, which the chapter draws heavily from, and I won't say much about these, because we talked about them at prior meetings, but they're listed here just for your reference.

We then talk about transportation as an access enabler, including examples of transportation-related barriers reported by our focus group participants, and then from survey data on beneficiaries who delayed care due to transportation barriers, we provide rates of reported barriers among Medicaid beneficiaries by age, income, race and ethnicity, and certain health conditions, and information on the characteristics of beneficiaries who

reported transportation barriers.

The chapter then turns to focus on how beneficiaries use NEMT. We include data on NEMT utilization by eligibility group, geographic area, and dually eligible status, and on the health conditions of beneficiaries using NEMT.

To examine medical services beneficiaries access using NEMT, we include data on NEMT utilization by service destination as well as examples of the types of services focus group participants are accessing using NEMT.

Turning to matters of administration, the chapter provides an overview of the different NEMT delivery models states can use, which include in-house management where states manage the benefit directly, a third-party broker model, or Medicaid managed care carve-in. We discuss the advantages and drawbacks of each approach and the factors states consider when choosing which model to use or planning a change in model.

We discuss NEMT services and providers, including data on NEMT utilization by mode of transportation, for example, shared van, taxi, public transportation, et cetera, and the factors that determine the mode of

transportation used for each ride. We then discuss the trend towards incorporation TNCs such as Uber and Lyft into the NEMT provider networks, and some of the opportunities they provide for improved program administration and beneficiary experience as well as some of the considerations for using them. We also discuss provider network challenges, which are widely cited by stakeholders as one of the most significant challenges in administering NEMT.

Next, we discuss NEMT program quality, including performance issues, some of which are listed on this slide. We also talk about NEMT policies at the state health plan or broker level that create difficulties or access barriers for beneficiaries, which include the requirements to book a ride 48 to 72 hours ahead of a medical appointment, policies that prevent beneficiaries from bringing their children in rides with them, and a general sense among beneficiaries that they have no recourse when problems arise.

Then we discuss some strategies states and brokers are using to improve performance and better meet the beneficiary needs and list opportunities for states and

the federal government to help improve NEMT programs that were identified by stakeholders and focus group participants.

We then discuss other issue of program administration, including the extent to which NEMT is coordinated with other federally funded transportation services and barriers to coordination, expanding use of technology in NEMT, and program integrity issues, including new program integrity requirements enacted in Public Law 116-260, which is the same law that added the requirement to provide NEMT into the Social Security Act.

Finally, we discussed the role of NEMT in Medicaid, including its role in promoting beneficiary physical and mental health, the value of NEMT including potential for cost savings and return on investment and the increasing provision of transportation by health plans that are not required to provide it, including Medicare Advantage Plans. And then we discussed the implications of the COVID-19 pandemic on NEMT's role. While we don't have data on this yet, we include anecdotal information about changes in utilization and future outlook.

So the chapter concludes by reiterating that NEMT

continues to be a vital service for beneficiaries and is likely to continue to play an important role in facilitating access to care. We also note that as states consider how to address issues such as racial disparities and COVID-19 vaccine distribution, they may wish to leverage NEMT by more widely promoting these services.

So that's the outline of the draft chapter. I'm here and Aaron is here to answer any questions that you may have, and we look forward to hearing your feedback.

CHAIR BELLA: Thank you, Kacey, for taking us through that so efficiently.

All right. Who would like to start? Comments or questions for Kacey and Aaron.

Anne, are you raising your hand?

EXECUTIVE DIRECTOR SCHWARTZ: No. I'm saying it's perfect.

CHAIR BELLA: Oh, okay. Yeah.

Martha?

COMMISSIONER CARTER: Basically the same thing. I thought it was a really good chapter. I could see that you all have incorporated our previous comments, and I think it's a great foundational chapter. I think we need

to keep track of this benefit to see how evaluation of the beneficiaries is utilized. Are people really getting to give feedback? Is there really quality improvement in this area? I think that's an area we want to track, but I think it's a great chapter.

CHAIR BELLA: Tricia? Thank you, Martha.

COMMISSIONER BROOKS: Thanks, Kacey and Aaron, great work here, as usual.

I just found it a little interesting to use the positive language that industry uses talking about a return on investment. I guess I don't necessarily see providing services that are mandatory as being something that you're necessarily investing in.

I think perhaps alternative language, because we know this is true, that increasing access to primary care drives more effective health care spending, and I guess I just don't see it being necessarily a return on investment.

CHAIR BELLA: Thank you, Tricia.

Chuck?

VICE CHAIR MILLIGAN: Thank you for the great work on this chapter.

I had a couple of comments, and I think this gets

more to future work to the extent that MACPAC continues to look at NEMT, and my comments, I think, are less about the current chapter and delivery per the requirement.

The first comment is I think it's going to be interesting to look at the extent to which utilization of NEMT might be affected by some of the telehealth expansions and some of the alternative home-based primary care models that we've seen emerge because of the pandemic.

I do anticipate that there is likely to be a little bit of a substitution effect if individuals can access primary care from home more readily and in fact other forms of care from home more readily and perhaps have less demand on transportation to get to their providers.

So I think coming out of the pandemic, we've talked in the past about what changes might become more permanent and what was more temporary as a necessary accommodation, and I think the relationship between telehealth and transportation is going to be something where it will be interesting to see how that goes.

The second element I wanted to mention -- and I think I mentioned this before about NEMT -- relates to dual eligibles and touches back on the integration work that we

talked about in the morning today.

Within Medicare Advantage and D-SNPs, network adequacy can often be a constraint because of how MA evaluates network adequacy requirements, and the Medicare Advantage program does not typically look at the availability of transportation to address network shortages in certain rural and frontier areas.

I think the duals office is better able to think about transportation when they look at MMP models because the duals office tends to look at the comprehensive benefit package, including all Medicaid and Medicare services, so they can look at network adequacy inclusive of an individual's ability to get a ride to a specialist, whereas a D-SNP as a stand-alone has to typically meet the other MA network adequacy standards, not mindful of transportation as a benefit to get to specialty care and to get to a lot of medical services.

And so I do think over time, it's going to be important to keep an eye on the policy discussion around using transportation benefits to access Medicare services and how and whether Medicaid's NEMT benefit is accommodated or incorporated in the analysis of network adequacy from a

D-SNP perspective, because I do think people in rural communities can get to a specialist through a Medicaid benefit in a way that the Medicare Advantage program doesn't typically recognize.

So I just want to put those out there as kind of things to keep an eye on in the future, to the extent this work continues, but for now, for this report, a great job and my compliments.

CHAIR BELLA: Thank you, Chuck. Other Commissioners?

[No response.]

CHAIR BELLA: I want to echo the great job on the work and note that I didn't even bring up the duals, so that's -- even though that was an important finding.

Okay. Do we have any comments, any last questions for these guys? Any last feedback on the chapter? Kacey or Aaron, anything you need from us? And then we'll go to public comment.

MS. BUDERI: I think on our end we're good.

CHAIR BELLA: Okay. Wonderful

MS. BUDERI: So thank you.

CHAIR BELLA: All right. We are going to invite

members of the public to comment on any of our sessions this afternoon, so that would be the sessions on adult and children and adolescent behavioral health, the EHR discussion, or the NEMT chapter and report that we just finished discussing. So if you would like to make a comment, please use your little hand icon, and we'll just give it a minute to see if anyone is interested in doing so.

[Pause.]

CHAIR BELLA: I think we peaked this morning in terms of public comment. All right. There don't appear to be any hands. We'll do a little bit of housekeeping and double check one more time.

So thank you, everyone, for your engagement today. We made it through obviously all the sessions. We made it through the recommendations. Tomorrow we will take formal votes on the recommendations and ask you all --

VICE CHAIR MILLIGAN: Melanie, we did have somebody just raise their hand, by the way.

MS. HUGHES: Yes.

CHAIR BELLA: Okay.

PUBLIC COMMENT

* MS. MacMURRAY: Yes, good afternoon. This is Nataki MacMurray from the Office of National Drug Control Policy. Nothing controversial to add to the conversation, but I just wanted to say that I am looking forward to reading the chapters and thank the Commission for discussing the non-emergency medical transportation benefits. We have been looking at and thinking about the benefit that seems to be underutilized, especially in our rural and underserved communities. We certainly want to know what states are doing and providers are doing to increase the awareness of the benefit and to be creative about using the benefit for the sake of clients that have mental health and/or substance use disorders who we know are also typically going to be using a number of physical health services. And so I'm anxious to see what the Commission is going to recommend about that.

And the same thing for the electronic health records piece for behavioral health. We have certainly been battling for a while to try and negotiate and balance the best of all worlds when it comes to electronic health records and the interoperability questions that providers and beneficiaries have, et cetera.

So I'm looking forward to seeing what the chapters will say and give to provide some insight as we at the federal level struggle, really struggle with trying to find the right balance. So, again, thank you for the discussion and the thought.

CHAIR BELLA: Thank you, Nataki.

All right. Just to reiterate, we will start tomorrow morning at 10:45. We'll start with a discussion on rebalancing. We'll then go into a session on quality. We will then take a break for lunch and come back and vote on our recommendations, the recommendations on accelerated approval and around adult and children's access to behavioral health services. And then we'll have a couple additional sessions in the afternoon, and then that will be a wrap. But let me see, Anne, is there anything else you want to say before we break?

EXECUTIVE DIRECTOR SCHWARTZ: No. Sounds good.

CHAIR BELLA: Okay. Any other comments or questions from Commissioners?

[No response.]

CHAIR BELLA: All right. So thank you all as usual for your engagement today, and we will see you

tomorrow at 10:45. Have a great evening.

* [Whereupon, at 4:18 p.m., the meeting was recessed, to reconvene at 10:45 a.m. on Friday, April 9, 2021.]

PUBLIC MEETING

Via GoToWebinar

Friday, April 9, 2021
10:45 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
CHARLES MILLIGAN, JD, MPH, Vice Chair
THOMAS BARKER, JD
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
STACEY LAMPKIN, FSA, MAAA, MPA
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
PETER SZILAGYI, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:45 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to the second day of MACPAC's meeting. We're going to wait just a few seconds for everybody to gather.

[Pause.]

CHAIR BELLA: All right. I think we'll go ahead and get started. Welcome, everybody. We're really excited to kick off today's meeting with a session on rebalancing, always helpful to hear what we learn from the states and what they're experiencing. So, with that, I am going to turn it over to Kristal and Tamara to get us started.

PROGRESS ON REBALANCING: LESSONS FROM THE STATES

* DR. VARDAMAN: Great. Good morning, Commissioners. As Melanie mentioned, today Tamara and I are here to talk to you all about insights on rebalancing. We'll start with a brief bit of background before moving into the results of some contractor research, and then we'll end with some policy considerations and a discussion of future work.

Shifting the reliance of the long-term services and supports system, or LTSS, from institutions to home-

and community-based services, or HCBS, has been a federal and state policy goal for several decades. This effort, known as "rebalancing," is often framed in terms of the proportion of LTSS spending that is for HCBS. Although we acknowledge that this is only one way of defining rebalancing and access to HCBS is more nuanced than spending alone, it's a convenient method for measuring progress and making comparisons across states.

At the national level, Medicaid spending on HCBS has exceeded that on institutions since fiscal year 2013. As of fiscal year 2018, about 56 percent of all LTSS spending was for HCBS.

However, national figures can obscure variation across states and populations. As you can see here, as of fiscal year 2018, HCBS spending as a percentage of LTSS spending remained under 50 percent in 18 states and the District of Columbia. I'll note that there are a few states here where data are missing due to a lack of managed care data, which the authors cited as being due to COVID-related reporting delays.

In terms of groups of people who use LTSS, HCBS accounts for nearly 80 percent of national spending for

people with intellectual or developmental disabilities, but less than 50 percent of all LTSS spending for other populations using LTSS, such as individuals aged 65 and older or individuals with mental health or substance use disorders.

The federal government has supported state efforts to rebalance in several ways. I won't go over these in detail today, but there are descriptions in your materials. Federal support has included enhanced funding, most recently in the American Rescue Plan Act, as well as guidance and technical assistance, including a recently published toolkit for states.

In order to understand why some states have made less progress in rebalancing than others, we contracted with RTI International and the Center for Health Care Strategies. I'd like to take a moment to thank Molly Knowles, Amarilys Bernacet, and the rest of the team for their work on this project. Specifically, their work focused on the following questions:

First, what factors have limited rebalancing in the states where HCBS spending remains under 50 percent of total LTSS spending?

Next, how can the federal government promote further rebalancing in these states?

And then, finally, do any of the flexibilities introduced by states to respond to the COVID-19 pandemic help expand access to HCBS in states with less developed HCBS systems?

The project team identified five study states that varied in use of HCBS state plan and waiver options, population density, participation in rebalancing programs like the Balancing Incentive Program, and adoption of managed long-term services and supports, or MLTSS. The states included were Mississippi, Louisiana, New Jersey, North Dakota, and West Virginia.

The case study states were selected using fiscal year 2016 data, but during the course of the study, fiscal year 2018 data became available, and the spending for these five states remained under 50 percent for HCBS.

The research team conducted a total of 28 stakeholder interviews, both in the states in the study, as well as a number of experts that gave a national perspective. So that included provider organizations, beneficiary advocates, researchers, and other experts.

The RTI and CHCS work culminated in a final report that we plan to publish on MACPAC's website in the coming weeks. Over the next few slides, I'll be highlighting some themes from that work.

First, in terms of investments in rebalancing, each of the case study states reported engaging in some rebalancing efforts. For example, two states reported increasing their Section 1915(c) waiver capacity. State officials expressed reservations about being judged primarily on HCBS spending, suggesting that there's more nuance to their stories.

States also noted that the Money Follows the Person program and the Balancing Incentive Program have provided valuable support for their rebalancing efforts. In particular, Money Follows the Person was cited as funding infrastructure that was used for rebalancing.

Finally, national-level interviewees noted incentives that MLTSS plans have to support rebalancing by transitioning beneficiaries out of or diverting them from institutions, but it's important to note that advocates voiced some concern about MLTSS and incentives that may be in place for them to authorize fewer services than

beneficiaries may need.

In general, many of the challenges that the team identified in states with relatively low levels of rebalancing are challenges that are common to all states in providing HCBS. For example, Medicaid's mandatory coverage of institutional care and structure bias towards institutions was a common theme. State capacity was also cited as an issue frequently. One stakeholder noted that the depletion of state staff in recent years has led to a lack of staff knowledge and community connections, which hinders their ability to administer complex HCBS programs. A lack of affordable and accessible housing and LTSS workforce shortages were also frequently cited issues, which we hear consistently in discussions about the difficulty of serving more people with LTSS needs in the community.

In some cases, these issues may be particularly acute for areas like rural areas where direct care workers must travel long distances between clients.

In addition, some barriers may have particularly significance in the states with lower levels of rebalancing. For example, stakeholders in the study states

sometimes cited a lack of executive and legislative champions as a barrier to increasing access to community-based services. In several states, stakeholders also said that the nursing home industry has a great deal of political clout. For example, in one state, legislation guarantees annual rate increases for nursing homes, but not HCBS providers. Stakeholders view the industry as being resistant to rebalancing and viewed HCBS provider advocates as having less influence on policymakers.

In terms of opportunities for supporting rebalancing, we heard a variety of options, including those listed here on the slide. Tamara in a few minutes will go over some of the areas that we plan to explore in our future work. But to highlight a few here, interviewees suggested, for example, presumptive eligibility for HCBS as one option to improve access and discussed the potential of making federal programs like Money Follows the Person and the Balancing Incentive Program permanent. They also thought that there were opportunities to help nursing facilities diversify their services, which could help overcome resistance to rebalancing, although there were some barriers to this cited such as certain requirements

under the HCBS settings rule.

Housing supports that leverage other state resources, such as one example of a county-based home-sharing program in one state were also mentioned. And there were a variety of examples of potential ways to address workforce challenges, including pass-through payments to HCBS providers that would support increased wages for direct care workers.

And the last thing I'll discuss are comments related to how the COVID-19 pandemic has affected access to HCBS. Stakeholders said that it has exacerbated workforce challenges in some areas and also noted where it has led to social isolation for some beneficiaries. States have found value in the federal flexibilities that have been provided to them under the public health emergency, and also many stakeholders noted that the pandemic has highlighted potential HCBS innovations such as assistive technologies that can help keep people in their homes. However, one provider stressed that some services are best done in person where you can see, you know, someone's living environment.

Again, we look forward to publishing the

contractor report, which will have some additional details on the results of the work, and with that I'll turn it over to Tamara.

* MS. HUSON: Thanks, Kristal. If we could go to the next slide, please.

So we proposed the following four policy questions for your consideration:

First, how can state efforts to rebalance be further encouraged and supported? The work with RTI that Kristal just summarized brought up a number of barriers to HCBS in states with relatively low levels of rebalancing. In particular, this work raised barriers related to the direct care workforce and housing.

Second, should there be fundamental changes in Medicaid LTSS policies? Discussions of the limitations of Medicaid LTSS frequently turned to the program's institutional bias. Changing the institutional bias would require a change in the Medicaid statute, and it would likely come at a significant cost. The cost of this change would depend on a variety of factors such as the eligibility criteria, the service package, and whether or not nursing facility services remain mandatory.

Third, how can nursing facility diversification be supported? Nursing facility industry stakeholders discussed the opportunities for nursing facilities to diversify their services to offer HCBS, but also identified barriers. For example, discussions with industry stakeholders highlighted the HCBS settings rule as deterring interested nursing facilities from offering HCBS, such as adult day services, at their facilities.

And, finally, what have been the effects of COVID on rebalancing LTSS efforts thus far? COVID has heightened state and beneficiary interest in the use of HCBS over institutional services, as well as highlighted several inefficiencies and challenges associated with providing care in institutional settings. In addition, temporary flexibilities have expanded access to HCBS, and stakeholders largely advocated for making these flexibilities permanent.

Next slide, please.

So as you respond to the policy questions proposed on the previous slide, we identify the following areas for particular consideration: What changes to Medicaid policy might address the areas listed on this

slide? For example, interviewees discussed how persistent and growing LTSS workforce shortages across settings and provider types are a primary barrier to increasing HCBS. Direct care workers providing HCBS typically receive low wages, inadequate training, and often have difficulty getting to clients in the community. As such, wage increases and added benefits, strengthened training supports, and non-wage incentives such as transportation benefits could help with recruiting and retaining staff.

Next slide, please.

The next two slides summarize work that staff has proposed over the course of the next year. The Consolidated Appropriations Act of 2021 directs MACPAC to write a report on MFP alignment with the HCBS settings rule. Specifically, MACPAC is to identify the types of home and community-based settings and associated services that are available to eligible individuals in both the MFP demonstration program and states in compliance with the HCBS final rule, and if determined appropriate by the Commission, recommend policies to align criteria for qualified residents with the criteria in the HCBS final rule.

Staff anticipate completing the necessary work to fulfill this mandate over the course of the 2021-22 cycle with presentations this fall and winter and a goal to publish a report as a chapter in one of our 2022 reports to Congress. As a note, the mandate due date is tied to the final implementation date of the HCBS settings rule, which is currently March 17, 2023.

Staff also plan to let a contract on the topic of how Medicaid policy can be used to support development of the HCBS direct care workforce. We anticipate a contractor will be able to review the literature and conduct interviews to identify issues and document what states are doing to support the direct care workforce. We welcome Commissioner feedback on this topic as we think through this scope of work.

Another project, as noted in the June 2021 draft chapter on access to behavioral health services for adults, is work that will examine barriers to designing HCBS benefits for enrollees with behavioral health care needs. This will include looking at the behavioral health care needs of beneficiaries who experience limitations in their activities of daily living, barriers that states encounter

when designing HCBS for this population, and whether existing federal authorities are suited to serving beneficiaries with significant impairment resulting from their behavioral health conditions.

Next slide, please.

In response to the question of if there should be fundamental changes in Medicaid LTSS policies, staff are considering the design issues and costs of making HCBS benefits more readily available. This work will likely include multiple stages, including external research contracts. The first stage may be to host a roundtable which will facilitate a discussion among LTSS policymakers and stakeholders on what to consider in the design of a benefits package as well as eligibility and administrative issues.

As a follow-on to the chapter and recent work on Medicaid estate recovery, Commissioners expressed interest in doing further work on LTSS eligibility policies. As such, staff are planning to do a deeper dive into this and consider the extent to which allowing presumptive eligibility for HCBS could expand access and whether LTSS financial eligibility criteria are a barrier to a

beneficiary's ability to remain in the community.

And, finally, staff will monitor guidance on the HCBS settings rule, as well as the results of CMS and state compliance assessments to understand any effects on access.

We welcome your thoughts on the policy questions and considerations we have posed as well as direction on the next steps for future LTSS work over the next year.

With that, I will turn it back over to the Chair. Thank you.

CHAIR BELLA: Thank you, Tamara. Thank you, Kristal.

I'll start by just saying I'm really appreciative and really excited about this work. I think we can make a real contribution here. Personally, I would love to see us tackle more of the benefit redesign, particularly for certain subpopulations, as well as workforce issues. It feels like there's a lot of other folks that are already kind of on the bandwagon for things like MFP and for BIP, but really tackling the hard issues around benefit redesign in particular feels like a unique contribution we might be able to make. And so I would love to turn it over to Commissioners for comments or questions. Sheldon and then

Brian and then Kit.

COMMISSIONER RETCHIN: Yeah, Kristal, Tamara, this is a great piece of work, and like Melanie just said, I think it's a very important contribution that we move to more of the balanced approach to long-term care.

So you know I'm going to probably say something about workforce, and that's what I want to focus on for a second.

So I've mentioned this before, but for direct care workers in the U.S., in particular in the HCBS and long-term care settings, we rely heavily on immigrants, on the immigrant population, and I think solving the workforce problem is never going to be done organically. I don't want to be morose about it, but I do think it's going to be a very heavy lift because we have more and more entries into long-term care as the Baby Boomers age in.

So I don't know if the contract would permit looking at this, on the reliance, because there's a huge amount of state variation. For example, if you look in California, about 28 percent of the population is first-generation immigrant. Then you look at West Virginia, it's less than 2 percent. And I don't know how that lines up in

terms of direct care workforce, but maybe the contractor can help us, because the numbers nationally are really prodigious. I don't know if you have any reaction to that or any of the other Commissioners do as well.

DR. VARDAMAN: Thanks. As Tamara mentioned, we're just starting up on scoping out that work, so I think that's a really helpful comment for us to think about as we think about what we're going to ask the contractor to do.

CHAIR BELLA: Thank you. Brian, then Kit, then Darin, then Chuck, then Stacey and Bill. Wow. Okay.

COMMISSIONER BURWELL: So, Kristal and Tamara, thank you for a very excellent chapter, and I think many of the kind of policy issues that you've raised in this chapter will be important ones as we move forward. I don't know if the Commission is aware of the tsunami that's about to happen in home- and community-based services with the enactment of the American Rescue Plan, which gives states a 10 percent bump in FMAP for HCBS services over a one-year period starting April 1st. That's about $12.7 billion if the states don't -- if the states spend the same state match, 12.7 billion new dollars will be funneled into the HCBS system with federal funds over the next year. That's

a huge amount of money. California's going to get $2 billion just to spend on HCBS; Pennsylvania, $700 million; I'm sure all the states are figuring this out. I know that there are people listening to this session from the states who are immediately being told how -- you know, starting to think about how we can spend all this money.

It's interesting that Congress put a year limit on states to spend this money, which obviously creates the dynamic of, well, we can't spend all this money just to expand services and populations and increase our waivers because if it goes away, the 10 percent goes away, we're stuck with the expanded services. And I think there's some intention -- I don't know where it came from -- that this money for this year is primarily intended for infrastructure development, new systems, new case management, new quality measurement, new workforce development, all kinds of things to prepare states for the $400 billion that the administration wants to pour into HCBS under the -- I don't even know the name of the bill. Jobs bill? Infrastructure bill? Whatever that's going to follow. So we've got $12.7 billion pushing now into HCBS this year, and it's just Medicaid, followed by a $400

billion confusion under the second bill. Of course, we don't know what's going to happen with that. But I guarantee you, the story over the next year is going to be what these states are going to do with the $12.7 billion that they're getting this year.

We were anticipating guidance from CMS in terms of what exact services can be paid for with this additional money, for example, you know, things that would normally be covered under admin, IT kind of stuff versus direct services. So we're all waiting for CMS to provide that guidance, but it's going to really impact the nature of HCBS system development over the next year.

And I want to make one final technical point. Kristal, I don't know which one it was, has made the point that we've got missing data now on the balance of spending for institutional versus HCBS, largely, because of the increasing number of states shifting to MLTSS and just reporting how much they pay in premiums and not getting the data behind those premiums about how the plans are spending the money, the MLTSS plans. It's not due to COVID, because I did these reports. It was occurring way before COVID, and it's just the inability of states to get plans to

submit quality encounter data.

So that's going to be an important issue with T-MSIS that plans keep track and report how they're spending their LTSS dollars.

Sorry to take the time.

CHAIR BELLA: Thanks, Brian. Kit and then Darin.

COMMISSIONER GORTON: So a lot of people want to talk. I'm going to be very succinct, and if we need to follow up we can do that.

One, I think MACPAC, with all of the work that we heard about yesterday and in the months past around behavioral health, I'm glad to see that LTSS for people with mental health and substance use disorders is in scope. I think that's incredibly important. I think my experience is that that's where some of the biggest gaps are, particularly with respect to housing. And so I think the in-house expertise around the behavioral health delivery system, and what exists and what doesn't, can really inform. Because while housing and workforce are a problem, the problem for LTSS, for behavioral health, are the service gaps that we talked a lot about yesterday. So they all feed in together, and I think MACPAC could do some

incredibly powerful work there.

One of the things that happens, and this is my second point, is that if housing is not available, particular in behavioral health, people tend to be put into public institutions. And I think an important thing for us to look at, as we look at the institutional care and the institutional bias, is where are those, and it varies state to state, where are people being placed in private facilities and where are people being placed in public facilities.

Because the challenges of getting people out of public facilities in some cases are easier because the government doesn't need to be in the business of LTSS. On the other hand, it's harder because state employees make a very good wage, and so closing a public institution can be enormously difficult. And so I think we need to look at that.

I would just say, as an example, last year, when I was in Massachusetts, which was 2018-2019, there was great fanfare about the State of Massachusetts opening a new 100-plus bed facility for aging veterans. It's like, why are you opening -- I mean, granted, you need to do

something with this, but why are states still investing in institutional care? I think that's an important question.

One of the things that's being done, and this is the third thing, one of the things that's being done in my state is a move towards in-home care, and that's great. But because of the workforce problems -- and I think this is an important component of workforce -- there's been a big push to move towards family caregivers, paid family caregivers. And while people who do work should be paid to do the work, and people who are not taking outside employment or in a care facility, I don't have a problem with that.

What we're seeing, in a variety of places, is this increased dependency, right, because all of a sudden the person's disability becomes an engine for the family's economic stability. And you hear of people going to grievance and appeals and saying, "Well, but my nephew needs more hours," and I don't think that was what we were trying to set up, that was the problem we were trying to solve with paid family caregiving.

But I think we need to look at that in the context of the workforce. And if we're going to use paid

family caregivers should they get an hourly rate or is there some other way that they should be paid, and I think we should shed some light on that.

And then the final piece, any time you're talking about institutional care, home and community services, I think you're incomplete if you're not talking about waitlists, because many of these things are waiverised services. I think Leanna has shared with us the tremendous waitlist. Last I heard -- and this is not from Leanna -- in North Carolina, the waitlist for services for young people with disabilities is so long that families are told when their kids are born with a disability, "Get on the waitlist, so maybe by the time they're teenagers you'll be in line for services." Now that's perhaps apocryphal and not true, but we should look into this phenomenon of waitlists, because again, we tend to focus on oh, well, this is available to states. Yeah, but if there's a 15-year waiting list for it, then maybe it's not quite as accessible as it needs to be. Thanks.

CHAIR BELLA: Thanks, Kit. I think we just published work on waitlists, so we can go back and see if some of that needs to be pulled over.

Kristal or Tamara, anything you want to add there? Otherwise, we'll just keep moving on the comments.

No? Okay. Darin, then Toby, then Chuck, then Stacey, then Bill.

COMMISSIONER GORDON: Thank you for your work on this. One thing that I think would be helpful when we look at this coalition of rebalancing is, in essence, the flow of new entrants receiving LTSS services, you know, basically trying to get a sense. And if you look at it just kind of where it is now, in some states you're capturing some of the legacy impact of how their model was set up versus really how their model is functioning today. And I say that because we experienced it. Depending on when you looked at Tennessee, you know, it took a while for us to shift the model, and that model to start generating change in what options were available to folks, whether it's HCBS or institutional.

So I think that's an important nuance when we're looking at this, and I think it's helpful that it be a predictor of sorts of where it's going versus being disproportionately weighted to where it's been. Hopefully that makes sense.

Secondly, you know, you talked about the different barriers that are out there. One that we didn't highlight that I think is an important barrier is really Medicare. When we look at the dual eligibles, the largest number of entrants into our program, when we looked at it historically, was due to the Medicare door, and then they came to us and they were in institutional settings, which really put us in a difficult spot in trying then, at that point, looking at how to move folks into the home- and community-based setting.

So, you know, this is where I think the whole dual integration discussion merges very strongly into this topic, because to the extent those tools that Medicare has are available to, in the case of MA, available to MA plans, then you might see less institutional volume than we are currently seeing. So, you know, that was actually one of the reasons we went down that dual integration path was if we can make those tools available then hopefully we can go further upstream and minimize the number of folks that are defaulting, to some degree, into institutional settings.

So just something I think that we should capture in some form or fashion in this discussion. Thank you.

CHAIR BELLA: Thank you, Darin. Sort of the pre-duals and a benefit on the Medicare side to keep them from coming in and spending on the Medicare side. Good point.

Toby, then Chuck.

COMMISSIONER DOUGLAS: Great work. I'll keep my comments pretty short. The area that I was surprised that didn't come up from the stakeholder interviews is just the financial implication from a state perspective of rebalancing. The problems that states face is nursing facilities spend, and those that go in, it's very clear-cut on eligibility and who's going to choose to be in an institutional setting. When you open up eligibility for home- and community-based services, the implications become a lot larger unless there are caps or different ways, and clearly there can, but this creates the challenge for states to go down this path. So definitely seeing the COVID relief package with the enhanced FMAP and the ability to provide the 10 percent, and I think we need to look at how we assess these options. I know it's only for one year. And would even creating higher FMAPs, more than what was under Money Follows the Person but really trying to restructure.

And this builds on, I was going to bring up the duals, because it is another area where the only way states really can justify some of these financial implications is when they have other balancing efforts from the acute side, and being able to have the full picture, equation, to work with as they're drawing out and opening up more services in a home- and community-based setting.

And then finally, I do want, Kit, the other piece is the workforce. You know, we can't underestimate this interaction with family caregivers and how much of home and community services in some states also becomes an important economic support for the family, and how that interacts as we think about both the right types of services and the right skill set, and how you bring family support up to the right level to provide services in the home, and that's a challenge too.

CHAIR BELLA: Thank you, Toby. Chuck, and then Stacey, and then Bill.

VICE CHAIR MILLIGAN: Thank you both for your work on this. I wanted to stay on the financing side for a second. One of the barriers that I've heard exists is the state dependence on nursing facility bed taxes and kind of

provider rate maximization issues, and the potential loss of some of that leveraged federal revenue. So I want to make sure that we keep that in the frame. And I want to make sure that we connect this work with the work that Rob is leading on nursing facility rate-setting, because I think that they are interrelated in ways that we need to make sure that we're staying on top of.

Along those lines, I think we're likely to see more demand for rate increases on the nursing facility side. There's movement toward single occupancy rooms. There's movement toward improving infectious disease controls and how nursing facilities prepare for kind of pandemic-related responses. And I also think that with nursing facilities having lower occupancy rates right now there's going to be nursing facility demand on state Medicaid programs to raise their rates to deal with the fact that not every bed is full.

And so as one caution about this, I think over time it's going to be less relevant or less meaningful to compare how much money is spent in HCBS versus how much is spent in nursing facilities, and those pie charts that we've been using for over 20 years that show the

distribution of LTSS funding by setting. I think it depicts a false picture around adequacy of rates in both places, because I don't think they should be competing quite that way. We have to make sure that we're adequately funding nursing facilities too, and if that's done that isn't, to me, a defeat of HCBS or the importance of rebalancing.

So I want to make sure that we keep all of that in the lens, and I want to make sure that this work is also anchored with the work that Rob is doing to paint a fuller picture.

So those are my comments. Thank you.

CHAIR BELLA: Thank you, Chuck. Stacey?

COMMISSIONER LAMPKIN: Thanks. So add me to the list of people who are delighted that we're picking this up and spending the time on it. It's a really important issue, and I support the policy questions and considerations that you all have presented.

My suggestion is that as we work our way through those policy considerations and questions that we keep an eye on, or weave in what we think the role of managed LTSS programs is on some of this, and in particular, on

accessible community housing options and workforce questions. I think, as we've heard before, that most MLTSS programs have MCO reimbursement structured with a blended rate that builds in a financial incentive to serve members in the community, wherever possible, and it's supposed to have a rebalancing effect.

What isn't really clear to the actuary setting those rates, especially as the program isn't brand new anymore and has reached a more mature level, is what's reasonable to expect the MCOs to do about these barriers when they confront them, when that starts to be the barrier to rebalancing? Does the MCO have the scale to really address the housing questions or the workforce questions? You know, if not, if we've kind of reached a stall point with the managed long-term care program, what does that imply in terms of what the incentives are anymore and how we finance that program?

So I hope we can keep an eye on the role of the plans in rebalancing for states that have chosen to go down this path.

CHAIR BELLA: Thank you, Stacey. Bill?

COMMISSIONER SCANLON: Yes. Thank you very much.

This is a very important area and there's a lot of very interesting information sort of in your report and your presentation.

I wanted to focus a bit on sort of what you had in Slide 6, which showed that about 80 percent of the dollars for people with intellectual and developmental disabilities are in home- and community-based services versus only 32 percent for people with physical disabilities or over 65. I think making that distinction is important, and carrying it throughout is key, because the nature of services, the size of the population, the ability of states and the role of states and the public sector for these two populations is very, very different.

Years ago, I worked on the design sort of, of payment systems for nursing facilities in a state, and then for the intermediate care facilities for people with intellectual and developmental disabilities. For the nursing facilities we were dealing with 100-bed homes, on average. For the ICFs we were dealing with very often houses, essentially, that were serving less than 15 people, and if they were not serving as an ICF it could have been a single-family home. And the nature of services is totally

different in terms of what people do during the day in each of those institutions.

So HCBS versus institutional care is very different in these two circumstances, and I think it's important to kind of keep that in mind and understand how that influences choices. I think part of that influence is what Toby was talking about, which is the issue of if I am a state, how well can I control these different sets of circumstances?

I would also add two questions to what the focus has been, and a little bit off of what Chuck was saying, maybe we're getting tired of the pie charts in terms of what share of the pie is going to home and community-based versus institutional. To me, we also should be asking how big is the pie, and is the pie big enough to serve the population in need in states?

Many, many years ago, I did a study on people in a cohort that was defined by, they had five or six activities of daily living dependencies, they were unmarried which meant they didn't have, sort of, who would have been their primary caregiver, and they were poor. At that point there wasn't HCBS. At that point, in states

that had a lot of nursing home beds, 90 percent of those people were in nursing homes, and it was not shocking, because you thought about all their needs. Well, they needed to get service and where would you get it within a nursing home? In the states with very few beds, only 50 percent of those people were in nursing homes. And the shock was how do those other 50 percent get by, given all of those needs? And so I think that's a question that needs to be addressed, in terms of the question of how big is the pie.

The other question about sort of balancing is we have to think about what happens when someone is not in a nursing facility but is being helped at home. Nursing facilities are supposed to provide 24/7 care, and yes, we know that there are issues with respect to how well nursing facilities do their job. Home- and community-based services are nowhere close to providing 24/7 care. It's a rare, rare instance when someone will get that much care through an HCBS program.

So the balancing factor there is the family ,and it's just a little bit counter to what Kit was talking about, which is when a family is being asked to do too much

and is potentially not being compensated at all monetarily, what are the consequences of that for family members? I think that's another question that has to be addressed as we look forward investigating sort of home- and community-based services.

Thank you very much. I'm looking forward to this work as we proceed.

CHAIR BELLA: Thank you, Bill.

Anyone else?

Kit and Tricia, and then we're going to wrap it up.

COMMISSIONER GORTON: So just to follow up with what Bill said, it's not counter to what I was trying to say. It's the other end of the spectrum. Yeah. So we're in the same place. We need to look at the economic, social, cultural impacts of family caregiving, paid and unpaid.

The other thing I would say just quickly with respect to Bill is I would argue we should tease out people who have physical disabilities, not resulting from aging, from people who have physical disabilities and mental disabilities as a result of aging. Those are two different

populations. They do tend to end up in nursing facilities, but serving them in the community is very, very different. And lumping them together, I think, blurs that difference.

CHAIR BELLA: Thanks, Kit.

Trisha?

COMMISSIONER BROOKS: Very briefly. Thank you. Great, great report. Not my area of expertise, but I also think it's important for us to examine these issues from the perspective of children versus adults, and I hope we can work that into the mix.

CHAIR BELLA: Thanks, Tricia.

Kristal and Tamara, you've heard a lot. Two things that come to my mind as we're having this conversation, as we to think about benefit redesign and the institutional bias, I hope we will talk with some states who have ideas and have requested some of those flexibilities from CMS. So short of trying to flip the paradigm and make HCBS mandatory in nursing home not, but finding other creative ways to sort of get at that outcome, and then hearing directly from them, I think was really going to be important.

And second, this goes in the bucket of it's not

just a Medicaid thing, but as we do talk about workforce, all of the conversations about a living wage and paid sick leave and minimum staffing ratios that have really been highlighted during COVID, I hope we'll also think about how to incorporate that into this work and what Medicaid's piece of that might be.

Other than that, my guess is you've heard well more than you could possibly accommodate, but let me ask. Do you have any questions for us? Did you get what you need? If the first question is, is the Commission interested, I think that's a resounding yes, and the second, where we're interesting, hopefully, you have a pretty good sense of that. But do you have any clarifying last questions?

DR. VARDAMAN: No. I really appreciated today's robust discussion, and Tamara and I are scoping out some new projects. So this will be really helpful as we think those through.

CHAIR BELLA: Well, that's wonderful. Thank you for this work. We look forward to it coming back.

Okay. We are going to move into our session on quality in Medicaid and CHIP, and Joanne and Naomi are

going to join us.

Just to remind folks, we'll get through this session, and then we'll take public comment on these two sessions. And then we'll take a break.

There's Joanne. There's Naomi. Welcome. This is your first time in front of us. Welcome, welcome. Joanne, I'll turn it over to you.

[Pause.]

CHAIR BELLA: Except we can't hear you. I don't know if you're talking.

ENSURING QUALITY IN MEDICAID AND CHIP

* MS. JEE: Sorry. That darn mute button.

CHAIR BELLA: Yep. You're good.

MS. JEE: Okay. So during this session, Naomi and I will be providing you an overview of quality in Medicaid and CHIP. Much of the presentation will really just be a refresher on some of the key quality improvement and measurement activities in the programs.

We provide this information as context that, hopefully, will facilitate your consideration of potential topics for future MACPAC work in this area and how some additional projects might be prioritized.

Slide 2 just provides an overview of what we'll cover. We won't have a chance really to go too deeply into each of these topics, but there's some additional information in your meeting materials.

All right. The federal quality requirements primarily reside in the Medicaid managed care rule at 42 CFR Subpart E. They apply to managed care entities, which are managed care organizations, or MCOs, the prepaid ambulatory health plans, the prepaid inpatient health plans, and then the primary care case management, or PCCM, entities.

Among the mandatory activities are the development of state quality strategies and managed care entity quality assessment and performance improvement programs. These both involve quality improvement approaches and activities, which are described in the documents that states and plans have to prepare.

PIP topics, or performance improvement project topics, are a part of the managed care entity quality assessment and performance improvement projects. Those topics can be state, plan, or CMS defined, and the projects can really vary in duration.

All PIPs must include performance measurement as well as the implementation and evaluation of quality improvement interventions.

States must also contract with external quality review organization for that review. There are four mandatory external quality review activities. They are the validation of the performance improvement projects, or the PIPs, validation of plan performance measures and validation of network adequacy, and finally, review of managed care entity compliance with quality assessment and performance improvement program requirements.

States can also engage their external quality review organization in optional activities such as validating encounter data or quality of care surveys, and the external quality review reports are to be posted on state websites each year.

States also must adopt quality rating systems. As a reminder, during the December 2020 Commission meeting, you all had a session on this topic. Staff shared with you that although the quality rating systems are not yet mandatory, several states, about 13 or so, were already using them in some manner, but that it was somewhat unclear

whether beneficiaries were using the systems to help inform their MCO choice.

Finally, the last bullet here, federal rules require CHIP programs to report on the Consumer Assessment of Healthcare Providers and Systems, or CAHPS survey, which is a survey of beneficiary experience with care.

The range of data sources and measures for quality, this slide lists some of the key ones. You are familiar with the core sets. They are measures that CMS developed to facilitate consistent data collection and quality measurement across states. We previously reported on this topic as well, specifically on state readiness to report on the child core set and the behavioral health measures of the adult core set in 2024 when that reporting becomes mandatory.

In addition to those two core sets, CMS has developed core sets for health homes, maternity care, and behavioral health.

I mentioned CAHPS on the last slide. The only thing I'll add here is that both the child and the adult core sets include the CAHPS as a measure, and that CMS has developed a CAHPS survey for home- and community-based

services.

As you know, state Medicaid programs must provide children enrolled with all medically necessary Medicaid coverable services through the Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, benefit. States report on their performance on EPSDT in the CMS 416, which provides information on whether children are getting the screening services that they should be getting.

Moving on to HCBS and LTSS, there are a couple of different sources of quality measures for those. For example, the Section 1915(c) waiver requirements provide that states must describe their quality strategies in their waiver applications and in their annual reports, and that they also must report on performance measures related to progress on their waiver activities and waiver requirements and assurances.

Several states also report on the national core indicator surveys for intellectual and developmental disabilities and for aging and disabilities services to measure HCBS program performance related to community living and health and welfare. The aging and disability services survey is included in the adult core set as a

measure.

CMS has also been developing a national set of measures for HCBS quality for voluntary use. They issued a request for information in the fall of 2020 to gather stakeholder feedback on the benefits and challenges of using a standardized measure set.

For Section 1115 demonstrations, reporting can be a good source of quality data. MACPAC staff have presented numerous times on Section 1115 waiver evaluations, including prior to our March 2020 report, which describe challenges associated with those evaluations, such as certain methodological challenges, data challenges, and the timing of those evaluations.

Lastly, on this slide, I just want to mention nursing facility quality and data related to that. I do acknowledge that it's a little bit of a different thing than quality measurement in some of the other areas that I talked about, but it is such an important issue. And we've been hearing a lot about that over the years and especially during the period of the pandemic.

The data sources for that include the survey and certification data, nurse staffing data, and other clinical

quality measures that are collected as a part of the minimum data set.

CMS also has a number of quality improvement initiatives. They really vary in terms of the scope of their activities and the intensity of state engagement. For example, initiatives with a greater degree of state engagement involve the maternal health, oral health, and asthma initiatives. Examples of activities that occurred under these are the establishment of improvement goals, working with states to test new performance measures, and learning collaboratives and state affinity groups through which CMS provides states some focused technical assistance.

Other initiatives appear to be more focused on the dissemination of information on state practices and approaches for quality improvement. CMS shares this information through activities like webinars and the posting of guidance and documents on its website. Examples of these types of initiative include the obesity initiative and the tobacco cessation initiatives.

Whoops. I think I skipped over health disparities. So. with respect to disparities, CMS is

really focused on sort of disseminating practices to reduce disparities, identifying QI or quality improvement opportunities, as well as improving the collection of data on race, ethnicity, sex, primary language, and disability status, both in terms of administration data and in survey data.

All right. So, with respect to value-based purchasing, you know that states and CMS have numerous efforts underway to adopt and expand these models as a way to drive quality improvement. We have examined and reported on some of these measures over the years. Most recently, you'll recall that in January, staff presented on findings from an analysis of value-based purchasing for maternity care, and evidence on the effectiveness of those initiatives to improve quality were somewhat mixed.

Before we leave this slide, I just want to mention that with the new administration, it's hard to know right now what their approach will be on these initiatives. They may choose to continue them or modify them or perhaps identify new priorities altogether.

And next, I'll turn it over to Naomi who will go through some data findings.

* MS. SHIN: Thanks, Joanne.

So CMS identifies core set measures that can be trended based on three criteria, including if the measure was publicly reported, if at least 20 states reported the measure, and if the measure's technical specifications were comparable year to year.

We selected a sample of the identified measures that can be trended in fiscal years 2017 through 2019 to explore their performance trends and found that performance on core set measures can vary widely.

Here, we show median performance on two adult and two child core set measures from the primary care access and preventive care domain. You will observe that the median performance for the cervical cancer screening and chlamydia screening measures show little to no change from 2017 to 2019. However, the median performance for adolescent well-care steadily increases while median performance for developmental screenings has an overall decrease. The variability was observed throughout the core set measures that can be trended in this time period.

Next slide, please. We also looked at outcomes and results from PIPs. External quality review

organizations, or EQROs, perform annual validations for the PIPs. Thus, we looked at a few EQRO technical reports for PIP validation information.

The existence of significant and sustained quality improvement is one subset of validation criteria. However, validation is also comprised of several checks on the procedures of designing a PIP, including selecting topics, target populations and variables and more. Thus, we explored both validation outcomes and quality improvement outcomes separately.

We found that states have mixed results on validation and quality improvement. States often had significant proportions of PIPs that did not meet their performance improvement targets or did not show improvement in the targeted quality measure. Your memo provides some examples of states. We also found that validation assessment and quality improvement outcomes did not necessarily correlate. A PIP could show improvement in the targeted quality measure but could receive a validation status indicating that the PIP did not meet validation criteria; conversely, a PIP could also show little to no improvement in the targeted quality measure but could be

scored as having met validation criteria.

It's unclear what happens or what the next steps are when PIPs end. Several states encourage plans to maintain successful PIP interventions and continue to monitor performance, but there's no federal requirement to integrate successful interventions. It's also unclear what the implications are for plans that have PIPs not meeting validation criteria or not resulting in quality improvement.

Next slide. Here, we show two rates for EPSDT for eligible children over five years in 2015 through 2019. The top row depicts the trend in the participant ratio, which is the percentage of eligible children receiving at least one screening service. The bottom row depicts the trend in the screening ratio which is the percentage of eligible children receiving the appropriate number of screenings based on the state's periodicity schedule.

In 1990, CMS had the goal for all states to achieve a participant ratio of 80 percent by 1995. You can see here that in the period from 2015 through 2019, the participant ratio has seen a slight increase, but as of fiscal year 2019, the national participant ratio was 20

percentage points below the initial goal. The screening ratio in 2015 was 100 percent but has declined since then.

Both ratios also vary by age group, with younger children more likely to have received screening services than older children.

Now I'll turn it back over to Joanne to wrap up the presentation on next steps.

MS. JEE: All right. So, Commissioners, hopefully, this overview has been a good reminder that CMS and states are involved in numerous activities on quality improvement and measure. However, based on our limited look at core set performance and results on the performance improvement projects that Naomi just went over, it's hard to discern just how effective those efforts have been, and this might point to some areas where MACPAC may wish to consider additional work for understanding how these activities support the goal of achieving sustained quality improvement.

For example, MACPAC could update its chapter on quality. This was last issued in 2011, so a lot has changed since then.

We could examine how states are using their

contracted external quality review organizations to drive meaningful quality improvements. We could dig deeper into the performance improvement projects, or the PIPs, to understand their effectiveness and how states and plans are using these projects.

We could consider work to understand where states and CMS are with respect to disparities in quality, including data collection efforts and their approaches. We also could look into how states and CMS are addressing quality improvement for beneficiaries with special health care needs. This could include, for example, specific populations like children or users with LTSS; behavioral health is another example.

And, of course, there might be other areas of interest to you all. It would be helpful to hear from you on where you think MACPAC might be most helpful here and what direction you'd like to see us go. And I just want to acknowledge that there's probably a ton of work that we could do, so if you could sort of indicate where you think we could prioritize work, that would also be useful.

Thank you.

CHAIR BELLA: Thank you both. It's obviously --

I appreciate the update. It's an important thing for us to keep an eye on. I think given the work that has gone into it, no matter what else we decide, we should be publishing an update. You have the information, and it's important information to have out there.

I think what's going through my head is while this is important, besides publishing the update and keeping an eye on it, like where can we add unique value and unique impact, particularly in light of all the other things we said, even in the past two days, that we want to be looking at. So I would ask Commissioners to think about kind of impact and prioritization as we consider where we might want to have additional work, and also, you know, people should feel free if they don't want to update or publish the chapter, but I'm going to guess that you're all in favor of updating based on this work.

Peter, then Martha, then Kathy.

COMMISSIONER SZILAGYI: Great. Thanks, Joanne, and welcome, Naomi. Very nice presentation.

I would agree, first of all, I think this is really important. Many people may see this as dry, but if we don't keep measuring quality, we will have no idea where

we are.

The second point is I would suggest updating another report, and I'd love to see a focus on two areas, both of which you mentioned. And one reason to keep monitoring this is that during the pandemic there has been a remarkable decline in quality of care through no fault of anybody except for the pandemic. Anything from immunizations to receipt of care to receipt of needed care has gone down. There's concern that it may not bounce back, and --

CHAIR BELLA: Peter, we are losing you. Peter, can you -- I'm going to go to Martha, and then we'll bring Peter back. Martha?

COMMISSIONER CARTER: Thank you. Yeah, so thank you for this chapter. I do think we need to publish it, or not the chapter but -- oh, there's Peter, maybe.

COMMISSIONER SZILAGYI: Yeah, I see that. Can you hear me now?

COMMISSIONER CARTER: Yes.

CHAIR BELLA: No.

COMMISSIONER SZILAGYI: All right. Okay. Go ahead.

COMMISSIONER CARTER: My question was: Are you aware of any states that routinely include Medicaid beneficiaries or their caregivers in the design of quality improvement, especially the performance improvement programs, or require the MCOs to include beneficiaries in the design of the programs? It seems -- it's not good that these PIPs happen and then there's no follow-up, and I'm wondering if what's being designed is really meaningful and whether there's a way to look into that, especially including beneficiaries in the design.

MS. JEE: So states and plans have all sorts of, you know, committees, advisory committees that could include beneficiaries. So I think some states do. I don't know which those are, and I can't quantify, but that's something that we could certainly take a look at.

CHAIR BELLA: Peter, you want to finish your thought?

COMMISSIONER SZILAGYI: Oh, if I'm back. Sorry, I was having internet problems. Can you hear me now? Okay. So one point was that the importance of this particularly post-pandemic, I'd love to see continued focus on disparities within the Medicaid program and within CHIP.

I think this is super important. We need to keep highlighting it. And I would love to connect a couple parts for this session.

I would love to continue to focus on the PIPs, particularly mental health and behavioral health, which would connect us to some of the other foci that we're really interested in. I'm not surprised that many PIPs -- that it's not 100 percent positive. If we weren't doing performance improvement in areas that are hard to improve, then we're not doing our jobs. And so I think kind of a deep dive into what seems to be working, why certain ones appear to be working better, even if that's qualitative, to what extent does payment or other modalities drive improvement in PIPs versus other PIPs that don't help, and maybe kind of a focus on not all PIPs but on mental health and behavioral health might be one way to go.

Thank you.

CHAIR BELLA: Thank you, Peter. Kathy, then Tricia, then Brian.

COMMISSIONER WENO: I'll echo Peter's comments. I don't find this dry at all, and I think it's really important. And I thank you guys, wonderful summary of all

of the quality improvement things that are going on at CMS. And, you know, as it is quite an extensive list and as someone who has worked on a lot of these oral health initiatives, I have had a lot of trouble raising enthusiasm in states and among providers for quality improvement based on a lot of this measurement and performance quality review fatigue issue, especially in the oral health components that are optional, getting a state to participate when something is optional and they are already participating in several other PIP programs, it's very difficult to get their attention, especially around an oral health issue.

I'm wondering -- we tried several efforts to try and align some of these quality improvement measures so a state could only have to, you know, be able to use some of the performance measures in multiple PIP programs. I was wondering what other efforts you guys had heard about to try and align performance measurements in order to reduce some of these burdens. And I also am interested specifically among disparities in the PIPs and the EQRs, like what has been working and the efforts of states to integrate those into the program on a long-term basis.

MS. JEE: Okay. So thanks for that, Kathy.

There has been a lot of effort to align measures and reduce burden. I think that is a sort of well-recognized challenge to all of the activities. CMS sort of reimagined its agency-wide quality plan, and a big focus of that was to look at the measures. I mean, it's actually called "Meaningful Measures," is the framework, so to look at which measures are sort of the most useful ones.

CHAIR BELLA: Sorry. I am having trouble unmuting myself. Tricia, then Brian, then Fred.

COMMISSIONER BROOKS: Joanne, this is an amazing body of work, pulling together all of these various components into one document. The compilation is extraordinary, and I was actually going to suggest that we at least release this as a brief. If this isn't in line for a June report, I'd hate to wait until next March to get something out in the public domain.

I'm a little concerned that, you know, we've got mandatory reporting of the core set coming in 2024. We've seen no guidance from CMS on that. I worry that it might get pushed back as a result of COVID, no matter how many years we've had to prepare.

You also noted at one place in the report about

stakeholders finding it difficult to find quality data, to find the EQRO reports. We certainly try to educate the child health advocacy community on this. We suggest they look for the quality strategies, look for the EQR reports, search for child, search for pediatric, and when you can find it, many -- perhaps "many" is an overstatement, but a number of states don't even have any focus on child quality whatsoever. But the lack of transparency and the ability to get your arms around what is or isn't happening in a state I think is very difficult, so I'd really like to see a little more emphasis on that.

The other piece that I've been grappling with a little bit, because we trend out the core set data for specific states that we work really closely with, so I'm very sensitive to the performance of states that varies due to things like socioeconomic status of the region, ready access to health care. CMS put out one report on who were the leaders in quality back in 2015 after we first started to get our feet really wet on the child core set. And the Northeast states were the ones that weren't selling, and the Northeast states have, you know, higher education levels, higher income levels, you know, a lot of pretty

fabulous medical centers, and yet the South, you know, comes up short because of some of these particular issues. And I just think that when we're comparing state to state, we need to lift that up a little bit more, and that it's not so much about, you know, becoming a leader but doing better than what your baseline is and always, you know, looking to improve over where you are.

And then, lastly, the disaggregation needs to happen not only on race and ethnicity, but by managed care plan. We have a team that's been looking very closely at this, and, you know, there are certainly some states -- I give kudos to Darin. Tennessee has done a really good job of presenting a lot of the data on an MCO basis. Pennsylvania does as well. We need to see more of that so that we can really hold plans accountable for quality as well.

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

COMMISSIONER BURWELL: I put myself very much in the Martha camp about my interest in consumer grouping, quality metrics, and where do CAHPS surveys fall in the range of measures that states use to assess providers and

health plans and make those data available to consumers.

MS. JEE: So CAHPS is optional for states, with the exception of CHIP. But I think several states, probably most states are doing CAHPS. Through the core set work, we learned that states sometimes have a hard time doing the CAHPS every year because the cost of doing the CAHPS we understand is quite high, and so they have to make some decisions. Sometimes they might alternate doing the adult CAHPS one year and the child CAHPS another year. But it is certainly a survey that states are using.

As far as where they are publishing those data, you know, to the extent that -- if it's in the EQRO report, you know, they would -- it would be -- there would be some mention of it, and the EQR report is a public report. And if they intend to use it as a part of their sort of overarching quality approach, states would probably have described that in their quality strategy. And then, again, for the plans, you know, as plans are doing it, and, you know, usually what you see is that a state would require a plan to do it in their contract, but I would expect to see that the plans would also note that in their quality assessment and in their quality -- the plan, sorry, quality

improvement plan.

CHAIR BELLA: Thanks, Joanne. Fred?

COMMISSIONER CERISE: Thanks. So Peter mentioned the two points I was going to make, but I will elaborate just a little bit. So the first one is about stratifying according to subgroups. I think that's important work to do, and others have mentioned that, and I'm on board with that as well.

And then regarding PIPs, I thought, again, Peter made an important point about not all those should be expected to be positive. It did look like the mandatory PIPs had a higher success rate than the plan-driven ones, and there may be some lessons there.

You mentioned the fact that we've talked before about the demonstration waivers and not having consistent reporting of outcomes there. And I think that would be something to drive home again. These are demonstration waivers. They should be expected to see some outcomes. And then, you know, perhaps you could look in terms of the mandatory PIPs or the PIPs that you would push out to plans, you know, you could develop a menu of the ones that we know improve quality and lower costs, and there may be a

select few, but, you know, have a balance of mandatory ones that we learn from experience are effective and push those out, you know, use the information that we're getting a little bit more -- you know, in a more structured way.

CHAIR BELLA: Thank you, Fred. We have a comment, and then we'll be making our way to public comment. I see Kit's hand as well. Toby?

COMMISSIONER DOUGLAS: Yeah, I'm just going to touch -- there's one piece, Joanne and Naomi, that you talk about in the report as related to this, the EHRs and the IT infrastructure. I really don't want us to forget that one of the biggest pieces here is the ability for providers, for the delivery system to have the capacity to provide the care and have the tools. And there was the HITECH Act, and I don't know when we and MACPAC looked at the implications, the impact on that, on really advancing infrastructure different than this. But I do think if we're going to talk about quality, we need to remember that these tools are so essential for really driving quality. And we need to look at the investment again and how that is played out within -- or even MITA. So just something different, off base, but I think really important.

CHAIR BELLA: Thank you, Toby. Kit.

COMMISSIONER GORTON: So just in terms of subpopulations, I do think we also need to keep in mind that we -- I do this, too -- an arc to managed care because there's a much more robust quality infrastructure built there. Many states still have significant fee-for-service populations, and some of them are very vulnerable special needs populations. And the statewide measures, particularly in states with large managed care penetration, the managed care performance will shade out the performance, or lack thereof, in the fee-for-service population. So I do think that it's important where we can -- and it's hard to do. States have struggled for years. I don't want to suggest it's easy. But where we can, make sure that there's a little bit of light shed on management of quality in the fee-for-service side of the program. I think that's an important thing to include.

CHAIR BELLA: Thank you, Kit. I have not seen any other Commissioner hands. Okay. Joanne and Naomi, thank you again. Do you have what you need from us?

MS. JEE: Yeah, with lots of food for thought, so that helps. Thanks.

CHAIR BELLA: And I think just to clarify, we can do an update any point. We don't have to wait until a chapter in a report to address Tricia's point, I believe is correct. Is that right?

MS. JEE: Yeah, I mean, we have other types of publications that aren't tied to the March-June time frame, but if we wanted it to be a chapter, you know, it would be May and June.

CHAIR BELLA: Okay. All of that is meant to say we have some flexibility there. Okay. Wonderful. Thank you very much.

We are going to now turn to public comment on these sessions or other comments. And I will remind commenters, please indicate that you'd like to speak by hitting the little hand icon, and that as mentioned yesterday, we are asking comments to stay within three minutes, so we can make sure that we have time to get to all of them. If you hit your three-minute mark you will hear from me, thanking you, and letting you know that your time has expired and asking you to please wrap it up. And if for some reason you don't wrap it up I will turn you off, but I haven't had to do that yet.

So we will open that up now.

MS. HUGHES: All right. Amber, you have been unmuted. You can unmute your line as well.

PUBLIC COMMENT

* MS. CHRIST: Hi. This is Amber Christ with Justice in Aging. Thank you to the Commission for taking up the topic of rebalancing. I want to emphasize the inequities in rebalancing across states and across populations. As Commissioner Scanlon noted, and was in the slide, the average spending on older adults and those with physical disabilities is just 32.8 percent, and, in fact, half of the states are spending less than 33 percent on HCBS for this population.

I also note that there are inequities based on disability among older adults. For example, 75 percent of older adults at age 80 with Alzheimer's and dementia are in a nursing home, compared to just 4 percent of the general population at age 80.

So as many Commissioners noted, we do need specific strategies to address these inequities and why states are spending so little on HCBS for older adults, that take into consideration who is being

disproportionately harmed by the institutional bias, including older adults of color, and the strain on families who are serving as unpaid caregivers to fill the gaps, that also disproportionately harms women of color.

I also want to emphasize that these strategies for older adults must go beyond clearing waiting lists. Thirty-three states have no zero older adults on their waiting lists, yet 28 of those states are spending significantly more on institutional care for older adults than on HCBS.

And lastly, I want to emphasize the need for missing data, as Commissioner Burwell noted. Almost exclusively the data is missing from managed LTSS states, and it is particularly problematic since these states are supposed to be testing, and CMS is supposed to be monitoring how well managed care plans are delivering long-term services and supports. How can we possibly be assessing how well these plans are doing if we do not have that data? And, additionally, there is no LTSS data based on demographics beyond the major population groups, including race and ethnicity, which makes it difficult if not impossible, to assess the extent of disparities more

broadly.

So again, thank you for taking up this important issue and for the opportunity to provide public comment, and it's great seeing you all.

CHAIR BELLA: Thank you, Amber.

MS. HUGHES: All right. We have Nataki. You have yourself unmuted.

MS. MacMURRAY: Good. Good afternoon, all. This is Nataki MacMurray from the Office of National Drug Control Policy, and I also join with others in thanking the Commission for their continued diligence and intelligence on these issues.

I just wanted to make a comment, and hopefully we'll hear more, about the quality measures looking at screening. And I know we talked about screening and also the use of the EPSDT option for children. And I'm not sure if we are closing the loop in our discussion of the quality when we focus only on the screening, which, of course, we see is not at full capacity. But also understanding whether or not that screening leads to services, especially in places where we know children may be screened positive for various conditions, syndromes and diseases, disorders,

but may not actually be able to access care for quite some time after their diagnosis.

So I'm sure that as you all have been looking at that there may be some thought about that. I hope that I will see that in the recommendations and report of how we closed the loop on moving past just ensuring we're doing the screening but making sure that we're also providing the services that address what the screens show as positive and need for action afterwards. And thank you again.

CHAIR BELLA: Thank you, Nataki. You are our most consistent participant in public sessions, so thank you.

MS. MacMURRAY: Is there a prize, or gold star or a red star or something? Thank you all.

CHAIR BELLA: A verbal gold star, yes. Thank you.

MS. HUGHES: And Camille, you have been unmuted. You can unmute your own line and make your comment.

MS. DOBSON: Good morning, Commissioners. Camille Dobson, Deputy Executive Director at ADvancing States. We represent the aging and disability directors that deliver LTSS to those Medicaid and non-Medicaid

individuals across the country. I wanted to commend you on the work on rebalancing. It continues to be a significant issue that our members are worried about. We have spent some time also looking at barriers, focused on those states that are underperforming, if you want to call it, in terms of serving folks in the community.

I wanted to echo two comments from the Commissioners. One is Chuck's comment around nursing home financing and not missing the significant issue of the reliance on nursing home taxes, the taxes for financing the program. It's problematic to include those in a managed care setting. It tends to be one of the biggest barriers for states moving to a managed care system, which we continue to try and think through -- which I was surprised it didn't come up, especially in a couple of the states that you talked to. They are a very, very large percentage of the states' LTSS budget, almost all of it, in fact.

And then the other issue was I wanted to echo the concern that Kit mentioned about reliance on paid family caregivers and the dichotomy that occurs when the family members' care for the loved on becomes the primary source of income and the difficult position that places consumers.

We have a number of states that are increasing self-direction as a way to address the workforce shortage, because they can usually find a family member or a friend faster and easier than they can find a paid worker from an agency. But it comes with unintended consequences, and our states continue to struggle with that, especially during COVID, when many states expanded the use of paid family caregivers to address the lack of day activities for folks.

So I just wanted to say thank you again. I don't envy Kristal and Tamara trying to wade through all of the topics that were raised today and offshoots of the work. And we're also actually very interested in the benefit design issue that Melanie raised. You know, there are a handful of states that have successfully built a pre-duals, at-risk population benefit package and have been successful, based on their evidence, in diverting or delaying full Medicaid eligibility. And so I think that's a really interesting area for you to pursue as well. Thank you.

CHAIR BELLA: Thank you, Camille. You also get a gold star for consistent participation, and we appreciate your input very much.

MS. DOBSON: Thank you.

MS. HUGHES: Sue, you have been unmuted.

MS. PESCHIN: Hi, did you say Sue?

MS. HUGHES: Yes.

MS. PESCHIN: Oh, hi. Okay. Thank you. My name is Sue Peschin and I serve as President and CEO of the Alliance for Aging Research, and the Alliance is the leading nonprofit that promotes research to improve aging and health. And I am here today to try to urge you to please delay the votes on the proposals for limited Medicaid coverage for accelerated approval drugs, and I have three quick reasons why.

First is we joined the Partnership to Fight Chronic Diseases and 31 other patient-focused groups in a comment letter that I think you all have, highlight an economic analysis by Dr. Ken Thorpe at the Rollins School of Public Health at Emory, and Chair of the Partnership, and Doug Holtz-Eakin, who is a former economics professor at Syracuse and former Director of CBO.

And these guys are worth listening to, and they found that the accelerated approval drugs account for less than 1 percent of overall Medicaid spending a year, between

2007 and 2018, but those drugs often represent the only treatment options available for beneficiaries. And they had the commentary in AJMC, where they said, "Limiting Medicaid coverage for accelerated approval drugs would have a devastating impact on patients benefitting from these treatments, while having a de minimis impact on spending."

So the bottom line is you're not going to get a lot of juice for the squeeze, except hurting patients with rare and complex diseases that don't have other options.

I wanted to give a shout-out to Commissioner Tom Barker, who is correct when he suggests that issues with the accelerated approval program should be addressed by the FDA. They know it and they are taking action, and, in fact, they have a meeting next week with Friends of Cancer Research to discuss this very topic. And the FDA's Oncologic Drugs Advisory Committee is holding a three-day meeting at the end of the month on confirmatory studies.

The FDA Oncology Center of Excellence Director, Richard Padzur, has called for a re-examination of the accelerated approval strengths and weaknesses and consideration for changes within the 21st Century Cures 2.0 legislation. So why vote now before the experts on this

issue convene?

And my last point is that comments made by some yesterday about sharing risks, putting pressure on industry, not to mention the one about how this will help patients, are just plain wrong. In many instances, industry is going to respond by abandoning clinical development for rare diseases with small populations, and even ISER said this in a recent policy paper they had on the subject. In short, and this is a quote, "AAP might dry up entirely with companies only willing to invest in the areas where they can use the regular approval pathway."

And I don't know if any of you have personal family experiences with cystic fibrosis, sickle cell diseases, or rare cancers, not to mention HIV/AIDS, who have all benefitted from accelerated approval drugs. This is life or death for them. Delays in access barriers are going to have deadly consequences.

So I want you to please let the FDA do their work on this over the next 6 to 12 months, and delay this vote. You will not regret it. Please do it.

CHAIR BELLA: Thank you, Sue. I want to see if we have any other comments and then I just want to clarify

a couple of points for the record. It doesn't look like we have any other comments.

Just to clarify, on the recommendation, nothing in that recommendation changes the accelerated approval process, nor does it limit Medicaid coverage of the drugs. So I want to be very clear. Medicaid will still be required to cover those products, and we are not at all making any changes to the accelerated approval process. And so if that is not clear we are happy to have additional conversations outside of this meeting, but it's very important to make sure that we are clear on the record for that. Nothing changes in the coverage of Medicaid of these products with this recommendation I will be voting on this afternoon. But I do appreciate your comments. Thank you.

Okay. We are wrapping up this session and heading into a break. We will come back at 1:15, after the break, and we will vote on the recommendations for the June report. Following the vote on the recommendations, we will have an update on T-MSIS and then we will finish the day with a panel discussion on what states are learning from the expanded use of telehealth.

Thank you, everyone.

Thank you, Commissioners, thank you to the public who joined, and we will reconvene at 1:15. Thank you.

* [Whereupon, at 12:19 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:16 p.m.]

CHAIR BELLA: Welcome back, everyone. I'll try to figure out how to get my face back up there, but I don't want to delay the votes.

I think we are ready to turn to the vote. Chuck, did you want to do the conflict of interest?

VOTES ON RECOMMENDATIONS FOR JUNE 2021 REPORT TO CONGRESS

* VICE CHAIR MILLIGAN: Yes, happy to.

This is a voting meeting, and as a result, MACPAC's conflict of interest rules apply. Our policies are posted on the MACPAC website under the tab about MACPAC.

On March 22nd, the MACPAC Conflict of Interest Committee met by conference call and determines that for purposes of our votes today, under the particularly, directly, predictably, and significantly standard that governs our deliberations, no Commissioner has an interest that present a potential or actual conflict of interest related to the recommendations under consideration today.

CHAIR BELLA: Thank you, Chuck.

Anne, do you want to take us through the votes?

EXECUTIVE DIRECTOR SCHWARTZ: Sure. We're going to go through the votes. We have six votes. I apologize. It will be a little bit tedious because we're also going to read the recommendation language off the slides so they'll be in the transcript.

Chris is here with us. Chris, do you mind advancing the slide to the first recommendation accelerating approval drugs?

MR. PARK: Okay. Recommendation 1 reads: "Congress should amend Section 1927(c)(1) of the Social Security Act to increase the minimum rebate percentage on drugs that receive approval from the U.S. Food and Drug Administration through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased rebate percentage would apply until the manufacturer has completed the postmarketing confirmatory trial and been granted traditional FDA approval. Once the FDA grants traditional approval, the minimum rebate percentage would revert back to the amount listed under Section 1927(c)(1)(B)(i)."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Thanks,

Chris.

I'm going to call the roll in alphabetical order, the chair last, and you can vote yes, no, or abstain.

Tom Barker?

COMMISSIONER BARKER: No.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That's 16 yea, 1 nay.

Okay. Chris, if you could advance the slide.

MR. PARK: Okay. Recommendation 2 reads: "Congress should amend Section 1927(c)(2) of the Social Security Act to increase the additional inflationary rebate on drugs that receive approval from the U.S. Food and Drug

Administration through the accelerated approval pathway under Section 506(c) of the Federal Food, Drug, and Cosmetic Act. This increased inflationary rebate would go into effect if the manufacturer has not yet completed the postmarketing confirmatory trial and been granted traditional FDA approval after a specified number of years. Once the FDA grants traditional approval, the inflationary rebate would revert back to the amount typically calculated under Section 1927(c)(2)."

EXECUTIVE DIRECTOR SCHWARTZ: Thank you.

Okay. Calling the roll. Tom Barker?

COMMISSIONER BARKER: No.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. 16 yes and 1 no.

That completes the accelerated approval drugs.

Next, we have the two recommendations from the chapter on mental health services for adults.

[Pause.]

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I don't know if Erin is going to join us. It's not absolutely necessary. Oh, there she is. Okay.

Erin, you can advance the slide, and if you would read the recommendation.

MS. McMULLEN: Okay. Give me one second. Sorry. It looks like I'm having trouble advancing them.

MR. BOISSONNAULT: Erin, you have the mouse now.

MS. McMULLEN: Thanks. There we go. All right.

So Recommendation 2.1 reads: "The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration to issue joint sub-regulatory that addresses how Medicaid and the state Children's Health Insurance Program can be used to fund a crisis continuum for beneficiaries

experiencing behavioral health crises."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Call in the roll.

Tom Barker?

COMMISSIONER BARKER: Oops. Sorry. I was on mute.

I vote yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: 17 yes.

Next recommendation.

MS. McMULLEN: Okay. Recommendation 2.2 reads: "The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers

for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in crisis in real-time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis services."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Tom Barker?

COMMISSIONER BARKER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. 17 in favor. Okay. That concludes that chapter, and we're

moving on to children and adolescents.

Melinda, go for it.

MS. ROACH: "The Secretary of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint sub-regulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the state Children's Health Insurance Program."

EXECUTIVE DIRECTOR SCHWARTZ: Okay. Tom Barker?

COMMISSIONER BARKER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: 17 in favor.

Last one.

MS. ROACH: "The Secretary of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the state Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services."

CHAIR BELLA: Okay. Tom Barker?

COMMISSIONER BARKER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kisha Davis?

COMMISSIONER DAVIS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Toby Douglas?

COMMISSIONER DOUGLAS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Leanna George?

COMMISSIONER GEORGE: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kit Gorton?

COMMISSIONER GORTON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Stacey Lampkin?

COMMISSIONER LAMPKIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. That concludes the voting with six recommendations adopted. The record of the vote on each becomes a part of each chapter when our June report is published.

CHAIR BELLA: Okay. Thank you, Anne. Thank you, Commissioners.

We are now going to roll into our second-to-last session which is an update on the T-MSIS work. Aaron and Chris are joining us for this session. I turn it over to you guys whenever you're ready to get started.

UPDATE ON WORK WITH T-MSIS

* MR. PERVIN: Thank you, Commissioners.

In 2019, Chris provided an overview of the Transformed Medicaid Statistical Information System, or T-MSIS. Today Chris and I will provide an update on that dataset.

Also, even though Chris and I are presenting this work, many others have helped in T-MSIS assessment, including Jerry Mi, Kirstin Blom, Ashley Semanskee, and also Kacey Buderi on the NEMT work.

So I wanted to provide an overview of the presentation; first of all, provide a little bit of background on T-MSIS. Then we will provide a summary on how data has improved between the 2016 and 2018 data years. We will then walk you through a couple of examples of our T-MSIS validation process. Then we will discuss some of the challenges with working with T-MSIS data and also some of its limitations. Finally, we will conclude the presentation by showing how we are incorporating T-MSIS into our 2022 report cycle.

First, as a little bit of background, T-MSIS is an update of the old Medicaid Statistical Information System, and states started transitioning to T-MSIS starting in 2013 and most recently completed their transition by 2016. T-MSIS also remains the only Medicaid data source for information on eligibility, demographics, service use, and spending at the person level. Compared to MSIS, there are 1,400 data elements, and CMS runs over 2,800 automated

quality checks. There are eight data files, which includes a demographic and eligibility file, four claim files for patient, inpatient, drugs, long-term services and supports, and other services. There's also managed care and a third-party liability file.

As of this year, all states, D.C., Puerto Rico, and the U.S. Virgin Islands are regularly submitting data. Parts of this presentation will also include data from CMS's Data Quality Atlas. The DQ Atlas is a must-read for data wonks and summarizes the quality of state-level data submissions.

Overall, the quality of data has improved since our previous presentation on 2016 data. We used CMS's DQ Atlas to update some of the analyses we presented in 2019. The Data Quality Atlas categorizes states as having a low, medium, or high concern or unusable data for specific variables. This chart provides an example of how enrollment data improved between the 2016 and 2018 data years.

We looked at the variables that are used to identify overall Medicaid enrollment, enrollment among the Medicaid expansion population, those who are dually

eligible for both Medicare and Medicaid, and the managed care enrollment. As you can see, the number of states that are either a low or medium concern, according to CMS, increased within three of these categories and stayed the same for managed care enrollment. It should also be noted that states are rarely submitting uniformly good data. Different states are good at submitting different kinds of variable, but states with a low concern for dually eligible, that does not mean they are a low concern for newly eligible.

For example, we see here that there are 31 states that are the low or medium concern for the Medicaid expansion population and 36 states that are low or medium concern for managed care enrollment. If we wanted to do an analysis on the newly eligible within managed care, however, we would only have 24 states that are low or medium concern. Therefore, when validating our results, we can't just assume that a state with good data for some variables has good data for the other variables. Any time we add a parameter to our analyses, we need to assess its validity for each state.

We have used T-MSIS in two different publications

this year. We were able to use Fiscal Year 2018 T-MSIS data for the 2020 MACStats data book. This included enrollment and spending by states and eligibility groups. We were also able to use this data in our mandatory report to Congress on non-emergency medical transportation, which Kacey presented yesterday. The NEMT report uses T-MSIS to determine NEMT use eligibility group and some selected diagnoses, and it was also used to calculate NEMT spending.

The data team has relied on a couple of methods to ensure the reliability of different analyses. One method that we used is to aggregate enrollment for spending into large and recognizable buckets. When we aggregate the data into all the tables, for example, that tends to be more accurate than if we looked at a more granular eligibility group such as qualified disabled and working individuals.

Similarly, if we aggregate some spending data into all acute care spending, that is more accurate than just looking at diagnostic and screening services. We also find that states tend to be better are reporting variables that were also reporting in MSIS, likely due to the familiarity that they had in reporting that information.

Thirdly, we also find when we rely on variables that are required for provider payment, such as diagnosis or procedure codes, there tends to be greater reliability in our findings.

This chart shows how reported T-MSIS spending compared to reported CMS-64 spending on the financial management reports, or FMRs. As you can see, 43 states are within 20 percent of the FMRs. Again, however, when you start looking at more granular spending buckets, inaccuracies may increase.

I will now turn the presentation over to Chris who will provide a few examples for how we validate our results.

* MR. PARK: Thanks, Aaron. If you could go to the next slide.

So even though we were able to use T-MSIS data to produce state-level estimates on enrollment and spending for MACStats we still need to review each state's data if we want to do a more granular analysis, for specific populations or specific services. The MACStats methodology aggregates services into large categories that allow us to make adjustments to match the CMS-64. This adjustment to

the CMS-64 smooths out some of the problematic spending anomalies that we saw in the earlier slide. This adjustment cannot necessarily be applied to analyses of more granular data such as specific services and provider types, so we will need to continue to review each state's results for anomalies to determine if they should be included in the specific analysis.

As mentioned earlier, states are generally reporting a reasonable number of total enrollees, but there may be some large differences at the specific eligibility level. For example, as noted in our MACStats exhibits, Vermont did not report any enrollment in the new adult group for fiscal year 2018, but has reported approximately 58,000 average monthly enrollees on the CMS-64 enrollment report. Because Vermont's total enrollment in T-MSIS matched fairly well with the CMS-64 enrollment report, it indicates that the state likely classified beneficiaries that should have been in the new adult group under some other adult category.

Additionally, there may be multiple variables that can be used to identify a particular type of service, such as home and community-based services. States may not

be consistently classifying a claim the same way across these different variables, and we need to do investigations on which variables to use to identify those services. I'll walk you through this example in the next couple of slides.

Finally, we will need to investigate the completeness of managed care encounter data. Our early analyses have shown that states are submitting more encounter data than they did previously, but we must still check to see if all plans in the states are reporting sufficient encounter data for all types of services.

Next slide.

On these next couple of slides I'll walk you through the work we did to identify non-institutional long-term services and supports or LTSS for MACStats analyses. This graph shows the amount of spending identified by the multiple variables that could be used to identify non-institutional LTSS, including program type, type of service, HCBS service codes, CMS-64 service codes, and waiver type. We also used procedure codes to identify personal care services.

We looked at each of these variables individually to see how much non-institutional LTSS spending was

identified compared to what was reported on the CMS-64. We also looked at the aggregate of non-institutional LTSS spending identified by any combination of these variables, which is this first bar, labeled "any variable," on the left.

Amounts of spending under each variable was also identified by one of the other variables. The green part of the bar shows how much spending overlapped with other variables, and the dark blue part shows the amount of spending that was identified by the variable alone, that is, the amount of spending that was identified by that variable but no other variable. For example, of the $59.7 billion that was identified by type of service, $12.3 billion was only identified by type of service while $47.4 billion was identified by at least one other variable.

As shown on the graph, using any combination of these variables, the far-left bar, overstated the amount of non-institutional LTSS spending, $83.9 billion in T-MSIS nationally compared to the $71.5 billion reported on the CMS-64. However, each variable by itself did not show enough spending compared to the CMS-64. The most by any single variable was $59.7 billion under type of service.

Next slide.

I'll walk through this slide in more detail, but the main takeaway here is that because spending from any single variable was too low and the spending from all variables together was too high, we had to look at different combinations of the variables to see if we could improve the identification algorithm.

The dark blue line at the top shows the national amounts of spending, identified as non-institutional LTSS, on the various combinations of variables. The dark green bars at the bottom show the number of states with T-MSIS spending that was within 20 percent of the value the state reported on the CMS-64. Starting from the left, the "any variable" category is the same as the previous slide. The next category, "at least two variables," means that at least two variables on the claim corresponded to non-institutional LTSS. This approach would be less likely to falsely identify a claim as non-institutional LTSS, because at least two variables would be in agreement. But it is a conservative approach. As you can see, it only identified $56.4 billion in spending, in the blue line at the top, and 32 states in the green bar at the bottom were within 20

percent of the CMS-64.

Next we moved to a combination of program type or type of service, which is combination A on the chart, since those two variables identified the most spending individually. This combination identified $69.6 billion in spending and got close to the CMS-64 total of $71.5 billion, and 38 states were within 20 percent.

Moving right to combination B, we then added the CMS-64 service category variable to the previous combination. That moves us even closer with $70.3 billion, and we still had 38 states within 20 percent. We then move to combination C, which added personal care procedure codes to combination B. Spending moved even closer to the CMS-64 benchmark, but it reduced the number of states within the 20 percent range, to 36. And then in combination D, which added waiver type, we see that we go over the CMS-64 benchmark and even fewer states are within that 20 percent range.

So ultimately we used combination B, which is highlighted in the red square, because it had the best match of both the national spending level and the most states that were within 20 percent of the state's CMS-64

spending.

Next slide.

As mentioned previously, states are submitting more encounter data in T-MSIS compared to MSIS. Our work for the June chapter on NEMT identified several million NEMT encounter claims from both comprehensive managed care and transportation plans. However, this analysis only looked at a subset of all encounters and of all plans, and not all plans in the state were submitting similar amounts of encounter data. Although we included encounter data as part of our analyses for the NEMT chapter, more work is needed to determine whether encounter data is complete for other analyses. For example, CMS has identified eight states in 2018 as having inpatient encounter data that are either a high concern or unusable.

Next slide.

As we move forward, there will be ongoing challenges in using the T-MSIS data for certain analyses. Certain services do not have a standard definition. States have a large degree of autonomy in how these services are defined. For example, behavioral health does not have a specific type of service value and could be included in

multiple categories, such as physician or clinic services. Additionally, there is not a standard set of services, and states vary in what services they cover, including services offered through a waiver that may use state specific billing codes. Consequently, MACPAC may need to come up with a state-specific selection criteria to define these set of services.

As we presented last September, there are high rates of missing or unknown values for race and ethnicity for states within T-MSIS. It is difficult to know whether this is because the state is not reporting these data properly or whether these data are not collected on the application. Individuals may choose not to disclose their race or ethnicity when applying for or renewing coverage.

Additionally, many of the data improvements that have been made have only been applied going forward, and we don't know if states will eventually go back to making improvements to earlier time periods. As such, the data for earlier years may not be as complete and we may have difficulty in using these data from those years.

Next slide.

While T-MSIS provides a wealth of information,

data are generally limited to beneficiary information collected on the application and service utilization and spending information captured on claims. It does not have information on the beneficiary experience such as satisfaction or unmet needs, which may be captured by surveys. Additionally, while medical claims can measure utilization, they cannot be used to measure certain health outcomes or complications. T-MSIS does not include information that is captured in medical records but not included on a claim, such as lab test results. This means that T-MSIS is limited in its ability to identify certain outcomes.

Next slide.

Looking forward, MACPAC expects to use T-MSIS for several purposes. We will assess the usability of T-MSIS for other projects, but our current priorities include the following. We will update the MACStats data book for the 2021 publication. We are also planning on doing the joint data book with MedPAC on beneficiaries dually eligible for Medicare and Medicaid. As you heard earlier this morning, we will be looking at data for beneficiaries under Money Follows the Person. We will also do analyses on

beneficiaries with behavioral health diagnoses. And as we go along, we will still continue our work on assessing the completeness and accuracy of additional variables for other projects.

And with that I'll turn it back over to the Commission for any questions or comments.

CHAIR BELLA: Thank you both. I think I can speak on behalf of all of us to say that we appreciate the regular updates, and I am happy to see that you are showing us some areas of progress, along with some ongoing challenges.

Let me open it up to Commissioners to see if you have questions or clarifications. Again, this is solely meant to be an update at this point, but certainly you all might have some comments or questions.

Darin?

COMMISSIONER GORDON: So when I think about some of the variation, Chris, the assumption is that how things report on the 64, you know, that they're being done accurately, and I don't mean total amounts, but by buckets. I remember, and you all will have to tell me kind of where it is from a current state of things, but I remember awhile

back where some states were bucketing things incorrectly on the 64, and CMS, you know, at times they would catch it and they would get them to try to make adjustments, but other times it would go through. And I give a very big example of this, but it dates back really far, but, you know, there's questions in the back of my mind, where for the longest time they had us report, in Tennessee, everything under managed care. And so you had no breakdowns of anything. And then, obviously, over time, they would look to break that out in greater detail.

I don't know if that might be an issue today, but I'm just curious of your thoughts to the degree of sophistication and improvement on the proper classification of spending within the 64s.

MR. PARK: Sure, and that's one of the reasons why we don't necessarily apply this matching between T-MSIS and the 64 on a much more granular level. We're generally aggregating it to large categories like hospital, or bucketing all of the other acute services into a large category. And that's specifically, to the point that you're talking about, sometimes states may classify things different on the CMS-64 versus how they do it in T-MSIS,

even though they may have the exact same name, like home health services.

So it's difficult for us to say, you know, specifically how accurate the classification is on the CMS-64 versus T-MSIS, since we don't necessarily have another benchmark that we trust as reliably as the CMS-64. So, you know, we will try to look for other state reports and things like that, if necessary, to kind of confirm the findings that we're seeing, but certainly states, because the matching rate is generally the same for most services, it's not like a huge deal that a state recorded spending under inpatient supplemental payments versus the inpatient hospital line, at the end of the day. But that is definitely something, you know, we certainly struggle with, but I don't think we have a good handle of exactly how accurate states are reporting on the CMS-64.

COMMISSIONER GORDON: But to your point, if in the aggregate they are reasonably close then that should give you some degree of confidence. It's just a matter of bucketing correctly. You know, I think of how states who may transition programs, let's say, from fee-for-service into managed care, did they appropriately update how

they're reporting those things on the 64?

So your points are extremely valid. You know, I was just thinking whether or not that could still be an issue, and it sounds like it could be, but still using that -- and I agree with you. I think it's probably your best resource or tool for doing some high-level confirmation on the accuracy and completeness of the T-MSIS data. I appreciate your comments.

CHAIR BELLA: Other questions?

Chris, I apologize if you said this and I missed it, but what's the time frame for the duals data book?

MR. PARK: Sure. We are doing some additional validation work, to look at the T-MSIS data, and I think we're beginning discussions with MedPAC to try to work out a schedule. The plan would be to publish it on the timeline that we had previously, so with the data book coming out early next year.

CHAIR BELLA: Okay. Great. Brian, it looks like you have a question?

COMMISSIONER BURWELL: A couple of questions. Is it still true, Chris, that 64 data are date of payment and T-MSIS data are date of service?

MR. PARK: The T-MSIS data do have both date of payment or date of service. The research files, the T-MSIS analytic file, the TAF file that CMS produces, that is by date of service. But we do have access to the raw T-MSIS data, and so we could look at it either way.

COMMISSIONER BURWELL: So the comparisons made in this presentation are date of service to date of payment?

MR. PARK: So for MACStats we did use date of service, and so that is one place why we wouldn't expect 100 percent agreement. And another reason why we might not except 100 percent agreement is one I presented a year ago about the prior period adjustments and how that can lead to certain anomalies on the CMS-64.

COMMISSIONER BURWELL: Right. And the T-MSIS data, when you're making comparisons, are these some kind of files that have gotten a certain stamp of approval, like these are the file, files and there are not going to be any more adjustments or more lagged claims come in, that are going to be changed in the future? How does that work?

MR. PARK: Everything we're running is pulled out as of a certain date. So certainly states are continuing to make adjustments, and some of the early work we're doing

to the data, now we've been looking back at the 2018 data, and we do see some differences between what we had, based on data as of the end of 2020 versus the data based on the end of 2019. So they always kind of reflect a point in time, you know, estimate, based on how much information they submitted, and it depends on whether they go back and make any adjustments the prior years.

COMMISSIONER BURWELL: As researchers start using the T-MSIS files more, is there a cutoff date where, say, this the file?

MR. PARK: At least for MACStats we'll generally say these reflect T-MSIS data as of like whatever, like August 2020, or something like that. For the research-ready files, the TAF files, CMS usually basically, you know, there's one version of that and they cut it off at a certain date, usually with 12 months of claims run out. I don't know if they have any plans of re-releasing any of the years as they move forward. So, you know, there's always going to be potentially a slight disconnect between what we find in our analyses and what another researcher might find for the same time period, using the TAF files.

COMMISSIONER BURWELL: Would you say that the

more granular the analysis the more likely there may be discrepancies?

MR. PARK: That's certainly possible if states -- like the example I showed on Vermont was they didn't classify the new eligible, the new adult group. It looks like maybe this year they went back and reclassified those adults as the new adult group. So if we rerun the 2018 data, we may find that Vermont has enrollees in the new adult group now.

COMMISSIONER BURWELL: Mm-hmm. In your first slide you showed a bar graph of changes in quality of the data, those that were either of low or medium concern. Is that correct? Little or medium?

MR. PARK: Aaron, do you want to go back?

COMMISSIONER BURWELL: Low or medium concern. I wonder why you chose to group those two together. I mean, would we see any different trends if you just showed low or showed medium?

MR. PERVIN: I don't remember. We grouped it this way mostly because medium is where there's a 20 percent cutoff, to make it consistent with the slide later on. But we can get back to you with an answer to that.

COMMISSIONER BURWELL: Low concern is --

MR. PERVIN: We actually expect that [inaudible] quality. Sorry. Go ahead, Chris.

MR. PARK: Oh, I think it's within 10 percent difference.

COMMISSIONER BURWELL: So we obviously want to increase the number of states with low concern too, right?

MR. PARK: Certainly. We're hoping to see improvement as we go along, like year over year, hopefully, the number of states with low concern will keep increasing.

COMMISSIONER BURWELL: Has the number of states with data that is considered unusable been declining?

MR. PARK: It depends on the variable.

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: Did you have any further questions, Brian?

COMMISSIONER BURWELL: No. I'm sorry.

CHAIR BELLA: That's fine. Anyone else have questions?

[No response.]

CHAIR BELLA: Okay, Chris or Aaron, any final words?

MR. PARK: No. We certainly hope as we move along over the year we'll be bringing back more analyses using the data.

CHAIR BELLA: That's great. Well, thank you for keeping us updated.

Okay. With that, we can go get ready for our next session. We're a few minutes early, so we may be waiting on the panelists, but we can get set up for that.

MR. OCHIENG: All right, I'm making myself the presenter. And now I'm giving the controls to Joanne.

CHAIR BELLA: All right. So we are in the home stretch, everybody. Thank you for hanging in there.

We're going to have a panel on telehealth, which is something that we talk about often and I know is near and dear to many of our hearts. Joanne and Michelle are going to lead us through that. I think Joanne's probably going to lead us through it. And I realize we're a couple minutes early. We can start, Joanne, whenever everyone's here and we're ready to go.

So the goal for today is to hear from our three speakers and leave a little bit of time for discussion, and then we will let them off the hook at 3 o'clock, and we can

continue to have a little bit of Commissioner discussion.

PANEL DISCUSSION: WHAT STATES ARE LEARNING FROM EXPANDED USE OF TELEHEALTH

* MS. JEE: Great. Okay, so I do see all of our panelists, so if that's fine, then we'll go ahead and get started.

Commissioners, this afternoon we're really happy to have a panel of leaders from three states to discuss what states are learning from expanded use of telehealth during the pandemic. Let's see. I can just -- oh, there we go.

So our panelists are Dr. Chethan Bachireddy. He is the chief medical officer from the Virginia Department of Medical Assistance Services.

Next we'll have Tracy Johnson, who is the Medicaid director from the Colorado Department of Health Care Policy and Financing.

And last, but not least, we'll have Dr. Sara Salek, who is the chief medical officer from the Arizona Health Care Cost Containment System.

I won't say any more about their bios than that. You have more details in your meeting materials. I know we

have a lot to say, the state officials have a lot to say, so we're just going to jump right in with Dr. Bachireddy.

* DR. BACHIREDDY: Hi. Good afternoon. Can you hear me okay?

MS. JEE: Yes.

DR. BACHIREDDY: All right. Well, good afternoon. Thanks so much for inviting us here and spending some time to hear about some of what we've been learning, some of the key questions we've been wrestling with, and maybe even some recommendations for future policy development and where we think telehealth is going and how we might be able to collaborate to take it there. My name is Chethan Bachireddy. I'm the chief medical officer at Virginia Medicaid, and I'm also a practicing physician, so I've had the experience of this telehealth transformation, evolution, revolution as a policymaker, a payer, a practitioner physician, and as a patient. And it has been quite incredible, and so I look forward to the discussion.

First of all, I'll be sharing a few slides, and folks here will be keeping me on time as well. Please do not be shy about doing that.

Next slide, please.

All right. And so really I think all of us understand this in spades, everyone here, that the COVID-19 pandemic has really highlighted the potential that telehealth can play in ensuring equitable access to care, to health services, and, of course, this is nowhere more important than in Medicaid. What we're learning is that almost 70 percent of primary care providers, at least in Virginia, were motivated to use telehealth to meet patient needs and reported lower no-show rates with telehealth compared to in person, and I saw this in my own clinic as well where we went from 27 percent no-show rate to a 3 percent no-show rate when we were primarily using virtual care.

In our Medicaid data, we saw that telehealth use increased almost more than 15-fold during the public health emergency and remains at an elevated level. It's been a force for equity in our state and for our program and pretty good for racial equity. We saw in our data -- we see in our data that telehealth use has increased disproportionately among African-American populations who've experienced particularly rapid uptake.

Finally, telehealth has had an outsize impact and

has really been concentrated, again, in Virginia Medicaid, among those with substance use and behavioral health conditions. Indeed, the top nine of ten coded diagnoses for telehealth fit into one of these buckets -- behavioral health or substance use disorders.

We're doing additional internal analyses in understanding that telehealth and, in particular, audio-only services, which we reimbursed during the pandemic, have ensured access to care for those with opioid use disorder. There were two policies in particular that made that possible. One was SAMHSA, DEA, HHS at the federal level waived the Ryan Haight Act requirement for in-person evaluation for buprenorphine initiation, which meant as the pandemic worsened, more and more folks were able to initiate buprenorphine in particular, the audio-only or audio-visual, and at that the state Medicaid level, of course, we also opened up reimbursement for audio-only services, which made that possible to ensure access to care, and particularly for buprenorphine for those with opioid use disorder.

The Commonwealth, our state, is taking important steps as well to facilitate long-term telehealth, so

there's a lot of excitement in our state, and we just finished our state legislative session, and from that session a number of policies were put forth and memorialized related to telehealth. One was removal of restrictions on originating site from the Virginia code, and then the second is really around telehealth services and modalities. So our state also authorized remote patient monitoring for selected populations and conditions -- e-consults, store-and-forward, audio-only services, in addition to audio-visual telemedicine services, all beginning in July 2021, and this is a focus on not so much what did we do during the pandemic, but what does medium-term and long-term telehealth look like?

Next slide, please.

And so as we've been really experiencing this tremendous interest and surge in telehealth and have had lots of support internally and certainly at the state level and nationally and among our providers, we've been learning a fair amount about what our goals are with telehealth and some key operating principles as we think about medium-term and long-term telehealth policy. So the two goals that are front and center for us are, you know, first and foremost,

increase and sustain Medicaid members', patients' equitable access to service, while maintaining and improving quality through coverage and evaluation.

Then to really meet that first goal, the second goal is to increase and sustain providers' willingness to offer services delivered via telehealth by establishing appropriate incentives and certainty, and this is really just maybe the obvious point that if we want to meet the goals and improve the health of our members, our patients, we really have to invest in our providers as well, and telehealth policy is a big part of that.

And so some of the operating principles that we've put down on paper to guide us in our discussions and as we think about medium- and long-term telehealth, the first is that telehealth is a modality. I heard someone once call it "electricity," and it should be governed by the same parameters as in-person care, where appropriate. Telehealth policy development should allow for inherent uncertainty, and along with that uncertainty is a nimbleness as well in terms of policy development and course correction. And this really leads into the next point, which is that key to telehealth policy is to

establish robust monitoring and evaluation structures so that we can make those data-driven corrections, something that we don't always do in Medicaid, but that feels extraordinarily important with telehealth, as we're just at the beginning of this, of opening up this field. Outcomes, access, experience, costs, the things we care about, they need to be defined at the patient and population level, not only at the billing and service level. The risk of provider misuse must be weighed against the benefits of provider flexibility in determining the optimal modality of care for their patients, and really what this gets at is it really, you know, connects to the earlier point, that there is so much uncertainty here that often when from a payer perspective there is certainly a focus on not only member outcomes, patient outcomes, but also on fraud, waste, and abuse. And in an area where there is uncertainty worth thinking about our policies in terms of the risks and benefits of provider misuse against the benefits of provider flexibility.

And then the last is that simplicity is essential, that, you know, from a provider perspective, if you have ten different payers and payer policies that

you're trying to figure out, that will stunt your ability to be able to invest in telehealth over the long term.

Next slide, please.

So the next slide is really key questions. So what questions are we asking ourselves and really trying to tackle and understand in detail and make good on? So the first is: What are the components of robust monitoring and evaluation? And how does this align with established quality standards like NCQA? Should services delivered via synchronous audio-visual telehealth be reimbursed at parity with in-person visits? Really, with this idea that audio-visual telehealth initially will require investments in infrastructure, work flows, technology, new way of doing business. And so if we do that, how long should that last? And how does that impact providers' willingness to deliver audio-visual telehealth over the longer term? What services should be allowable via audio-only telehealth and at what reimbursement rate compared to in-person visits?

There is a consensus that audio-only telehealth is inferior to synchronous audio-visual telehealth. Of course, there's much more evidence and data that we need to establish that fact, but that's the general consensus among

many providers. And so with that in mind, what should the reimbursement rate be?

On the flip side of that, we understand certainly in Medicaid programs across the country that about 20 percent of our members live in households without reliable access to broadband. So when we talk about audio-only telehealth, we have to talk about -- yes, we have to talk about quality and how does that compare to other services, but we also have to talk about equitable access. And so this is a really important question for us.

The last question that we're really wrestling with is: How can telehealth policy be simple, be more closely aligned across payers to make it easier for providers to adopt, with this idea that the more complexity we introduce into the system, the more costly it is for providers to adopt and really invest in stepping into the potential of telehealth.

Next slide, please.

All right. So if I may be so bold, here are some areas of possible federal policy development that we've come to, and this list is by no means exhaustive, but I think it's a start. It's certainly where we could benefit

from additional dialogue and so forth. The first is evaluation. I've mentioned this a few times. What does "good" look like when we talk about telehealth? And so to the extent that we can develop national evaluation frameworks, that would be very helpful. Certainly -- we're a Medicaid program -- FMAP is very important to us, as is, you know, investing in evaluation. In this time of fiscal austerity at the state level, to make sure that we can invest in the learning that we need to do and this sort of rapid evaluation and course correction that we'll need to do along the way, it would be beneficial to have some level of enhanced FMAP to invest, incentivize evaluation for Medicaid agency telehealth policy.

The second one is related to the first, that to be able to really extract insights from our data, we need to have some standards around audio-only telehealth billing. Some states have figured it out. Many have not. And in conversations with other states, and certainly in Virginia, we have a difficult time actually distinguishing between audio-only and audio-visual. So the data we get is from the health system level, not from the payer, not from our own data. And so any way there could be assistance

there, it would be much appreciated.

The final two -- the next one is focus on infrastructure, again, understanding that we're just at the beginning of this journey. It's not enough to just open up policies. I've seen firsthand how we all have improved in terms of telehealth from March of last year to March-April. When I was in clinic this morning and they had telehealth, we have gotten a lot better -- patients, providers, clinic work flow. And so a question -- and we don't want to stop that momentum, so to continue to build that momentum, we really need to think about investing in infrastructure at the community level, think broadband, provider level, education, you know, maybe this is payment, and at the patient level, technology in particular, digital literacy as well.

And then the last -- and, again, this may be an obvious point, and I may really be preaching to the choir here, but at the end of the day, you know, telehealth is a modality, and it's really a tool in the toolkit. We really want to move from paying for health care to paying for health, and so value-based payment is key to really allowing all of us to put these pieces together and

ultimately unlock the potential of telehealth to achieve the outcomes we care about -- experience, cost, access, and equity.

And so, with that, I'll stop talking, and I just want to say thank you again for the invitation. Thank you for the interest and your work, and I look forward to the conversation.

* DR. JOHNSON: Okay. I think I'm up next. I'm Tracy Johnson, Colorado Medicaid Director, and you'll hear some pretty similar themes from my presentation.

Next slide, please.

Just to level set for you, Colorado had an existing telemedicine policy prior to the pandemic, but in March 2020, which was the start of the first wave in Colorado, we were one of the earlier states; we did expand our policy, and we actually made it permanent in state statute just a few months later, in June 2020. So highlighted here are some of the changes we made. We allowed telephone-only modality, for certain services anyway, and live chat, so that was in addition to the preexisting policy of audio-visual. We allowed new providers to bill the state directly. We are partially a

fee-for-service state. We're fee-for-service in the physical health side, and we do capitated behavior health, so this really refers to our fee-for-service policy.

Our newly eligible providers were FQHCs, rural health centers, Indian Health Services, community mental health centers, a variety of therapists and home health services, and we pay parity, which was a preexisting policy that we continued for these emergency and then permanent rules.

Next slide.

We have completed a full evaluation, and so I'm going to share some data with you so you can see what we're learning. On the left is our fee-for-service data that, again, is primarily physical health services with a few carved out behavioral health service. And on the right is our capitated behavioral health data provided by our health plans. And in both instances, you can see a dramatic ramp-up peaking in April that attenuates over time, but it comes down more for physical health services. It peaked a little bit above 30 percent in April and came down closer to 15; whereas, for behavioral health it peaked closer to 60 percent and did not attenuate quite as much, down to about

50 percent. And in both instances, we're hearing from providers that telemedicine is here to stay.

Next slide.

In terms of who's using telehealth and telemedicine and how, for children the major utilization is in the therapy category, and that has to do with, that we allow therapists to use telemedicine, which not all states do, and that early intervention services went all virtual in Colorado, and they're reimbursable by Medicaid, so this is a trend driven particularly by young children using early intervention.

As the prior speaker noted, opioid dependence was one of the top diagnoses for our adults, and that had to do with both federal and state policy changes, as well as depression and anxiety. We were initially surprised to see so much of that, you know, behavioral health service use in our fee-for-service data, but, again, it speaks to the demand for those kinds of services, the policy changes, and, you know, just the need. The other thing we saw was chronic disease management. For our adults with disabilities and our waiver populations, they too use telemedicine most commonly for chronic disease management.

Next slide.

Here's some data -- it's a little bit of a busy slide -- that shows services eligible for telemedicine, and the blue bars represent in-person care, and then the orange bars represent telemedicine services. And here you can see some of the differentials between rural and urban providers. The top two charts are federally qualified health centers divided according to rural or urban status. We have lots of rural areas in Colorado, so you can imagine. And while both sort of have the same shape that, you know, dramatic ramp-up through March-April, kind of attenuating over time, you can see the ramp-up was higher in the urban areas. And so while having telephone-only services did help with the digital divide, a lot of our rural providers have, you know, trouble with broadband access and things like that, it did not fully close that rural-urban divide.

The other thing to notice is just the difference between, say, the rural FQHCs and our rural health centers. Our rural health centers, you know, did have a ramp-up. You can actually see the waves if you look very carefully, like with a magnifying glass, in that data. In Colorado,

our waves were, you know, in April -- March-April, late summer-early fall, and December-January. You can see a little blip up in orange in each of those time frames. But what was interesting to me about this data is that, you know, again, the rural FQHCs could ramp up more than the rural health centers. And when I asked our rural health center partners, you know, why, I got a variety of reasons, but one sort of touched on the prior presentation. You know, the rural health centers don't have quite the administrative infrastructure that the federally qualified health centers do, and the fact that, you know, Medicare, commercial, Medicaid, all had different payment policies and, you know, the uncertainty about what would continue, you know, just sort of was a barrier to ramping up more dramatically. So just to show you some data to support the point in the earlier presentation.

Next slide.

The other thing we noticed was some interesting substitution that we wondered if we could be more intentional about going forward. We looked at emergency department use, which was down, you know, across the board, but in particular, for potentially avoidable visits related

to pediatric upper respiratory infections. And again on the left you see the final quarter in our fiscal year, in 2019, so prior to the pandemic, and then the final quarter in 2020, during the pandemic, and, you know, in-person visits were down dramatically, which, again, was not particular to this service. But what we saw was, you know, a big tick up in telemedicine for this particular diagnosis. And so we're wondering, you know, since this is a policy area we've been working on for a long time, if we might be able to be more intentional about this going forward and encourage people to use telemedicine as an alternative to going to the ED for these kinds of services.

Next slide.

I think the final thing I'll close with is you've asked us to reflect on key considerations going forward, and as I noted, we've codified a lot of our emergency policies into permanent state statute. But there's still a great deal of work and need for regulatory and sub-regulatory guidance to really distinguish our emergency policies from our permanent policies.

By way of example, we allow well-child checks to happen vis telemedicine during the ongoing public health

emergency, and we don't anticipate doing that post-pandemic. So there's a lot of those kind of decisions that need to be made.

Additionally, Colorado has dedicated nearly two decades to focus on building primary care capacity and ensuring that our members have high-quality medical homes and coordinated medical neighborhoods, and we want to make sure we're layering in this telemedicine capacity in a way that's well integrated and complementary and doesn't in any way undercut those sort of hard-won health reform achievements in our delivery system.

So, as we emerge from the pandemic, we're going to continue to monitor access, quality, equity, utilization, and cost, a lot of those same things you heard from the prior presentation.

One trend we're watching with a great deal of interest is the rapid growth in entities that provide exclusively telemedicine services or nearly so, and here, we see both opportunities of potential to address longstanding access challenges, but also some risk. As I said, Colorado has large rural areas. We have a lot of small and rural providers, and some of them are starting to

report destabilizing competition from these kinds of providers. And we're wanting to sort of balance preserving access to in-person care while continuing to expand virtual opportunities for our members. So we think there's a lot of policy work, some of which is regulatory and sub-regulatory, that could be done in that area.

In a partially fee-for-service state, these entities largely exist outside our current regulatory framework, and so some of our work in the coming year will be really thinking about that accountability framework as described again in the prior presentation broadly, but also as it pertains to this category of entity, telemedicine entity.

Then, finally, we're monitoring federal policy changes. We agree very much with the comments from the prior presentation around the need to align as much as possible and looking for payment policy that was value-based payment models that will allow us to continue to innovate in a way that's hard sometimes with fee-for-service.

So thank you very much for inviting me.

* DR. SALEK: Great. Thank you very much.

My name is Sara Salek. I'm the medical director for the Arizona Medicaid Program, and I'm the last speaker. I know we're in the homestretch, and it's Friday afternoon. So, hopefully, you all have your cup of coffee with you. I know I've got mine. It's morning still here in Arizona.

What I wanted to focus on is really some more detailed policy decisions in Arizona, and Arizona has actually really leveraged telehealth for decades now, including in the tele-behavioral space. And I'll go a little bit more into detail on that.

But we were very fortunate in that we had a very vocal stakeholder group that said our telehealth coverage policy needed to change, years before the pandemic hit, and so we implemented the vast majority of changes to our telehealth coverage policy prior to the onset of the pandemic, which put us in a really helpful position during the very difficult time.

So some of those changes we made prior to the pandemic included broadening the place of service, allowable for both distance sites where the practitioner is located, as well as originating site where the member is located. So where we had to quickly shift gear and provide

services based on stay-at-home orders to members located in at home, we had already permitted that pre-pandemic.

Additionally, we broadened our coverage decisions related to telemedicine, remote patient monitoring, and asynchronous technologies prior to pandemic, and I'll go a little bit more into detail what that looked like.

We also clarified that we covered telehealth in both rural as well as urban communities, and prior to the pandemic, we allowed our managed care organizations to determine when they wanted to leverage telehealth within a network versus not.

Next slide. All right. So prior to our major policy changes, prior to pandemic -- so that was 10/1 of '19 -- we in Arizona Medicaid policy limited telemedicine, which is that that synchronous audio/video coverage to 17 specific disciplines outlined in policy, and we switched gears and determined that as the payer, we were going to rely upon the standard of care as well as the licensing boards to determine what was within the scope of practice. And so there were certain licensing boards that said, for example, that a licensed practitioner such as a physical therapist could not conduct telemedicine physical therapy,

and so we really deferred to licensing boards and opened up our policy around coverage.

Next slide, please. And then in regard to asynchronous, prior to 10/1/19, we covered asynchronous in very limited circumstances, but starting 10/1/19, we covered these nine specific disciplines based on both our public policy work group as well as public comment.

Next slide. And then prior to 10/1/19, we did cover telemonitoring but only for congestive heart failure based on the evidence but removed that diagnostic restriction starting 10/1/19 and really again deferred to what was medically necessary, cost effective, and as my colleagues had mentioned in regards to really focused on quality as well as bending the cost curve in reverse to keeping individuals out of the hospital and out of the emergency department.

Next slide. And so I'm going to just take you through some of the major updates that we made to our telehealth policy during the pandemic.

Next slide. And so we were really engaged with our provider member and other stakeholders during the pandemic, and it was very clear early on that both from the

member as well as provider-based perspective, we needed to expand our audio-only coverage.

I did want to note that we covered audio-only services prior to the pandemic, although much more limited and greatly expanded audio-only coverage for the reasons previously mentioned.

We also expanded our coverage by adding additional codes to both synchronous and as well as asynchronous technologies, and based on executive orders here in Arizona as well as policy decisions here, we required our managed care organizations to shift. So prior to the pandemic, we allowed them flexibility in telehealth coverage, but during the pandemic, we required them to cover it and at the same rate as in-person services.

Next slide. So we do actually have a pretty detailed coverage chart here, which is also on our telehealth Web page that we created. I did want to note early on in the pandemic, we had to make the decision on do we continue with this modifier usage as well as identify a modifier for audio-only services, or do we basically take the approach of please provide the service. We recognize it's going to be a combination of in-person as well as

telehealth modalities.

So, fortunately, we did make the decision to stay course and still continue to require modifiers and identified a non-use modifier for audio-only, and so we do have the ability to differentiate audiovisual versus asynchronous versus audio-only based on those decisions. I won't go into additional detail, but I did want to note that we have a coding-based solution that assists us with some of those more detailed monitoring and data analytics that my colleagues had mentioned.

Next slide. All right. So what is the data telling us? I'm just going to provide really two high-level graphics, although we do have more detailed information as well, but due to the interest of time, I'll just stick with these two.

So the first is looking at all of our Title XIX and XXI programs for state fiscal years '20 as well as '21, and it's looking at it from the perspective of the percentage of enrolled members with one or more telehealth claims or encounters and telehealth in this context includes audio-only, and we're looking at a rolling 12 months.

So prior to the pandemic, about 10 percent of our members have one or more telehealth claims, and as the pandemic hit, we see this slope upward and continued increased growth, and part of that is just controlling through that 12-month rolling, and now we see almost 30 percent, receiving one or more services via telehealth.

Next slide. And then this graphic is looking at a different snapshot, which is number of services rendered per 10,000 enrolled members by month, and it's separating it out based on diagnostic, ICD diagnostic code, mental health versus physical health versus substance use. And not surprisingly and similar to experience in other states, mental health is our number one in regards to number of services rendered per 10,000, followed by physical health, and then subsequently substance use.

We have seen, as Tracy had mentioned, a significant uptick in opioid-related diagnoses being treated via telehealth, which is important because of the increased opioid-related morbidity and mortality we're seeing confounded by the COVID pandemic.

Next slide. All right. So what are we doing post-pandemic in Arizona for planning?

Next slide. As my colleagues had mentioned, we are evaluating audio-only coverage and weighing three major factors, including clinical appropriateness, health care access in regards to that ongoing concern related to broadband access for our members, and from my perspective and what I've heard, both from the provider as well as member experience, audio-only coverage is critically important until we have that broadband coverage issue resolved, and so based on multiple interviews, based on multiple engagements with our provider community, including pediatricians, and the ongoing concern around despair during the pandemic, we really do feel audio-only coverage is critically important until that broadband issue throughout our nation is addressed.

In addition, we're also cognizant of the impact that performance measure stewards have on our coverage, and so I did want to note that, ultimately, we're only as good as how we're measured, right? So NCQA as well as CMS played a huge role in regards to what Arizona and what other states determine is coverage, covered via telehealth modalities.

Then we have had our ongoing fiscal analysis. I

wanted to note that we have seen an offset in non-emergency medical transportation, which we expected to see. We obviously also saw a decrease in in-person visits that also offset the utilization, but we are seeing an increased trend as far as utilization. We're monitoring that, including for any signs of fraud, waste, or abuse through our Office of Inspector General.

Last but not least, it's important -- and I think this is a great note to end on, which is member satisfaction. We have our CAHPS survey right now going on, and we actually adopted Oregon's supplemental telehealth questions to get a better understanding of what the member experience is specific to telehealth.

So, with that, I'll turn it back to Joanne.

MS. JEE: Great. So thanks to the panelists, and I will go ahead and turn it back over to Melanie.

CHAIR BELLA: Well, thank you. First, I want to say how much we love to hear from states, so thanks to all three of you for spending your time with us. Second, you couldn't have given us a better presentation in terms of like pre/post. Then, third, anytime you tell us what we could be doing or what policy recommendations are, that's

wonderful. You checked all three boxes.

Having said that, I know that my fellow Commissioners will have many questions for you. So let me get started with Kit and then Peter and then Fred and then Martha and then Sheldon.

COMMISSIONER GORTON: So a quick observation with regard to time lapse. When I became Pennsylvania's first Medicaid chief medical officer in 1996, I was one of 10 in the country, and none of us were full-time. You can just see how far states have upgraded their capability in the course of the last 25 years, and I think it's wonderful. No slight at all on the non-clinical professional staff who have also upgraded substantially.

So for those of us who have been watching Medicaid a long time, it's very reassuring to see what the states have done with their investments.

My question for you is -- for all three of you, whoever wants to go first, is this. When you went into the changes that came with the public health emergency, there were changes that you made that you thought, yeah, this is going to work. It will be fine. No brainer. We'll do this and this and this, and it will all be fine. Or,

alternatively, you went into stuff and said, well, people are asking for this, and it will never fly, but it's a public health emergency, so what the heck. We're just going to throw everything at the wall and see what sticks.

So what I'm interested in is what surprised you? What did you see over the course of your opening up, particularly of audio-only telehealth, that worked, that you didn't expect to work, or that fell flat on its face that you thought was going to be a slam-dunk?

Thanks.

DR. SALEK: I'm happy to -- oh, go ahead, please.

DR. JOHNSON: This is Tracy from Colorado.

I would say that the thing that surprised me, but pleasantly, was the creative ways we were able to use telemedicine to help high-risk populations. The opioid dependence issue was referenced, I think, in all three of our presentations.

Another example I'll give you is for homeless persons, a lot of folks during the pandemic were put in hotels or motels to keep them safe if they were positive, and that sort of created an opportunity where people had phones. And so there was a lot of creative use of

telemedicine to really sort of keep eyes on a population that was isolated.

There's also been some really creative use of kind of smart backpacks, where nurses could go to shelters or encampments and provide telemedicine-enhanced direct services, you know, street medicine, and there were just lots and lots of examples of that, group therapies, things you never thought you could be doing via telemedicine. People were trying, and some of it worked.

DR. SALEK: And then just commenting from Arizona's perspective, I think one thing that surprised me is that we didn't really see a huge uptick in EPSDT well-child visits at all, and I think a couple reasons for that. I think as far as pediatricians and family practitioners, it's still kind of new versus in the behavioral health space we've been using it for years. And there's ongoing concern around how do you get that objective data. Obviously, when you need immunizations, you got to go in person, but for some of the other things, such as, you know, being able to do otoscopic exam or cardio exam, there are unique tools via telehealth, and it's just not yet taken off.

So that was one thing that kind of I was interested in because a very low uptick in EPSDT well-child visits being done via interactive audio-video in Arizona to date.

DR. BACHIREDDY: Hi. This is Chethan.

So I love that question because there's a lot that surprised me throughout the pandemic as we opened up telehealth. We went from basically minimal, about 5,000, 6,000 telehealth visits a month to over 100,000 a month in a very short time. We didn't have quite the same robust pre-pandemic telehealth policy as some of my colleagues mentioned. So there's a lot that surprised us.

So one of them was -- one of the services -- as I was digging through the evidence, how much more we have to learn, that surprised me, how much more we have to learn about telehealth, and how much -- just in the practice, like I said, as a practitioner in my own clinic, the amount of somewhat cultural workflow change, we had to go through but were willing to go through. What we're reckoning with and many others is what does this look like for the future, and a big part of that, I think, has to do with reimbursement and policy.

Relatedly, we can really -- one thing that telehealth for sure has given us that I'm very grateful for is access, and like I said, our no-show rate went from 27 percent to 3 percent in our practice, in our primary care, and addiction clinic. When we look at our data across the state, we see that not only was care maintained, but it was actually slightly increased. Now, we're checking to see how significant that is, but for opioid use disorder, that's quite significant. I did not expect that, and certainly, there's more need. But I really did not expect that, and telehealth has allowed that to come into being.

So really, this new modality that increases access, of course, will have an impact on outcomes as well, and I think the question is how much and for what conditions. So I think we're at this really exciting time, but I think of it as the beginning of really investing in telehealth.

The last thing I'll say just to really reinforce that last point about investing in capabilities all throughout community, provider, patient is e-consults. So we opened up e-consults, remote patient monitoring for COVID-19 in particular, and for something like e-consults,

my understanding of it is that it's sort of a win all the way around, increased access, increased efficiency, decreased costs. It may put a little more burden on the primary care provider. Overall, though, a win, something that we can all say fairly objectively would be high value.

When we looked almost a year later at the number of visits, there were just no visits for e-consults, and that has everything to do with the fact that to develop an e-consult system -- I mean, maybe this is obvious for folks who have done it -- you have to invest in it. You have to build it out. You have to feel as if investing in that will be -- the juice will be worth the squeeze, that there will be a reimbursement moving forward.

So an important principle for us is as we're providing that certainty moving forward to our stakeholders and providers, so a lot of things that surprised me. Thanks.

CHAIR BELLA: That's great. Thank you.

Peter and then Fred and then Martha.

COMMISSIONER SZILAGYI: Thank you very much. This was a really exciting and very thoughtful presentation. I'm a general pediatrician. I've had a fair

amount of experience with telehealth prior to COVID in Rochester, New York, with a very high-risk Medicaid population, and, obviously, during COVID. I have a couple questions, but first a comment.

My experience prior to COVID was that with a robust telemedicine program, we actually had data about patient satisfaction, reduced ED visits in the pediatric world when we did telehealth, and lack of drift or unnecessary telehealth use, and some of that has been published.

My question for you is: The pediatric community across the United States is kind of in many places reverting back to the work as it was prior to COVID, and I'm worried that there is an opportunity that may be missed, that there was real changes during COVID, and in some areas -- maybe not in your states but in other states -- in some areas people are just kind of going back to business as usual. What are the one or two policy changes that would enable high-level telemedicine to continue?

And my second question was: What do you know about patient satisfaction with telemedicine? Because my experience is very high patient satisfaction with

telemedicine.

CHAIR BELLA: Anybody want to go first?

DR. SALEK: I'm happy to take it first. Yeah, thank you so much, and it's helpful to kind of hear a pediatric perspective on things as well. You know, I think from my standpoint, where we're seeing that there is shift towards sustainable change is through like our integrated clinic to using a hybrid-based approach. And so I think when you think about the medical coding structure, it doesn't necessarily contemplate that you can do certain visits, like certain parts of the EPSDT visit in a virtual visit versus other components needs to be done in person.

And so I think probably as we're thinking about leveraged telehealth moving forward, in particular around the well-child visit, how do we expand and understand how to update our coding system to account for that hybrid-based model. So that would be, you know, one of the major areas that I would like to see addressed at the federal level.

And then remind me, Peter, of your second question?

COMMISSIONER SZILAGYI: The level of patient

satisfaction with telehealth.

DR. SALEK: Oh, yeah.

COMMISSIONER SZILAGYI: You mentioned that you're doing the CAHPS with telemedicine, but we didn't hear results.

DR. SALEK: Yes, and so it actually just launched this month in April, so we should have preliminary results no later than early fall, and so I'll be able to tell you from a systematic perspective what the patient satisfaction is. But anecdotally, absolutely, as you said, on the patient-based perspective, anecdotally very happy, and the provider-based perspective very happy because the no-show rates, as Chethan had mentioned, are down anecdotally. And I can just tell you, I mean, similar to Chethan, you know, I've had that experience both as a practicing clinician providing telehealth services as well as being a patient, right? And I know many of us probably received telehealth services during the pandemic, and it is an easy way to access care, especially because we are so busy. And so I'm looking forward to sharing the results of our CAHPS, and because we did adopt Oregon's supplemental questions, we can do some cross-state analysis as well.

DR. JOHNSON: I can go next. This is Tracy again from Colorado. I think building on the comments that Sara made, I think, for example, the well-child example, I think there's a payment piece, too. How do you figure out a way in which you don't end up paying twice for one well-child visit, for example, which is essentially what we're doing now, and, you know, we're in a public health emergency, visits are down. You know, we're doing that. But that's the most common child service, and so taking the most common child service and multiplying by two is not going to be practical going forward. And so sort of -- there's some payment policy there as well.

We are also in the same place where we have survey questions added to a state-level survey on telehealth, so we'll know more about what people think actually across payers, but we can disaggregate by Medicaid in the fall. We've done a convenience survey. We have a virtual member advisory committee, and those data, which are, you know, self-selected people who participate in that and tend to be higher risk on average, very satisfied with telemedicine.

In my slides, there was a link to our evaluation

report, and so I invite you to go look at those data if you are curious to see more precisely.

DR. BACHIREDDY: So I'll say a word here, again, echoing a lot of what my colleagues have brought up. One is a signal particularly from the national -- the federal government that telehealth is here to stay, both from what are we paying for and what we're willing to pay for, and allow providers flexibility to decide and use their judgment in terms of what type of service they want to deliver or not via telehealth. Part of that, again, is policy. Another part is to the extent that we can at the state level and at the national level really encourage payer alignment to make it as easy as possible.

And then the last thing I'll say regarding signaling, both in terms of policy, payer alignment, is investment in infrastructure. I brought that up a few times, and I think that if there is proactive investment now, we're able to really capture the excitement, the momentum, the sort of positive spillover effect of the disaster that has been COVID, you know, which is telehealth.

And so all of that will be very helpful in terms

of maintaining the momentum and excitement that really exists, and, again, I've also seen in my own clinic where we have drifted back and, you know, part of what we're trying to ask ourselves is: Do we really need for a visit to be in person, you know, particularly if we know the patient, they're very stable, and there are no other services that they need at that particular visit? So we're trying to push and really implement protocols at the front desk so that we can create that work. But it's taking time. It's taking time, and my trying to convince folks that, you know, telehealth is here to stay, but you guys know I'm very positive on the outlook of telehealth.

The last thing I'll say -- and I said it before -- is really value-based payment will help us figure out and right-size what the appropriate amount of virtual care is or isn't, and so you could have a virtual visit every single day and that could be entirely appropriate. And value-based payment really allows that, and I've seen this in my colleagues who work in capitated environments, they've been able to use virtual care in a way that is not possible in a lot of clinics that are fee-for-service, even if we reimburse for virtual care. And so we're seeing it

in Medicare Advantage. We're seeing it in other capitated environments. And so to the extent that we can replicate that across the system, I really think that -- now that folks have had a shift in their cultural mind-set and understand the possibilities of telehealth, if we can support that as much as possible and invest in it, then I think we'll be very proud of ourselves five years from now, and virtual care will really look quite a bit better and different than it is today.

COMMISSIONER SZILAGYI: Thank you very much.

CHAIR BELLA: Thank you. Just to level set, we have about ten minutes left with our guests, and I want to be sensitive to their time. We have at least four of you left to ask questions, so please keep that in mind as we're trying to glean as much as we can from these folks. Fred, no pressure. Fred, then Sheldon, then Toby.

COMMISSIONER CERISE: Chethan has really elaborated on a lot of my questions. I just loved all the presentations, and you really are hitting on what in my mind are the critical points. What I'm seeing is lots of utilization, audio-only, not a lot of results yet in terms of outcomes, but I suspect they're going to be positive.

You're starting to see it come out, and we've had some come out of our shop as well, both on satisfaction and on clinical outcomes. You're not losing anything with the audio-only.

So to shorten this for the sake of time, I'd just say I appreciate you pointing us in the right direction because I think things around supporting evaluation and billing guidance seems like it's going to be important. But like everything else, this is a modality, and to be effective it's got to line up with the practices. And so things like you talked about with e-consults are going to be important to get alignment from the provider side.

Let me just ask if any of you want to elaborate on the alignment and -- you know, alignment of payers and how do you see that -- how important is that in order so these changes gaining traction within Medicaid if the others are not aligned. And then, Tracy, you hit on something that I hadn't really thought a lot about, but I thought it was a terrific point, and that is, destabilizing components for other providers, if the sort of easy stuff kind of goes off on audio-only and then the people on the ground are left with more complex stuff and there's payer

parity, how worried are you about that?

CHAIR BELLA: Anybody on either -- Tracy, do you want to go on your specific one? And then you guys can talk about care alignment.

DR. JOHNSON: Sure, I mean, as I teed up, we've been giving a fair amount of thought to, you know, the opportunities and the risks associated with great interest honestly in the Medicaid program newly among these entities that provide telemedicine-only services, and so how do we capture the potential of those kinds of entities that are fairly new to the Medicaid program -- you know, increased access, that kind of thing. But, again, for a fee-for-service state, we pay parity. You know, there's a possibility -- there's, you know, a number of possibilities that when we create an accountability framework, we want to kind of create guardrails around. We don't want high-volume, low-value care. We want connections to our medical homes and our medical neighborhoods, so, you know, EHR data, is it flowing between the entities? Those kinds of considerations. And we don't want to see our smaller, particularly rural providers destabilized such that in-person care is not available to our members. We want, you

know, telemedicine to add and not, you know, actually create new kinds of health equity concerns.

So those are the sorts of things we're thinking about as we think about an accountability framework, and I guess the only other thing is just, you know, quality metrics. You know, what are the appropriate metrics to put in place for telemedicine in general, but also for this category of provider that, as I said, right now kind of exists outside of all of our current practices. And we've been engaging with telemedicine entities like this, and they're very interested in working with us. So we're really hopeful that we can find a balance there, and that's going to be actually a very active area of inquiry in Colorado this coming year.

CHAIR BELLA: Would anyone like to make additional comments?

DR. BACHIREDDY: I'll just make some quick points. I'm sorry. Go ahead, Sara.

DR. SALEK: No -- just really I'll be really brief. I think the more that we can align within coding, the better we'll be as far as being able to do cross-state analysis and also at a national level. So, you know, I

think it would be really helpful, and I think it is a relatively simple solution. Of course, I say that, but it's always complicated. But, you know, we've been able to figure out a coding structure that we can differentiate the different forms of telehealth. So I know it is feasible. And for Arizona, it would be beneficial as far as if our commercial private payers adopted a similar approach, just from a simplicity standpoint for providers. So that's a frequent complaint from the provider system, that every payer does it a little bit differently.

DR. BACHIREDDY: So on the alignment piece -- and I'll try to be brief here -- that will, I imagine, have to be something that's led at the state level, maybe with guidance at the federal level or a strong recommendation. Ultimately a lot of us look to Medicare. I know we do, and certainly we have specific, very Medicaid-specific considerations, obviously, but also, you know, Medicare makes a statement -- right? -- and, you know, really sends a powerful signal. To the extent that, you know, Medicare policy is sort of acceptable, and to the extent that states at the highest levels are willing to lead that sort of all-payer alignment, it will make a great deal of difference in

terms of reducing the costs of engaging in telehealth.

And I just want to segue to that other point as well. Tracy, thank you for bringing that up. It is really important, and one sort of consideration -- we haven't fully thought this out -- is whether short term there should be payment parity. You heard me say short term, medium term, long term. Maybe short to medium term, there's payment parity, and then longer term the costs may change reflective of, you know, what overhead is necessary or not. So I haven't fully thought that through, but that might be one option.

The other two things I'll say is in Virginia we're putting in our regulation and our subregulation statements around patients having their medical records send to their medical home or primary care provider if the telehealth provider is not part of their medical home. And the second is that telehealth providers be able to have some sort of relationship with an on-site provider in the case of an urgency or the need to really convert a telehealth visit to an in-person visit.

Now, what that will actually do and what that will translate to is anybody's best guess, but those are

small ways that we're trying to address that very question.

COMMISSIONER CERISE: Yeah, that's important. That's a big deal.

CHAIR BELLA: Thank you. Can I ask the three of you, are you able to stay a few minutes over, or do you need to right at 3 o'clock? Okay.

So they have very kindly given us some extra time. We have four of you who still want to talk, so please try to direct your question to a specific panelist if you can. Martha and then Sheldon and then Toby and then Chuck.

COMMISSIONER CARTER: I'm listening for areas that we as a Commission could make recommendations to support ongoing use of telehealth. This app is going to do a really good job of this, so I was going to elaborate what I heard, but I think I won't.

But I think one of the things to pull out is the whole question of creating standard codes that allow differentiation between audio-only, audio-visual, and synchronous modalities so that we can then, you know, address the issues that we had in the T-MSIS data that we can't distinguish what's what, so that these same codes can

be used for quality metrics. I think it's a very fundamental foundational type of action and recommendation that the Commission could take.

The other question that -- that wasn't really a question. That was just a statement, and I'd like to hear if you agree with me about that that's really sort of a basic step that needs to happen.

I had a question about the business about making permanent dropping the requirement for in-person visit for initiation of buprenorphine. Was that made permanent? Or is there room for us to talk about that? Dr. Bachireddy, I think that was you.

DR. BACHIREDDY: Oh, yeah, sure.

COMMISSIONER CARTER: I think that was you who said that.

DR. BACHIREDDY: Yeah, I did mention it. You know, if you'd be willing to make a recommendation, I would certainly be delighted for you all to do that. You know, the initial guidance came out from SAMHSA, DEA, and HHS to waive a restriction from the Ryan Haight Act, specifically focused -- you know, which required an in-person exam and visit before actually initiating prescriptions of

buprenorphine. And so during the pandemic, as soon as that was lifted, that really allowed us in Virginia and across the country -- so many of my colleagues as well have really thought of this as a wonderful opportunity to lower the threshold for entering into treatment. And so one of the models that we've developed even just in the short -- I guess this past year at a number of health systems in Virginia is a virtual bridge model. And so really it's -- you know, if folks come into the emergency room, they're leaving jail or prison, their risk for overdose can be as high as 120 times higher than the general population, overdose deaths. And they can initiate treatment with buprenorphine which can cut that risk in more than half. They can initiate virtually, right? And so if they have challenges with transportation -- like one of my patients couldn't make it today because his transportation didn't work out, but guess what? Because of telehealth, because of virtual visits, because of audio-only, I was able to prescribe him buprenorphine. And so the idea is to allow that for new patients who are even at higher risk than my patient was today, who I know very well. Newer patients who are at much higher risk, how do we lower that

threshold?

So from a practitioner, from a public health, from a patient perspective, absolutely wonderful recommendation because of how relatively safe buprenorphine is and how significant the impact could be and has been on patients' lives in the past year.

COMMISSIONER CARTER: Thank you. I've heard practices talk about doing buprenorphine initiation in the patient home, and that works well in some situations. And I just wondered if there was an action that needed to happen or was that a temporary lifting or has that been made permanent? Or maybe that's something the staff can explore in more detail.

DR. BACHIREDDY: Yeah, and I'll just say one word if it's okay. It's temporary right now. It's temporary.

COMMISSIONER CARTER: Okay. Thank you.

CHAIR BELLA: And, Martha, we can bring it up after -- when we have our discussion after this panel, if you want to --

COMMISSIONER CARTER: Great. Thanks. I can't promise that we'll make a recommendation. I just wanted to know if there was -- if that was an area that was -- that

we should consider. Thank you.

DR. SALEK: Yeah, and this is Sara. You know, I am also a buprenorphine-waivered clinician. I've provided addiction virtual services via telehealth. And, you know, I wish that there was like a simple answer to that question. I think folks within addiction medicine may feel differently, but obviously it's becoming more of a primary care, which is great as far as increased access to care.

I would say that definitely for addiction services it's not a one-size-fits-all, and some individuals are better served through opioid treatment programs than through, you know, Suboxone through an OBOT. The only other thing I would add is that similar to what I was describing earlier around some of the challenges around the objective data, like urinalysis, for example, when it comes -- you know, urine drug screens or other labs, you know, Breathalyzer, et cetera, that there's still room for ongoing improvement in regard to a hybrid-based model for opioid addiction treatment.

CHAIR BELLA: Thank you. Sheldon, Toby, Chuck, and a friendly reminder to please keep your questions targeted.

Sheldon, I think you're on mute.

COMMISSIONER RETCHIN: This is going to be really targeted. So Tracy, in the early '90s -- actually, perhaps, really quick -- most of the discussions I heard about telehealth involve its ability to be a proxy substitute technology for analog medicine. Can we do what we do in person, do it digitally?

I haven't heard novel increases or expanded uses that might be superior to an analog experience, and in particular, in the early '90s there was a physician, I don't know if you know about this, John Scott, out of Denver, who introduced what he called group visits, which later became shared medical appointments. And the idea was to get primary care physicians to get all their type 2 diabetics in a room, and then they would be almost a group medical therapy. And he showed incredible results. And I went out and observed them, actually, as part of a grant.

It kind of faded away, and there may be some semblance of that, but I wonder if telehealth might be an opportunity to revive it. For example, the best-known mechanism for encouraging somebody who has vaccine hesitancy for COVID vaccine is if their own physician

recommends it and is able to answer their questions. And I've wondered why primary care physicians haven't used telehealth to get to panels, large group panels, 300 patients at a time, because I've down town halls like that on COVID, that might decrease vaccine hesitancy and other uses. I don't know if any of the panelists have tried doing anything like that.

DR. JOHNSON: Since you mentioned me I'll answer first and let others chime in. I'm aware of group visits on the behavioral health side. I'm not aware of group visits on the physical health side, but it's possible I just haven't heard about that. But there definitely has been some experimentation and, anecdotally anyway, some success with group visits on the behavioral health side.

CHAIR BELLA: Thank you. Toby, and then Chuck.

COMMISSIONER DOUGLAS: Great. Great presentations, and as always, it's great to hear from the states.

My question is really around FQHCs and telehealth, and really the tension. I haven't heard that being -- I'm putting on my state Medicaid hat -- there's always concerns around the PPS and that the payment rate,

and clearly, with telehealth and audio, and this question -- I'm making sure, Melanie, I'm being direct -- has Tracy given you guys' past legislation that allows for audio-only, when that means that you're going to have to pay at the PPS, and this tension, which might be the right thing but it is a financial implication and inability to change the rates to align with audio, you know, with the concept here of aligning payment to the type of modality.

And so question for you, Tracy, is if that came up. Others can chime in if they're thinking about how FQHC payment policies could be incorporated within telehealth.

DR. JOHNSON: Yeah, great question. Thank you. I mentioned earlier about, you know, our well child check dilemma, and it being a payment issue. It really is an FQHC payment issue. We're able to figure out how to spread a single payment across two visits on the fee schedule side. We just haven't been able to figure it out on the FQHC side, so your point is well taken.

What we're doing in Colorado, and this predates the pandemic, is we are working with our FQHC partners to develop a prepayment modality. So it's not quite a capitation but it has some of that per-member payment

aspects. And that was already something that the FQHCs wanted to do, because it frees them up clinically a little bit, but particularly post-pandemic, we're waiting for CMS approval on this, but, you know, the three pilot sites have other FQHCs stacking up behind them, wanting to participate, because, you know, the downsides of being a fee-for-service provider were made evident during the pandemic when people had no visits, and so a per-member payment would have been stabilizing during the pandemic, and to your point, allows telemedicine to be provided more flexibly, and so could get around some of those tensions you're referencing.

COMMISSIONER DOUGLAS: Great. Is this an alternative payment methodology that you guys are looking at?

DR. JOHNSON: Yeah. We already have an alternative payment methodology, but this is one that would allow us to really sort of take an attributed member population and calculated based initially on past utilization, you know, what a per-member payment would be. And then going forward, you know, maybe adjust that with some sort of inflationary type factor. So we have a policy

like this sitting in front of CMS right now, looking for approval.

COMMISSIONER DOUGLAS: Thank you.

CHAIR BELLA: Thank you. Chuck, last question.

VICE CHAIR MILLIGAN: Thank you all very much, and Tracy, I wanted to ask you a question as well. I think the former Medicaid directors are picking on you a little bit here.

My question is really about dual eligibles and the bi-play with Medicare. And we had a discussion earlier today about rebalancing, so I want to just help focus the question by thinking about somebody in a home and community-based setting but they need primary care. They're often a dual eligible. To be said that Medicare doesn't stay as flexible or as expanded as Medicaid, the Medicaid program might have some jeopardy around rebalancing, because you have lost the modality of in-home care through telehealth for some of the people with ADL limitations. But also you might have a financial impact because you've lost the ability to coordinate benefits with Medicare if you expand your telehealth modality beyond what Medicare covers and Medicaid suddenly becomes primary

instead of secondary.

And so I'm curious about whether the Medicaid directors, you or others, are advocating through your delegations or advocating with CMS around the relationship for duals and the importance of Medicare from a coordination of benefits financial part of it, but also in support of rebalancing efforts for home-based telehealth care. So that's the kind of area I just wanted to ask what the state of play is.

DR. JOHNSON: Yeah. I think there's another Medicare issue that's worth mentioning, so I'm going to answer your question a little bit indirectly, but you know, it sort of underlines your point that coordinating Medicaid and Medicare policy is going to be really helpful here.

During the pandemic, as I said, we initiated our rules and then our public health agency that certifies -- I don't know if I'm using quite the right word -- home health agencies contacted us and said, "We didn't know you were doing this, and we're hearing from home health agencies that we need to address our policies." And it took me a second to get my head around what the issue was, but basically home health agencies, that see both Medicare and

Medicaid patients and duals, are kind of getting conflicting guidance from the Medicare policy on telemedicine and with our new emergency policies on the Medicaid side. And so while Medicaid would have been permissive about doing certain forms of telemedicine, Medicare was saying those things were not actually allowed. And so we had to quickly get our state public health agency aligned.

And so having differences across Medicaid and Medicare has a lot of those kind of impacts, and so as my colleague from Virginia said, really having policies aligned as much as possible is helpful on a number of different fronts.

VICE CHAIR MILLIGAN: And Dr. Bachireddy, I would have directed it toward you, but we've run out of time. But I do think, Tracy, it's not just the issue you mentioned but I think there is a risk of cost-shifting the Medicaid of otherwise previously Medicare-covered services if you expand beyond where they've expanded, and now you're primary. So thank you all.

CHAIR BELLA: Thank you, Commissioners. But more importantly, thank you, Chethan, Sara, and Tracy. If there

are things that you didn't get to say or that you think afterwards, "Boy, I wish I would have said that," please feel free at any time, because this is an area of great interest to us and where we can help you is what matters to us. So please don't hesitate to reach out if anything comes up. And I want to thank you for not only making the time but staying past time with us. So please enjoy the rest of your Friday and thank you very much again.

DR. SALEK: Thank you.

DR. BACHIREDDY: Thanks so much. Bye.

FURTHER DISCUSSION BY THE COMMISSION

* CHAIR BELLA: Okay. We have a little bit of time left, I'm going to say about 15 minutes, to have some discussion and to share some more thoughts with Joanne and Michelle. And let me to say to Joanne and Michelle, thank you for pulling those three together. That was a fabulous panel. Those kinds of panels are so informative and so valuable to our work, so thank you for that.

Who would like to share some feedback. Kisha?

COMMISSIONER DAVIS: Thanks. That was a great panel. You know, in thinking about some next steps I would love to see us wrestle a little bit with the value-based

care aspect of telehealth. You know, so there's certainly benefit of being able to say to a provider, say to a primary care physician, "You own the patient relationship and you know and trust your patient enough to be able to make the call on whether that patient needs to be seen in person, on the phone, via audiovisual, and to get compensated accurately for that and not have to worry about, I have to bring that patient in because I'm not going to get paid enough to do it."

And there's the flip side of that, you know, fraud, waste, and abuse piece, so that that's not abused and that patients are getting seen, and that patients who don't have access to broadband and telehealth are not getting left out of that equation.

So there are complexities there, and so just how we wrestle with the payment piece of it so that we're not tied down into, "Yeah, well, you've got to come in because that pays more," but really coming at it from what's best for the patient.

CHAIR BELLA: Thank you, Kisha. Others? Martha, was that your hand?

COMMISSIONER CARTER: Yeah, thanks. I think

there are just so many places that we could go with this. I do want to think about a system of coding convention or a set of codes that really help distinguish the types of telehealth. And I don't know if that's an area that we would do or if that's CMS, or make a recommendation that that happens, because it seems like it's foundational.

I think the other place that I heard -- lots of places -- investment in infrastructure, to make sure that states have the capacity to do the analysis to set up quality measuring, to set up patient satisfaction. And by the way, I think there's another potential sort of national recommendation around adding like -- I forget who it was who talked about adding specific telehealth questions to the CAHPS, so that everybody is doing it the same, because right now as states are innovating they're going to wind up with a bunch of different products and it makes it hard to compare across states and to look at national data.

I would like to look at that business about dropping a requirement for in-person visits for initiation of buprenorphine. I think that's huge, and to the extent that we can weigh in on that I think would be extremely beneficial. So it's related to telehealth, because you'd

still have to have some kind of a visit. You'd still have to have some kind of a monitoring, but it could be done through telehealth rather than in person.

Right now the person has to sit around, they get a dose -- Kisha can talk to this -- but they get a dose and you wait and see if that eliminates their cravings or their withdrawal, and then they get another dose and you decide where they land and then they go home. And there's probably more to it, Kisha, but there's a fair amount of time spent in the office that can be done at home, but there still needs to be some interaction with a health care provider through all this. So I think that's an area ripe for some work on our behalf.

MS. JEE: Can I just hop in there for just a quick sec, on that issue, Martha? Erin is reminding me that the administration has signaled that they're looking into this issue. You know, they still have to do the work of it. So that's sort of one point.

The second point is that, you know, just a reminder that that policy is a policy of the Drug Enforcement Agency and SAMHSA, so lives outside of Medicaid, unfortunately. I just put that out there. You

know, it doesn't make it less of an issue, but it might put some limitations on sort of like how far MACPAC could go with that.

COMMISSIONER CARTER: Sure, although we make recommendations that other agencies look at different things. We did that today. I get your point, though. It's not something that is directly controlled by Medicaid. Thanks.

CHAIR BELLA: Other folks?

CHAIR BELLA: All right. Well, while people are thinking let me turn to the public to see if we have any public comment on our afternoon sessions. If you would like to make a comment please indicate so by hitting your little hand icon.

[Pause.]

PUBLIC COMMENT

* [No Response.]

CHAIR BELLA: No hands coming. We just lost Joanne and Michelle. I assume could tell -- there's Joanne -- you could see a lot of the areas of interest by the questions that were asked, and so my sense is a lot of that isn't getting repeated here, but I saw you taking furious

notes on all those things, and the states were wonderful in sort of teeing up for us, here's what would be helpful, from a policy perspective.

So we don't have any public commenters. Did we have any additional Commissioners comments, or Joanne or Michelle, anything else you need from us to indicate where we'd like to take some of this additional future work?

MS. JEE: I mean, you've definitely given us a lot of food for thought. I mean, I think that there's going to be -- we going to need to sort of think about how we prioritize some of these things, right, and then the memo had some other areas of potential work. So just thinking about the things that we discussed today, that you all discussed today with that. But I think I have a good sense of some of the key areas.

CHAIR BELLA: Yes, we have prioritization to do across all of our areas, so point well taken.

All right. Oh, Sheldon, did you have a comment?

COMMISSIONER RETCHIN: Yeah. I wanted to just circle back a little bit, real quickly, with something Fred had brought up, and it caught my attention as well. With every novel technology there is something that's disrupted,

and as you start to round out the portfolio for telehealth, it would be interesting just to track the growth of public and private companies that are going across state lines or providing a competitive service, and addressing that, not just in terms of the frontier, in-person practices that may be disrupted but urban, inner city. But they're going to provide a service, and so there are a bunch of questions that come out of that, among them the moral hazard of providing that.

Anyway, it's an interesting area, but there's going to be a lot of other issues that are going to arise if this technology stays as robust as it looks now.

CHAIR BELLA: Thank you, Sheldon. Any other comments?

All right. Well, I want to take just a minute. As Commissioners, we've had a chance to thank our colleagues, but I want to publicly recognize that this is the last meeting for five of our Commissioners, and publicly acknowledge their service and thank them, although some of them are popping off the screen, which is not cool. So this is the last meeting for Chuck, for Sheldon, for Peter, for Leanna, and for Tom. And so I am speaking on

behalf of the Commission and the staff as well in saying what an exceptional group of leaders and Commissioners those five have been, and there will be a huge gap, big shoes to fill by the next group that comes in. And thank you, all of you, for your service.

And I'm not kidding. I expect to see you in the audience, making public comment with the areas that we know are near and dear to your heart.

So anything else to say? No. I thought we'd also, on behalf of all the Commissioners, I want to thank Anne and the staff. Once again, this is thoughtful information, and thoughtful work for us to try to do our duty. So I really appreciate that and the continued effort you're making during the less-than-normal pandemic time, so thank you very much.

I'm looking to see if there's any last hands. Any final jokes from anyone? No? Okay.

Once again, thank you very much.

COMMISSIONER BURWELL: We'll miss you guys.

CHAIR BELLA: Thank you, everybody. Have a wonderful weekend.

* [Whereupon, at 3:22 p.m., the meeting was

adjourned.]