PUBLIC MEETING

Via GoToWebinar

Thursday, January 28, 2021
10:31 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

Session 1: Postpartum Coverage: Review of Draft Chapter and Recommendation Decisions

Martha Heberlein, Principal Analyst and Research Advisor.....5

Session 2: Estate Recovery: Review of Draft Chapter and Recommendation Decisions

Tamara Huson, Analyst.....48

Kristal Vardaman, Principal Analyst.....54

Public Comment.....78

Session 3: Automatic Countercyclical Financing Adjustment: Review of Draft Chapter and Recommendation Decisions

Moira Forbes, Policy Director.....119

Chris Park, Principal Analyst and Data Analytics Advisor.....n/a

Session 4: Design Considerations in Creating a New Unified Program for Dually Eligible Beneficiaries: Review of Draft Chapter

Kirstin Blom, Principal Analyst.....137

Public Comment.....160

Session 5: Review of Secretary’s Report on Medicaid Housing Supports for Individuals with Substance Use Disorder

Melinda Becker Roach, Senior Analyst.....164

Recess.....185

AGENDA PAGE

Session 6: Panel: State Budget Outlook and Implications for Medicaid

Panelists:

Shelby Kerns, National Association of State Budget Officers.....186

Susie Perez Quinn, National Governors Association.....196

Emily Blanford, National Conference of State Legislatures.....205

Session 7: Value-Based Payment for Maternity Services

Martha Heberlein, Principal Analyst and Research Advisor.....233

Public Comment.....254

Adjourn Day 1.....257

P R O C E E D I N G S

[10:31 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to the January MACPAC meeting. Thank you for joining. Welcome to all the Commissioners. We have a jam-packed couple of days. We're going to have two sessions before lunch this morning, one on postpartum and one on estate recovery, and because we have so much to get through we're going to launch right into the postpartum coverage discussion with Martha, who I do not see on camera yet. Yep.

Just to remind folks who are joining us from the public, we will take public comment on the first two sessions at the conclusion of the second session, before we break for lunch. We will not be doing votes on any of the recommendations until tomorrow. So we'll be doing the discussion and public comment today, and we have a block of time for voting on the recommendations tomorrow.

And Jim, we just need Martha back.

POSTPARTUM COVERAGE: REVIEW OF DRAFT CHAPTER AND RECOMMENDATION DECISIONS

* MS. HEBERLEIN: Hi. I'm sorry. I somehow

managed to turn off my webcam and can't get it back on. It's not just because I'm in my pajamas. But I will just go ahead. I don't want to take too much of our time, or lose too much of our time for this discussion. So just give me one second to try to get my slides up.

CHAIR BELLA: Your slides look like they're there, so that's good.

MS. HEBERLEIN: Okay. So thank you all. We're going to continue our conversation on extending the postpartum coverage period as we move toward a vote on the recommendations tomorrow. I will begin by providing a quick overview of what is included in the draft chapter that will accompany those recommendations. I will then provide information on the two issues that remained outstanding after the December meeting before turning to the draft recommendations, the rationale, and the implications.

Okay. So a full draft chapter is included in your materials. Much of it should look familiar, as we have covered this information in past meetings. The chapter begins by describing the current coverage landscape for pregnant women in Medicaid and in CHIP, including

eligibility and benefits. I want to pause here to note that MACPAC uses the terms "pregnant" and "postpartum women" as these are the terms in statute and regulations. However, other terms are more inclusive and recognize that not all individuals who become pregnant and give birth identify as women.

The chapter then goes on to describe the changes in coverage that occur throughout and following an individual's pregnancy. It then discusses the health issues facing postpartum individuals. The chapter then highlights recent state and federal action to extend the postpartum coverage period. The chapter concludes with the key areas the Commission discussed during its deliberations. This includes the effects on health equity, insurance coverage, and continuity of care, as well as issues related to state flexibility and financing.

So to the outstanding issues. During prior discussions, the Commission coalesced around three recommendations: extending the postpartum coverage period for 12 continuous months, mirroring the recommendation in CHIP, and reiterating the March 2014 recommendation requiring full Medicaid benefits for pregnancy-related

eligibility pathways.

While the Commission agreed on a mandatory extension with an enhanced match at the December meeting, you remained undecided on two points. The first was whether to require the extension for all postpartum individuals or to require the extension with the enhanced match to those with incomes below 133 percent of the federal poverty level, and provide an option for states to extend coverage for those with higher incomes but without enhanced financing. The rationale for this alternative was to mirror the eligibility threshold for the Medicaid expansion population with the goal of filling in a gap in coverage in non-expansion states.

Making a tiered recommendation would be less costly to the federal government. However, it would be more complicated to administer and affect relatively fewer individuals. Just four states -- Idaho, Louisiana, Oklahoma, and South Dakota -- cover pregnant women only to 133 percent of the FPL, and as of October the median threshold for pregnant women was 195 percent. Many higher eligibility levels are longstanding and may be required by federal law. For example, there are 19 states that have a

mandatory minimum threshold for pregnant women above 133 percent FPL.

While most uninsured new mothers likely to become eligible for Medicaid or CHIP following an extension live in non-expansion states, these states vary in current eligibility for pregnant women. For example, five non-expansion states are among the 19 with higher mandatory minimums.

A tiered requirement would also have implications for requiring the postpartum coverage extension in CHIP. The argument for the requirement was that this would result in a consistent application across programs and reflect existing policy. However, CHIP, by design, covers higher-income women.

So also at the December meeting, the Commission agreed that a mandatory extension should receive an enhanced federal matching rate. The rationale was that states are facing substantial budget constraints and should not be required to take on major new responsibilities without additional federal funding. Moreover, the Commission commented that unacceptably high rates of material morbidity and mortality, the disproportionate

impacts among people of color, and poor outcomes for infants make expanded postpartum coverage a federal priority.

The Commission was undecided as to whether the extension should be fully federally funded or if states should receive a 90 percent federal matching rate. An argument for 90 percent is that it would provide parity with the Medicaid expansion, while the argument for 100 percent was to fully cover additional costs for states.

There are several existing FMAP exceptions for certain populations, providers, and services, and there is a table in your appendix, Commissioners, that describes these in more detail.

There is precedent for 100 percent federal matching rate. For example, states have long been required to pay Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent FPL. States receive 100 percent federal match for qualifying individuals up to a specified dollar allotment.

More recently, the Families First Coronavirus Response Act gave states the option to extend Medicaid coverage for COVID-19 testing and related services to

otherwise uninsured individuals. States that adopt this option receive 100 percent federal funding for medical assistance and administrative costs associated with the coverage. A 90 percent federal matching rate has also been authorized. For example, the federal matching rate for the expansion population was phased down and states now receive 90 percent.

Regardless of the federal matching rate the Commission recommends, states will need to make administrative changes to track and claim the enhanced matching rate. To begin, states will need to track postpartum individuals to ensure that coverage is maintained for an entire year and that the appropriate matching rate is claimed. States must already maintain continuous eligibility for pregnant women through the 60-day postpartum coverage period, and so extending the postpartum coverage period for one year would require changing the length of the enrollment period, which should be feasible for states given the current requirements.

States also have experience with claiming differential matching rates for certain populations and services. For example, states that have adopted the

Medicaid expansion need to identify those eligible for the enhanced match.

So moving on to the recommendations. The text on the first recommendation can be seen on this slide. It would extend the postpartum coverage period from 60 days to a full year of continuous coverage. The actual federal matching rate that the Commission agrees to will be included in the recommendation language that you vote on tomorrow. This recommendation would not alter the existing flexibility provided to states in establishing income eligibility thresholds for pregnancy-related and other eligibility categories.

An extension of the postpartum coverage period would build on the legislative history of expanding coverage to pregnant women as a way to address poor maternal and infant health outcomes. Individuals may experience significant risks to their health and life during the postpartum period, and an extension of coverage could help ensure that individuals receive ongoing medical care during this critical clinical period. In addition, as the health of the child is interwoven with that of the mother, improving outcomes for her may also result in

improvements for her children.

Furthermore, given the racial and ethnic disparities in maternal outcomes, an extension of the postpartum coverage period could serve as a way to improve health equity. In the Commission's view, however, states should not be expected to bear the cost of such a mandate, especially given the current budget challenges states are facing due to COVID-19 and the accompanying economic downturn.

So the mandatory extension of the postpartum coverage period would result in increased federal spending of between $30 billion and $40 billion over 10 years. Note that these costs also include the extension of CHIP, which is Recommendation 2.

While the federal government, will bear a greater share of the cost of an extended postpartum period, depending on the match, states may also need to contribute. States would also need to adjust administrative processes, as I mentioned before, to ensure that individuals remain enrolled and claim the appropriate match.

Postpartum individuals enrolled in Medicaid would be able to maintain their existing coverage for a full

year. Approximately 123,000 uninsured new mothers would become newly eligible for Medicaid or CHIP through an extension. More than one-third of Black, non-Hispanic, and white non-Hispanic uninsured new mothers, one-quarter of Hispanic uninsured new mothers would become eligible under an extension.

Extending the postpartum coverage period would help ensure that providers could continue to provide and get paid for services furnished to individuals they have seen throughout pregnancy and delivery. An extended postpartum coverage period could reduce administrative burden on plans as postpartum individuals no longer shift coverage sources at 60 days postpartum, and could also assist with efforts to improve management of enrollees' care.

So moving on to Recommendation 2, which you can see on this slide. This recommendation would extend the postpartum coverage period in CHIP in the states that have adopted the option. It would not include an increased federal matching rate as states already receive the CHIP enhanced federal matching rate for covering low-income pregnant women.

The same rationale for extending the postpartum coverage period for individuals in Medicaid applies to those who are covered in CHIP. In the Commission's view, requiring an extended postpartum coverage period in both programs would ensure that individuals are provided the same length of coverage regardless of whether they are enrolled in Medicaid or CHIP, and would maintain the consistent application of the coverage period across programs.

As I mentioned, the federal cost of the extension is included in the estimated provided on the previous slide. As for the states, the six states that have adopted the option to cover low-income pregnant women would face additional costs to extend postpartum, given that they would receive the state's regular enhanced matching rate. And as in Medicaid, states would also need to adjust their administrative procedures.

Similar to the implications for Medicaid, postpartum individuals enrolled in CHIP would maintain their existing coverage for a full year and the estimates provided for Recommendation 1 include individuals in CHIP. Providers and plans in CHIP would likely face similar

effects as to those anticipated in Medicaid.

So the last recommendation, as seen in this slide, would eliminate the state option to provide pregnancy-only services to pregnant women with incomes above the state's threshold for the former Aid to Families with Dependent Children, or AFDC, program. The recommendation would not limit state ability to provide a broader benefit package to pregnant women, nor would it require that they provide any additional optional benefits. It would also not alter the benefit package provided to pregnant women in CHIP.

So the view of the Commission is that all pregnant and postpartum individuals should be provided comprehensive coverage and that states should not have the option to limit coverage to pregnancy-only services. While pregnancy-related services may be broad in scope, as they are defined as those that are necessary for the health of the pregnant women and fetus, the definitions differ across the four states providing pregnancy-only services, and the provision of certain benefits may depend on a provider or plan determining that a particular service is pregnancy-related.

Furthermore, services that are considered pregnancy-related while an individual is pregnant may not be considered pregnancy-related once that pregnancy ends. Requiring the full Medicaid benefit package for individuals enrolled in all pregnancy-related pathways may help to ensure the best possible outcomes in maternal health.

So this recommendation would increase federal spending by less than $1 billion over the 10-year budget window. This is the smallest non-zero category of spending used by the CBO. If the four states currently covering only pregnancy-related services are not providing a broad benefit package, covering additionally medically necessary but not pregnancy-related services may increase their expenditures. If almost all medically necessary services are already provided, however, expanding coverage to the full Medicaid benefit package should not add substantial new costs.

Under this recommendation, pregnant and postpartum women with pregnancy-only coverage in four states would become eligible for additional non-pregnancy-related services that are not already covered. Requiring states to provide full Medicaid benefits would eliminate

the need for providers to determine whether specific services are pregnancy-related, and they would be able to bill for all medically covered services provided. Plans would not need to differentiate services or provide separate benefit packages for pregnancy-related services.

So as I mentioned at the outset, the Commission will vote tomorrow on the recommendations that reflect the decisions you make today, particularly related to the matching rate. I look forward to your discussion on the remaining issues as well as any feedback you have on the chapter. And with that I will turn it over to you.

CHAIR BELLA: Thank you, Martha. Your work has been just phenomenal in getting us to this point, and this is such an important place to be. As I said last month, when I think about the Medicaid programs and ways we can strengthen it and individuals on it, expanding postpartum coverage rises to the top. So this is really exciting that you've gotten us to this point.

The recommendations put forward today in my mind not only address our troubling maternal mortality and morbidity rates but very importantly also address equity, disparities, access, all the things that the Commission has

said are important.

So Martha highlighted we have two outstanding issues, one on tiering and one on 90 versus 100. I actually think the issue really is on the 90 versus 100. I think that the tiering may be less of an issue for us. But I'm going to start with putting Toby on the spot, because tiering was something he had raised at the last meeting. And if my hunch is correct that that's not as big of an issue for the group I would ask the Commissioners to really focus your comments on whether you are in support of 90 percent or 100 percent match, so that we can keep the discussion moving and get Martha what she needs to finalize this set of recommendations.

So Toby to start, please.

COMMISSIONER DOUGLAS: Yeah. Can you hear me okay?

CHAIR BELLA: Yep.

COMMISSIONER DOUGLAS: Great. So first, again, Martha, you've done an excellent job and just really thoughtful and continue to analyze and provide great information back and feedback. And especially on this issue of the idea of tiering. I thought that this would be

a way to solve for part of the problem in terms of non-expansion states. And clearly the data and where states line up today with the pregnancy coverage and postpartum coverage, it wouldn't solve for the problem given that the vast majority, as you know, of states are above 133 percent. And you add to that that most of the states are even just far above that, we're not going to solve anything by creating a bright line.

So I don't see that as part. For myself, I know that we're -- I think Chuck had looked at it too, or thought about it too, but it doesn't seem to solve any problem here, and so I would not continue to be proposing that to be part of the recommendations.

CHAIR BELLA: While you have the floor, Toby, can you give us your opinion on 90 versus 100?

COMMISSIONER DOUGLAS: Yeah. I could go either way, but I continue to see -- I see Medicaid as a state-federal partnership, and fundamentally I think the best recommendation would be to go with a 90 percent, that this continues to be a state-federal program that the federal government is saying this is a very, very important component and that Congress and the administration is

enacting some of that so that they want states to do this. But states need to be part of investing in the program too.

CHAIR BELLA: Okay, great. Martha and then Sheldon.

COMMISSIONER CARTER: I don't think I had my hand up.

CHAIR BELLA: Oh, I'm sorry.

COMMISSIONER CARTER: That's okay. You know, I had some thoughts. When we started this conversation I thought that we would want to tailor something that was most legislatively palatable, but I've come to the point that I think that we should recommend what's best for pregnant women, pregnant individuals and their families.

And so I actually can do either way also on the match, and I think there are better minds than mine on that topic. I really commend the Commission and the staff for bringing this to the point that it is, and I'm just thrilled that we're going to make this recommendation.

CHAIR BELLA: Thank you, Martha. Sheldon?

COMMISSIONER RETCHIN: Yeah. I agree with Toby, maybe with a little twist. It's a pretty tough time to, even for hitting the states for 10 percent, even though

it's a modest figure, in the greater scheme of things. One alternative that we haven't discussed is to mirror the ACA and allow states to get 100 percent for the first three years and then ratchet it down to 90 percent. Just a thought.

In general, though, I will say in the long run I think hitting the precedent where even though it's a very important policy, and Martha knows, I wasn't really convinced it solves the problem in terms of serious maternal morbidity and mortality. But nonetheless, in terms of extending coverage for a very difficult population, I'm all for it. But I think the states do have a role in this. In essence it would be an unfunded mandate moving for the 10 percent.

But I'm comfortable with that and I think if we continue to erode in any new policy that comes up, no matter the attractiveness and importance, the states, this is a state-federal partnership. I'm in favor of either a three-year 100 percent, because that may be, administratively, very difficult, but it's just a different twist.

CHAIR BELLA: Thank you, Sheldon.

Peter and then Tricia.

COMMISSIONER SZILAGYI: Yeah. Martha, wonderful job. I read the chapter carefully, and I really think it's excellent and will be used by many.

I'm also in favor of these recommendations and want to point out that the health of the mother is intricately connected to the health of the child, not just during pregnancy, but particularly during the first year of life.

And just as an example, postpartum depression is just about as common in month five as it is in month one after delivery, and so that's just one example of the importance of benefitting the health of mothers through the first year.

In terms of the 90 percent, 100 percent, philosophically, I lean more toward the 90 percent overall. I mean, I really do believe in this federal-state partnership.

And I hadn't thought of the ACA, but I actually was going to make a similar recommendation. The states are hurting so badly because of COVID, and they will be for several years. I was actually going to suggest something

similar, although I hadn't thought of the ACA concept is that for a year or two, would it be reasonable to have 100 percent match just because of how badly the states are going to be off economically.

And one final point, to me, $3- to $4 billion per year to cover all mothers on Medicaid for a year is cheap. It's a low cost and high benefit and very high value, so thank you.

CHAIR BELLA: Thank you, Peter.

Tricia and then Darin.

COMMISSIONER BROOKS: I was somewhat inclined to say 100 percent, although I really like Sheldon's comment and particularly in light of the current situations for states.

I understand the state-federal partnership, but the state could easily say if you're putting a mandate on me without my agreement, then it's not really a partnership in that regard. So I think that does support 100 percent, but I can see doing something that models similar to the adult expansion.

CHAIR BELLA: Thank you, Tricia.

Darin, then Bill, then Fred.

COMMISSIONER GORDON: Yeah. Tricia's point is well said. That's kind of where my thinking was going. It's a partnership when you have a choice. When you're saying it's mandated, then I don't think the state has a choice in that particular situation.

I think the policy itself is sound, and I think it can have tremendous impact. My whole focus is really around the funding aspect of this and thinking about where states currently find themselves, and when we say in the whole scheme of things, it's not a lot of money, right now they've having to make decisions about reducing program expenditures. They don't have the luxury of even making other investments that are also important and needed in their programs.

So I am more inclined if you're going to mandate it that it's 100 percent. It's funny that Sheldon's commentary -- and Peter had commented on this as well -- I had thought about mimicking the ACA funding for expansion and giving time, but that would be like a secondary thing from my perspective because it still gets at "I'm telling you, you have to do this and come up with the money to do it." At that point, I think the partnership doesn't feel

much like a partnership.

CHAIR BELLA: Thank you, Darin.

Bill, Fred, Chuck, Kit.

COMMISSIONER SCANLON: Yes. I'm fully supportive of the expansion of the benefit, but I'm going to end up being an outlier sort of in terms of increasing the FMAP. I think I will need to abstain on both 90 or 100.

To me, sort of the current situation of the states is certainly sort of relevant, but it is temporary. Later this afternoon, we're going to be talking about countercyclical financing. To me, that's a more appropriate response to if we've got a situation that is temporary, that you make temporary changes to the FMAP. So the idea of proposing a permanent change does not make sense.

Secondly, when I look at the precedence in terms of changes to the FMAP, I couldn't see a pattern there or a set of principles in terms of guiding that, and I would say that the common theme is Congress decided to do this. So my comfort level is more in leaving it to the Congress. I could think about recommending that there be an increase in FMAP but not something as specific as 90 or 100, which

dramatically changes what the FMAP is.

We have states that are at 50 percent FMAP that are there because we have a floor. If you use the FMAP formula and did not apply a floor, there would be states at 40 percent of FMAP. So we'd be talking about a 50-percentage-point increase which to me, again, is huge, and so on this, I understand where the Commission is. But I just can't bring myself to be at the same point.

Thank you.

CHAIR BELLA: Thank you, Bill.

Fred and then Chuck.

COMMISSIONER CERISE: I'll agree with others that the policy is, I think, the right policy. I share some of Darin's concerns about requiring states to do this and then come up with match. So I do have a question, and that is, if you look at the five states that are going to make up 83 percent of the increase, three of them either have waivers that already cover parts of this and two of them have eligibility criteria well above 133.

Would it be possible, would states conceivably reduce their eligibility numbers if they had to come up with the extra 10 percent? First off, would that be

allowable here? Does anybody think that's a real concern? If you're at 196 percent of poverty for pregnancy, would you go down some if now you've got a covered 10 percent match for, you know, per year?

MS. HEBERLEIN: Yes. So I think the five states that have the mandatory -- well, there's five non-expansion states that account for two-thirds of new mothers likely to benefit, and those are Florida, Georgia, Missouri, North Carolina, and Texas.

Florida has a higher minimum threshold and is currently at 191 percent FPL. Georgia is at 220, and does not have a higher mandatory minimum.

It's also been considering -- it has put in -- well, I don't know if it submitted a waiver. I can't remember, but it's got a six-month extension that it's proposing.

Missouri is at 196 and has coverage of pregnancy women in CHIP up to 300, and also it has a waiver with CMS that has not yet been approved.

North Carolina is another state. They have a higher mandatory minimum and are at 196.

And Texas is the last one which is at 195 and, as

you mentioned has a waiver in place to try to extend additional coverage in the postpartum period.

So I think the existing eligibility in those states sort of shows you what value the states have placed on coverage for this population already. I think rolling back coverage is a lot harder than expanding coverage, especially for this population. I think it would be unpalatable in some states to do that. So I think it would be unlikely that they would roll back coverage, but I can't say it wouldn't happen.

COMMISSIONER CERISE: Yeah.

CHAIR BELLA: Fred, did you have any additional comment?

COMMISSIONER CERISE: No, no. Just that I am concerned that -- well, I don't have any other comments at this point.

CHAIR BELLA: Okay. Thank you.

Chuck, then Kit, then Kathy -- then I think, Sheldon, I saw your hand again -- and Stacey.

VICE CHAIR MILLIGAN: Martha, thank you for the great work. I land in the 90 percent camp. I'm supportive of the recommendations. I land in the 90 percent camp.

There's a couple of reasons I land there. One is ease of administration for states. I think tracking a woman who's expansion and then becomes pregnant, it might shift FMAP, and then one-year postpartum shifts back to 90 percent as an expansion. I think the state tracking the state financial piece of this is not to be underestimated in terms of ease of administration.

And I think the stairstep ACA approach of 100 percent for three years, I think all of that is just administratively cumbersome and complicated. I share Toby's point of view that the federal-state partnership requires state contribution, but I don't go so far as to say that this is a lack of partnership because it would be a mandate and, therefore, the federal government should pick up 100 percent.

And the final comment I would make is where we've seen 100 percent FMAP -- and Martha gave some examples -- they tend to be service-related expansions, testing or certain services. They tend not to be coverage-related expansions or population- or eligibility group-related expansions. I have some concerns about setting a precedent in which we look at 100 percent FMAP for a population as a

group. So I'm in the 90 percent camp.

Thanks.

CHAIR BELLA: Thank you, Chuck.

Kit and then Kathy.

[No response.]

CHAIR BELLA: We can't hear you, Kit.

[Pause.]

CHAIR BELLA: I'm actually going to go to Kathy, and then we'll come back.

COMMISSIONER GORTON: Okay. I got it. I think I got it, right? Yes?

CHAIR BELLA: Yep, yep. You're good.

COMMISSIONER GORTON: Okay. Sorry.

So I'd just echo all the compliments to the staff, particularly, Martha, on the work that went into this. It's a complicated issue. We've gotten to a point that I didn't think we'd get to, but the discussion has certainly convinced me.

I just want to say I think this is a strong and important policy recommendation, and at its core, what it means is fewer people will die and more people will be healthier. And that's the fundamental purpose of the

Medicaid program.

I think both of those changes in terms of fewer deaths and more health will be material changes. So I think it's really important.

And I think that others who have not had the opportunity to spend the time deliberating on this and thinking about this may not quickly get to the place that we have gotten to, and I would just encourage us to be as strong as possible in the final text of the chapter around the recommendations.

This is a good, strong evidence-based recommendation, and we want people to know that we're not -- this is not sort of "Yeah, you could kind of do this." This is "We really should do this," because it really will matter to an awful lot of people in an awful lot of places in the country.

Going quickly to the match percentage, my inclination for the reasons that others have said -- and I won't reiterate -- is to go with the 90. I'm not allergic to 100 percent, and if we felt we needed to go to 100 percent for some period of time, I would feel better about that than just 100 percent forever.

And I agree with -- somebody made the point that we're going to talk about countercyclical, so the fact that -- and if the states are already getting an extra 6 percent, 6.2 now, to the end of the public health emergency.

So, again, I don't know that that would push me to go to 100 percent out of the gate. So my leaning is towards 90 percent. Certainly my head won't explode if we go to 100.

CHAIR BELLA: Thank you, Kit.

Kathy and then Sheldon and then Stacey.

COMMISSIONER WENO: Kit kind of stole my thunder in the first half of what he was talking about, the importance of this issue, but based on that, I kind of fall on the 100 percent end. I think as far as policy, this would be something that would be a great statement from MACPAC to make about how important this issue is.

So although I find the 90 percent arguments somewhat persuasive and I'm not going to stand the way of a 90 percent recommendation, I still think that the 100 percent of FMAP is the way to go.

CHAIR BELLA: Thank you, Kathy.

Sheldon?

[No response.]

CHAIR BELLA: If you're talking, we can't hear you.

COMMISSIONER RETCHIN: How about now? How about now?

CHAIR BELLA: Yep.

COMMISSIONER RETCHIN: Yeah. I just wanted to circle back just to note that I asked Martha, and Martha, I do want to say, that her specialty and her specialization -- and you'll hear about value-based purchasing later -- just a tremendous piece of work, Martha. And it's going to do enormous good.

I asked the question: What are the precedents? I reminded myself that OBRA 1990 changed optional coverage for pregnancy and made it mandatory. Congress can do that, and we all recognize that.

In this case, I'm still eventually at 90 percent. Even though the administrative complications may be there, I think it would be more palatable in a severe recession to go to 100 percent for some period of time. Let's say two years and then drop back down to 90. But this is not

unprecedented for the mandatory unfunded benefit if you want to just talk about the partnership.

CHAIR BELLA: Thank you, Sheldon.

Stacey. And then, Kisha, did I see your hand?

[No response.]

CHAIR BELLA: Okay. Perfect.

COMMISSIONER GORTON:

COMMISSIONER LAMPKIN: Thank you. I'm just going to start by complimenting Martha and the team. The chapter is excellent, and I really appreciate that.

Just to also say on most subjects related to eligibility or additional benefits, I kind of lean towards the state option or less than 100 percent side, partnership side, but in this particular case, I'm just convinced that this is so important. This is such a critical coverage gap that it meets the standard for mandatory coverage and part of the floor of the Medicaid standards. So I'm 100 percent behind all three recommendations and the mandatory component and the full benefits component.

On the share of FMAP, I do struggle with this one, but at the end, I'm with Kathy. I actually lean a little bit more towards the 100 percent side. Great

arguments today for less than that. If we were already in a countercyclical -- automatic countercyclical world, that would make me feel a little bit better, and I won't vote against 90 if that's where the rest of the Commission is. But I can definitely see a preference to 100.

CHAIR BELLA: Thank you, Stacey.

Kisha?

COMMISSIONER DAVIS: Thanks. I want to echo a few comments. Again, Martha, this was just an amazing chapter, and I think what you really did well was highlighted the impact that this coverage would have on our minority communities and closing disparities in maternal outcomes. And I think that is really where this -- you know, the impact of this lies and more kids having their moms around. If you want to impact the next generation, this is really huge.

So that's why I land more in the 100 percent category. I don't want to give states any excuse to not adopt this and really to push it forward.

I wouldn't vote against 90 percent. I certainly could live with that. I think it's so important but don't want unfunded mandates. I also can certainly live with a

transition with 100 percent for a couple years to help states get through everything, all of the increased budget costs associated with COVID right now and then it transitions to a 90 percent. But I just wanted to kind of put my stake in the 100 percent camp.

CHAIR BELLA: Thank you, Kisha.

Tom?

COMMISSIONER BARKER: Thanks, Melanie.

I must say I found Sheldon's argument quite persuasive. Sheldon, you've made a very good point which is that Congress did make the coverage to pregnant women a mandatory benefit in the late '80s or early '90s in one of the OBRAs back then. So I'm in favor of mandatory coverage, and I would say I'm in the 90 percent camp. I certainly see the argument for 100 percent but just sort of in the spirit of Medicaid as a partnership.

And I really cannot think -- and I raised this in our last meeting. I can't think of another benefit where Congress has created 100 percent match for any benefit, and so I like the ACA analogy that Chuck made. So I'm in the 90 percent camp.

CHAIR BELLA: Kit?

COMMISSIONER GORTON: While we're talking about some of the mandates in the past, OBRA '89 and expanded EPSDT was probably the largest unfunded mandate that Congress ever passed, and while states have grumbled about it for years, it was an important thing to do. At that point, there was no enhanced match. You just got your regular match, and you started to pay for all of these medically necessary services for children.

So I think there's more than ample precedent to mandate this benefit, and I think that doing it at 90 percent is for me a very comfortable place. And I don't think we need to go to 100, but that's just where I am.

CHAIR BELLA: Okay. Oh, Chuck. I'm going to try to wrap this up here. I'm going to summarize where I think we are and then bring it back to the group, but do you want to add to that?

VICE CHAIR MILLIGAN: Yeah, I hadn't intended to jump back in. The one comment I want to make is there are other examples in the past of mandatory coverage expansions. I mean, there's stairstep, the Waxman Children, going up for different ages to different poverty levels, there's examples in the past.

The comment I would like to make, I think, is that it's important to reflect that the reason the ACA mandate for the Medicaid expansion for adults in general was litigated, got to the Supreme Court, is I think that the magnitude of that expansion and the threat to state matching funds triggered a decision in the Sebelius case. I don't think this rises to that level for a whole bunch of reasons, and I think, depending on how we want to frame and where we land with these final votes, Martha, I think we might need to just touch on the mandate issue with respect to the Sebelius decision.

So I do want to contextualize it, and I think we need to get there in the chapter.

CHAIR BELLA: Okay. First of all, thank you to the Commissioners that we've made so much progress to get to consensus on this, and we really are at one spot. And the majority of you are either open -- what I'm hearing is the majority of you are either open to 90 or 100, or if one is not your favorite, it won't stop your vote, which is interesting.

In that vein, my proposal would be we bring forward the 100 percent. If that is not comfortable to the

Commission, then we can talk about the 100 percent for three years or two years, and then it steps down. That is how I would like to proceed. But for those of you that feel strongly against 100 percent, I want -- and, Bill, I appreciate your point of view. I completely understand that. I don't think we're going to persuade you on 90 or 100 either way, so that's why I'm going forward on this path.

But for those of you that feel like that's a terrible approach to bring it back in that manner, I would like to give you a chance to make a comment. Toby?

COMMISSIONER DOUGLAS: Well, not a comment, but what was the split of just -- did anyone count like in terms of leaning one way or the other?

CHAIR BELLA: Yeah, I have a listing of that, but people also hedged to say, "I want this, but I would be fine with this," or, "I want this, but I like Sheldon's idea." So it's not that it's -- that's why it's a little -- there are very few of you that are saying, "It has to be this, or I will not vote for it." There are maybe two of you --

COMMISSIONER DOUGLAS: That's fair, but I just

thought, yeah -- I mean --

COMMISSIONER CERISE: Yeah, I'm with Toby. I'd like to just hear maybe what the leanings are, because I didn't say -- I didn't say anything one way or another, but given the two choices --

CHAIR BELLA: Okay. I'm going to go around and ask you -- this is going to be a speed round.

COMMISSIONER DOUGLAS: Okay.

CHAIR BELLA: You say 100, 90, or Sheldon, and I'm going to go in the order of my screen, so I'm going to start with Kisha.

COMMISSIONER CARTER: Could we look at the 100 percent going for three years first and see who's on that one?

CHAIR BELLA: Sure.

COMMISSIONER BURWELL: That's the Sheldon option, and you can vote on that.

COMMISSIONER CARTER: I think that's a compromise position, and I'd like to see who's in on it.

CHAIR BELLA: I just want to -- I think for efficiency I'm just going to ask, go person to person and say you can say 90, 100, or Sheldon. Kisha.

COMMISSIONER DAVIS: 100.

CHAIR BELLA: Stacey?

COMMISSIONER LAMPKIN: 100.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: 100.

CHAIR BELLA: Sheldon?

COMMISSIONER RETCHIN: Sheldon.

CHAIR BELLA: Okay. Leanna?

COMMISSIONER GEORGE: Sheldon.

CHAIR BELLA: Sheldon. Kit?

COMMISSIONER GORTON: 90.

CHAIR BELLA: Fred?

COMMISSIONER CARTER: 90.

CHAIR BELLA: Toby?

COMMISSIONER DOUGLAS: 90.

CHAIR BELLA: Peter?

COMMISSIONER SZILAGYI: Sheldon.

CHAIR BELLA: Kathy?

COMMISSIONER WENO: 100.

CHAIR BELLA: Bill, abstain, right?

COMMISSIONER SCANLON: Abstain, right.

CHAIR BELLA: Chuck.

VICE CHAIR MILLIGAN: If you had called it something else, maybe Sheldon, but 90.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: 90.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: 100.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: 100.

CHAIR BELLA: Tom?

COMMISSIONER BARKER: 90.

CHAIR BELLA: Okay, and I am in the 100 camp. So one, two, three, four, five, six, seven --

COMMISSIONER DAVIS: Melanie, can I make a quick comment? I just want to point something out to the Commission the gender divide on that vote, if anybody noticed, with the exception of one. I think it's important as a Commission that we recognize where the women fell on this maternal issue and where the men fell on this maternal issue. I don't think it changes anybody's vote, but I just think that's an important thing to recognize.

CHAIR BELLA: So in case that's not clear to folks, six women voted for 100 and six men voted for 90.

No women voted for 90, just to make Kisha's point very clear.

COMMISSIONER GORDON: And a man did vote for 100, just to be clear.

CHAIR BELLA: Yes. We'll give you an award later, Darin.

Okay. So just because people wanted a count, we have seven people in the 100 camp, six people in the 90 camp, three people in the Sheldon camp, and one person abstaining. So let me go to those of you in the 90 camp and ask how many of you are 90 or nothing. Can you -- Tom --

COMMISSIONER BURWELL: Not I. I'll go with 100 if that's the majority.

CHAIR BELLA: Okay. Tom? Tom, you're on mute.

COMMISSIONER BARKER: Sorry. I'm sorry. I don't know why I couldn't get off mute. Is the choice between 90, 100, or Sheldon? Or is it between 90 and 100? Because I'd be with Sheldon, if not at 90.

CHAIR BELLA: Okay. Kit?

COMMISSIONER GORTON: So kudos to Kisha. I'm going with the people who know most about this issue, and

I'm going to change to 100. Thanks.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: I would agree with Tom. I would go to Sheldon just because I'm not in favor of 100, and, Kisha, it's not because I don't want to do the program, because I think financially it should be a partnership. But, yeah, I would prefer Sheldon's plan.

CHAIR BELLA: Okay. Toby?

COMMISSIONER DOUGLAS: Just to reiterate, you know, I'm open to both. This is to me -- it's not about a policy -- there's policy, which is saying that it's mandatory, and I 100 percent agree this should be a mandatory benefit. And then there's the question about the state-federal participation from a financial standpoint, which has nothing to do with the policy. It has more to do with how we financially structure a program. And so I still think 90 is better, but I will go with 100.

CHAIR BELLA: Chuck.

VICE CHAIR MILLIGAN: I'm not adamant to 90, and in light of Kisha's comment, my back-up is 140.

CHAIR BELLA: Okay. So given that, I'm going to ask Martha to bring back the recommendation at 100 percent,

and that is what we're going to vote on tomorrow, because as a fallback we have the Sheldon approach, but I'd like her to bring it back at 100 given that the majority of Commissioners are in the 100 percent category. Is that comfortable to all of you?

COMMISSIONER CARTER: Yes.

COMMISSIONER CERISE: Melanie, I'll just ask how important -- I mean, like I guess you capture our comments, so, you know, you don't have to vote against 100, but I think it's important to kind of have it known that I guess we've had this discussion and that there's not full agreement on that point, but that we can agree the policy is more important to go forward.

CHAIR BELLA: Yeah, I mean --

COMMISSIONER CERISE: I mean, how important is it? I realize all the pieces that go into a recommendation, and you're not going to get 100 percent agreement on it. I just hope that, you know, the flavor of this discussion gets captured.

CHAIR BELLA: Yes, I think that there is -- it is critical that the flavor of the discussion gets captured, and I think we all have such confidence in Martha's work to

trust that she will go back and reflect this part of the discussion in the chapter that will accompany the recommendation. Sheldon?

COMMISSIONER RETCHIN: Yeah, can you hear me?

CHAIR BELLA: Yes.

COMMISSIONER RETCHIN: In the end, Congress still has the prerogative to change the FMAP, so, you know, I don't know how you want to -- if you could reflect that in the recommendation? But that's certainly in terms of the flavor of the discussion. I still -- listen, I just want to make clear we all -- I am absolutely 100 percent with the mandated policy. This is really an issue about financing, and so -- but we all have to recognize that Congress has the option and prerogative to do that.

COMMISSIONER CARTER: Yeah.

CHAIR BELLA: Okay. Thank you all. We'll have another chance at this before we will take a vote on this tomorrow. Thank you.

Martha, do you have any last questions or comments or anything you need from us?

MS. HEBERLEIN: No. Thank you. And I'll definitely explain more in the rationale about the debate

about the FMAP and the financing versus policy point of view. And apologies again for my technical difficulties, and thank you for bearing with me.

CHAIR BELLA: You know, even when we can't see your face, you're still --

MS. HEBERLEIN: I'm smiling.

CHAIR BELLA: Thank you. We can actually tell you're smiling. It comes through in your voice, so thank you.

Okay. We are going to move to estate recovery now. This is another area where we've had several discussions as a Commission, and we are looking at a set of recommendations. But I will turn it over -- I see Tamara, Kristal. I'm not sure which one of you is starting, but we are ready whenever you are.

ESTATE RECOVERY: REVIEW OF DRAFT CHAPTER AND RECOMMENDATION DECISIONS

* MS. HUSON: Okay, great. I'm starting. There's Kristal. Perfect.

So good morning, Commissioners. Kristal and I are here today to go over the draft chapter on Medicaid estate recovery. This chapter includes three draft

recommendations which we presented last month but have tweaked slightly in response to your discussion.

Next slide, please.

This slide lists the different sections of the chapter. You'll note that we added some background information on LTSS financial eligibility, which I will go over briefly in a moment, as well as the legislative history and requirements and program administration of the Medicaid estate recovery program to help provide more context for the chapter.

The draft chapter also reviews the results of the Commission's analyses over the past few months, which have included reviewing the literature and federal guidance on estate recovery program operations, extracting information from Medicaid estate plans to understand the extent to which states pursue recovery beyond the federal minimum requirements, compiling aggregate data on estate recovery collections for fiscal years 2015 to 2019, surveying a sample of states regarding the number and size of estates recovered, hardship waivers granted, and opinions on whether to continue to pursue recovery if this requirement were to be made optional, and interviewing stakeholders and

reviewing the literature for insights into whether estate recovery has had an effect on access to LTSS.

Next slide, please.

There are many eligibility pathways for Medicaid LTSS. While states are generally required to cover beneficiaries who receive Supplemental Security Income, all states also cover individuals through one or more optional pathways, which you can see listed on the slide. These pathways each target different population groups, such as individuals with disabilities who work, and they also have various income thresholds and asset limits. The most commonly used asset limit is the SSI amounts of $2,000 for an individual and $3,000 for a couple. Please refer to the chapter for more details.

Next slide, please.

Financial eligibility for Medicaid LTSS is determined by both income and asset limits, also called resources. In general, countable income includes earned income, such as wages, and unearned income, such as Social Security benefits, trusts, and unemployment benefits. Some income is excluded, such as the first $65 of monthly income plus one-half of the remaining amount up to certain limits.

Countable assets may include cash and other liquid resources, such as stocks and bonds, and some assets are excluded, such as a primary residence, household goods and personal effects, and one automobile. And while a primary residence is not considered a countable resource for Medicaid eligibility under SSI program rules, its value can affect eligibility for Medicaid LTSS specifically. And for 2021, the minimum home equity limit is $603,000 and the maximum limit is $906,000, meaning that if an individual's home equity is above the limit chosen by the state, they will be deemed ineligible to receive Medicaid LTSS.

In 2018, 40 states used the federal minimum, nine states used the maximum, one state set a limit in between, and one state had no limit. The home equity does not apply if a beneficiary has a spouse, a child under age 21, or a child with a disability of any age who resides in the home.

There are also rules pertaining to post-eligibility treatment of income and protections against spousal impoverishment which allow an institutionalized Medicaid beneficiary's spouse to retain some income and assets in order to remain living in the community. For more on those rules, please refer to the chapter.

Next slide, please.

Based on a review of the literature, we found that for low-income beneficiaries their homes represent a large majority of their assets. As such, they may find it difficult to draw down that wealth if they need funds to cover expenses as they age. And in order to learn more about assets held by older adults, MACPAC contracted with the University of Massachusetts to review the Health and Retirement Study, or HRS, which is a longitudinal survey of adults age 50 and older. They identified Medicaid beneficiaries enrolled in the HRS who died during the 2012, 2014, or 2016 survey period. We have received the first round of initial outputs from the contractor which describes the demographics, income, and wealth of 578 Medicaid beneficiaries in the sample.

In general, the study found that the assets of older adults on Medicaid are quite modest, with a substantial portion of individuals having little to no wealth. More specifically, we found that at age 65 and older, the average net wealth was $44,393. The lowest quartile of the group had negative net wealth. On average, this group's debt exceeded its assets by $14,000. And the

highest quartile held an average of over $173,000 in net wealth. Three-quarters of the sample had net wealth of less than $48,500.

The data also show that, overall, home equity held by the total sample was only $27,364. The lowest quartile had a negative home equity of almost $7,000, and the highest quartile held an average of $98,694 in home equity. This data indicates that the assets that Medicaid programs can recover from after a beneficiary's death are limited, particularly for individuals who do not own their own homes.

We will be getting additional data from the contractor and may be able to update this section of the chapter with more details before final publication of the report in March.

Next slide, please.

Commissioners will probably recognize this slide from our previous presentations outlining the basic requirements for estate recovery programs. We included it as a refresher, but we point you to the draft chapter for more information.

Next slide, please.

Finally, to quickly review the key findings of our analytic work which we presented last fall, we found that estate recovery programs vary by state, with some more expansive than others. We found that states recovered a total of $733.4 million in 2019, but overall, average recoveries are modest and few hardship waivers are granted.

Finally, stakeholders we spoke with said that those with significant means can avoid estate recovery through estate planning, but for many without such means, estate recovery can deter individuals from seeking Medicaid coverage for LTSS.

And with that, I'm going to turn it over to Kristal to walk us through the draft recommendations.

* DR. VARDAMAN: Thank you, Tamara. Now I'll go over the three draft recommendations and rationale. We made several changes in response to your comments in December.

The first recommendation, draft recommendation, which is unchanged from December, reads, Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it's required under

current law.

As you discussed in December, this recommendation would give states increased flexibility, allowing some to cease recovery if they determine the return on their investment is low, while others could continue the practice. States most likely to opt out could be those with lower collection amounts relative to other states and those that only pursued the mandatory populations and services.

We asked our colleagues at the Congressional Budget Office to provide us with estimates for this recommendation. I thank them for their work. Please note that this estimate is a range rather than a point estimate, as it's not legislative language, which is what they would need to develop an exact figure.

We went over a lot of this rationale last month so I'm just going to go through it quickly, and the implications quickly. Again, CBO did have this estimated as something that would increase federal spending by $50 to $250 million per year during that budget horizon, due to those states not collecting that revenue. In terms of beneficiaries, we would assume that some individuals might

seek services who may have not done so previously, and it could protect some heirs from economic hardship and address equity concerns. We don't see any direct effects of this on plans and providers.

The second draft recommendation, which we have amended from last month, reads, Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the services used by a beneficiary were less than the capitation payment made to a managed care plan.

So currently, as we've discussed, if a state elects to pursue recovery for all Medicaid services they must pursue recovery for the total capitation payment or a portion of the capitation payment attributed to the services for which they seek recovery. So this change would allow states with managed long-term services and supports to pursue recovery based on the cost of care provided to its beneficiaries. As written, it does not currently require states to do that.

However, they would be able to recover only up to

the cost of the capitation payment, which is a change you asked us to make last month. This means that in states that continue recovery, have managed care, and take up this option, the estate of an individual who used limited amounts of LTSS would not pay more than what was spent on their capitation, unlike under current policy. Beneficiaries who did use a lot of care, such as those who were institutionalized for significant periods, would continue to have their claim capped at the capitation payment, which is the amount the state paid to the plan that assumed the risk for their care. We assume that this approach would be easier for heirs to understand and also give states more flexibility in administration.

And again, the implications here are mostly unchanged from last month. Because some of this depends on the effects on federal spending depends on how Recommendation 1 would be taken up, some states would cease recovery completely. CBO wasn't able to give us a score because the amount, how much this would affect federal spending, would depend on how many states decided to retain estate recovery.

But again, we do expect that this would increase

federal spending by a modest amount, that beneficiaries might be more willing to seek services, and that it would have little to no effect on plans and no effect on providers.

And so the last draft recommendation, which also has been amended since last month, reads, Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue recovery for any asset that's the sole income-producing asset of survivors, homes of modest value, or any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards.

So compared to last month, here we've asked Congress to direct the Secretary to mandate these new requirements, rather than directing the Secretary to come up with criteria. We also added the threshold under which states could not pursue recovery, in response to your feedback. We left some elements to Congress to determine, or to direct the Secretary to do, such as the value of the

threshold.

This recommendation would address some concerns about how estate recovery may perpetuate poverty and provide for more consistent treatment by putting in place minimum federal standards. As we discussed in the past, CMS currently suggests but does not require certain criteria, and states can define their own criteria that they use, either in addition to or instead of CMS's examples. Under this recommendation, states would be able to continue to have their own standards that exceed federal minimums.

I should also note here that depending on what threshold is set for the minimum estate size, that would certainly affect the number of estates for which hardship exemptions would be needed, as recovery would be waived for those small estates, regardless of any hardship criteria that might also apply.

Again, CBO did not give us an estimate for this option, but we would expect that it would increase federal spending somewhat given the new estate value threshold and potential for the additional hardship waivers. We would also expect, under this recommendation, that more estates

would have recovery waived, which would decrease state collections. And again this would protect heirs from economic hardships, and we don't see any effect of this recommendation on plans or providers.

And so with that we look forward to your discussion and feedback on the draft chapter and these draft recommendations. In particular, please let us know if there are any edits you would like us to incorporate into the recommendation language in advance of tomorrow's vote.

So with that I'll turn it back to the Chair. Thank you.

CHAIR BELLA: Thank you both for taking us through that and for the work that you've done over the past several months as we've explored a variety of issues. As everyone knows, we've looked at a lot of things. We've landed on three recommendations, as discussed last month, and reiterated just now. The discussion today and the vote tomorrow is about estate recovery, so just to remind us that it's not about eligibility issues. Those are also important but that is not what the topic at hand is for these recommendations and our vote.

As the chapter well indicated, and as we heard just now, we will talk about exploration into eligibility issues and whether there is need for policy improvements in that area, and we will keep monitoring that.

So in the time that we have left, I would ask Commissioners who wish to speak to please indicate your support for or concerns with the three recommendations on estate recovery. I will start by saying I am in support of all three. This work has convinced me that estate recovery is in need of reform for a variety of reasons that I don't need to rehash, but I am enthusiastic to support the recommendations and move them forward.

I will turn to Chuck, I see, and then Darin.

VICE CHAIR MILLIGAN: Tamara and Kristal, thank you very much for your work getting us here. I am going to be in support of all three recommendations as well. I do want to articulate just a few reasons, and I'll try to be brief.

With respect to 3.1 and making it optional, I do think that much like we made the recovery audit contractor process optional in a recommendation two years ago, I do think states should have the option if they think that this

is not a cost-effective, cost-beneficial activity, which I think in many states is the case.

Second, and I made this point at the last meeting, I do think that states have a compliance risk if HHS OIG comes in after the fact and says the recovery rate should be higher, for a variety of reasons I think the HHS OIG may not understand. So I'm supportive of optional, for those and other reasons.

I'm going to focus my comments on 3.3 and the thresholds. So if a state does pursue the option and they do elect to continue pursuing recovery, I want to reiterate Melanie's comment that I think this is very distinct from eligibility-related activities to become a Medicaid LTSS beneficiary. I do think that should the Commission want to get into looking at potential abuses of Medicaid estate planning activities around how individuals make gifts or create trusts or shelter assets, I think that is absolutely fair game for the Commission. I think of that as distinct, because I think a lot of individuals who die with estates didn't use those financial or estate-planning activities. They have a house because they paid off a mortgage, and they have a house. They didn't do any gimmicks to get

there.

So I think those are distinct bodies of work and distinct issues, and for me I would not want to pursue estate recovery because we think that there was a failure on the eligibility side to qualify because of how sheltering may occur, because I do think there is an imperfect relationship.

So let me just focus then on the rationales for me recommending minimum thresholds. The first I want to mention is we don't pursue estate recovery in Medicaid for other disease states, other conditions, other kinds of services. This is fairly unique to LTSS, and I think that there are equity issues based on what an individual's just lottery, created as their particular medical condition and medical need. And I think that having estate recovery on a particular group, when we spend a lot of money on other groups that have no estate recovery risk, I think it's inequitable.

Second, there are a lot of other federal entitlement programs without any estate recovery activities whatsoever. There isn't estate recovery for a lot of other means-tested programs, there isn't estate recovery for

other federal entitlement programs, and I think it's inequitable to impose this simply in Medicaid and simply in one type of area of Medicaid.

Third, and as you mentioned, Kristal, I wouldn't want to discourage anybody from utilizing services for risk of recovery. I think that impedes the value and philosophy around the entitlement program.

Fourth, I think it's critical that we allow individuals to pass minimum estates, however Congress would choose to define it, to their heirs, their children, as a component of breaking a cycle of poverty. And I think estate recovery works against breaking a cycle of poverty in the way in which it denies families below the poverty level a means of getting started when somebody who received LTSS passes away.

And the final comment I'll make, and perhaps the most political comment I'll make here, is to the extent people think of estate recovery as a way of recovering funds that can then be reinvested in the program and finance the program for the next set of Medicaid beneficiaries, I think this is a very, very regressive form of creating financing.

We have seen Congress, in recent years and for a long time, whittle away at and eliminate estate taxes or so-called death taxes for very high-income individuals, often under this somewhat mythical rubric of the family farm and mythical rubrics in other ways. And I think if we have a financing challenge in Medicaid related to how to finance based on decedents, financing Medicaid or creating federal and state funding on the backs of Medicaid beneficiaries without recognizing the inequity and the regressive nature of that financing system, in the context of Congress's kind of refusal to have estate taxes for much higher-income people, that could flow funding back into the system to finance these programs, I just think is a form of regressive financing taxation that I'm not supportive of.

So I'll end there. For those reasons I'm going to be in support of all of these recommendations. Thank you.

CHAIR BELLA: Thank you, Chuck. Darin, you have the privilege of following that.

COMMISSIONER GORDON: Yes, it's always fun following Chuck. Tamara and Kristal, you all did a wonderful job. That goes without saying, actually. I will

say that I align myself with Melanie and Chuck, for many of the reasons Chuck articulated, so I will be very brief.

CHAIR BELLA: Thank you, Darin. Brian, and then Kit.

COMMISSIONER BURWELL: Can you hear me?

CHAIR BELLA: Yes.

COMMISSIONER BURWELL: So obviously I have a very different point of view. From the start of looking at this issue I have said pretty strongly that I think the Medicaid estate recovery program has been at the bottom of the net worth distribution and at the top, and we need radical -- the program is not working, it's broken and needs major structural reform. That's my major objection to the recommendations. I don't think that they go far enough. I think this is a program that really needs major reform. It's not working. It's not meeting its purpose. I think we need to work on it more and come back with stronger recommendations about reform.

I think the data that we just received recently from the HRS analyses is very illuminating, and we have to discuss that data and maybe dice it a little more to get at the truth. It's the first time the data has been made

available on the actual estates of Medicaid decedents. And the data show pretty much the strong narrative that three-quarters of decedents have estates of little or no value, less than $40,000, and we could set a floor of exemptions up to $40,000, and exclude 75 percent of the estates of decedents. But in that top quartile the total percentage of the total value of all estates is 98 percent. Ninety-eight percent of the value of all estates of Medicaid decedents is at the top end, and there's obvious leakage going on in Medicaid eligibility rules, of people who were able to avoid Medicaid estate recovery.

I think it's very important that the Medicaid program maintain its role as a safety net program, and Medicaid eligibility, financial eligibility policy is a way to convey that fact to the public. You cannot get full coverage for LTSS services and keep all your money. I think that's a very important policy statement, and I disagree with Chuck and Melanie that Medicaid estate recovery is distinct from front-end financial eligibility. I think they are integrally linked together. They are two parts of the overall financial eligibility policy, primarily because estate recovery primarily deals with home

equity, which is over 60 percent of total home equity for a lot of Medicaid recipients.

So I also want this structural reform because I also am very invested in the bigger picture, which is LTSS financing reform. I am personally for a publicly financed LTSS program to provide services separate from Medicaid. There has been very little public support for such an option. It's only around 15 percent. And I think if we continue to allow this leakage to go on in the Medicaid program, for people to get LTSS coverage and keep their money, there's going to be less support for overall LTSS reform.

So this is a small program, but in terms of policy and policy statements I think it's a very important program to underline the fact that it is only for people who meet the safety net financial eligibility requirements and not for people who are able to manipulate the rules.

CHAIR BELLA: Thank you, Brian. Kit, and then Bill.

COMMISSIONER GORTON: So, first, I want to applaud Brian for passionately stating he had a different point of view. I think that's important in our process,

and in a consensus-driven organization, it can be hard and painful. And I have some experience with that myself, and I agree in principle with many of the things that Brian said about estate recovery.

That said, I'm not persuaded that his recommended approach is the best thing to do, and I am supportive of all three of these as an interim step forward. And the reason for that is because I think what the data show us is that this estate recovery piece doesn't work at all. As Brian said, it's broken, and I don't think we have enough information yet to say do away with it altogether. But for my purposes, I think we're close to that.

I absolutely agree that we need a long, hard, deep look at eligibility because that's where the problem lies in my view, and that's where the solution has to come from.

But that said, I think this is a reasonable interim step because I think it allows states that want to stop this and never wanted to start it, like West Virginia that was dragged kicking and screaming into this program -- it allows them to stop, right? And so I think as an interim step for me, it makes sense to say the states that

want to stop this, stop it.

In terms of the states that want to continue, I think the chapter on this needs to be very strong in terms of cautioning those states about the risks of continuing it, about the increasing generational poverty, about the inherent racial biases that are built into this program. States can do this and recover, but they better look at who they're recovering from because I think that they're going to find that they're recovering from a very biased sample of people. And they should not feel good about that, even if they're recovering large amounts. We should point them to eligibility as being a place to do more work and this back end recovery not.

So I'll stop there, but in terms of the arguments that Melanie and Chuck have made, I agree with those. I agree with Brian's point in principle, but I think these three recommendations are good first steps to deal with a much larger problem of having people who are really not low-income people ending up having their LTSS paid for by the Medicaid program.

CHAIR BELLA: Thank you, Kit.

Bill and then Sheldon.

COMMISSIONER SCANLON: Tamara and Kristal, you gave us an incredible amount to ponder here. Thank you very much for that.

I guess, Kit, it might be my day for masochism because I'm going to present another divergent sort of view.

The data are very clear that Medicaid LTSS users do not have a lot of resources, and so, therefore, we shouldn't be too surprised when the recoveries are relatively modest. But at the same time, we know there's a phenomenon out there which is that there are people who are assisted by sort of profiteers, so to speak, who are sheltering assets inappropriately and depriving other Medicaid eligibles of resources for LTSS. And there is, if anything, a significant underinvestment in Medicaid LTSS. There's a lot of unmet need among sort of the Medicaid beneficiaries receiving LTSS.

For that reason, I think it's important to preserve a national principle that we do not want to have these pathways work sheltering your sort of assets and becoming Medicaid eligible to continue to exist. I think we need to have estate recovery that is efficient, and we

need to learn how to do that, do that well.

I mean, I noticed over the past number of years that state taxes are becoming incredibly more effective in terms of identifying sort of options for getting people to pay revenue that they should have been paying and were not doing.

So I would oppose sort of the first recommendation and making it optional because I think we need to put in place and see how we can improve it rather than scrapping it.

In terms of the other two recommendations, I support those. In particular, I think that the idea of having a floor for the hardship exemptions is important.

For this to be an equitable sort of set of policies, it shouldn't be a function of where you live. There should be some kind of national protection again, and therefore, a federal minimum should be established.

This is a dream of mine, and I know it's not going to happen. If there was a federal minimum, I would love it to be sort of adjusted for differences in cost of living across areas. I would apply the same thing to eligibility criteria as well. That's not going to happen

either, but that would be my wish in the long run.

In terms of the second recommendation, I think that's just a no-brainer. We shouldn't be asking people to recover -- their assets to be recovered for services that they never received.

So where I am is I'm in favor of sort of 2 and 3 but not No. 1.

CHAIR BELLA: Thank you, Bill.

Sheldon?

[No response.]

CHAIR BELLA: You're on mute.

[No response.]

CHAIR BELLA: Still on mute.

COMMISSIONER RETCHIN: Hi. I guess I was being blocked actively.

As I understand it, Recommendation 3, individuals would have to apply for a hardship to be exempt. Is that correct in the way the recommendation is formatted, Tamara and Kristal?

DR. VARDAMAN: Yeah. So as written now, any estate that was under the threshold would automatically be waived --

COMMISSIONER RETCHIN: Okay.

DR. VARDAMAN: -- and there would still need to be some process to grant the hardship waivers under those two mandated criteria and also any additional criteria that states might have in place.

COMMISSIONER RETCHIN: Yeah. I have to say I'm affected by Brian's argument. I'm not sure how to deal with it, but it is concerning. And Bill's points are well made as well.

I'm not sure. In terms of the regressivity of this, the vast majority of the Medicaid -- the estates are zero. So in terms of regressivity, the preservation of the opportunity for estates that are $900,000 to be continued, which I think this would actually still do, to Brian's point, but I don't know. I'm still puzzled by the right policy.

I'll continue to listen. Thanks.

CHAIR BELLA: Kit, are you holding your hand up? I can't tell. Okay. Go ahead.

I just want to remind us all, we are approaching the end, and I want to leave time for public comment, because we also have to have comment on postpartum, just a

quick time check for everyone.

So, Kit?

COMMISSIONER GORTON: So I just have a quick comment which is when we talk about the size of these estates -- and I only had time to do a quick review of the data that Kristal and Tamara had sent us from the HRS study -- those are estates after the assets have been protected. So those estate numbers are what happen when they came -- I believe when they came to probate, right? So these are estates that have -- you're not seeing the estate before the irrevocable trust was created and all the assets were put in it. You're seeing the estate after the assets were put in the trust.

So we need to be careful about these data, and we need to talk about that more in the eligibility discussion, which I hope that we will have in a direct discussion about protecting assets. But we need to be careful when we interpret these data because I think they don't include the big bump at the end for the protected assets.

CHAIR BELLA: Brian, quick comment?

[No response.]

CHAIR BELLA: You're on mute.

COMMISSIONER BURWELL: In terms of the potential that could be recovered if we recovered more aggressively, I just did a quick back-of-the-envelope estimation of the total value of all estates, and it was over $12 billion. So the amount of recoveries that states are collecting is just a very small percentage of the potential recoveries that could be made. We're not talking nickels and dimes here.

CHAIR BELLA: Thank you, Brian.

DR. VARDAMAN: I just want to make one note to Kit's point. We are still working with the contractor on some additional information, and one of those things is more backing information about the assets that underlie the total wealth calculations. So we will make sure we understand there which, because this is a survey, and once people pass away, their heirs basically help confirm the assets that were held in their estate when they pass. So I'm not sure exactly what goes in and out in terms of how much it accounts for things that were maybe protected, but we will definitely follow up about that.

CHAIR BELLA: Yeah. I mean, to Kit's point and Brian's point, there is a lot of work to be done here.

We're not saying that we're done after we take a vote on this tomorrow. We're saying that there are some opportunities in front of us right now that we could be doing while we advance other issues that this has brought to light.

All right. Are there any comments from any other Commissioners?

[No response.]

CHAIR BELLA: Tamara or Kristal, do you need anything from us? And then we're going to turn to public comment.

DR. VARDAMAN: No, I think we're all set. Thank you.

CHAIR BELLA: Okay. We're now going to open it up to public comment. I just want to remind folks that we're interested in hearing from you on the two items we discussed today, and if there are specific questions you have or background questions you have, I would ask that you not raise those in this forum. You can certainly email us for that kind of information. We really would like to just hear comments about our discussion and comments about the recommendations and our path forward.

So, with that, if you would like to make a comment, please hit the little icon hand on your computer, and we will unmute you and recognize you.

[Pause.]

CHAIR BELLA: All right. We can start unmuting whenever you're ready, and I would remind everyone to please announce yourself and the organization you're representing before you make your comment.

Can we start with Adriana, please?

[No response.]

CHAIR BELLA: Okay. Adriana, you're unmuted.

PUBLIC COMMENT

* MS. KOHLER: Oh, great. There we go. Thank you. Can you hear me okay?

CHAIR BELLA: Yes.

MS. KOHLER: All right. Wonderful. My name is Adriana Kohler. I'm policy director at Texans Care for Children. We are a statewide children's advocacy organization in Texas. I'm also a postpartum mama myself with a five-month baby boy. So this issue is very important to me personally as well.

Thank you for the Commission for having this

great discussion today about its recommendation on postpartum coverage. I respectfully urge you to recommend the highest possible federal matching rate and provide clear expectations to states.

Here in Texas, we have 400,000 births each year. Here in Texas, one in four women of reproductive age are uninsured. This is the worst uninsured rate in the country. This was before the COVID-19 pandemic. It's gotten worse since then.

Texas Medicaid expires 60 days after child birth, leaving many new moms without access to medical and behavioral health care during this critical time.

We have a significant challenge with maternal mortality and pregnancy complications in Texas. Our review committee came out with its recent report just a month ago. The vast majority of our maternal deaths in Texas occurred after pregnancy, and a third occurred 43 days to one year postpartum.

While all families are at risk, they're disturbing racial disparities and maternal health and birth outcomes. The December 2020 report continued to find that Black women are three times more likely to die of

pregnancy-related causes in Texas.

I just want to give you a few stories from the field that we're hearing. I worked with one local organization that helps moms with postpartum depression. This local organization, she spent weeks trying to find a mental health therapist for this client who did not have insurance. She could not find a therapist who would take her without insurance. It took weeks and weeks, and during this time, the mom's anxiety and depression got worse and worse.

I want to contrast that to a recent story. As you know, under the public health emergency, moms have been able to continue their Medicaid coverage. I've heard from a nurse-family partnership nurse today. She said she was working with a client who had severe postpartum depression. She was working with her OB to manage the symptoms in that first 60 days of Medicaid. Things were still not better. She was able to continue working with her OB to modify the dosage of her medication over the next several weeks and months. This was only possible because of the extension of Medicaid coverage. This extension could have saved her life.

Just one last thing, I want to clarify a thing that was mentioned earlier. It was mentioned that Texas has an 1115 waiver for an extension. This is not an extension of Medicaid for postpartum moms. Rather, this is an 1115 waiver to add postpartum services to our family planning waiver. This program has virtually zero mental health therapists. It has no cardiologists. It has no specialists. This is a preventative care family planning waiver, and our state is trying to extend it to add some services. There's no provider network.

We need state action to extend comprehensive coverage in Medicaid for 12 months postpartum. Please recommend 100 percent FMAP. Please don't give our state an excuse not to act. Even a small state match will give Texas an excuse not to adopt these policies for moms or, worse, could give Texas a reason to reduce income eligibility for moms in pregnancy Medicaid.

I thank you so much for your time today and for your expertise.

CHAIR BELLA: Thank you very much for your comments.

We could just keep moving down the list to

Adrienne.

MS. GRIFFEN: Good morning. My name is Adrienne Griffen. I'm the executive director of Maternal Mental Health Leadership Alliance.

We applaud the Commission's decision to put forth the recommendation to extend pregnancy-related Medicaid coverage for eligible individuals at 100 percent FMAP.

As many of the Commissioners noted, the health of the mother is intrinsic to the health of a child, and we're thrilled to hear that Commissioners recognize that extending Medicaid coverage to women at this medically vulnerable period in their lives will ensure that fewer people will die, and more children will have healthy mothers.

As the previous speaker mentioned, mental health conditions are one of the most common complications of pregnancy and child birth. In fact, suicide and overdose are one of the leading causes of death to women in first year postpartum.

Our organization submitted a letter to Congress in December with over 100 like-minded organizations co-signing, all supporting extending Medicaid coverage to a

full year postpartum.

Thank you to the Commissioners for paying such close attention to this very, very important matter and for recognizing that healthy families need healthy mothers. Thank you.

CHAIR BELLA: Thank you for your comments.

We're moving on to Donna, please.

[No response.]

CHAIR BELLA: Donna, you should be unmuted.

MS. KREUZER: Can you hear me now?

CHAIR BELLA: Yes.

MS. KREUZER: Okay. Thank you so much.

My name is Donna Kreuzer, and I'm the advisor of legislative affairs for the nonprofit Pregnancy and Postpartum Health Alliance of Texas.

In this hopefully projected remarkable year, it is my greatest hope and prayer that expanded Medicaid for postpartum mothers will finally be increased from the 60 days after delivery to the suggested 12 full months as recommended by MACPAC and countless other studies performed by various organizations nationwide.

I'm speaking on behalf of my cherished only child

who greatly suffered from severe postpartum depression after safely delivering her first baby from April 22nd, 2010, through October 1, 2010, almost five and a half months postpartum, well beyond the 60 days postpartum.

Yes, this is personal, and most regrettably today marks 3,770 days in which all dearly loved, respected, and needed our daughter, including her dearly beloved husband and most desired and cherished baby daughter. We have had to manage life without her for those 3,770 days so far.

Our amazing daughter lost all hope of ever returning to her vivacious, courageous, intelligent, and successful self, despite the fact that we had offered and she received numerous professionals' assistance as well as family and friends' support on a daily basis. We all lost when she ended her ferocious battle and struggle of severe postpartum depression on October 1, 2010.

As I have testified on various bills at our Texas legislative sessions since my daughter's death, I consistently mention how deeply concerned I remain for the less fortunate population of mommies and their families and friends who do not have the resources available to them after 60 days postpartum.

You all, postpartum depression isn't prejudiced nor knows any boundaries. Fortunately, we were able to provide all the help conceivably available to our daughter, yet five and a half months postpartum, we still lost our only child. There are no words, especially -- I'm sorry. I'm so sorry. There are no words to describe the loss of life of a loved one, especially your own flesh and blood. There's just absolutely no words.

So in honor and memory of not only my daughter but scores of other mommies who have suffered and lost their incredibly precious life, please seriously consider and allow this year to be the year we expand Medicaid to one year postpartum. And I believe in doing so, lives, not numbers, not only cost savings will prove successful, but countless other lives exponentially may be saved.

I commend you for the work you all have done, and I sincerely thank you for your valuable time and careful consideration. Thank you.

CHAIR BELLA: Donna, thank you. I know I'm speaking on behalf of all Commissioners when I say we're deeply sorry for your loss and thank you for taking the time to share that with us and to help us understand your

perspective. It matters, so thank you.

MS. KREUZER: Thank you.

CHAIR BELLA: Okay. If we could keep moving down the list, please. Okay. I'm just going to start unmuting, if that works, so we can keep going.

MS. GUTIERREZ: Hi. Good afternoon. My name is Lynanne Gutierrez. I'm the Assistant Director at Groundwork Ohio. Groundwork is Ohio's statewide nonpartisan, public policy research and advocacy organization that champions high-quality early learning to healthy development strategies from the prenatal period to age 5, that lay a strong foundation for Ohio kids, families, and communities. We are governed by a robust advisory committee of child-focused health and education experts from across the state. Thank you so much for the opportunity to provide public comment to the Commission today, and please hear our resounding support for this body taking bold action this morning in your recommendations on postpartum coverage.

Healthy moms are the foundation of healthy children. Whether infants are born healthy and with the potential to thrive as they grow greatly depends on their

mother's well-being. To have a healthy pregnancy and positive birth outcomes, women and their infants require access to appropriate health care services before, during, and after birth.

More than half of all babies in Ohio are born to women who receive Medicaid, and 49 percent of infants and toddlers in Ohio receive health coverage through Medicaid and Healthy Start. Women in Ohio with pregnancy-related Medicaid coverage currently lose their benefits 60 days after the end of pregnancy. Our state's rate of maternal mortality is rising, and a growing body of evidence shows that many of these deaths, particularly from preventable causes occur after pregnancy-related Medicaid coverage.

In Ohio, between 2008 and 2016, pregnancy-related deaths occurred at a ratio 14.7 per 100,000 live births. Over half of these deaths, 57 percent, were considered preventable. Additionally, Black women in Ohio died at a rate of more than 2.5 times that of white women, making up 34 percent of deaths but only 17 percent of births. This data is one of a series of metrics for which the pervasive racial disparity determines outcomes for both parents and child. The experiences of both mothers and infants are

inextricably linked, although they are often considered separately. This is particularly important when it comes to babies and women of color, due to the intergenerational effects with experiences of racism. These factors are influential during and after pregnancy and affect their baby's start in life.

We know that where these disparities and gaps present themselves during the prenatal period and after birth may often persist across the life course, beginning with these shameful outcomes for infants in Ohio. The first is that nearly 12 percent of all Ohio births are preterm, and this rate is 50 to 80 percent higher for moms receiving Medicaid compared to their higher-income peers, and 1 in 7 Black babies are born premature, compared to 1 in 10 white babies.

Secondly, we know that Black babies are more than 2.5 times more likely to die before their first birthday, compared to white babies in Ohio.

Extending Medicaid coverage can help eradicate preventable maternal deaths and improve outcomes for both mom and baby. As the larger payer of maternity care in Ohio, Medicaid has a critical role to play in ensuring

healthy moms and babies. Our state Medicaid program is available to pregnant women and families with income up to 200 percent of the federal poverty level, but Ohio needs your support to ensure that all individuals whose pregnancies are covered by Medicaid can keep their Medicaid coverage for at least one year postpartum, including coverage for services such as case management and outreach, substance use disorder treatment, and mental health screening and treatment.

Many states have taken additional action to make progress towards extending postpartum coverage, including Ohio. As part of House bill 166, Ohio's operating budget for fiscal years 2020 and 2021, Ohio committed to pursuing CMS approval for continuous 12-month Medicaid eligibility for postpartum women with substance abuse disorders. This represented a $15 million investment, of which $5.4 million were state general revenue funds.

At this time, in large part we understand due to the onset of COVID-19 our state has not yet submitted a Section 1115 waiver to CMS to provide this enhanced care. Our advocacy continues to seek to maintain and expanding this investment, in addition to calling for immediate

action to implement the state's commitment.

As we anticipate our state biennial budget process, however, beginning as soon as next week, we are very concerned that even with leadership from our governor and Department of Medicaid, that the ability to maintain and ultimately implement even this narrow scope of extended postpartum coverage will continue to be paused.

With this Commission's leadership and a clear recommendation to Congress that provides for the highest possible FMAP rate and clear expectations for states, this Commission can play a powerful role in supporting state leaders, pregnant women, and young children in our state. By doing so, you will help save lives and support the continuum of care that we know our families not only need to live but to thrive.

Thank you again for your work, and we appreciate you, especially Commissioner Retchin, for your service and leadership on behalf of your fellow Ohio early childhood stakeholders. Thanks so much.

CHAIR BELLA: Thank you for your comments.

MS. HUGHES: Michelle has been unmuted. Michelle, can you click and unmute your own? There you go.

MS. ADYNIEC: Sorry about that. Hi, everyone. Thank you for hearing our comments today. My name is Michelle Adyniec. I'm a nurse with the Camden Coalition. The Camden Coalition is a regional coalition of diverse health care stakeholders committed to local, community-based, and data-driven innovation to improve quality and access to health care delivery system for people with complex health and social needs. I am also here today from a community health worker that I work alongside, and I will go into more detail.

But I just wanted to explain that we have been working for the last three years with some of Camden's most vulnerable women who are pregnant and parenting. Something that's unique about our program is that in addition to going to the many appointments that pregnant women have during and after pregnancy for their children, we also are with them through the bureaucratic system that they have to access services like food, financial assistance, and then Medicaid, of course.

This is during that very fragile time after they have their baby when there's a lot of changes going on, physically and emotionally, for them. It happened very

often that they got kicked off of their Medicaid abruptly. This is very stressful and a very time-consuming process to get them back onto Medicaid. Most of them did qualify for Medicaid, even after they lost their pregnancy Medicaid, but this gap in service was detrimental often to their mental health, as our patient panel had -- over 80 percent of our patients had a mental health diagnosis, especially depression. And so this could actually cause a gap in access to their medications.

This was a huge problem that we ran into, so I wanted to highlight that today, and the community health worker that I work with, on the call, will talk about a few of the other barriers that it caused. But thank you for hearing my comments today, and thank you for supporting this extension of the Medicaid coverage for pregnant women.

CHAIR BELLA: Thank you for your comments. It looks like Jessica is --

MS. CORDERO: Yes, I can hear you. Commissioners, thank you for the opportunity to provide comments and support of expanding postpartum medical coverage for pregnant women. I work for the Camden Coalition and I work alongside with Michelle. And in our

program we had a program called Camden Delivers, and we work with pregnant women from the city of Camden who were living with substance use disorder.

Medicaid coverage is essential for new moms, and I've seen it firsthand. Medical coverage is a must, especially for new moms who are living with mental health and postpartum depression. The feeling of being overwhelmed with a new baby and possibly not having health care coverage will only add to stress and barriers to getting care. Medical coverage is also very important for family planning and having access and coverage to getting birth control, and not running a risk of becoming pregnant shortly after giving birth.

Medical coverage is also essential for access to medicines, for mental health and maintenance meds. If mental health meds are abruptly stopped, this could possibly put someone in crisis mode, having them to go into the ER with a newborn baby. We need our moms to be healthy, both physically and mentally.

I have also sat many times with our participants at the Board of Social Services, and this can take half of your day. The challenges of going to the Board of Social

Services with a newborn and having to sit there for several hours waiting to be called, especially during COVID, can be not only challenging but risky.

Having insurance dropped in such a short amount of time, when moms are still healing and bonding with their babies, will only cause more stress for mom and baby. By extending coverage, this will give moms peace of mind and allow them to be at their best so they can take care of their babies and themselves.

I urge you to recommend that Congress extend postpartum Medicaid coverage with strong funding and that coverage is mandated for all states. Thank you.

CHAIR BELLA: Thank you for your comments.

MS. CORDERO: Thank you.

CHAIR BELLA: Just so Commissioners know, because I'm not sure if you can see this, we have about six more people waiting to comment.

MS. HUGHES: Erin, you've been unmuted. You just need to unmute your own line.

MS. MILLER: Hi. Can you hear me?

CHAIR BELLA: Yep.

MS. MILLER: Okay. Sorry. I'm not familiar with

this platform. My name is Erin Miller. I'm Vice President of Health Initiatives at the Colorado Children's Campaign. The Colorado Children's Campaign is a nonprofit and nonpartisan policy research and advocacy organization, working for every chance for every kid in Colorado. We've been fighting for every kid in Colorado since 1985. I really admire the work of MACPAC and really appreciate the opportunity to comment in front of all of you today.

As many have said, I appreciate your critical work on this policy priority and want to comment on just a few key pieces that will be important for kids and families in Colorado. First, as other folks have mentioned, it is critical that the expansion be mandatory and funded with the highest possible FMAP, and that it apply to standalone CHIP programs as well.

So to take each of these in turn, the FMAP increase will be critical for a state like Colorado that has constitutional limitations on our ability to raise funds. Our legislature can't increase taxes on their own. Every vote has to go to a vote of the people, and that makes our budget very tight and really limits our flexibility and policy planning. So it will be critical

that this come with additional financial assistance.

Colorado is one of the states with a standalone CHIP program, and it's critical that this be required and mirrored in standalone CHIP programs as well.

And lastly, it's critical that it be mandatory. And I think that the mandatory piece really comes from this history of structural racism and Medicaid. Medicaid is a program that is steeped in that history, where states intentionally wanted to have an increased ability to limit access to services in their own states for people of color and to create additional bureaucratic barriers for folks receiving the coverage and care that they need.

Childbirth, more than potentially any other health event, is steeped in the history of 400 years of racism, and making this expansion mandatory will help level that playing field and make sure that all moms can get the care that they need in that postpartum period.

In Colorado, as in many states across the country, we have an increasing rate of maternal mortality that has roughly doubled since just 2008, and the highest number of these deaths happen in the postpartum period, after six weeks postpartum. Folks who use Medicaid for

their coverage during their births are more than twice as likely to die from pregnancy-related causes as folks who don't use Medicaid coverage in Colorado.

And I want to talk personally, also, about why this is important. I gave birth to my first child about four years ago, and experienced poor maternal health care that I think is common in a lot of places. An unconsented episiotomy was performed leading to a fourth-degree tear, and I am in my fourth year of physical therapy to recover from that event. People who are on Medicaid lose their coverage six weeks after, which is before you would even be able to receive one physical therapy appointment. So it is critical that folks maintain that coverage, that they can get the physical therapy and other physical services that they need, as well as addressing critical behavioral health issues, as folks have spoken to here today.

So I want to thank you for this work. I strongly encourage that the expansion be recommended, that it be mandatory, with as high as possible match as possible, and that it is applied to standalone CHIP programs.

Lastly, I want to talk just briefly about another priority to put on your radar for future work around

prenatal care for people without proper documentation. Colorado does not provide care for this population. The only available option that comes with increased funding from the federal level is the unborn child option. And Colorado has a strong history of reproductive rates, and does not feel comfortable taking an unborn child option, especially with the shift on the Supreme Court.

As important as postpartum coverage is, and it's critical as you've heard today, ensuring that folks have coverage in that prenatal period and that they can go into childbirth with the financial security and access to health services that health insurance brings is also critical. And so I encourage you to turn your attention to that work in the future.

Thank you very much, and I'm happy to take any questions.

CHAIR BELLA: Thank you for your comments and for sharing your personal story as well.

Victoria, it looks like you're unmuted?

MS. HUGHES: I also have Natasha, if Natasha is ready.

MS. PULOS: Hi, everyone. My name is Victoria

Pulos. I'm a senior health attorney with a poverty law and policy center based in Boston, called the Massachusetts Law Reform Institute. I will skip my comments of support of the postpartum coverage at 100 percent FMAP. You've heard very eloquent testimony already. But I would like to speak to the subject of estate recovery.

Massachusetts, you will probably not be surprised to know but most people would be, has the dubious distinction of collecting more in estate recovery than any other state. It elected the option of estate recovery before 1993, when it was optional. So we know Massachusetts will be doing estate recovery, and I am currently working with a senior rights organization and disability rights organization on estate recovery reform in Massachusetts, which the state itself is re-examining.

I would first urge you not to hold estate recovery reform hostage to the conundrum of how we pay for long-term services and supports in nursing homes, specifically how middle class and upper middle-class families pay for those expenses. I don't know the answer to that, but estate recovery is not the answer. And we have seen how unfairly the burden of estate recovery falls

on extended families of poor people. In Massachusetts, from all data, we know 80 percent of the amount recovered is from sale of the family home. No surprise, the family home is about the only asset of any value that people on Medicaid can retain. And most of the clients we work with are poor people, the families of poor people, they who die, whose family members, whose best health beneficiary family members have died at home and not in a nursing home. People are often stunned to discover there's such a thing as estate recovery for people who have never been long-term nursing facility residents.

In Massachusetts -- I just want to emphasize here the specific comments I want to make about managed care. We would urge you to make the reforms you're proposing for managed care, that is that the recovery be for the actual services received up to the premium amount paid to the managed care company, a mandate and not an option. And we think that is a change that the agency itself could do without congressional authorization.

The only guidance for states, and for those of us now looking at what options states have to reform estate recovery on managed care is that 2001 provision in the

state Medicaid manual when there was very little managed care, especially in the world of long-term services and supports.

And I'd like to tell you a story from a specific case. The facts are actually in the public record, because in Massachusetts when a claim is made and the family disputes it, it's litigated, so the details are in the public court records. This woman, the Medicaid beneficiary, was an SSI recipient. She was on Medicaid for many, many years, died at home. She happened to own her property as a co-tenant with her children, instead of as a joint tenant. In Massachusetts, one of the options for states, of course, with estate recovery is that the estate recovery only applies to assets that go into the probate estate. That makes it relatively easy to avoid estate recovery for people who receive estate planning. In fact, a transfer to your children would typically be totally permissible in Medicaid for transfer of asset of purposes. So that people who are subject to estate recovery and their extended families are those who don't have the sophistication, the resources, the wherewithal to do any kind of estate recovery.

So this woman, as I said, she was on SSI, she was on Medicare, she was a dual eligible. She was also in a home- and community-based services waiver to help avoid nursing home care. What's fascinating about the account in the public record is you can see the spending in the home- and community-based services waiver, in fee-for-service, and then you can see how it changed when she went into managed care, which in this case wasn't integrated Medicaid-Medicare managed care product where Medicaid pays a premium, Medicare pays a separate premium, and the state recovers, of course, only its Medicaid spending.

So in the 12 months before and after she enrolled in managed care, the expenses went up by $24,000. Because she was nursing home certifiable, the payment rate, the premium was $2,800 a month. She would have signed up having seen promotional materials approved by the state, saying "Sign up for the senior care options, at no cost to you. We will waive that nominal $3 premium you have to pay for your drugs," but having no idea what this consequence could mean for the family of the house which represents a lifetime investment.

Even more dramatically, she did experience a few

episodes of short-term nursing home care. Remember, she had Medicare. She was eligible for the Medicare savings program to pay the Medicaid cost-sharing for her Medicare. If she had been in fee-for-service these short-term nursing home stays of a month or two would have incurred no estate recovery obligation whatsoever. Medicare doesn't recover under MIPPA since 2010. Medicaid cost-sharing is not recoverable.

But during these months, because she was now not just nursing home certifiable, she was in a nursing home, the monthly payment to the managed care organization went from $2,800 to $4,500 a month, and Massachusetts takes the position that the MIPPA prohibition on estate recovery does not extend to spending by managed care organizations or to its premium payment, but only in the fee-for-service system. We think that's wrong, but that's the position they take.

This, I think, just dramatizes how unfair the current policy of collecting the full premium is. In fact, this Commission, in 2013, wrote a chapter on the difficulties of setting Medicaid capitation rates in integrated care plans, just because of the huge variation

in the extent of long-term services and supports that people pay. So when you think about how managed care premiums are determined and what is fair for an extended family to pay back, there's just no connection at all. So I would urge you both to make the managed care provision mandatory and not optional, and to urge CMS to provide guidance to states and to those of us trying to reform estate recovery on a whole host of issues that that 2001 state Medicaid manual just doesn't address.

And specifically the notice requirement. It has a very weak notice requirement, saying that states should tell people how they're going to do estate recovery in managed care. Our experience has been that has been unenforceable. The state of Massachusetts does not give any such notice. The courts have said "so what."

So again, I very much appreciate -- I think it's very timely that you're pursuing estate recovery. I can't really improve on the comments made by one of the Commissioners on all the reasons why estate recovery really makes no sense whatsoever. We would certainly support its elimination. But I urge you to at least take the steps that you're proposing, not hold them hostage to the much

more challenging problem of how to pay for not long-term services and supports generally, and make that managed care provision mandatory. Thank you.

CHAIR BELLA: Thank you very much, and we are so appreciative of the number of you who want to comment. I would ask, though, that we -- I want to make sure that the Commissioners have a chance to hear from everyone, and we are starting to lose a few people. So if you all could keep your comments -- let us know your -- certainly your top-line comments, and there's always an opportunity to submit additional comments to us as well for the record.

We have about six people remaining. I think, Natasha, you're next.

MS. DRAVID: Hi. Can you hear me?

CHAIR BELLA: Yes.

MS. DRAVID: Great. Thank you so much, Commissioners, for the opportunity to provide comments in support of expanding postpartum Medicaid coverage for pregnant woman. My name is Natasha Dravid. I serve as director of Clinical Redesign at the Camden Coalition of Healthcare Providers, and I also serve as co-chair for a statewide workgroup related to maternal-infant health

funded by the Pritzker Foundation and in partnership with Advocates for the Children of New Jersey.

You heard from my colleagues, Michelle and Jessica, before. They described what we all know too well as the pain and complexity that limitations and gaps in Medicaid coverage can cause for pregnant and postpartum individuals.

The postpartum period is fragile for everyone and disproportionately so for individuals living in poverty and those who are affected by systemic racism across our health care and social services systems.

I personally am a mother of a one-year-old and a three-year-old, and I often reflect on my own experience and how the uninterrupted access that I had to mental health services and excellent pediatrician and breastfeeding support were critical to my own wellness and ability to cope. This should be the case for all people, regardless of their insurance status.

I want to join the voices of the advocates on this call and urge you to recommend that Congress extend postpartum Medicaid coverage with strong funding and that coverage is mandated for all states. We can't leave this

up to managed care organizations to make the decision. It needs to be a mandate.

Thank you again for allowing me to speak.

CHAIR BELLA: Thank you very much.

Just in the interest of time of some folks, I just want to make sure everyone understands that the recommendation is for it to be mandatory. So we certainly appreciate folks that are verifying that, but you don't have to convince us to make it mandatory. That's the direction we're proceeding, as the rest of you make your comments.

Again, with an eye toward time, I would ask, with gratitude, if you could please, please make your comments -- make them the way you need to make them but with an eye toward brevity, please.

MS. HUGHES: Victoria, you've been unmuted.

CHAIR BELLA: Victoria, you're up, if you can hear us, and if you're talking, we can't hear you.

[No response.]

CHAIR BELLA: Okay. Can we go to the next commenter, please?

MS. HUGHES: Michael, you've been unmuted. You

can unmute your own line now, please.

MR. STELMACK: Hello. Good afternoon, Commissioners. My name is Mike Stelmack. I am a probate attorney in Baltimore, Maryland. I'm calling on behalf of myself. I appreciate you taking up the issue of estate recovery.

Estate recovery befuddles many of the estates that I end up working on, and I just want to give a few quick comments. I want to piggyback on what the advocate from Massachusetts said, which is, one, I'm not an elder law attorney. I don't do Medicaid planning. The vast majority of estates that I see that have estate recovery involved are for lower and lower middle-class families, not people who have done any sort of Medicaid planning, and that's because those people know how to get around the probate process. So their assets don't end up being probate-able for the most part.

I'd also just like to say that I think that estate recovery creates a deadweight drag on the probate process because many lower and lower middle-class families know that it's not worth opening an estate for their loved one because the state will make a claim against their

estate. So that means that houses are left sitting. Bank accounts are left sitting.

In many of my cases, there are asbestos claims. Many of these people have asbestos claims from working in the shipyards, the railroads, or the steel mills. The families who would otherwise be entitled to settlements from those bankruptcies just don't take them because they know that that money is going to end up going to the state.

And I just want to say that I was shocked to learn that the State of Maryland is making claims against people who were not in long-term care but are receiving community Medicaid. This has happened in a number of my estates now where people who are not in nursing homes, you end up getting a surprise claim by the State of Maryland. Their families didn't know they were receiving Medicaid, and so instead of an expected claim that comes in from the State of Maryland, you get the state filing a claim at the very last possible minute that they're entitled to in an estate that might not have been worth working on. The family might not have made the choice to open the estate if they knew that there was going to be this large claim coming in and that there was really no point in them

administering the estate.

So, again, thank you for your comments. I really do appreciate you taking up this issue. If you have any questions, I'm happy to answer them.

CHAIR BELLA: Thank you very much.

We are going to try to wrap this up in the next five minutes. Again, not to disadvantage those of you that are at the end of the comment line. There is always an opportunity to submit comments to us as comments@macpac.gov, but just with an eye towards time.

It looks like, Sara, you are unmuted.

MS. JANN: Thanks so much. Good afternoon. My name is Sara Jann. I'm the director of Policy and Advocacy at Maternity Care Coalition in Philadelphia. I also lead the Maternal Health Campaign for Pennsylvania's Prenatal to Three Collaborative, and I applaud the Commission's direction in your recommendations on postpartum coverage.

I just wanted to share a bit about what's at stake. Earlier this week, Pennsylvania's Department of Health released a report on pregnancy-associated deaths from 2013 to 2018. With this report, we learned that 58 percent of maternal deaths occurred between 43 and 365 days

postpartum. Fifty-three percent of the pregnancy-associated deaths were among women whose births were paid for by Medicaid. This is staggering when we consider that only 32 percent of all births during this same time period were paid for by Medicaid.

Finally, the report confirmed what we already knew, which was that racial disparities persist. Black women account for 14 percent of the births during this period but represented 23 percent of pregnancy-associated deaths.

Our collaborative is advocating for action at the state and federal level to extend postpartum coverage. We've advocated that our state submit Section 1115 waiver to CMS to extend postpartum coverage. We also wrote our U.S. Senators urging them as members of the Senate Committee on Finance to prioritize legislation on this issue. We've demonstrated broad support in our letter for this policy. Signers included the PA Coalition of Medicaid Assistance MCOs, the PA Chapter of the American Academy of Pediatrics, the Children's Hospital of Philadelphia, and Einstein Medical Center.

Even our current Secretary of Human Services,

Teresa Miller, and our former Secretary of Health, Dr. Rachel Levin, signed on.

As you can see, we have significant support for this policy in Pennsylvania, but cost continues to be an impediment to moving forward. By recommending that Congress provide the highest possible FMAP rate and by providing clear expectations for state, this Commission can precipitate a necessary first step in addressing our maternal health crisis.

Thank you so much for your time. I'll end there. I really appreciate it.

CHAIR BELLA: Thank you very much for your comments.

MS. HUGHES: Kaylan, you've been unmuted.

MS. SZAFRANSKI: Yes. Thank you.

Good afternoon, everyone. My name is Kaylan Szafranski. I am the health program director at NC Child, and I appreciate this opportunity to speak with you all today.

In the spirit of brevity, I will not read my full comments and will rather submit them over email, but I just wanted to thank the Commission for pursuing mandatory 12-

month postpartum coverage.

For all the reasons that advocates have listed out today, we are in strong support of this. I just wanted to once again kind of double-down on why we need that to be fully funded.

The 100 percent match is incredibly critical, especially in states like ours that have not expanded to Medicaid expansion under the ACA. We have grave concerns that the state would use the state match as an excuse to either tinker with eligibility or, if this were not mandatory, opt out of this extension. And we know that for the 55 percent of the deliveries that occur in our state, that this is a huge, huge issue, especially given the racial disparities that are so incredibly pervasive in North Carolina, showing that both Black parenting and birthing individuals and Black infants are dying at twice the rates of their white counterparts.

So I just wanted to thank you again for following the recommendations that you set forth and for the discussion earlier. Thank you so much for this opportunity.

CHAIR BELLA: Thank you for your comments, and

please do feel free to submit additional comments to the comments@macpac.gov. And we appreciate your eye toward brevity.

MS. HUGHES: Yuki, you've been unmuted. You may ask your question or make your comments.

MS. DAVIS: Wonderful. Thank you so much, and like the advocate before me, I will be sure to submit written comments and keep these comments short.

My name is Yuki Davis, and I am the manager of Policy and Advocacy at Every Mother Counts. I want to thank the Commissioners for your prioritization of mandatory postpartum Medicaid extension and for the opportunity to speak today.

Every Mother Counts is a national nonprofit that works to achieve quality, respectful, and equitable maternity care for all childbearing people and families. Our organization strongly supports the extension of full Medicaid benefits to cover pregnant and childbearing people through the full postpartum year as a mandatory change to Medicaid for all postpartum individuals.

We support the increase in FMAP to 100 percent. That would facilitate state's implementation of the

coverage extension. As the Commissioners recognize, extending Medicaid and CHIP coverage to the full year postpartum is an essential lever to addressing maternal health equity. However, the extension of postpartum Medicaid coverage will only address these disparities if it is consistently implemented by all states, made possibly by an increase to match to 100 percent.

Our action to ensure equitable access in coverage is overdue, and the 100 percent FMAP will make sure that all states, especially those where coverage gaps and disparities are the widest, are able to implement this policy.

Thank you for your time.

CHAIR BELLA: Thank you very much.

It looks like we have one last speaker or commenter.

MS. HUGHES: Victoria, you've been unmuted.

[No response.]

CHAIR BELLA: Victoria, are you able to make your comments?

[No response.]

MS. HUGHES: Perhaps does not have a mic on her

computer.

Do you want to move on to Rachel?

CHAIR BELLA: Yes. Can we move on?

And this is going to be our last comment, unfortunately.

MS. RUEL: Hello. Good afternoon. My name is Rachel Ruel, and I am the co-director for Sister to Sister Community Doulas of Essex County, New Jersey.

I'm testifying today in favor of extending the Medicaid postpartum up to one year.

Our program, we are a community-based doula project who supports Black and brown families in Essex County, New Jersey. We consider the fourth trimester, the mother-baby dyad, to be inseparable. In the current Medicaid system, we place significant effort on maintaining the insurance of babies, newborn babies, and children, without question. We provide full Medicaid coverage for babies and children.

However, we don't for mothers, and in considering that last trimester is a mother-baby dyad are inseparable, it's critical that we extend this coverage.

Currently, in New Jersey, we provide doula

coverage for mothers that have Medicaid. It's a benefit of Medicaid.

And in two circumstances, we've had mothers with severe mental health challenges and DVT, which is deep leg thrombosis, which was caught at seven weeks postpartum, and it requires long-term monitoring medication in support.

Well, I stand, we stand at Sister to Sister in solidarity with the organizations and individuals on this call to extend the Medicaid coverage to one year, and, Commissioners, I thank you for giving me the opportunity to provide this testimony. Thank you.

CHAIR BELLA: Thank you very much.

We actually have gotten through all of the folks who wanted to make a comment. Thank you for those of you that have done so, and if anyone else would like to submit a comment, one more time, the email address is comments@macpack.gov.

I apologize to Commissioners for the lengthy run over on the agenda, but I think it was important that we heard from all these folks.

I'm going to ask you to come back at 1:15. I'm trying to get you as close to a 30-minute break as

possible. We'll make up five minutes in each of the other sessions. So we'll steal five minutes from everybody after lunch and would ask that you're back at 1:15, energized and ready to go for the afternoon, and thanks again for everyone that joined us for the morning session. We will reconvene at 1:15.

* [Whereupon, at 12:51, the meeting was recessed for lunch, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION

[1:15 p.m.]

CHAIR BELLA: Okay. Welcome back, everyone, to the afternoon session of our meeting. We'll be flexible on some of the timing. As mentioned, we're running a little behind. We're going to make that up. Moira, we're going to try to shave five minutes off this session. You are a fast talker, and we have been through this often. So hopefully that doesn't put too much pressure on you. And if we need the time, we'll take the time, by all means. But, again, it should be a topic that's pretty familiar to the Commissioners at this point, and we are looking forward to sort of bringing it across the line with you today. So I will go ahead and turn it over to you.

AUTOMATIC COUNTERCYCLICAL FINANCING ADJUSTMENT: REVIEW OF DRAFT CHAPTER AND RECOMMENDATION DECISIONS

* MS. FORBES: Okay. Thanks, Melanie. An advantage of being from New England, I can talk fast.

So Chris and I are here today to present the draft chapter on countercyclical financing and go over the draft recommendation with you prior to your vote tomorrow.

Before I get into the presentation, I'll say that instead of providing you with a separate decision memo or list of options, we've only included one draft recommendation here for discussion. That's because at the December meeting we talked about a few -- you talked about a few options, and it seemed like there was a lot of consensus on what the Commission was interested in seeing in a recommendation. So we drafted something based on that discussion, which is what we included here today.

The draft chapter is based on material that has all been presented and discussed at prior Commission meetings. Some of the content includes details that we haven't gone through in some time, so I'll quickly recap the main topics. If you have specific comments or edits on the text, you can send those to us after the meeting. But if there are things that you think need to be added or clarified in the chapter, feel free to raise those today. Then we'll turn to the draft recommendation, which is to adopt an automatic Medicaid countercyclical financing model

with some specific policy riders.

So the first section of the chapter sets up the concept of Medicaid as a countercyclical program, describing how demand for assistance is countercyclical to economic growth in that enrollment and spending increase when there's a downturn in the economic cycle. We show how Medicaid enrollment grows during normal economic times and then during and after a recession. We also show how the consequences for states -- we show the consequences for states when there are declines in state revenue during an economic downturn, coupled with increases in Medicaid enrollment and the resulting spending growth.

Then the next section addresses the role of Medicaid as an automatic stabilizer and as a fiscal stimulus. We explain how the financing structure of the program allows it to automatically offset some cyclical changes in economic activity without additional governmental intervention, but that this is based on the requirement for states to contribute a fixed percentage of program expenditures, which can be harder for them to do when they're facing revenue declines during an economic downturn as they cannot run deficits or take on debt for

program expenses.

Then the chapter provides several examples of how Congress has used Medicaid as a fiscal stimulus during prior recessions by creating temporary increases in the Medicaid FMAP as part of financial assistance to states. This section also makes the point that while Congress has often acted to increase Medicaid financing during significant economic downturns, the timing and targeting of this assistance has not always aligned well with state need.

The third section identifies a permanent Medicaid countercyclical financing mechanism as an alternative to the kinds of one-off legislative interventions that were just described. Such a mechanism would need to be authorized by Congress, but then could automatically increase the federal share of Medicaid expenditures in order to allow federal financial stimulus to be directed to the states more quickly during economic downturns, and it would provide states with greater budget predictability.

This section also describes the specific objectives that the Commission had identified for a permanent mechanism during its prior discussions, which

are: that it should be automatic with objective, timely indicators to trigger changes in federal assistance; that it should have a threshold that is sensitive enough to signal the beginning or end of an economic downturn quickly but not be so sensitive that small fluctuations trigger frequent adjustments; and that it should be able to target any additional federal financing for states based on state-level factors.

We then describe the prototype countercyclical financing model developed by the Government Accountability Office in light of these three objectives and show that the design of the model -- their model lines up with all three objectives. We give a summary of the information that was presented in several of the prior Commission meetings to illustrate this, and we show a comparison of the results of the model to the prior recessions and the current economic conditions that we've also previously shown you at meetings to show that the results of the model, when applied to real-world data, achieve the objectives the Commission has identified.

The last section before the recommendation identifies a number of additional policy issues related to

countercyclical financing. They're not addressed by the GAO model as it pretty much is about the mechanics of calculating a revised FMAP. These policy issues should be addressed in conjunction with a permanent change to a federal financing mechanism. They include: whether additional rules such as a maintenance-of-effort provision should be attached to the use of federal matching funds to ensure that states use additional funds to support the cost of increased Medicaid enrollment and replace reduced state revenues rather than substitute for state contributions; whether to have an upper bound or cap on increased FMAP to ensure that federal contributions to states for medical assistance are limited to 100 percent of state expenditures regardless of the contribution calculation; and whether additional FMAP should be applied to special matching rates such as the 90 percent FMAP for the newly eligible adults, or whether services and populations that already have statutory exceptions to the regular FMAP should maintain those exceptions; and whether to exclude services and programs with caps or allotments to avoid putting them at risk for drawing down those funds too quickly due to a higher-than-expected FMAP rate.

So that's the organization of the chapter, what we did with the materials you have seen before, and then this is the text of the draft recommendation. It's based on -- you could vote on this tomorrow unless you suggest changes today. It's based on your discussion at last month's Commission meeting. It just says that Congress should adopt a permanent countercyclical financing model based on the GAO prototype with three related policies, which were the maintenance of effort, the cap of 100 percent, and excluding the enhanced FMAP from those services and populations that receive special matching rates or are otherwise capped. And then following the recommendation, as we always have in our chapters, is the rationale. A statutory mechanism would allow federal financial stimulus to be directed to states more quickly. We talk about the gradual -- each of past recessions made it difficult for Congress to be proactive in identifying state need and taking action. It has been hard for Congress to proactively determine how long to leave a FMAP increase in place or how to target assistance to states.

The GAO models meets the Commission's objectives for a countercyclical financing mechanism, and a policy for

enhanced federal financing can be designed with appropriate policy limits like the ones that have been included in that recommendation.

So that's what was included in the draft chapter that we prepared based on the December discussion. As I said, we're happy to answer any questions or take any other feedback on the chapter. And Chris is here as well if anything else comes up on the model or anything like that.

Thanks.

CHAIR BELLA: Moira, that was amazing and very clear. Thank you as always. And, Chris, thank you for all your work on this. If we could put the slide back on the recommendation, that would be helpful.

Let me first start and say does anybody have any clarifying questions or any just general questions for Moira or Chris on any of the analysis? Then we'll talk about the recommendation. Tricia?

COMMISSIONER BROOKS: Yes, thank you, Moira and Chris, for this.

I believe that past increases in the FMAP did go to the territories. I'm not sure if the cap was increased, but another option is to disregard the cap. So could you

just speak to historically what's happened in that regard? I guess I'm a little fuzzy on why we've chosen to disregard the territories in the recommendation.

MS. FORBES: So in the past, when an increase has gone to the territories, it's been part of legislation that has also increased the cap. And since this would work automatically, there's not a mechanism to also increase the territorial allotment. It would just result in a faster drawdown of their allotment, which is why we think that a policy that excludes them would be appropriate. There's nothing precluding Congress from passing a stimulus that would increase a territorial allotment if there were a downturn. But since the intent of this is to happen automatically, a faster drawdown of their allotment wouldn't help them in a recession.

COMMISSIONER BROOKS: A follow-up, please. I'm just curious whether there's any history on a recommendation that we would say for the purposes of this to disregard the cap for the enhancing FMAP.

CHAIR BELLA: I think that would probably have to come through a separate body of work and discussion. Am I thinking about that the right way? Anne or Moira.

MS. FORBES: If Chris were here, I'd be looking at him. That's not something we've specifically looked at.

MR. PARK: Yes, I don't think it's ever been done where they just ignored the territorial cap. I think historically what they've done is just figured some additional amount to give the territories in the cap.

CHAIR BELLA: Tricia, I think we can certainly -- I mean, we can certainly continue the discussion about territories generally alongside of -- I would ask that we would be able to continue to move this body of work and this recommendation, and if you'd like us to also look at territories, and knowing this could be a piece we look at, too, we could do that. Anne?

EXECUTIVE DIRECTOR SCHWARTZ: I was just going to say we could certainly cull out a little bit more of the unique situation for the territories as opposed to DSH in the text of the chapter. We are planning to come back to the territories as early as next meeting because there's going to be yet another fiscal cliff. And so we could do more analysis on this in connection with that.

COMMISSIONER BROOKS: Great, that sounds good. Thank you.

CHAIR BELLA: Okay, thank you.

If we could go to the slide that has the recommendation on it, please. And then we'd love to hear from -- as Moira said, this is -- you know, we've reached consensus on this. There's been a lot of agreement. We had a healthy discussion about it last month. Does anyone want to -- I will say I fully support this recommendation. I guess it would be great to hear from anybody that has any concerns with this recommendation or any additional comments folks want to make. Fred?

COMMISSIONER CERISE: Not a concern. I support it as well. I have a clarifying question, though. The eligibility maintenance of effort, is that different than the eligibility and the continuous enrollment maintenance of effort that we're having right now? And can you talk about how similar or different that would play out?

MS. FORBES: Yes, and I think we can, again, clarify that in the language in the chapter. Those are different. Continuous coverage and maintenance of effort are different provisions with very different implications. And I think what we had anticipated was that this would include maintenance of effort, as continuous coverage was

related more to the public health emergency. And so we can be clearer about that if it's not already, which I think --

COMMISSIONER CERISE: I thought it was, but --

MS. FORBES: -- in your memo, but not in the chapter.

COMMISSIONER CERISE: Thanks.

CHAIR BELLA: Thanks, Fred. Darin?

COMMISSIONER GORDON: On that maintenance-of-effort requirement, I think as we have it currently, but, Moira, please clarify if I'm misunderstanding, that we're not necessarily describing the criteria of the maintenance of effort. And the only reason I raise that question, as we've discussed before, is that there's been different maintenance-of-effort requirements based on prior downturns and increases in FMAP. So, I mean, is this something we're going to just suggest be included as part of it and let them decide the mechanics of it? Or are we going to kind of offer some specificity to which the maintenance-of-effort model as we've seen historically that should flow as part of the recommendation?

MS. FORBES: The intent isn't to write anything more specific. I mean, we're not offering legislative

language. Obviously, they would have to be a lot more specific around the model and things like that would have to go into actual statute here. But I think that clarification around maintenance of effort versus continuous coverage probably could be helpful given that we do talk about actions that Congress has taken in this recession versus the two prior recessions.

COMMISSIONER GORDON: Yeah, okay. Thank you.

CHAIR BELLA: Sheldon?

COMMISSIONER RETCHIN: Yeah, Moira and Chris, this is great work. I think it's just -- let me say we've really worked this out, and it'll be interesting to see in the 3 o'clock discussion on state budget outlook how a countercyclical recommendation would be changing the state outlook. I don't know it would have that dramatic an impression. But I just have one question. On special allotments, supplemental payments, the disproportionate share hospital payments, UPL, CPE, I see those would be excluded, as they should. But I guess what you would do then would be to, I guess, authenticate the true FMAP? Is that what you would be doing so that those payments were already included in -- how would that be done? And

especially since I remember or recall that we've had a hard time in the past being able to actually quantify supplemental payments, I thought.

MS. FORBES: So it depends on what type of supplemental payment you mean. Usually the way that this match is applied depends on -- it depends on what line is claimed on the CMS-64. And so the DSH lines and things like that, it would not be applied to. The hospital lines it would be applied to. I don't know how they apply it to a special -- FMAP would be applied to a UPL, supplemental payment line. That will be something for the financial people to work out, depending on what's in the legislative language. But they do it line by line when they're applying FMAPs. So there would be a way for -- CMS would have to determine, again, based on their interpretation of what the statute intends, how to apply it; and then as the state expenditures come in, how to allocate the additional FMAP. There would have to be some clarity around what it's applied to.

MR. PARK: And just to chime in for Sheldon, you know, inpatient supplemental payments like the UPL supplemental payment, they're a separate line, as well as

nursing home, ICFs, and physicians. To the extent that there are supplemental payments, you know, unlike directed payments being made in managed care, those are distinctly identified on the CMS-64.

CHAIR BELLA: Other comments or questions? Come on. You guys are supposed to come back energized after your lively lunch break. This is pretty groundbreaking that we're actually moving this forward, so I hope folks are excited about it and Sheldon's point is not lost about timing, given the session we'll have this afternoon about state budgets. So anything else? Tom.

COMMISSIONER BARKER: Well, just in the spirit, Melanie, of coming back energized and enthused, I'll just say that I worked on the Hill back in the '80s and early '90s, and I can remember there being discussions about countercyclical back then. And so I will just -- I support the recommendations, and I concur with you that this is a pretty significant change. But I think it's a good one, and I think that the experience with the economic downturn in the past year demonstrates that and the associated challenges that states are having. So that was my only comment.

CHAIR BELLA: Thank you, Tom. Bill and then Toby.

COMMISSIONER SCANLON: Yeah, I just would echo Tom. I would say I'm very enthused about the recommendation because it actually goes back, to the discussion of countercyclical, 50 years, which is five years after the program began. It probably would have started exactly when the program began if we hadn't had the first recession five years later. It was 1970 when we noticed that this was an issue, and the idea that 50 years later maybe something will be done about it is tremendous. So thank you.

CHAIR BELLA: Thank you, Bill. Toby and then Chuck.

COMMISSIONER DOUGLAS: No, I just wanted to chime in to say, one, the work is wonderful and really, really thoughtful, and this would be a huge step forward, and I'm glad we're recommending it. From a state perspective, thinking back as a Medicaid director having this predictability and knowing that there would be triggers in place and not having to spend time through a budget process with assessing whether Congress would act, it creates just

predictability, not just from a federal level but also as you go from states to how they're being able to set up their budgets and decision making. So I'm really excited about this.

CHAIR BELLA: Okay. Chuck and then Stacey.

VICE CHAIR MILLIGAN: I agree with those comments. A couple of things I do want to add, and one comment we made at our last meeting is this would be a good framework to have in law, and Congress then obviously could continue to make adjustments, whether it's adjustments to territories or adjustments in other ways. But having this be a baseline framework I think would be a big improvement.

The second comment I wanted to make is I think it ties the need more directly to the root cause of the need in terms of producing state revenue, which is more tied to unemployment and revenue from state income taxes and other sources. And so I do think that this mechanism, not tying it to a health issue but to actually the state revenue issue, is a more precise mechanism to tailor the need to the cause of the need.

CHAIR BELLA: Thank you, Chuck. Stacey?

COMMISSIONER LAMPKIN: I would just add my

agreement with the comments that Chuck just made, especially the customization at the state level seems particularly a nice feature of this. And then I would just say to Moira and Chris, the chapter is excellent, and the graphics you selected here really do make the points that they need to make very viscerally, so thank you for all the work on the chapter. It's very persuasive.

CHAIR BELLA: All right. So this will be coming back tomorrow for a vote. Moira, it sounds like we're in good shape, no wording changes. So do you need anything from us?

MS. FORBES: No. We're good. Thank you.

CHAIR BELLA: Thank you both for this work, and thank you for helping us make up a little time.

CHAIR BELLA: We are now going to flip to talking about duals. In case any of you thought we were not going to talk about duals at one of our meetings you're sadly mistaken. It's back. And Kirstin is going to lead a discussion today, picking up on the panel we had in October about what a new unified program might look like. And then we also have a duals discussion tomorrow. But today is more big picture, kind of thinking big.

So, Kirstin, take it away.

DESIGN CONSIDERATIONS IN CREATING A NEW UNIFIED PROGRAM FOR DUALLY ELIGIBLE BENEFICIARIES: REVIEW OF DRAFT CHAPTER

* MS. BLOM: Thanks, Melanie. Good afternoon, everybody. I'm here to walk through our draft chapter, as Melanie said, to go over the key design considerations that we've identified for establishing a unified program for dually eligible beneficiaries. We've been pretty focused on ways to integrate care between Medicare and Medicaid for a long time now, both to improve beneficiary experience and reduce costs, but there are, of course, limitations to that approach, which have led us to explore whether or not a wholly new approach, a unified program, would better serve the population to replace sort of the fragmented system that we have today.

The chapter is organized as you see on this slide. We do start out with a little bit of background on the existing models, because the discussion does build, in some cases, on the existing structure that we have. And then we move into design considerations that we've identified for the new program. We've bucketed these into

the groupings that you see here -- eligibility, beneficiary protections and enrollments, benefits, delivery system and model of care, administration, and financing. So I'll walk through those and then we'll talk about next steps.

You are all familiar with these models and you have information on them in your materials, so I won't spend too much time on this. But these basically are the most fully integrated models that are out there now, so these are the ones that we'll be talking about in the chapter.

There are two proposals to fully integrate care for this population that are publicly available, and you'll remember that we heard about the details of both of these last year, in October, when we had a panel come and speak to us. The Bipartisan Policy Center's proposal, which was published last year in July, would develop a fully integrated option for the dually eligible population, building on the current structure, with a federal fallback for states who choose not to set up an integrated model.

And then the other proposal we have heard about is from the Dual Eligible Coalition, which is affiliated with Leavitt Partners, which would establish an entirely

new program under a new title of the Social Security Act, and would move dually eligible beneficiaries as well as their associated funding streams into that program.

And so we'll be drawing on examples from these two proposals throughout the chapter. We are not providing a comprehensive review or description of those proposals in the chapter. We're simply using examples from them to illustrate the points that we're making about design considerations.

So I'll walk through the top lines of these considerations that we identified, in the interest of time. For each set of these, we tried to think about tradeoffs and are not viewing these as like right or wrong answers. It's really just an attempt to draw out the policy and design issues that would need to be settled in developing a new approach to serving this population.

For eligibility, we were looking at these four items: limiting eligibility to full-benefit duals; continuous eligibility for Medicaid, meaning like 12 months; population carve-outs; and maintenance of effort. On the limiting eligibility, this is kind of an issue that's come up a number of times before, and is currently

being used in the MMPs to limit eligibility to people who are eligible for full Medicaid benefits, which is the group that has benefits integrated with Medicare. The partial-benefit duals, you'll remember, are only eligible for Medicaid assistance with Medicare premiums and cost-sharing.

In terms of continuous eligibility, a unified program could consider providing 12 months of Medicaid eligibility to the dually eligible population. Under current law, this is not allowed unless you have a waiver. We've heard that renewals for Medicaid can be really cumbersome for the dually eligible population, almost as if they were applying for the program from brand new. And given that income and other circumstances among this group may not really change that much, it can lead to temporary losses of coverage. So this is something that we definitely want to consider for the new program.

The other two items on this slide are population carve-outs and maintenance of effort. Population carve-outs occur under current law. The main group that people think of are individuals with intellectual and developmental disabilities. They are often carved out from

managed care, and that's related to the complexity of their care networks. So this is something to keep in mind as we're going forward.

Maintenance of effort, like the one that was included as part of the ACA, and which we just touched on, actually, in the countercyclical FMAP discussion, is designed to keep eligibility levels from decreasing under a new program. It requires states to maintain their existing levels, but generally allows them to go higher than that if they would like.

For beneficiary protections and enrollments we're focusing on beneficiary choice, access to existing providers, enrollment processes, and integrating appeals and grievances. Beneficiary choice has been a longstanding protection in both programs, although Medicaid has allowed more constraints on this, such as allowing automatic enrollment with an opt-out. Automatic enrollment does occur under current law into the MMPs, through passive enrollment, and into D-SNPs through default enrollment.

And we have seen some preliminary numbers around opt-out rates related to default, which shows those -- this is from one state, I should say -- which shows that those

numbers are in the single digits, around 4 or 5 percent. But that's something that we are continuing to monitor.

And as you heard from the panel in October of last year, people are starting to debate the merits of making fewer plans available for beneficiaries, because perhaps a narrower set of options would make it easier for individuals to compare the plans that are available to them and make a more informed choice.

Maintaining access to existing providers is on here because this has been a key concern for beneficiaries in integrated models, particularly in the MMPs. We know that in California a number of people opted out, and the primary reason that they cited was concern over losing access to their current provider. So the composition of provider networks and the feasibility of helping beneficiaries maintain access to their existing provider is going to be important in any discussion of a new program.

We'll also have to figure out how enrollees would enroll in a unified program. There might be interest in setting up something like a ”no wrong door”, where they could come in through Medicaid, they could come in through Medicare, or they could use SHIPs or AAAs. We have heard

concerns that SHIPs are already operating with limited resources, so additional funding might be something to have to consider there.

And then the final one, appeals and grievances, this is something that's happening now. A lot of the MMP states made efforts to either more fully integrate or fully integrate the appeals and grievance processes, but that's presumably something we would want to do under a new model.

Benefits considerations are focused here on uniform benefit package and particularly Medicaid benefit carve-outs. As you all know, under Medicare the benefit package is uniform but in Medicaid it varies by state and also by type of beneficiary. A new program could simplify this complexity by just providing the same package to all duals. Both of the proposals that we looked at would do this.

Another issue that's specific to Medicaid is the benefit carve-outs, which is carving out a benefit from the comprehensive managed care contract. Many states do this with behavioral health, for example, again, for a number of reasons, including historical precedent or inexperience with managed care, and instead provide those services

separately through a specialty provider.

But a key consideration going forward will be whether to allow that to occur under a unified program, and the Dual Eligible Coalition proposal would prohibit carve-outs under a unified program.

Under current law, integrated care occurs in managed care and risk-based managed care arrangements, where the health plan can act as a single point of contact to both manage and coordinate care for the beneficiary, and both of the proposals that we looked at would do the same.

In terms of provider participation, educating providers on the benefits of integrated care has been something that has come up a lot, both to encourage them to participate and to encourage eligible enrollees to participate. Issues of network adequacy, especially in rural areas, will have to be taken into account, given the limitations on the number of providers and the types of providers in those areas.

And a program that is going to be designed exclusively for the dually eligible population would presumably require participating plans to establish a model of care that meets the needs of that group, which is now

the case for D-SNPs, for example. They are required to submit a model of care to CMS for approval. Model of care includes things like a plan for care coordination for the beneficiary and identifies care management teams. One thing we'll have to consider with the model of care is whether or not the inclusion of a partial benefit population is going to have an effect on integration that's possible under that plan.

In terms of administration, we focused on issues around federal oversight and state flexibility. Under current law, as you know, the Medicare program is administered by CMS, and states administer Medicaid but with oversight from CMS. Both proposals that we looked at would allow states to administer their programs but with oversight from the Secretary through the Medicare-Medicaid Coordination Office, which is the office within CMS that was established to ensure access to care for duals.

Another consideration is whether or not to give states the option to participate. State flexibility has been a long-standing principle in Medicaid. Of course, Medicaid itself is optional. And some states do have limited experience with managed care for a sparsely

distributed population that might make it difficult, even if they're interested in establishing a fully integrated program for them to do that.

Also, of course, we shouldn't forget to mention COVID. States might be operating under limited capacity under normal circumstances, but of course now with the pandemic they are struggling even more.

And then finally we looked at financing considerations, which we grouped into these buckets. Both proposals we reviewed would maintain a shared financing system between states and the federal government and would allow states to share in savings generated by a fully integrated program. Risk mitigation strategies could help plans offset the uncertainties that they probably would be facing in a new market and offering a new product, including lack of experience with how much the enrolled population will cost and what their utilization of services will look like.

And then depending on how the program is financed, decisions would need to be made about how funding amounts for states would be determined, especially if states are managing a program and assuming the risk. So

things like spending levels, what year is going to be the base year, what are the growth rates on those levels going to look like, and then what happens when there are unforeseen events, like the pandemic we're experiencing now.

Just to conclude, this chapter reflects our thinking thus far, but in any of the buckets obviously there are a lot more specifics or details or work that we could do. And so that is definitely something that we can explore in the next meeting cycle, if that's of interest to the Commission.

Our next steps at this point are to incorporate any feedback we get from you guys today, as well as the feedback we've received from you all and from our external reviewers, and then publish this chapter in our March report.

I would like to say thanks to everyone who has already submitted comments. That's been super helpful to have those this far in advance.

So with that I'll wrap up. I look forward to your discussion, and I'm happy to answer any questions.

CHAIR BELLA: Kirstin, thank you. Super well

organized and a really nice walk-through of all the different pieces. And I want to just say, for full disclosure, I had the opportunity to participate in the Leavitt Partners Dual Eligible Coalition work. I think I mentioned that in October. I just want to mention it again for full transparency.

And the purpose, like Kirstin said, of today is we're not making recommendations. It's really just to opine on this piece that's going to advance work in this area. And so it's up to Commissioners to kind of direct comments her way, and particularly if there are other areas you would like to explore as we look at the possibility of a unified program.

I saw Sheldon to start, and then Martha.

COMMISSIONER RETCHIN: Can you hear me?

CHAIR BELLA: Yes.

COMMISSIONER RETCHIN: Okay. Thanks. Kirstin, each time I think we're getting closer and closer to understanding different options for taking care of the dual population, so I really appreciate your contribution. And, in full disclosure, Tamara and I have -- I mean, Kirstin and I have been on emails going back and forth about this.

My concern, and I've said this many times, is that we really are focusing more on integrated financial models for taking care of dual eligibles. The challenge is going to be on constructing integrated clinical models of care. And to that end, I think the role of primary care is critical and comes at especially a difficult time for primary care, because of everything. I mean, just the decline in the number of primary care physicians. In fact, we recently looked -- we just published an analysis of looking at high-density dual populations by county, and showed that there are actually primary care deserts where there is no primary care and a high density of dual eligibles.

So I just want to raise that, and, of course, I always keep bringing back the PACE model, which is very different than the other integrated models we're talking, D-SNPs or the Financial Alignment Initiative. I'm a big fan of PACE. I know they're not quite as prevalent, but I mentioned this last meeting, they now have for-profits who are participating in the PACE program, which they did not have before. So it's obviously an area where taking full risk, being able to deliver on a clinical model I think is

a superior approach. And I just wanted to make that point, and I appreciate you recognizing that in terms of the network adequacy issues that were raised in the chapter. Well done. Thank you.

CHAIR BELLA: Thank you, Sheldon. Martha?

COMMISSIONER CARTER: Thanks. I think Sheldon got a similar comment. I'd like to see this chapter address more that the current model development hasn't really focused on involvement of the FQHCs. I know there's some but there really isn't much, and we don't have anything in our chapter except to acknowledge that there is a goal of maintaining continuity of care and maintaining current provider. So we know that more than 1 million people who are dually eligible are already patients of community health centers, and this number is growing as that Medicaid population ages into Medicare.

So I think it's really important that we bring that up as a development goal, that the FQHCs are considered in the beginning, because we want continuity of care, because it actually could affect network adequacy, and because the community health centers are experts in integrated care.

CHAIR BELLA: Thank you, Martha. Darin?

COMMISSIONER GORDON: Just I hear Sheldon, and we've had this discussion before, and my comments aren't in disagreement with some of the comments Sheldon made. But as I have pointed out before, I do think -- and this is based on my experience in doing this both on the physical and behavioral health side, but also seeing this on the dual side -- that until you simplify and integrate at the financing level it is hard, if not impossible, to get integration at the provider and services level. It makes it far too complicated, far too siloed for providers to treat the whole person.

So I think this is an integral step to get to where Sheldon is talking about, so I think it's important to get this right so that, you know, as Sheldon, and, quite frankly, as Martha have said, it enables the success at the provider level. Thank you.

CHAIR BELLA: Thanks, Darin. Toby?

COMMISSIONER DOUGLAS: Yeah. Just the same, further on what Darin is saying even from a state perspective is that we don't work on this integration and the financial incentives from a state level. It doesn't

force and drive the really, really difficult decisions on the structure of services and whether it's carveout benefits and the value of trying to change the structure because it might lead to cost savings that otherwise wouldn't happen. And so if we just keep focusing at integration and we don't bring it up, we're not able to drive these consequential decisions on the way that the services are structured that will ultimately have impacts, most importantly, on dual eligible individuals, but we not force the integration upstream all the way to the state and federal level to really drive the changes.

CHAIR BELLA: Thank you, Toby.

Brian?

COMMISSIONER BURWELL: I have a quick question to start out. Is the Leavitt Partners' proposal going to have a final report in the near future? We don't really have something written down, a final deliverable, do we? Kirstin?

MS. BLOM: We've been in communication with Charlene Frizzera, who spoke to us on the panel, and she has provided some sort of high-level summaries, but we understand that there will be something more than that

probably coming out soon.

COMMISSIONER BURWELL: So I see this as not a long-term initiative. I don't think -- you know, this isn't going to happen in the next three months, six months, et cetera, and so we should kind of proceed with our contribution on a long-term agenda. There are lots of details that would have to be worked out and so forth.

I would like to actually see a part of the chapter talk about kind of where things stand about these other proposals. The Arnold Foundation is hoping to get very deep into this issue and any kind of thing where we would just like give a lay of the land about where various contingent -- various people are in terms of developing this idea.

I think there are three key design considerations that I would like to see focused on. One is payment policy, how plans or whatever, entities are chosen to deliver these services, where the risk lies, either at the plan level, the state level, the federal level, so the whole idea of risk around some kind of baseline payment is important.

Second is financing. I think that issue is

avoided quite a bit in these kinds of task forces, et cetera. Are we just thinking about existing expenditures as a way to finance this, or are we thinking about new expenditures over and above what Medicare and Medicaid currently spend?

And three is the issue of administration of the program, I think, is a huge issue, whether it's going to be optional to states, optional to beneficiaries, how oversight of the program will be divided between the federal government and states.

I don't think we have answers there, but I would like to see those three main -- I think they're going to be obstacles or major points of contention, and I think we should just lay them out sooner rather than later.

CHAIR BELLA: Thank you, Brian.

I have a couple comments, and I want to see if I missed anybody.

Kisha?

COMMISSIONER DAVIS: Hi. Thanks, Kirstin.

I just want to say that it's really exciting to be looking at this chapter and thinking about doing something new, and looking at the potential for integration

here is really -- a lot of times, it feels like we're kind of doing the same things and putting little tweaks on programs that are already in existence, and so it's really good to be kind of focusing in this area.

A couple things that came to mind, one just around pulling out this group separately from Medicare and Medicaid. Does that have implications in terms of disparities and how they are perceived? We know that when you compare how Medicaid beneficiaries are perceived, first the Medicare beneficiaries in terms of equity and pulling on the system and health disparity issues, that they are viewed differently, even though they are both getting funds from the government, whether it be state or federal.

So are there implications or unintended consequences that we see by pulling this group out and creating a group in and of themselves, whether that be that you take an already very marginalized group and make them more marginalized because now they're not Medicare or Medicaid, or looking at Medicaid by pulling out those folks who are receiving the most support or the most disadvantaged? And do people look at the folks who remain in Medicaid as being able-bodied and less worthy of the

program?

I don't think that any of those are reasons to not go forward. I'm really [inaudible] about this as a possibility. I just want us to make sure that we are having an eye towards equity and unintended consequences.

CHAIR BELLA: Yeah. Super important point.

I saw Sheldon. Tom, did you have your hand up? Is that something -- Sheldon, go ahead, and I'll figure out Tom.

COMMISSIONER RETCHIN: Yeah. I'm just going to take another quick run, and I'm not -- and then I'm going to debate about the issue of clinical integration and financial in the order of the day.

Having participated in this as a payer myself when I was in Richmond in the Financial Alignment Initiative, just to say when you put these together in the financial alignment, there is a tremendous infrastructure investment up front so that you can get a clinical model that's integrated in the coordination of care, and having an up-front 8 percent withhold or reduction in payments after cost can make it very difficult. We lost $21 million in the first year, as Melanie knows.

So I remember there was some reference about risk corridors or something, but as we go forward, integrating this financially, there's going to need to be a runway for even sophisticated large plans.

CHAIR BELLA: Thank you, Sheldon.

Other Commissioners?

[No response.]

CHAIR BELLA: Well, Kirstin, not surprisingly, I'm super excited and very supportive of the work. I would just call out a couple of things.

I think you've done a wonderful job of framing design considerations. Our work can continue alongside of that of others.

The big issue is just how do we make something attractive to states. Sheldon, not to take, of course, providers too, but when you look around today, we talked a lot about states need support and bandwidth and capacity to be able to do these things, and so thinking about how we arm them to do these programs well and make sure they're well funded and the providers are on board, I don't want to lose sight of the state piece, particularly if it's an option for states to do something like this, continuing to

understand for states that aren't doing these things today. What would it take to get them to the table to be able to do this, so we start to have more availability for duals across the country and not just in certain states for access to these types of programs?

And the second piece is -- and I think this has become more telling as CMS rolls out more models like direct contracting -- we're running a risk that there are too many choices, and we've lost the benefit of choice if there are so many choices that it's confusing for beneficiaries. It downgrades the value of integration.

You see entities that are maybe putting people in programs based on financial incentive versus good choices for people and their needs, and so I think we just need to keep an eye towards -- one of our goals in having a unified program is to certainly make it easier so you're not navigating two different sets of rules and everything, but it's also to make it easier for people to understand what they're getting and why they would choose to be in a program like this. And we can hold those entities providing those services more accountable.

So I want us to be keeping an eye on the myriad

of things that compete to go after dual eligibles and making sure that we're thinking about anything new we create has a very, very high bar for integrating physical, behavioral health, long-term care, and social services and does also contribute to reducing some of the noise that continues to grow.

I was told the other day that if you're a dual in L.A. County, there are 91 choices on the Medicare side. How in the world would you navigate through 91 choices? So like whatever we do, cannot make this the 92nd -- however you would say that, 92nd thing. It has to provide some rationalization on that front too.

Any other comments from Commissioners?

[No response.]

CHAIR BELLA: Okay. Kirstin, do you have questions for us?

MS. BLOM: No. I think I'm good. This has been super helpful.

CHAIR BELLA: Okay. We have made up some time. So, Anne, I think that I'm going to ask if anyone wants to make public comment on either countercyclical or this discussion since we have some time right now, if that works

for you.

Okay. Is there anyone who's joining us in the audience who would like to make a public comment either on countercyclical or the discussion we just had on the unified program for duals? If so, please mark your little hand icon, and we will unmute you.

[No response.]

CHAIR BELLA: We exhausted all of our public commenters last time around, it looks like. We'll give it just one more minute.

MS. HUGHES: We have one from Leonard.

CHAIR BELLA: Great.

MS. HUGHES: Leonard, you've been unmuted. If you could unmute your own line.

CHAIR BELLA: And then please introduce yourself and who you're representing.

PUBLIC COMMENT

* DR. KIRSCHNER: Yeah. Leonard Kirschner. I was the AHCCCS Medicaid director in Arizona back a number of years ago. We've met a number of folks on the panel.

We were dealing because the AHCCCS model was a managed care, prepaid, capitated system, and as we had

those dual eligibles, that became a problem in the '80s and '90s.

I know that, Melanie, you've been dealing with this forever, and so have I. And I still have a favorite letter I had gotten back in 1990 from Mary Dewayne saying that we're going to solve the dual eligible problem this year, and that was 30 years ago.

So I'm delighted to see we're still attempting to do it, but it has been an incredibly difficult process. And I congratulate you on continuing to work to solve the problem because it is a critical issue going forward.

Thank you very much.

CHAIR BELLA: Nice to hear your voice. Thanks for taking time to join and provide comment.

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

MR. CLARK: Oh, hi. Can you hear me?

CHAIR BELLA: Yes.

MR. CLARK: Oh. I'm Bill Clark. I'm a senior fellow at NORC at the University of Chicago.

Just two comments on the duals proposal. One, I would worry about the states' capability for administering

the Medicare portions of the combined benefit package if that's what they would need to do, particularly in keeping up to date with Medicare regulations and statutes that change every year. So I'm not quite sure how the proposal addresses the Medicare responsibilities that states would need to assume if this was under their purview, but that was a question that I had.

The other point I wanted to raise was there are a lot of dual people in institutional SNPs at this point, and I didn't see the proposal as covering institution SNP members. So I think that might be something for the Commission to consider further.

Thank you.

CHAIR BELLA: Thank you, Bill, and nice to hear your voice as well. I appreciate you joining.

MR. CLARK: Thanks, Melanie.

CHAIR BELLA: All right. Is there anyone else that would like to make a comment at this point?

MS. HUGHES: Yes. We have one hand raised.

Kyle, you've been unmuted. You can unmute yourself and make your comment.

DR. ALLEN: Thank you. Kyle Allen. I'm a

geriatrician, currently serving in the Health and Aging Policy Fellowship, and this is directed at the dual eligible and strategies for integration.

One of the things I didn't hear much about is the integration of community-based organizations, and I think there's some evidence from this community-based care transitions demonstration that was done about the impact of using community-based organizations to reduced 30-day readmissions. So as per the other discussions around clinical integration, I think there's some evidence there and maybe lower cost alternatives versus the health plans building that out versus partnering with community agencies and effective payment policy and that type of thing.

So that was one area that I wanted to bring some light to and comment to. Thank you.

CHAIR BELLA: Thank you very much, Kyle.

Anyone else like to make a comment at this point on either the duals or countercyclical proposals?

[No response.]

MS. HUGHES: No hands. No one.

CHAIR BELLA: Okay. Thank you very much.

Kirstin, thank you for the continued work in this

area. We'll look forward to ongoing discussion.

We will go ahead and move into the next session, which is talking about the Secretary's report on Medicaid housing supports for individuals with substance use disorder and the requirement that we comment on the report.

Melinda, welcome. I'll turn it over to you.

REVIEW OF SECRETARY'S REPORTING MEDICAID HOUSING SUPPORTS FOR INDIVIDUALS WITH SUBSTANCE USE DISORDER

* MS. ROACH: Great. Thanks, Melanie. I'm just going to make sure I can advance the slides.

So the purpose of this session is to review the Secretary's report to Congress on Medicaid housing supports for individuals with SUD and to discuss potential areas for MACPAC comment.

I'll start with some brief background information and summarize highlights from the report before we move on to areas where Commissioners may want to provide comment. Then we'll close with a brief discussion of next steps.

HHS is required to issue this report under the SUPPORT Act, which directed the Secretary to report to Congress on several areas related to Medicaid housing

supports for people with SUD who are experiencing or at risk of homelessness. These include Medicaid authorities states may use to cover housing-related services for this population and lessons learned from states; the use of Sections 1115 and 1915 of the Social Security Act; state initiatives that have increased housing stability for this population; strategies used by Medicaid managed care organizations, hospitals, accountable care organizations, and other care coordination entities to provide housing-related services and supports; and state Medicaid program efforts to identify and enroll eligible individuals with SUD who are experiencing or at risk of homelessness.

As a required by the SUPPORT Act, the report describes federal authorities states can pursue to provide housing supports including Medicaid health homes, Section 1915(c) home and community-based services waivers, Section 1915(I) HCBS state plan authority, and Section 1115 demonstrations.

The report describes efforts by state Medicaid programs that have increased housing stability among Medicaid beneficiaries and SUD who are experiencing or at risk of homelessness. The five programs highlighted in

this section generally target high-cost, high-need Medicaid beneficiaries, a population in which SUD is highly prevalent.

Washington provides statewide coverage of housing-related services, while the programs in California; Maryland; Maricopa County, Arizona; and Philadelphia serve more limited geographic areas.

Given the limitations on the use of Medicaid funding, programs must coordinate multiple federal, state, local, and philanthropic resources to provide non-Medicaid services and increase affordable housing opportunities.

Strategies broadly adopted by these programs include peer supports, care coordination, and technical assistance to health care and housing providers.

The report also describes how local stakeholders contribute to the design and implementation of these programs.

As far as outcomes, the report finds that these programs show promising results in terms of housing retention rates, reductions in emergency department services and inpatient admissions, increased connection to primary and behavioral health care, and overall reductions

in per-person expenditures, but it also cautions that evaluations are pending and more research is needed to understand the effects of these programs.

The SUPPORT Act also required the Secretary to discuss lessons learned from states using Sections 1115 and 1915 to provide housing-related services to individuals with SUD who are experiencing or at risk of homelessness.

One of the findings is that states often have difficulty determining the appropriate Medicaid authority to use. The report finds that states most often use 1115 demonstration authority, given the flexibility it provides to limit housing-related services to specific geographic areas and target populations.

Few states use 1915(c) waiver authority, which can only be used for individuals who need an institutional level of care. While individuals with SUD may have complex health needs, many do not meet that criteria.

States can use 1915(I) state plan authority to provide HCBS to individuals who don't meet requirements for an institutional level of care. However, some have reported difficulty using that authority to create targeted programs. Despite those challenges, the report finds that

states are increasingly interested in using 1915(I).

The Secretary is also required to report on strategies used by Medicaid managed care organizations, hospitals, accountable care organizations, and other care coordination entities to provide housing-related services and supports. The report notes that many plans and providers are focused on expanding services, including housing supports, to holistically improve outcomes and avoid unnecessary spending for high-cost, high-need Medicaid beneficiaries.

Examples include Hennepin health, a county-administered MCO in Minnesota that employs housing navigators, and the Camden Coalition, an ACO in New Jersey that administers the Housing First pilot program that provides rental assistance and optional wraparound services. The report also notes that some hospitals fund short-term housing known as "medical respite programs" to care for people experiencing homelessness who are too sick to recover on the streets or in the shelter but not sick enough to remain in the hospital.

The last part of the report describes state Medicaid program efforts to identify and enroll eligible

individuals with SUD who are experiencing or at risk of homelessness. It describes CMS regulations and policies that give states flexibility in addressing common barriers such as lack of documentation or a fixed address. It also identifies innovative state efforts such as data-matching among homeless service providers, MCOs, hospitals, and other public systems to identify people experiencing homelessness, peer support specialists and community health workers providing outreach and engagement, and other strategies to facilitate Medicaid enrollment for individuals upon release from prison or jail, given the prevalence of SUD and increased risk of homelessness among this population.

Given the Commission's interest in Medicaid's role in housing and the well-established relationship between housing and health, there are several potential areas where MACPAC may wish to comment. These include encouraging CMS to issue comprehensive guidance to states on opportunities to provide Medicaid HCBS, including housing-related services, to individuals with behavioral health conditions. Previous guidance addressing supportive housing and behavioral health, including the recent

guidance on social determinants of health, doesn't provide a comprehensive roadmap for designing an HCBS benefit geared toward beneficiaries with SUD and mental health conditions.

The Commission may also consider asking CMS to revise or provide additional Section 1115 guidance to address housing-related services for beneficiaries with behavioral health conditions, something that's minimally addressed in existing 1115 guidance for demonstrations targeting people with SUD and serious mental illness or serious emotional disturbance.

With respect to additional guidance, the Commission may also consider encouraging CMS to address the housing needs of individuals leaving incarceration and guidance on Section 1115 demonstration opportunities to improve care transitions for individuals leaving incarceration.

This guidance is required by the SUPPORT Act but has not yet been issued.

Additionally, Commissioners may consider commenting on the importance of addressing non-Medicaid barriers to housing stability that may require

congressional action, such as the time-limited ban against living in certain federally supported housing for individuals evicted due to drug-related activities, federal policies allowing housing agencies to prohibit or limit housing assistance to individuals who have a past history of drug use or are considered at risk for engaging in illegal drug use, and limited funding for rental assistance, which results in many eligible households going without help.

In terms of next steps, Commissioners will have an opportunity now to discuss the report and possible areas for comment. Following the meeting, staff will draft a letter to the HHS Secretary and relevant congressional committees reflecting the discussion.

That concludes my presentation, and I'm happy to take any questions, and I look forward to the conversation.

CHAIR BELLA: Thank you, Melinda. You walked us through that very clearly. Let's flip back to a couple of the slides that have potential areas for comments, please. And I'll open it up to the Commissioners. Questions? Comments? Either in response to the comments posed or other things that you might like to address. Kit?

COMMISSIONER GORTON: Thank you. So my question, Melinda, I didn't see, in the memo, and I apologize if I missed it, is there anything in this report about racial bias? And if not, would it not be appropriate for the Commission to comment, based on what we know, about racialization in housing in general and what we know about the disproportionate impacts of substance use disorder on Black and indigenous people of color? Again, going back to my hobby horse of we should to this always -- I apologize. I'm going to shut up. That's my comment.

MS. ROACH: In response to your question, Kit, about whether that's addressed in the report, it is not addressed at any length. There is a very brief mention but it's not a prominent part of the discussion.

CHAIR BELLA: Then perhaps that could be one of our comments.

Okay, Martha, then Chuck, and Toby, and Sheldon, and Brian.

COMMISSIONER CARTER: Thank you. Melinda, I'm going to admit that I did not read the full report from the Secretary, and at the risk of sounding like a broken record on this, I wondered if the report mentioned the role of

FQHCs and health centers. In 2019, health centers provided care for 1.4 million people experiencing homelessness, and 81 percent provide care management onsite, 95 percent of health centers provide behavioral health onsite, and almost 60 percent have providers that are waivered to provide MAT services. So it's clear that the health centers have a role in housing supports, and I wondered if that was part of the report, and if it's not I think we should call it out.

MS. ROACH: That does come through in the report, which notes that four of the five programs that are highlighted partner with FQHCs in various ways. The report also notes the role of FQHCs in health care for the homeless programs. So I think that they are acknowledged, but it's certainly something we could further sort of highlight.

CHAIR BELLA: Thank you, Martha. Chuck?

VICE CHAIR MILLIGAN: Thank you, Melinda. One of the things that I just want to flag for a second, and then it may turn into a possible area of comment is one of the issues that is in the environment right now is that a lot of states are going to be settling litigation with pharma

coming up around OUD and prescribing. And I think it's going to look, in many ways, like the tobacco settlement process. There's probably going to be in the neighborhood of $70 billion to $100 billion in the settlements over kind of a 15-year time span.

And I think one of the areas where HHS can make contributions is how they provide guidance to states on the relationship of some of that funding, which some of it derives from Medicaid payment for pharmaceuticals and Medicaid payment for hospitalizations and other things related to adverse effects.

So I think one of the things that HHS can do is to talk about the importance of reinvesting some of those settlement funds in services for people with SUD, including housing supports, and including addressing issues of homelessness. And I also think it would be helpful for HHS to give some guidance back to states around the permissibility of how some of those settlement funds can interact with the Medicare program.

The reason I mention all of that is once the states start to realize the settlement funds, there can be a tendency then to try to fill other budget holes or not

utilize the funding related back to the cause of the state and local government over-expenditure caused by some of the prescribing practices and marketing activities of drug companies.

So I did want to mention that point, and Melinda, I just wanted to ask you whether you think that would be within the spirit of commenting on this report.

MS. ROACH: I might also defer somewhat to Anne, and just note that I think the issue that you raise certainly is much broader than the topic of this report, which is housing-related services for people with SUD. So I do think it has much broader implications which is something you may want to consider when weighing whether or not to add this element to a comment letter. But I don't know if Anne wanted to add anything.

EXECUTIVE DIRECTOR SCHWARTZ: I think we can probably figure out how to touch on it without going into any detail. I mean, it is a letter, so it is, by its nature, short, and so we can think about how we might pick up on that.

VICE CHAIR MILLIGAN: That's all, Melanie. Thank you.

CHAIR BELLA: Thanks, Chuck. Toby, then Sheldon, then Brian, then Fred.

COMMISSIONER DOUGLAS: Sorry. My microphone is falling off.

Thinking back to state efforts in the Medicaid space around housing, what always comes up is that there's only so much Medicaid can do, and this report says this. And really, this is a huge crisis that we're facing with just housing insecurity as well as homelessness, and it does have huge implications on Medicaid. But I really feel like we need to be commenting on what HHS can be providing in terms of rental support to areas outside of Medicaid, that this can't fall on Medicaid, yet the implications on Medicaid in terms of how the behavioral health impacts are significant, but Medicaid can't be the ones to address the housing crisis.

CHAIR BELLA: Thanks, Toby. Sheldon?

COMMISSIONER RETCHIN: Yeah. I'm going to comment on possibly making a comment that was missing in the report, and that's on the sheer effects of Medicaid on -- I've talked about this before -- on home evictions. You don't become homeless unless you've been evicted, if you've

been a renter in the past. And I noticed, and Melinda did a great job, in one of the slides it says "encourage those who have been released from prison to be involved in Medicaid." I might amend that to say "enroll all Medicaid-eligible individuals," because the effects of Medicaid coverage on eviction rates, work done by Heidi Allen and others, and in the report all five states studied are expansion states, Medicaid coverage has been shown to mitigate evictions directly by reducing the cost of medical care and indirectly by protecting earnings potential through better health, reducing medical debt, unmet health care needs.

So providing health care coverage reduces rental eviction, and, you know, I think it's worthwhile commenting on that, because otherwise health care competes with housing obligations. I know that's an area talking about expansion states versus non-expansion states, but I think it's worthwhile underscoring that sheer coverage makes a difference in homelessness.

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

COMMISSIONER BURWELL: So I did a little

background reading on this, and one of the reasons I did was I'm not a housing expert but I've heard about these programs, that the way to deal with homelessness was to provide people a place to live. And in a little reading, you know, on the homelessness side there is this group that advocates for housing first. You know, just give homeless people a place to live, provide stable housing as the first step before providing services. And then the debates seem to have evolved to the point, well, that's not a solution. People still have drug addiction. You know, have to do housing and services, which is obviously true. The question is, like how do you get those two together?

I was also involved in the Medicaid Innovation Accelerator Program that provided TA to states around various policy issues, and one was developing more housing for people with SUD. And the basic idea was to link Medicaid agencies with public housing agencies, either at the state level or the local level. And that was considered very successful, but the amount of time and effort it takes just to get those two entities to talk to each other, and understand what you're talking about, and try to move towards some type of outcomes was just huge. I

mean, there were three years of talking before anything substantial ever emerged from those initiatives.

I'm not sure it's our role, but it seems that there's got to be some -- any time you get Medicaid and housing people involved in trying to solve a problem it's just going to be a lot of administrative work just to make it happen. So some type of consolidated approach or simplified approach that can provide people with substance abuse issues with a place to live and the services together in some kind of bundled, like a home health initiative, would seem to be to be a reasonable path to go. But as I said, I don't work in this area but there just seems to be a lot of overhead involved in trying to address this problem.

CHAIR BELLA: Thanks, Brian. Fred, and then Kit.

COMMISSIONER CERISE: Yeah, I think, Melinda, you mentioned something about a roadmap and being able to identify how we can better use Medicaid to kind of partner with other agencies to bring us to some solutions. I think that's an important piece. There's a lot of activity in this space, by a lot of people, and it's uncoordinated and people that don't understand where you can make an impact,

well-intended people. And to follow on Martha's comment, there's a lot going on on the provider side. Hospitals consume 30 percent of that health dollar, and a lot of individual places are trying to do things in this space that's unconnected. You mentioned navigators and rental assistance and recuperative care, and those types of things.

So I think if some of the effort could be towards identifying how to -- you know, a roadmap that would look at using Medicaid to support working towards, with community-based organizations, braided funding streams, HUD, other housing streams, that could then be, where you could focus some of the work among provider systems. We all have to do a community health needs assessment. We all have community benefit obligations. And if that could be directed better, to have more of an impact, I think states with 1115 guidance, perhaps, if they're more explicit, could help to make a bigger impact.

Because we all want to do something, but everybody is doing a little recuperative care program over here, or navigators over here. And we know the outcomes we've got to look at as well, and that Camden program, you

know, if the outcomes is hospital readmissions, that may not be the answer you're looking for. We need to look at outcomes that matter to the people that we're trying to provide the services for.

CHAIR BELLA: Thank you, Fred. Kit, and then Kisha.

Kit, we can't hear you.

Kisha, do you want to go while Kit is getting ready?

COMMISSIONER DAVIS: Sure. I wanted to kind of tie a thread between what Sheldon was saying and Toby, and Brian a little bit too, you know, this idea that you have to do housing or Medicaid, and who pays for what. You know, I really actually want to echo Toby's point that not all of your best dollars for health, to achieve health, are spent in health care. And so if we're thinking about how do we improve health, then maybe that dollar needs to be invested in housing, or education, or transportation, and making sure that that line is running through kind of what we're saying. You know, our job is to advise HHS and Congress, but maybe we also need to be advising HUD that they need to be investing in Housing First programs if you

really want to save money in health care, because Medicaid can't finance all of it.

You know, to Sheldon's point of having Medicaid coverage gives you a level of safety and support and financial coverage so that you're not then falling into homelessness because of debt, you need to have both and you need to have the health care coverage but you also need to have that social support so that you're not then relying on Medicaid for everything.

I think those are just tensions that we need to make sure are being brought forward in the discussion.

CHAIR BELLA: Thanks, Kisha. Kit?

Pass? Oh, sorry. On my thing is says your phone is green, for what that's worth.

All right. Melinda, Kit reserves the right to add additional comment for your consideration. Do any other Commissioners have any comments for Melinda?

[No response.]

CHAIR BELLA: All right. Since we have a little bit of time we'll just see if anyone in the public wants to make any comments on the letter that we'll be writing. If anyone in the audience would like to make a comment, please

hit your little hand button.

[No response.]

CHAIR BELLA: Melinda, while we're waiting for that do you need anything else from us, any clarifications or anything?

MS. ROACH: I don't think so. This has been helpful. Thanks.

CHAIR BELLA: We don't expect it to be a 20-page or a 10-page letter. We realize that you will succinctly get our points across, but hopefully this feedback has been helpful.

MS. ROACH: Thanks.

CHAIR BELLA: All right. It does not --

MS. HUGHES: Nataki has been unmuted by the organizer.

CHAIR BELLA: Oh, great. Nataki, if you could introduce yourself and your organization that would be great.

Nataki, you should be unmuted if you'd like to go ahead with your comment.

[No response.]

CHAIR BELLA: Okay. We'll give it one more try.

Nataki, if you'd like to make a comment please go ahead.

[No response.]

CHAIR BELLA: Okay. I'm going to assume there are technical difficulties of some sort and just remind folks that if you do want to make a comment you can also submit that via email to comments@MACPAC.gov.

And with that we are wrapping up this session, and we have a break before coming back to do a panel on the state budget outlook and implications for Medicaid [inaudible].

COMMISSIONER BARKER: Melanie, we were having trouble hearing you.

MS. HUGHES: Sounded like the volume just went down, Melanie.

COMMISSIONER BARKER: Yeah, exactly.

VICE CHAIR MILLIGAN: I think Melanie said we're going to take a break until the top of the hour, and we'll hear a panel on the state budget outlook for Medicaid. So I think she said if you didn't have time to each lunch earlier you can eat lunch now, and we're adjourned until the top of the hour.

COMMISSIONER CERISE: Thanks, Chuck.

VICE CHAIR MILLIGAN: Thanks.

* [Recess.]

CHAIR BELLA: All right. We're going to go ahead and get started. Welcome back, everyone, and welcome to our guests. We have with us this afternoon Shelby Kerns from the National Association of State Budget Officers, Susie Perez Quinn from the National Governors Association, and Emily Blanford from National Conference of State Legislatures.

As you can imagine, folks on this Commission are thinking a lot about what's going on with budgets and how it's impacting states, and I'm sure the three of you are doing a lot of these road shows. And so we are very appreciative that you're here to talk to us today. We're hoping to spend about 30 minutes hearing from the three of you and then leave about half the time for Q&A with the Commissioners. And so because we have such a tight time frame and I know there will be lots of questions, I'm just going to ask the Commissioners to take a look at the bios that are in your materials and just jump right in to get started with the panel.

Shelby, I think you're going to kick us off, and

thank you again to the three of you for being here today.

PANEL: STATE BUDGET OUTLOOK AND IMPLICATIONS FOR MEDICAID

* MS. KERNS: Thank you, and thank you, Commissioners. I'm going to start off today with setting the stage with some information on state budget expenditures, state revenues, and state rainy day funds just to give you an overall picture of the fiscal health of state budgets and where we're at today.

The data that I'm going to be citing will come through NASBO's recently released 2020 fall fiscal survey, which collects information on states' enacted budgets. It's really important to note that the data represents a point in time when a state completed the survey, and those points in time differ by state depending on when the state enacted its budget for fiscal year 2021 and also how often a state revises its revenue forecast. That's always the case, but things have changed so quickly this year that it can have an outsize impact. So I just want to make sure that you're aware that the budget figures in this survey were enacted as long ago as April 2019 for some states with biennial budgets and as recently as September 2020 for

others.

While some of the more dire predictions of the last ten months for state revenue thankfully did not come to pass, our data does show that states are continuing to face fiscal stress. After nine consecutive years of growth, states saw revenue declines in fiscal 2020, and greater declines are forecasted for fiscal 2021, leading to enacted budgets for fiscal 2021 calling for the first general fund funding decrease since the Great Recession.

Preliminary actual general fund spending for fiscal 2020 came in at $903.1 billion. That's a 4 percent annual increase. And while actual general fund spending for fiscal 2020 did increase, it was 1.7 percent below the level that states expected to spend prior to the COVID-19 crisis. That really speaks to the severe rapid impacts of the COVID-19 crisis, given that there's typically a lag between the start of an economic downturn and state fiscal stress necessitating budget cuts.

The pandemic and ensuing economic impacts hit late in the fiscal year, which made it hard for states to rely too much on spending cuts to close budget shortfalls. Still, states did take steps to rein in spending for the

remainder of the year, including targeted and across-the-board spending cuts, hiring freezes, furloughs, layoffs, and other strategies.

States' enacted budgets for fiscal 2021 are projected to reduce general fund spending by 1.1 percent compared to those preliminary actual fiscal 2020 levels. This will be the first time states enacted a net spending decrease in more than a decade.

However, it's really important to note that a net spending decrease does not capture the whole picture that states are facing, since they budget on a projection. Compared to Governors' budget proposals for fiscal 2021--which for most states are released just a few months earlier--states' enacted budgets showed a 5.5 percent reduction in general fund spending. So states had to considerably adjust their spending plans in the spring and the summer compared to what Governors had recommended in the winter due to that rapid transformation of states' fiscal conditions.

K-12 saw the largest reduction in expenditures, and higher education and transportation and all other government programs saw net decreases as well. Medicaid

and public assistance saw sizable increases in spending, reflecting rising caseloads and spending pressure for health and human services as a result of the economic downturn.

Medicaid is, of course, vital as unemployment rises and individuals seek to continue health care coverage. So far, states reported approving net reductions post-enactment for fiscal 2021 due to a budget shortfall.

Just really quickly, the most commonly used strategies by states to manage their budgets and address those shortfalls were: spending cuts, both targeted and across the board; personnel actions, including hiring freezes, furloughs, layoffs; and also use of one-time measures -- rainy day funds, transfers, pulling money from other funds, using prior-year balances, and deferring paying some bills that had come in. Only a few states used revenue increases. And some states reported using federal assistance to offset some eligible general fund costs associated to the pandemic response and relief.

But often what you'll see is you'll see these decreases in general fund spending, but then you'll see an increase on the federal fund expenditure side. And some

states did reduce local aid to meet those budget cuts, and some did enact Medicaid preemption. For example, we saw that some states changed their Medicaid managed care capitation rates.

I'll share some more specific Medicaid numbers as I wrap up. I'll keep those until the end so those figures are top of your mind going forward.

In addition to the spending side of the state budget, our survey takes a look at the revenue side of the ledger. Again, there are some timing issues to be aware of. The fiscal 2021 figures are based on states' most current general fund revenue estimates at the time of data collection, and then we compare those to the preliminary actual revenues for fiscal 2020. So it's really important to note that we didn't adjust these numbers I'm going to share with you for the impact of the tax deadline shift, and that deflated fiscal 2020 revenue and inflated fiscal 2021 revenue for many states.

So before the COVID-19 crisis hit, states were expecting general fund revenue growth of 2.9 percent in fiscal 2020 and 3 percent in fiscal 2021. Compared to those pre-COVID projections, preliminary actual fiscal 2020

general fund collections declined 3.8 percent and fiscal 2021 current estimates show a decline of 10.8 percent. Such a steep revenue loss in just a one-year period is noteworthy, particularly since federal stimulus measures, including enhanced unemployment compensation, the Paycheck Protection Program, direct checks to individuals, and other measures were in place that really helped prop up the economy, and that, of course, propped up state revenues during much of that time.

It's also important to remember that state tax collections, particularly from income taxes, usually lag economic downturns. So seeing such a drastic loss of revenue so early gives us a lot of concern for what we might see in the future. With states facing these consecutive years of general fund revenue declines in fiscal 2020 and fiscal 2021, there's a great deal of uncertainty about how long it will take for state budgets to recover.

For some context on that, after the Great Recession, even though revenues began to grow again in fiscal 2011, it took until fiscal 2013 for state general fund revenues to surpass the fiscal 2008 level without

adjusting for inflation. States did not see revenue fully restored to fiscal 2008 levels until fiscal 2018 in inflation-adjusted terms.

States also report on their rainy day funds. Some states did use those funds to close shortfalls in fiscal 2020, and we've also seen some make use of their savings to address projected gaps in fiscal 2021, either in enacted or revised budgets.

Before the COVID-19 crisis hit, state rainy day funds were at an all-time high after executive rebuilding following the Great Recession. Total rainy day balances as a percentage of general fund spending declined from 9.1 percent in fiscal 2019 to 7.8 percent in fiscal 2020, though the median rainy day fund balance did not yet record a decline. And I know a lot of people were expecting to see those rainy day accounts drained to balance budgets, but generally states will couple the use of savings with cuts to smooth out the cuts over the course of a downturn.

As states began their 2021 legislative session, there continues to be a lot of uncertainty around the state budget conditions. As we look ahead, slowdown in jobs recovery, lack of direct federal aid to states, and surging

caseloads are really expected to continue to strain many state economies and budgets further.

Most states, fortunately, have been able to avoid the severe budget cuts that were projected earlier, but state tax collections do generally lag economic downturns, and the steepest spending reductions tend to follow later. We observed that after the Great Recession. And we don't want to see states enact spending cuts and personnel reductions just as the rest of the economy is beginning to rebound and then have that drag out the recovery.

As state tax revenues do recover from substantial declines induced by the pandemic, rising spending demands from an uneven economic recovery are expected to put added pressure on state budgets. Medicaid is a key piece of that. We're seeing that the lower-wage workers are disproportionately impacted by this crisis, and so we expect that they will more quickly turn to public assistance if they are not able to find employment again.

Positive vaccine developments have offered some reason for optimism, but the challenges that lie ahead for vaccine distribution and related steps are also significant and will strain state budgets further. But, again, on a

positive note, we've seen improved revenue projections and collections for some states. That's the good news. The bad news, of course, is that improved -- compared to the catastrophic predictions in the spring and summer -- doesn't necessarily translate to a positive or even a return to the pre-COVID outlook.

We're also seeing that that impact and recovery on state revenue has been uneven. Energy-producing states and those dependent upon tourism and with higher unemployment rates are seeing greater impacts, and states with economies more reliant upon services are being hit harder. Tax structures and virus transmission levels are also affecting the impact on state revenues. But due to that unevenness, the aggregate numbers that we report mask that there are some states who are still experiencing dire revenue shortfalls, and others that are maybe faring a little bit better.

But a quick note on Medicaid expenditures specifically. Since the beginning of the Great Recession and then continuing through the enactment of the Affordable Care Act, Medicaid has risen as a percentage of total state spending, growing from 20.5 percent in fiscal 2008 to 29.3

percent in fiscal 2018. However, in the last few years, Medicaid spending has slightly declined as a share of total state spending, falling to 28.8 percent in 2019 and 28.6 percent in estimated expenditures for fiscal 2020.

I know Susie is going to talk a little bit more about the federal aid that has been provided, including the 6.2-percentage-point increase in the federal medical assistance percentage, but I just want to leave you with some of those figures to keep in mind. In fiscal 2020, federal funds comprised 62.7 percent of total Medicaid spending; and general funds, 27.3 percent. Other funds were at 10 percent. We've seen a slight increase in federal funds as a share of expenditures, and we'd expect to see that share grow larger in fiscal 2021 due to the greater amount of Federal money that's flowing into the Medicaid program.

Total Medicaid spending of $646.7 billion for fiscal 2020 was an increase of $43.2 billion over what was spent in fiscal 2019, so it's a 7.2 percent increase. Spending from state funds increased 4.4 percent, and federal fund spending grew 8.9 percent in fiscal 2020. That increase in spending in fiscal 2020 really reflects

the impacts of the COVID-19 pandemic and the ensuing economic fallout as we saw the rise in unemployment, which will affect, of course, Medicaid enrollment and spending.

So I'll go ahead and turn it over to Susie. I know she can talk a little bit more about specifically how that looks for states.

* MS. QUINN: Thanks, Shelby. Good afternoon, Commissioners. Thank you for inviting me to speak to you today about state budgets and COVID. We work closely with Shelby and her team at NASBO, and I can't do my job effectively without their data and insight.

So just a quick retrospective to frame things. No one expected a year like 2020. Going into the year, our federal agenda for Governors was focused on National Guard issues; health care issues like surprise medical billing, which was finally dealt with at the end of 2020; prescription drug costs; cybersecurity; and infrastructure.

When we held our winter meeting and brought the Governors together in Washington nearly one year ago, the policy discussion focused on vaping, workforce, broadband, and resiliency, and at the very last minute, there was a briefing by senior administration officials to provide an

update on COVID.

Quickly, everything changed, with the first multi-billion-dollar supplemental spending bill's passage. And back then, an $8.3 billion bill was a big deal. The focus was on emergency powers of Governors and testing. And then in the spring it became PPE supplies, ventilators, stay-at-home orders. All of those things cost money in one way or another.

Under the leadership of our Chair at the time, Maryland Governor Larry Hogan, and continuing with our current Chair, Governor Andrew Cuomo, and Vice Chair Asa Hutchinson, we convened Governors to share information, best practices, and items of concern with the administration and the Congress.

So very rapidly, the public health emergency became an economic emergency, and a lot of our focus at NGA, as directed by Governors, was on the impact of COVID on state budgets. In very short order, we worked with some other organizations, including NASBO, to look at the last major federal stimulus following the Great Recession and what it did for states and territories, what worked, and how to best make a very large request. And as a result,

there was $150 billion provided in the CARES Act, known as the "Coronavirus Relief Fund."

It was intended to be flexible. We know that that is not what it ended up with. In statute and in regulation, it was pretty vastly different than what Governors requested. They wanted direct and flexible assistance. However, it did cover a great deal of costs associated with the response to COVID.

The number one thing we would hear through the passage of four more supplementals was the need for certainty, and so some of the things I'm going to lay out to you this afternoon have changed recently, but they get into that question of certainty and the impact of COVID response from state budgets, which then get also into Medicaid.

So I'll start with the National Guard. Since the start of the COVID pandemic, Governors were strongly advocating for the use of Title 32 for National Guard response efforts. So this would allow for continued extension by the administration to address ongoing recovery, talk about reopening, and vaccine distribution efforts across the states and territories.

So the Governors were provided with Title 32 authority. They were challenged in September by a new requirement to contribute 25 percent of the cost of using the National Guard in this status. And so that was from September to January, and it was for all states and territories, excluding three. So as a whole, that added about $300 million in additional funds that states needed to dig into their coffers for. We estimate, you know, again, that that would be around $306 million.

Now, last week that changed when President Biden issued a memorandum that provides 100 percent federal cost share for the use of the Guard starting on the 21st. Governors are still looking to find relief for the costs incurred last year through a retroactive 100 percent cost share. That's still an open question.

Cost share, however, is not only about the use of the National Guard, so this goes hand in hand. The federal cost share issue also applies to the FEMA public assistance program under the major disaster declaration for COVID. So the statute that President Trump invoked, part of the Stafford Act, to declare a national emergency for COVID acknowledges that the primary responsibility for response

rests with the United States. The U.S. Federal Government exercises exclusive or preeminent responsibility and authority. However, the previous administration set a 25 percent state match on public assistance.

NGA, along with state and local partners, requested early on that FEMA waive the cost share requirement, as they can, for states and territories because Governors believed that the unprecedented size, scale, and duration of COVID's impacts far exceeded the response capabilities of states and territories. So waiving that cost share requirement would ensure that states and territories are able to adequately and rapidly respond to support their constituents, and it would also ease a significant financial burden.

Based on the monthly reporting from FEMA on their Disaster Relief Fund expenditures, the state and territorial match on the whole, from the period of March through December, totaled around $2 billion. Now, again last week, President Biden through a presidential memorandum extended that FEMA cost share to 100 percent. Like the Guard match, this effort was not retroactive, meaning that states and territories are still on the hook

for finding $2 billion to meet their match.

The Biden administration has also prioritized FEMA funding via the Disaster Relief Fund to robustly support vaccine operations, sending over $1 billion to several states just this week. So the other piece, moving part here, is that there is a drawdown of those FEMA Disaster Relief Funds, so getting that retroactivity could be a little bit tricky. NGA is hopeful that discussions will continue with the administration to address these fiscal challenges associated with match.

MS. QUINN: So that's going to take us to Medicaid, and as shall be noted, as you all are very aware, during recessions, Medicaid can play a key role in supporting health insurance and economic recovery. Its ability to do so depends on the state's ability to fund their share of the program.

In prior recessions, every percentage point increase in the unemployment rate would roughly translate to an increase in Medicaid enrollment of about 1 million new enrollees.

The enhanced match rate that was part of the American Recovery and Reinvestment Act, ARRA, provided

states over $100 million in additional federal funds during the Great Recession when unemployment peaked at 10 percent in October of 2009.

Because of these things, last year on behalf of governors, NGA advocated for a higher FMAP to states, and while we were happy to see some fiscal relief from Congress, it was not exactly what governors had requested. The Families First Coronavirus Response Act authorized the 6.2 percent increase in the FMAP with some strings attached with respect to the MOE.

That 6.2 percent has been incredibly helpful, but there's another layer to it in that it's tied to the public health emergency declaration. So in the early months of the pandemic -- and those declarations would last for a 90-day span. What we saw is that HHS would wait until a few days prior to the PHE's expiration to extend it.

It did change when the last two renewals were issued at least two weeks before the PHE expired, and it did provide some comfort, although HHS still retains that discretion determining the PHE at any time.

Most recently, last Friday -- and this was late Friday afternoon -- the Acting Secretary of Health and

Human Services sent a letter to all governors informing them that the public health emergency will remain in place likely through the entirety of the calendar year. In addition, once a decision is made to terminate the PHE or let it expire, HHS will provide states with 60 days' notice prior to the termination.

So these are all the things, and there is much more certainty on three big issues affecting state budgets, one directly affecting Medicaid, two directly affecting state cash flow. While states have seen relief, again, they've seen relief on the expense side and the cost side, not on the revenue side, which, as Shelby mentioned, we're seeing uneven impacts across states.

So just sharing a little bit more information on trends and enrollment, that preliminary data is showing total enrollment grew to 77.3 million in September, an increase of 6.1 million from actual enrollment in February 2020. So that's about 8.6 percent.

These trends reflect changes in the economy and then also provisions in the Families First Coronavirus Response Act that requires states to ensure continuous coverage.

We do also know that Medicaid enrollment usually lags beyond increases in unemployment, and data for subsequent periods could also show continued enrollment growth.

We did see it "past as prologue," Medicaid enrollment increase following the implementation of the Affordable Care Act, but that was declining in the two years prior to the pandemic.

So states anticipate increased Medicaid enrollment due to the downturn. Some of this is unclear, and states are in different places. For example, Florida's Medicaid enrollment was around 3.9 million people before the pandemic, and the predictions that we have are it will get to about 4.6 million. Arizona reached over 2 million people in Medicaid in July 2020, with over 200,000 newly approved applications since the COVID pandemic began in March.

So increasing that FMAP continues to provide timely and flexible relief to states. It frees up other resources for other government services, including K-12 and education.

So, in conclusion, FMAP will remain to be a hot

topic among governors. The easing of these cost share burdens with the presidential actions last week will help add, hopefully, some breathing room to state budgets who are in that season right now with over -- and I know we've got NCSL. So I'll let NCSL talk about how many states are in session, but many of the governors have delivered their state of the states in their budget as well.

Thank you.

CHAIR BELLA: Thank you, Susie.

Emily?

* MS. BLANFORD: [Inaudible] perspective on Medicaid and state budget, and yeah, I'm really just going to echo a lot of what Shelby and Susie said, but I wanted to share some specifics that we have for you.

So recently, our clinical team at NCSL conducted a survey, and we got a response from 29 states. [Inaudible.]

MR. BOISSONNAULT: Emily? Emily, you need to switch to phone call. Sorry to interrupt. There appears to be a bandwidth issue. If you can do the dial-in, that would be great. Thank you.

MS. BLANFORD: Okay. Yes.

MS. HUGHES: If you wouldn't mind going to the audio pane on your control panel and switch it from computer audio to phone call so that we don't have you on both forms of audio.

MS. BLANFORD: Okay.

[Pause.]

CHAIR BELLA: While we are getting that sorted out and so Emily doesn't feel like everyone is watching her dial in, does anybody have any questions for Shelby or Susie?

I think, Emily, on your little control panel, it says "phone call," in the middle. I think maybe you can dial in through that, through your computer. That's what they're suggesting.

In the meantime, do we have a question for Shelby or Susie while we're waiting?

Stacey, is that a hand?

COMMISSIONER LAMPKIN: I have a question I can go ahead and ask. Thanks.

If this is not the level of detail or the conversations you all are having, just let me know.

I'm a Medicaid managed care actuary in my day

job, and so my question is around how capitated managed care is performing in this environment from the state's perspective.

I know you all know that the prevalence of Medicaid managed care has grown tremendously over the last decade or so to the point where we have billions and billions of dollars in capitation.

Historically, we've thought of one of the positives of that is budget predictability, but what we saw last year was a lot of dropped, completely unexpected slowdown in Medicaid service utilization for plans that were already capitated and rates that didn't reflect that sort of thing.

States have historically been somewhat resistant to risk mitigation techniques. We did see some softening of that last year, but in general, I guess my question is, does this experience change the way states think about that service delivery model and its flexibility? Are there things that we should be thinking about in terms of how managed care can be more flexible in an extreme event situation like we saw in 2020?

MS. KERNS: This is Shelby. I can answer first,

and unfortunately, we haven't had a lot of conversations at that level at this point. We probably will around our spring meeting time see how states are approaching it.

There was a lot of talk about it last year, as you mentioned. So I suspect it will continue to be quite a hot topic, but I haven't heard a lot of consensus of have anything that I would feel was more than anecdotal to share.

CHAIR BELLA: Okay, great. Stacey, that's a great question. We'll maybe come back to that.

Emily, thank you for your patience. Please jump right in where you were.

MS. BLANFORD: Oh, dear. Thank you all for your patience.

CHAIR BELLA: Yep.

[Pause.]

CHAIR BELLA: Now we stopped hearing you.

Jim, can you tell what's the matter?

MS. BLANFORD: No, it should be okay. Sorry, sorry.

CHAIR BELLA: Okay.

MS. BLANFORD: They hit my unmute button, so I'll

just do it this way.

So as I was talking, I was talking about a survey that we had done at NCSL, and again, what we're really seeing is echoing everything you all heard from Shelby and Susie in that the revenue situation is looking a lot better than people thought it was going to look earlier in the pandemic.

We got 29 states who responded, and the vast majority of them are feeling -- I mean, I don't know if they're feeling good about their fiscal situation, but they don't feel like they need to make budget adjustments. They're feeling their fiscal year '21 budgets are balanced, and that they aren't going to have to make significant cuts. In fact, some are really working to restore some earlier cuts, including across-the-board rate decreases and things like that.

As a part of this survey and the 29 states, they all identified Medicaid in at least their top three of their budget priorities, and typically, that's true of state legislatures. Medicaid is a large chunk of budget [inaudible], but typically, they're looking to reduce spending and control costs. But in this case, you know,

[inaudible] you know, so that states can assure they're covering that [inaudible] as well as the other needs [inaudible] to COVID.

Now, there were some worries initially that the enhanced FMAP bump of 6.2 percent and the continuous coverage requirement, that maybe the continuous coverage would take a whole additional share of federal funds, but also, again, states aren't really seeing that come to fruition either.

And so while I will say we're not seeing a lot of states participating maybe because there are deep cuts in many places, there are still some states looking at ways to control spending and access, either through modifying optional benefits or in cost sharing policies and things like that.

Another area that's always in a hot topic in our legislatures is Medicaid expansion, and so this year, again, I'm sure, as you all know, Oklahoma and Missouri both had ballot initiatives passed to expand Medicaid in their states. So those legislatures now are tasked with finding the funding for the state share of that.

But we're also seeing in states that have not

expanded Medicaid, there's an ongoing discussion about potentially expanding, particularly in light of the pandemic. Now, for the states who have not yet expanded, a lot of them are more interested in the "Healthy Opportunity" or the block grants/limiting funding kind of arrangements. One state legislature gathered very quickly recently to pass legislation to support their block grant that was approved by the Trump administration, but now we're really going to be waiting to see how the Biden administration proceeds. But it will be interesting to see how those conversations in the states go who have not yet expanded Medicaid.

And I also just want to mention we're seeing some other expansions, like for postpartum coverage from 60 days to 12 months for women, seeing that across a lot of state legislatures. There were some policies passed last year that were put on hold due to the budget concerns, but it looks like some of them will be coming back in this coming year.

Also, behavioral health is still a major area of focus. States have done a lot of work to invest in behavioral health in the Medicaid space, starting with the

opioid epidemic, but expanding more to substance use more generally, and states are still looking to invest and support those programs.

Then just the last thing I wanted to touch on, to talk about FMAP, and I just want to mention that state legislatures, it's also a concern and a priority of theirs as well. I'm spending a lot of my time educating state legislatures on the enhanced FMAP, what they can do with it, and what the strings attached to it are. So they're very interested in particularly the concerns of when the FMAP comes to an end, again, the certainty, as Susie mentioned, and preparing for the end of that FMAP.

And with that, I think that's kind of just my high-level overview. Again, I'd really echo we're seeing a lot of the same things on the state legislature side.

CHAIR BELLA: Thank you very much.

Before we go on to questions, Susie or Emily, did you have anything to add to what Stacey had asked about managed care? Did either of you want to say anything on that front?

MS. QUINN: I am not in that level of granular detail, so I will take a pass.

MS. BLANFORD: Yeah. Unfortunately, me too.

CHAIR BELLA: Okay. I still think it's a really important question, Stacey. Hopefully, we will begin to get more insight into that, so thank you.

Okay. We're going to open it up. I saw Darin and then Sheldon.

COMMISSIONER GORDON: Thank you all for presenting.

I think adding to Stacey's question, I think we'll indicate to look at also this is the context of value-based purchasing as well, because I think the same is true there that this dynamic the pandemic created has caused a lot of folks to reflect on -- is there a better way or are there things they should be thinking about differently for these extreme types of circumstances.

Shifting to [inaudible.] you know, this is a downturn like none other. It's affecting people very, very, very differently, but it's also affecting states differently, as some of the presenters commented one.

I heard -- and you guys are going to be closer to this than I am, and so I'd like to hear you all expound upon it -- is I've just heard it anecdotally that some

states are actually looking at doing reductions in taxes while others are actually looking at potentially having to expand taxes. So if there's any commentary you all could provide on that, you know, if there's more data to back that up, I just found that -- I found that interesting. And some of the stories I heard, very, very stark differences between some states.

Thank you.

MS. KERNS: I can take a first stab at this one too. Maybe Emily has checked it closer. I don't know if NCSL has checked it closer. So my answer is a bit anecdotal as well that we are seeing more tax cuts than we would have anticipated a few months ago, it seems, and we've started tracking that, but only a small portion of state budgets have been released. But as they're being released and we hear governors present their “state of the states,” we are tracking what they're saying. And we're seeing tax cuts more than tax increases. There have only been a few states that have turned to revenue-increasing measures like that, and those may come later.

But a lot of what we're seeing are states focused on spurring their economic activity, getting more money in

the pockets of businesses, in the pockets of individuals to keep the spending levels up. So we're seeing some one-time tax measures and some ongoing, but we're seeing a mix there for sure. And it really does speak to that unevenness.

I always bring this up, but I'm from Idaho. So if you're spending time in Idaho, none of this really is reflecting your reality in state government where we have record revenue growth, but then you have other states that are looking 20 percent revenue declines. So when we talk in these aggregate numbers, it's really obscuring some of the pain that we're seeing but also some of that growth. So I think what you're seeing with tax decreases, that's what we're seeing, and it really reflects exactly that, just the differences we're seeing from state to state.

COMMISSIONER GORDON: Thank you.

I think I saw Emily was about to respond. Go ahead.

MS. BLANFORD: Well, I was just going to echo how we were seeing the same thing as well.

So the survey we just did was pretty in depth, and I didn't dive into everything in there. But we might have some data from that survey that I could share so we

could actually give you some data as to some of the specific policies from those 29 states, but yeah, I would echo we're seeing similar things.

COMMISSIONER GORDON: Then just the last thing I'll say is as an ex-budget officer -- I was a budget analyst for many years. The thing -- and everyone touched on it, but if you're not used to tracking all this stuff, a lot of this, once a budget gets put out there, then there's adjustments to that budget. It's a point in time, as some folks had said, but when they're talking about, hey, it wasn't as bad as they thought, they originally put a budget out there with pretty substantial reductions, assuming the worst, got more information, then made some adjustments to that budget. So this is just one of those times where you have multiple budgets coming out throughout the year, which is not normal, just like the circumstance. But it's hard to follow some of the pluses and minuses as budgets are getting adjusted or revised midyear, so just a comment.

Thank you.

MS. KERNS: We post summaries of proposed and enacted budgets. I'm not sure if I can share in the chat. I think I can only share that maybe with presenters and

organizers. But I will go ahead and put the link there and maybe it can be shared, if that's of interest to folks. We're still working on putting those out for this year, but we're working them up soon.

CHAIR BELLA: Thank you very much. Sheldon, then Kit, then Chuck.

COMMISSIONER RETCHIN: Yeah, I actually was going to make another comment, but Stacey's point, I guess, provoked me to explore that a little deeper. I don't know the answer to this, but I think a very large proportion of the managed care portfolio is through public companies, very large public companies, multistate public companies, who really are measured by quarterly earnings. During the pandemic -- and this is really unusual, it's not like just a normal recession -- because of the pandemic and the decrease in demand, the margins and quarterly earnings have been quite inflated.

Now, we don't know, because we haven't been through this in 100 years, but what kind of unmet or pent-up demand will there be and the pendulum will swing post-pandemic, and those same companies that had large margins, who are investor-owned, suddenly will have a huge impact on

them, possibly. And you won't be able to do it retrospectively, I don't think. I think that's a pretty interesting and difficult problem. Negotiations on premiums goes on an annual basis. The large pendulum swings, I mean, those are unprecedented.

COMMISSIONER LAMPKIN: I think it's worth a conversation, you know, maybe at another time, Melanie. And what if the impact do federal relations have on being able to smooth some of that out or restrict our ability to smooth some of that out and make the money flow in a sensible way?

CHAIR BELLA: Yeah, so noted. Thank you both. Sheldon, did you have an original question that you wanted to ask as well?

COMMISSIONER RETCHIN: Well, I was going to ask really more of a, I guess, balance sheet health. There's so much variation among the states in terms of credit ratings. Have you seen the large number of state credit rating downgrades, and what's the impact on that on debt servicing through the states? Has the pandemic affected that?

MS. KERNS: I can start off on that one as well.

I feel like we've gotten into this habit now of me going first. We're not seeing very many downgrades, actually, and was speaking with some rating agencies recently and they're seeing the same thing that you've heard from the three of us today, which is that, in general, most state balances are in good shape. They've still got savings. Their revenues are not falling too terribly badly. They're going to be able to meet their debt service. So there hasn't been a huge impact on credit ratings.

CHAIR BELLA: Anyone else on that?

Okay, thank you. Kit, and then Chuck.

COMMISSIONER GORDON: Can I ask one question, a follow-up on that? Didn't you say that the reserves were reduced by -- I mean, it sounded like a fairly significant percentage, while not maybe a significant dollar amount? I'm sure that would interplay with what was just being discussed. Can you just remind me what that percentage was?

MS. KERNS: Yeah. So that's kind of an interesting -- there's a couple different things at play in there. So when we talked about the total rainy-day balances as a percentage of general fund spending declined

from 9.1 percent in the full year 2019 to 7.9 percent in fiscal 2020, again, the median rainy-day fund balance has not declined.

So there's been a decline but not as far as you would expect. And we're also going to see, along with this talk of seeing, in proposed budgets, some tax cuts, we're also seeing some proposals from states to put money in their savings. So all of that is kind of evening out a little bit.

Of course, one of the things that is difficult is the state who maybe needs savings to balance out their budget might not be the same one to have it, of course, because again we're talking aggregate. But as an aggregate, the savings levels are still quite high and contributing to both the credit ratings being good and also that outlook for fiscal health.

CHAIR BELLA: Thank you. Kit, and then Chuck.

COMMISSIONER GORTON: Please tell me you can hear me.

CHAIR BELLA: Yes.

COMMISSIONER GORTON: Thank you. Okay. So thank you all for taking time to meet with us. Each of you, in

your introductory presentation, mentioned FMAP and changes in FMAP with respect to the pandemic. And you're probably aware that we're in the very final stages of putting together a recommendation to Congress about an automatic countercyclical adjustment mechanism for FMAP. And I'd just be interested, since we have you all here, at a very timely moment, in knowing if you have a perspective on behalf of your constituencies in terms of, do you like this idea, do you not like this idea, things we should think about before we finalize the recommendation.

MS. QUINN: I can jump in. I think academically the idea sounds amazing, and it's something that we've wanted to examine as almost like an after-action report from COVID, looking at the support programs like the FMAP, and also unemployment insurance. Those are automatic stabilizers.

There hasn't been that level of discourse. We haven't kind of gotten to the guts of it yet, with the governors, to see if that would be their preference. Politically, I'm really kind of curious how it would be greeted. It would be great if there were a disaster playbook where some of these programs would kick in

automatically, because I can say the strain -- FMAP is automatic and a lot easier, but the strain on states with respect to implementing new programs, particularly with UI and the coronavirus relief fund, even though it was meant to be flexible, there's also an administrative burden as well.

So if there were a way to have some lessons learned, to me it would seem very pragmatic and practical to have automatic stabilizers kick on for unexpected and sudden economic downturns. But that is a conversation that we need to examine more fully with governors.

MS. BLANFORD: And I would say the same is true on the legislative side. We only put forward lobbying that's bipartisan, supported by both sides. And so our constituency was very on board with requesting more FMAP, more comparable to the ARRA level of the 12 percent. But we've not had the specific conversation of, well, what if it was an automatic trigger? And so that would be an interesting conversation to have with them, and it's really hard for me to say how that would go.

But I would agree with Susie. Academically it sounds great. So I think they'd certainly be open to

talking about it. I'm not sure where we'd land on it.

COMMISSIONER GORTON: We're probably going to pass this recommendation so you'll have the opportunity to ask the question to constituencies pretty soon.

MS. KERNS: And I would say, from the perspective of budget officers, we also haven't really discussed it. Our policies, of course, are in line with governors, since that's who budget officers work for. But the certainty is something that, as a former state budget officer, I can tell you that that's what you always like, is something certain, and that's been one of the things that's been really difficult with having the current bump tied to the public health emergency. You have to budget on what you know, not what you hope or suspect. And so having that certainty, I think, would really help when you have a downturn. It would maybe count up some of these scenarios where a state makes budget cuts and then later doesn't have to because of the aid flow.

CHAIR BELLA: Wonderful. Chuck?

VICE CHAIR MILLIGAN: Thank you all very much. I'm going to have a question and it's going to be around the sources of state revenue, but let me just sort of set

the context first.

I've heard anecdotally that the states that are kind of managing through this better tend to be the states that generate a lot of the revenue through state income taxes, and I'll use, I think, California as an example. The pandemic has led to a lot of unemployment, but the employment situation has been a little shakier for people at lower income levels and more “gig economy,” whereas, in general, the people at higher income levels have had more stable employment, and in some cases there are certain individuals who have done quite well in the pandemic, a lot of quite high-income people.

And so for states that produce a lot of their state revenue through income taxes, they might not have seen quite the effect on state revenue because the higher-income people are producing a lot of that revenue and they haven't had that job insecurity, whereas states that maybe are more reliant on sales tax or other forms of revenue, and have seen reductions in economic activity in general, might have seen more wobbliness in the source of revenue, and other forms of revenue too, oil and gas, and all of the rest of it.

So the question I have to all of you is, is the disparate impact of the pandemic associated with that kind of issue, in terms of sources of state revenue? Is there a pattern to that, that is discernable, or is my hypothesis off-base, or there isn't data in one way or the other to look at the source of revenue for a state as a predictor of its economic downturn in this pandemic?

MS. KERNS: I'll start off again. You're right on target, but there are a lot of factors going into that. We've definitely seen that higher-income earners are not being impacted as much, but also typically any sort of recession for a state, the income tax gets hit later. You know, if you think about just the lagging nature of that, that you're collecting your income tax generally a year later, so you might have more refunds, but that's a lagging indicator of that work. So we do have some concern about that going forward, but we are seeing that higher earners are not being impacted, so income taxes are being a little bit more stable.

Sales tax has actually done quite well, especially in states that are collecting online sales tax. We're all more thankful for that than anyone would have

imagined. And, of course, states that collect taxes on groceries are doing better. That's been more of a stable source of funding. But a lot of what we're seeing is more what the economy is based on. So if you're an economy that's based on sales tax or some sort of service taxes related to tourism, you're getting hit harder. If you're an energy-dependent state, you're getting hit harder. So there are a lot of factors other than simply incomes that are really plugging into this. We're seeing some boosts in sales tax from like those expanded unemployment benefits and those direct checks. You know, we're seeing people spend money, and that's helped a lot with sales tax.

Emily, I can see you nodding. Do you have anything to add to that that you want to expand on?

MS. BLANFORD: No, I don't have anything to expand on. I'm just nodding along in agreement.

MS. QUINN: Yeah, I just happened to get something from Federal Funds Information for States, like literally in my inbox, and they're talking about Urban Institute's state and local finance initiatives, and they released data on state tax collections from April to September of 2020. And what was interesting is 5 of the 10

most populous states fared worse in the country, including Florida, which had a 17.5 percent reduction, and also taxes, that had a double-digit decline.

And I would just go back to something Shelby said too, is the *Wayfair* decision really made an impact, as well as the unemployment payments that are taxed, taxation of grocery goods in some states as well bumped up in unexpected ways.

MS. KERNS: And, you know, this has been such a different downturn too, but the shifts in spending have helped, if you have a sales tax, in some cases, because people shifted from services to goods. So you've seen people do a lot of work on their houses, right. Like we're all stuck at home, so if we're going to work from home and have our kids being educated at home, we might need to add an extra room or two. So you're seeing spending there. You're seeing people buy things to do at home. There was an uptick, interestingly enough, over the summer, in cars. People didn't want to be on public transportation so you saw people buying vehicles.

I don't know how long all of that lasts or what sort of changes in behavior it means, but it's been one of

the things that's made it really hard to project state revenue, is that these changes in consumer behavior, they're new. We don't have anything to base it on, and generally that's what you do, is you have a model that bases this on what you've seen before. You know, I think just from our own personal behavior we can realize we're not living the same as we did during the Great Recession or during a previous downturn.

So I don't know. I feel like I've spent the same amount of money, but differently.

VICE CHAIR MILLIGAN: And I really appreciate the nuanced way that all of you addressed my question, because I do think that unpacking sources of revenue at a state level, I mean, this is a very different -- and the tourism that you commented on, Shelby -- I think that that is just helpful insight for those of us looking sources of revenue to support safety net programs. Thank you.

CHAIR BELLA: This conversation made me think, Stacey, to start taxing puppies, since everybody seems to be getting COVID puppies.

MS. KERNS: I was a pandemic puppy person and I'll tell you what -- I spent a lot of money. I had no

idea how much money one would spend on a pet. It was crazy.

CHAIR BELLA: Have I missed any commissioners? Peter.

COMMISSIONER SZILAGYI: Yes. Thank you very much. I have a question about budgets and thinking and strategic planning about public health in states, Departments of Public Health. And let me set the context.

Many of us who are very involved with public health -- and I know this isn't specific to Medicaid but it's very relevant to Medicaid because Medicaid beneficiaries are highly dependent on public health. Many of us who are involved with public health have been worried for decades about what we see as a declining funding for public health compared to what many of us think is needed for state and local public health departments.

Early in the pandemic there was a lot of push to try to bolster public health because of contact tracing. We knew there would be hundreds of thousands of individual jobs that would be necessary just to do contact tracing. Starting in March and April, many of us were advocating extremely strongly -- this is more at the federal level,

but I assume at the state level -- to begin funding public health to prepare for the vaccine, because we knew that we would need hundreds of thousands of nurses and others to deliver vaccines. So that the implementation problems in the vaccine were entirely predictable, at least from the federal government point of view, because there wasn't any funding for it.

So I'm wondering, what were the discussions at the state level about overall funding for public health infrastructure, and are there lessons learned going forward, because I can almost guarantee you this is not the last pandemic.

CHAIR BELLA: Any takers on that one?

MS. BLANFORD: Yes, I can. I don't know that we've gotten to lessons learned yet. I would say, at least from our perspective, and in a lot of the meetings and convenings that we've been having, it's more been about educating the state policymakers that there is this gap in public health funding, and it's really about the pandemic just laid back out there and made it more top of mind, I think.

And so it was more discussions of how do we do

that strategic planning for the funding, and I don't know that they've arrived at that yet. I think they're kind of doing that work. And at least from what I'm hearing at the high level from state legislators that they've arrived at that yet, but it's definitely put this top of mind, whereas I don't know that it always was.

MS. KERNS: Yeah, I would agree with that. And I echo what Emily said, too, about we've had a lot of questions about lessons learned but we're not to that point yet of looking back. We're still in the midst of the same budget cycles and the same -- you know, just trying to get out of the current crisis. So it's hard to do a retrospective, and I'll be interested to hear if Susie has any insight into what maybe governors are looking at policy-wise.

But from the budget officer perspective, I feel like it's something we're starting to talk about and we're starting to look at where those gaps are, but at the same time, trying to talk about overall, so someone really -- the focus right now is on what's the funding to get vaccines out. You know, there's some very immediate problems that are really consuming our public health

officials that then will inform sort of the budget decisions.

So there is just a lot happening, and I don't think anybody has had time to step back and take that holistic view yet, in my opinion.

MS. QUINN: I would agree.

COMMISSIONER SZILAGYI: I think what would be a good to do is to address both the short-term crises and then step back and really think about the public health infrastructure. And it's super important for low-income individuals who are so dependent on public health.

CHAIR BELLA: Kisha, did I see your hand in the corner? No?

Well, that's, I think, probably a very good comment to end on, Peter. Thank you.

We want to respect your time, Shelby, Susie, and Emily. Thank you so much for coming. And if there's any way the Commission can be of assistance to you and your organizations as you do your work please don't hesitate to reach out, because what you're doing is super important and we all need to work together. So thank you very much for joining us.

MS. QUINN: Thank you very much.

MS. BLANFORD: Thank you.

MS. KERNS: Thank you all.

CHAIR BELLA: Okay.

All right. We are now in the home stretch. We have Martha to -- Martha started us off. She's going to wrap us up. I think we still have camera issues, but that we will hear her enthusiastic voice. And we are going to talk about value-based payment for maternity services.

So, Martha, take it away.

VALUE-BASED PAYMENT FOR MATERNITY SERVICES

* MS. HEBERLEIN: Thank you, and I am here.

So I want to start by saying that I'm presenting this work on behalf of myself and Amy Zettle, who really led this project.

As discussed earlier today, the Commission has been focused on Medicaid's role in improving maternal health, and this project is part of that broader portfolio.

Today I'm going to begin with a brief overview of MACPAC's prior work in this area before providing a quick description of the value-based payment models we will be discussing today. I will then spend the bulk of the time

discussing the findings from the case studies we conducted before turning it back to you for questions and discussion.

So as reported in last year's June chapter, states are pursuing a wide range of policies to improve maternal health, including in the realm of payment, and while considerable attention has been given to the potential of VBP models to improve quality and reduce cost, less than half of states implemented such an approach to improving maternity care.

Based on the review that Mathematica conducted for us, 14 states have implemented pay-for-performance programs, 10 have implemented a single payment for perinatal episode of care, and 4 states have implemented pregnancy medical homes.

Although this is our first look at the application of VBP specifically to maternity care, MACPAC has also conducted multiple projects to study the use of VBP in Medicaid more broadly. Most recently, MACPAC studied five states using managed care to implement VBP, and two of the study states we looked at, New York and Ohio, used episode-based payment models for maternity care. Contractor reports for these earlier projects are available

on our website.

So the project I'm going to present to you today came about from a direct request from the Commission to examine the use of VBP in improving maternal health, following the discussion of these two projects last spring.

So to start, I want to define the VBP models as we were viewing them. An episode of care payment is a single fixed payment for a group of services provided during a defined period of time. So instead of paying providers separately for each service delivered, a payment for an episode of care covers a set of services that relate to a specific illness, condition, or medical event, even if they are delivered across multiple settings.

Most perinatal episode of care models only apply to low-risk pregnancies and exclude comorbidities or conditions that are related to pregnancy.

I want to note that often the term "bundled payments" and "episode of care payments" are used interchangeably, but in this project, the models refer to an episode of care if the payment takes into account quality and cost thresholds.

A bundled payment may also use a single fixed

payment but does not take into account the achievement of specific quality measures.

So under pay-for-performance models, providers are given financial incentives to meet certain quality goals, but provider performance is not tied to cost targets. Some pay-for-performance models lower payment if a certain performance threshold is not met, while others may provide financial incentives to report on quality measures.

The pregnancy medical home is a delivery model that aims to improve maternal health outcomes by addressing clinical, behavioral, and social aspects of care. Providers that have participated in the pregnancy medical home model may receive bonus payments for providing key services or for achieving certain outcomes.

So we contracted with RTI International to examine how states are designing and implementing value-based payment models to improve maternity care for Medicaid beneficiaries. Specifically, the project examined the factors influencing model design and implementation. They reviewed data on their effectiveness and explored how the models are evolving. The project looked at the three types

of models I just described across five states: Arkansas, Connecticut, Colorado, North Carolina, and Tennessee. RTI conducted a document review and developed case studies describing the payment models in these states. They also interviewed state officials, managed care organizations, providers, beneficiary groups, the Centers for Medicare & Medicaid Services, and national experts.

So this table, which may be hard to read on the screen, shows some high-level design features of the various VBP models. Arkansas and Tennessee were early adopters of the perinatal episode of care model, and Colorado just launched its model back in November.

There are several key differences between the Colorado model and the other two episode of care models that are worth noting. First, Colorado is including some high-risk patients, specifically those beneficiaries with substance use disorder. Second, provider participation is voluntary, and third, the cost thresholds are established individually for each provider based on prior period spending. In Arkansas, the cost thresholds are set statewide, and in Tennessee, each managed care organization sets its own threshold.

Two states have pay-for-performance models. Connecticut's model targets the obstetric care provider, and Colorado's is a hospital-based program. In both of those models, participation is voluntary. Providers do not face downside risk, and all Medicaid beneficiaries served by the practices are included.

North Carolina has a longstanding pregnancy medical home model, which we heard about during the panel discussion in February. Participation in this model is voluntary, and providers receive one-time payments for certain activities such as completing a patient risk assessment as well as enhanced payment rates for service packages. North Carolina pays in the bundles. I do want to note that the program is expected to continue as the state transitions to managed care sometime later this year.

So several key themes emerge from this work. In our interviews with national experts, federal officials and beneficiary groups, interviewees suggested that the current delivery system fails to adequately utilize high-value care provided through midwives and birth centers. While some interviewees suggested that VBP models could be used to increase the use of such services, the existing models do

not intend to do this.

So the models included in this study do not incentivize one provider or setting over another and are instead built on the existing delivery system and payment structure.

Across all five study states, Medicaid officials shared that the goal of their VBP model is to improve the quality of maternity care provided to beneficiaries. In three of the six models, the value-based payment is based on provider performance or reporting on specific quality improvement efforts. Models in three of the five states aim to reduce variation in medical services and as a result reduce overall spending.

Some interviewees noted that in models for maternity care, Medicaid should be solely focused on improving quality rather than on constraining spending. They argue that Medicaid payments to providers for maternity care are already lower than those of other payers, and further efforts to constrain spending could have negative effects on quality and access.

Some interviewees also made the point that targeting low-risk pregnancies and delivering providers

limits the ability to constrain spending, as spending for higher-risk pregnancies and hospital-based care is where the greatest spending occurs.

National experts also noted that when models anchor payment to the delivering provider and do not share the value-based payment with those delivering prenatal or postpartum care, the impact on maternal health outcomes could be limited.

While the national dialogue has focused on the use of VBP models to address maternal mortality, morbidity, and racial disparities, the models included in this study do not directly connect payment to improvements in these areas. Instead, the models tie payment to standard clinical care practices and some clinical outcome measures related most specifically to delivery type.

Colorado also uses structural measures for their hospital program, giving credit for implementation of certain activities, such as programs to support exclusive breastfeeding.

Finally, some measures in Connecticut and North Carolina are used to encourage postpartum or early prenatal care visits.

Commissioners, a table in the appendix of your material describes the various measures across the models in more detail.

So there is limited evidence on the effectiveness of these study models. Three states -- Arkansas, Connecticut, and Tennessee -- have reported data on the measures associated with the value-based payments, while the program in Arkansas has been formally evaluated. Arkansas and Tennessee models are generally viewed by stakeholders as successful in containing cost. On the three quality measures tied to payment in those states, there was modest change.

Connecticut reports on some of the measures used for payment, although the results are mixed. However, because the model is voluntary and the volume of providers has increased over time, it's difficult to discern what the effects of the model actually are.

North Carolina attributes a number of improved quality outcomes to its model. For example, between the program's inception in 2011 and 2014, the incidence of low-birthweight infants covered by Medicaid in the state decreased. However, the state did not report on the

specific quality measures that are tied to payment.

Colorado does not report any information on the specific measures in its hospital-based program, and the episode of care model just began.

Many providers and national experts noted the importance of sharing quality and performance reporting with providers and said that these reports can engage practices in quality improvement efforts, and some providers noted that they are equally motivated by knowing how they perform against their peers as they are by the increases in payment.

So before concluding, I do want to note that our findings are related to the specific models as designed and implemented in these five study states. It's unclear whether the findings are the result of specific design components of the model; for example, the quality measures they are tied to or the payment amounts or whether the VBP model is the appropriate tool to improve quality in maternity care.

However, I also want to note that the findings are consistent with some of our prior work. Specifically, the work I mentioned at the beginning that looked at VDP

and managed care presented in February found that, in part, due to a lack of formal evaluation, little is known about whether the financial incentives are changing providers' care processes or which care processes result in quality and outcomes improvement.

As for next steps, we're working to finalize the individual case studies which will provide additional detail on the state models. We plan to incorporate these details into the cross-cutting findings I presented here and publish them as an issue brief in the next few months.

We're also continuing projects related to access to non-physician maternity providers, specifically midwives and birth centers as well as doulas. This work will be presented later in 2021.

So, with that, I will turn it back to you, and I look forward to your questions.

CHAIR BELLA: Martha, thank you.

Who would like to kick us off?

I'll start and then Tom and then Martha.

I guess maybe I had unrealistic expectations for what the findings were going to be, but it seems -- I guess, what surprised you by some of what you've discovered

in these models? Especially, I'm picking up on your comment about maybe VBP isn't an appropriate tool here, and so I'm just surprised a little bit about what payment incentives are and are not tied to and really a difficulty showing any impact on effectiveness overall.

I take your point that these are a handful of models and not necessarily representative, but I guess, were you surprised by any of this as well, or is this what you expected to see based on prior work?

MS. HEBERLEIN: I am not a payment person, and I am skeptical about many of these things, to begin with.

I think when you look at the measures that they're tied to, I think that is part of it. I think when you look at -- like some of the episode of care payment models are tied to what is viewed as standard clinical practice, like HIV screening should be done for every pregnant woman, right?

So where the question then comes up for me is whether that's sort of your starting point, where your HIV screening, for example, was so bad that you needed to improve that rate for safety and protection of the woman and her newborn. So that's your starting point, and you're

going to try to incentivize improvements in quality for that particular place.

I think to me, the question then becomes, if you get that to a good place, where do you go from there? And I think that's sort of the question I have, and I think the Colorado model is trying to learn from some of the early adopters, like Arkansas and Tennessee, and is thinking about bringing in higher-risk women and tying measures to other clinical care measures and so wondering sort of like what that's going to look like in the future. I think there may be things to learn from that.

CHAIR BELLA: That's really helpful. Thank you.

Martha and then Tom and then Darin.

COMMISSIONER CARTER: I wasn't surprised by this finding because we're basically doing the same thing and expecting a different outcome, and I think that we really need to look at different models.

I'm not sure that we need to give up on value-based payment. There are people who are doing work in that area, and I've given some of this information to Martha. Dr. Stevin Calvin, who is a perinatologist in Minnesota, has put together a proposal on a birth bundle, and the

Health Care Transformation Task Force maternity care hub has -- maternity health hub has put out some documents. So I think there's work in this area, but it's not just paying for the same thing and expecting a change. We need to change the model, and I think we need to factor in social determinants, pay for what matters, which is disparities, maternal mortality and morbidity, those kind of big things, and none of these models are really addressing that.

CHAIR BELLA: Thank you, Martha.

Tom?

COMMISSIONER BARKER: Thanks. Thanks, Melanie.

Martha, just a quick question, and I'm sorry if you mentioned this and I missed it. When you are referring to providers in your slides, can you just say what providers exactly are included in the VBP models in the states that you referenced? Is it OB/GYN, midwives? Are there other providers that are included as well?

MS. HEBERLEIN: Yes. So it depends on the state, and so -- sorry. I'm just taking a look so I can make sure I get this right.

So in Arkansas, for example, it's the PAP, the primary physician or -- the primary accountable provider is

what that stands for -- is designated through claims, and it could be an individual physician. It could be a nurse midwife, and the same in Colorado and Connecticut. They're not saying it needs to be one provider or another. The only one where it's -- so in Colorado, the HCIP program is specifically focused on hospitals, but in all the other ones, it is like the provider who is most accountable for the care. Usually, that is the delivering provider. In Colorado, that's different, but in the other cases, it's the obstetric care provider. And it's not limited to who that could be and what type of credentials that person could have.

I think the broader point is that -- and maybe this is what Martha was trying to get at too is that the models aren't targeting and saying you should increase the use of midwives. They're just -- they're being more agnostic about which type of provider.

Does that answer your question, Tom?

COMMISSIONER BARKER: It does, and the last thing that you said is exactly what I was getting at, so thank you very much.

CHAIR BELLA: Thank you.

Darin?

COMMISSIONER GORDON: So just, you know, looking at this, I would have thought we would have seen more in improvement. However, I will point out that I think we're still very early on in this transition and exploration of the value-based purchasing.

I launched the one in Tennessee, and you have to understand that each of these models, how folks approached it, in which case we actually sat down with the providers to decide and hear from them what measures were important and how we should think about that and how they should be measuring against performance of the -- you know, improvement on themselves to where they were historically or to their peers.

And a lot of that construction was really trying to get feedback from the providers in the community themselves, and let me just tell you, it took a while for folks to really engage with the new model, even though it was mandatory.

We got feedback even three years after we launched it from providers who said they ignored the reports. They were just thinking this whole thing was

going to go away, and then when they realized it wasn't going away, they actually started pressing in and trying to understand how and where they can improve. There were reports from their listening sessions across the state where those providers said they're happy to report that they're actually eligible for additional payments because they've made improvements.

So I'd be careful in making too many conclusions as if this is the end of a very long journey versus we're in the early innings of this, and I think I for one appreciate the experiment, the various experiments that are going on. I think we're learning as it goes. I think everyone is learning as we go.

There's been some improvement, but yeah, you would always hope for more when you deploy these things. But I would not want to discourage others from learning from building upon and trying new approaches to do this.

Getting to Martha's comment, one of the reasons we went down this path in Tennessee was to actually start making it to where those providers who do engage differently, who do look at those services that are your non-traditional health care services, that are your social

determinants of health, that they get rewarded financially for engaging in those other models. We heard from providers consistently that they know some things that could be done that could help improve how things are done. However, they just don't typically get reimbursed for those activities.

I think this type of movement -- and again, there's different models. We're still early on. There's still a lot to be learned, but I think that these models actually can help support those providers in engaging in those types of activities with those community-based organizations and in other creative ways.

So just more of a commentary, one, giving some historical perspective of how at least ours was constructed but also just a reminder that I think we're still really early on, even though we've been talking about VBP for a while. It isn't widespread across this country yet, and I think there's more over time.

CHAIR BELLA: Thank you, Darin.

Fred? And then Sheldon.

COMMISSIONER CERISE: Yeah, I'll agree with Darin on that. I mean, some of these measures that you just look

and you say, well, of course, we ought to be doing this. We weren't doing it, and sometimes it takes a little time, and you look back now and things that we do routinely, you know, 10 years ago we weren't doing routinely, and it's because of efforts like this.

And so things like you don't do early elective deliveries. Well, you know, nobody would disagree with that, but that was a common practice, and with these types of metrics you move the needle on that, and that translates into better birth outcomes, fewer NICU days, and that sort of thing.

And so I wouldn't minimize the impact on some of these common things, C-sections, some of the HIV and chlamydia screening and like these routine things that of course everybody ought to be doing, but everybody hasn't always done routinely, and so this would catch their attention.

Martha, I want to ask you if there's a way to tie in the thinking around some initiatives where you really have seen significant movement. Like in California, their Maternal Quality Initiative, where they showed significant reduction in maternal mortality, based on big system

changes, you know, and big collaboratives. If there's any lessons to learn from that, because, you know, maybe the next layer here is big systems changes to attack things like hemorrhage and things that you're not going to do with one-off from providers but that need systems support.

CHAIR BELLA: Thank you, Fred. Sheldon?

COMMISSIONER RETCHIN: Yeah. I had to jump off. Maybe you covered this. First of all, I really appreciate the effort and accumulating so much data out of this it really is illuminating.

One thing that struck me was, though, maybe we should learn from the Feds, but when you establish these clinical practice guidelines -- and I'm not an obstetrician so I don't know, but when I look at them some -- I mean, are you really going to improve that much on 85, 88 percent achievement in terms of the goal? If you go from 88 to 86, that's not necessarily a decline. You're really at the high end of the power curve.

Now, if you have something that is recommended and you're doing it 34 percent of the time, I think it's important to sometimes retire some of the values that we're using as clinical practice, or rotate them. But I do think

that they're all over the map, and some are much more worthwhile in terms of the influence in practice. I don't know how others feel about that.

CHAIR BELLA: Any comments on that, or any comments generally?

COMMISSIONER GORDON: I agree. I think once you see improvements in some areas then you can move to others. I totally agree.

CHAIR BELLA: Peter?

COMMISSIONER SZILAGYI: Yeah, yeah, I totally agree with what Darin and Sheldon were saying. It seems to me that -- I see some evidence of some improvement in the easier measures, but VBP like this, I would not expect improvement in mortality, for example, which is, first of all, rare, although the 800 cases are 800 tragedies. But as Fred said, you need more at the system level safety type of processes to reduce mortality.

But if you think about the John Eisenberg cascade of what it takes to achieve better outcomes, there are simpler things like obtaining access to care. It's a little bit more difficult to achieve quality measures, and then much more difficult to achieve better outcomes, which

are determined by a complex interplay of medical factors and social and other factors.

So I think, you know, this kind of structural change, this type of value-based payment, I would expect to perhaps improve the lower-level metrics. And I see some evidence of that. So I think as Darin said, I think this is a learning process. It's really hard to change practice. I would love to see some kind of a value-based payment program that really focuses on social risks, like bringing nurse-family partnership, high-level nurse-family partnership to pregnant, low-income women, because that's clearly an evidence-based program that's partly based on social risks and partly based on medical risks.

CHAIR BELLA: Thank you, Peter. Any other commissioners wish to comment?

[No response.]

CHAIR BELLA: All right. We'll turn to the public to see if there's any public comment. If so, please hit the little hand icon. I think we have one. Just a reminder to the commenters, please introduce yourself and your organization.

PUBLIC COMMENT

* MS. SATTERFIELD: Thank you. My name is Lisa Satterfield. I'm the Senior Director of the American College of Obstetricians and Gynecologists, and I oversee the health economics team. So thank you for this presentation today. It was very good, and I'm looking forward to the full reports as they're published.

As the Commissioners have discussed, you've identified several problems with the current value-based payment models that we agree with. There has been issues with excluding the high-risk pregnancies. Most of the models, with the exception of the Colorado model, have focused on the low-risk pregnancies, and quite frankly that's not where the maternal mortality and morbidity cases are occurring. Also, those are typically not the cases with racial inequities and disparities. So it's important for models to start evolving, and including the high-risk pregnancies.

The other issue that was mentioned is the low Medicaid payment rates or low payment rates that the physicians have indicated in their interviews, and we couldn't agree more. Medicaid payment for physicians and for other health care providers that are providing

perinatal services is often very low and it's quite often 60 percent of the national Medicare geographically adjusted rate. So if there is fear of losing more payment by entering a model, there is not any encouragement or incentivization to do so.

So I also want to express the ACOG strongly supports the inclusion of perinatal quality collaboratives as one way to address the maternal mortality and morbidity issues, and would strongly recommend that those perinatal quality collaboratives are a part of the need payment model.

ACOG looks forward to working with MACPAC and other policymakers on this issue, and again I thank you for your comments and for the report.

CHAIR BELLA: Thank you, Lisa. Anyone else in the audience want to comment? I don't see anyone.

While we're waiting on that, Martha H., do you need anything else from us?

MS. HEBERLEIN: No, this was really helpful. I do think the point about changing over time and bringing in the broader efforts, especially like the AIM model, I think will definitely be added to the brief to sort of flesh it

out a bit more. So thank you for the comments.

CHAIR BELLA: That's wonderful. All right, any last words from any Commissioners?

[No response.]

CHAIR BELLA: Okay. Thank you for today. It was robust, and I appreciate everybody's preparation and involvement. And thank you to the staff, especially, who no one is seeing on camera but we would not be having any of these discussions obviously were it not for them. Their work continues to be amazing, so thank you for that.

We are going to wrap up for today. We start tomorrow at 10:30. We have a panel on the role of Medicaid for individuals with intellectual and developmental disabilities. Following that panel we'll take a vote on our three recommendations and then we'll proceed with the rest of the day's agenda.

So thank you all and I look forward to seeing you tomorrow morning at 10:30. Have a great evening, everybody.

* [Whereupon, at 4:29 p.m., the meeting was recessed, to reconvene at 10:30 a.m. on Friday, January 29, 2021.]

PUBLIC MEETING

VIA GoToWebinar

Friday, January 29, 2021
10:30 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

Session 8: Panel: The Role of Medicaid for People with Intellectual and Developmental Disabilities

Introduction:

Kristal Vardaman, Principal Analyst.....262

Panelists:

Sharon Lewis, Health Management Associates.....266

Melissa Stone, Division of Developmental Disabilities Services, State of Arkansas.....273

Elizabeth Weintraub, Association of University Centers on Disabilities.....281

Further Discussion by Commission.....311

Public Comment.....313

Session 9: Votes on Recommendations for March Report to Congress: Postpartum Coverage, Estate Recovery, and Automatic Countercyclical Financing Adjustments

Postpartum Coverage.....322

Estate Recovery.....329

Automatic Countercyclical Financing Adjustments....335

Session 10: MACPAC Study on Non-Emergency Medical Transportation

Kacey Buderi, Senior Analyst.....340

Aaron Pervin, Senior Analyst.....343

Mike Perry, Perry Undem.....349

Session 11: Integration of Care for Dually Eligible Beneficiaries: New Analyses

Ashley Semanskee, Analyst.....391

Kirstin Blom, Principal Analyst.....396

Public Comment.....426

Recess.....431

AGENDA PAGE

Session 12: Payment and Coverage of High-Cost Specialty Drugs: Report from Technical Advisory Panel

Chris Park, Principal Analyst and Data Analytics Advisor.....431

Session 13: Mental Health Parity in Medicaid

Erin McMullen, Principal Analyst.....467

Public Comment.....484

Adjourn Day 2.....491

P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to Day 2 of our January MACPAC meeting. We are thrilled to kick off the morning with a panel about Medicaid's role for people with intellectual and developmental disabilities. Kristal, welcome. I'm going to hand it over to you to get us started.

PANEL: THE ROLE OF MEDICAID FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

* DR. VARDAMAN: Good morning, Commissioners. I will today introduce you to a panel on Medicaid's role in serving the needs of people with intellectual or developmental disabilities, or ID/DD. The Commission's ongoing discussions of long-term services and supports, or LTSS, has highlighted the importance of understanding the unique needs of, and services provided to, different groups of people who use LTSS.

For example, in March 2018, you all discussed the results of contracted work on state adoption of managed long-term services and supports for people with ID/DD. That work identified how states have tailored those

programs for these individuals, including implementing specific requirements for case managers.

During the discussion of that work, Commissioners expressed their interest in having a broader conversation about the needs of people with intellectual or developmental disabilities and how Medicaid serves them. Given that interest, we contracted with Health Management Associates, or HMA, to conduct a literature review and interviews with people with ID/DD, state and federal officials, provider associations, and consumer groups. Their work focused on a wide range of issues, such as the role and evolution of person-centered planning and self-directed services, living situations and preferences, supports for family caregivers, workforce shortage, and gaps in disparities and access to clinical services.

The results of that work is in HMA's final report, which is included in your materials, and has been published on MACPAC's website. I would like to thank Sharon Lewis, one of today's panelists, Sarah Barth, and their colleagues at HMA for their hard work on the report. In addition, I would like to thank Liz Weintraub, another panelist today, and her colleagues at the Association of

University Centers on Disabilities, who worked with HMA to create a plain language version of the report. This version is designed to be accessible to a wide audience, including people with intellectual or developmental disabilities, and is also posted on our website.

Today, Commissioners will have a chance to hear from and engage with three experts on Medicaid services for people with ID/DD. After the panel, Commissioners will have additional time to discuss potential future work on Medicaid's role in serving people with intellectual or developmental disabilities. Staff are interested in hearing your comments today on policy questions of interest and what areas should be prioritized.

We have an excellent group of panelists today. I will be brief with my introductions, but you have their complete biographies in your materials.

First you will hear from Sharon Lewis, a Principal at HMA. At HMA, she works with federal agencies, states, providers, and consumer advocates to advance opportunities for people with disabilities to fully participate in the community. Ms. Lewis came to HMA having served as co-founder and Principal Deputy Administrator of

the Administration for Community Living, Senior Disability Policy Advisor to the Secretary of Health and Human Services, and Commissioner of the Administration on Intellectual and Developmental Disabilities. She has also worked as a policy advisor on the Hill and led strategy for advocacy organizations.

Next you'll hear from Melissa Stone, who serves as the Director of Arkansas' Division of Developmental Disability Services, a division of Arkansas' Medicaid program. Programs under her division's umbrella include day treatment programs for children and adults, community-based programs, applied behavioral analysis for children with autism, intermediate care facilities, a program for children with chronic health care needs, as well as occupational therapy, speech therapy, and physical therapy.

Prior to becoming division Director, Ms. Stone served as a Deputy Director, and she started her career at the Department of Human Services legal department in roles including Deputy Chief Counsel.

After Ms. Stone, you will hear from Elizabeth Weintraub, or Liz Weintraub, who has a long history of leadership and self-advocacy, and has had many board and

advisory positions at state and national organizations. She is a senior advocacy specialist at the Association of University Centers on Disabilities, and is the host of "Tuesdays with Liz: Disability Policy for All," a video series that highlights current issues in disability policy.

In 2018, Ms. Weintraub served as a fellow in the office of Senator Bob Casey of Pennsylvania, where she helped lead disability policy development. Prior to coming to AUCD, Ms. Weintraub worked for the Council on Quality and Leadership, and she is a past chair of the Maryland Developmental Disabilities Council.

And with that I'll turn it over to Sharon who will kick us off. Thank you.

* MS. LEWIS: Well, good morning. Thank you, Commissioners, for taking the time to focus on issues related to people with intellectual and developmental disabilities, for supporting the work in this report as well as the plain language version of the report, which we were all very excited to be able to produce to ensure that this information is accessible to the broadest audience possible. We are optimistic and hopeful that the report will provide a great opportunity for additional

understanding and as a resource to the Commission as you continue to determine priorities. There is a tremendous body of information in the report, and today I'm just going to touch on a few key takeaways and look forward to hearing from both Melissa and Liz.

Central to understanding the service and supports that are funded by Medicaid for people with intellectual and developmental disabilities is understanding that this is a very heterogeneous population. We have a tremendous amount of diversity in terms of health needs as well as day-to-day support needs for home and community-based services. There is a distinct difference in the needs of people with intellectual and developmental disabilities in the lifelong nature of supports. This is a population that frequently will require some level of support from birth to death, and as such has a relationship often with Medicaid that stretches over decades and affects day-to-day life as opposed to just intersecting with medical care.

Additionally, as we delved into the report and looked at the data and looked at research, clearly there is a need for understanding the diversity of racial and cultural needs of people with intellectual and

developmental disabilities across the country.

The IDD system of supports has long been focused on a holistic approach that is inclusive of social determinants of health. Medicaid home- and community-based services, or the lack of access to home- and community-based services, due to wait lists and limited resources, affects nearly every facet of people with intellectual and developmental disabilities lives -- their health, education, employment, family support, housing, and more. It is our day-to-day instrumental supports that ensures that people have the opportunity to have a quality of life.

As such, the importance of good case management and supports coordination and person-centered practices can really not be understated. People with intellectual and developmental disabilities rely on their case managers, their support coordinators as navigators across multiple publicly funded systems. As states are seeking to address a wide range of people with IDD, and facing these resource challenges, often they are focused on balancing supports coordination, supports waivers, and comprehensive waivers in ensuring that the allocation of limited resources are provided to the maximum number of people, and in that to

expand relationship-based services such as shared living to ensure more individualized community-based options that also are more cost-effective and allows access to support more people.

The 2014 HCBS regulation, the settings regulation as some folks call it as a shortcut, allowed time for states to bring provider settings into compliance with federal requirements under the regulation, and that has been expanded until March of 2023. States are still working on that. But the person-centered planning elements of the rule did not offer this transition period, and states are continuing to move to implement and operationalize more person-centered thinking, planning, and practices in the services for people with intellectual and developmental disabilities. States, case management entities, and providers are still seeking to scale person-centered practices. There are pockets of excellence as well as areas of great need across the country.

The pandemic has made it very clear that person-centered practices and good supports coordination are critical to ensuring both the health and safety of individuals, as well as pointing out some gaps in equitable

access to services and technology.

We also found that the vast majority of people with intellectual and developmental disabilities live with family for extended periods of time. When we look at the population of people with IDD as a whole, only about 10 percent, estimated, based on prevalence data, of individuals live in residential settings, whether those are institutional settings or home and community-based settings that are provider controlled. The vast majority of people continue to live either on their own or with families or with roommates. Among people who are receiving services, about a quarter of the population lives in a residential setting that is supported by Medicaid.

States are increasingly seeking to support families and understanding that caregiver role, and trying to find the balance between assisting those families as caregivers and as foundational supports for people with IDD, both as children and as adults, and that need to facilitate self-determination and independence and continue to focus on the individual, and that balance can sometimes be challenging.

A critical challenge within the IDD system, and I

think within all home and community-based services at this point, is the direct support workforce. Shortages of direct support workers are a significant challenge. I don't think there was a single stakeholder that we talked to from any perspective that did not mention challenges with the workforce and how that then affects quality. High turnover rates, consistent vacancy, and low wages limit the provider capacity to really ensure a quality workforce and compromise the ability of states and providers to ensure health and safety and quality of supports for people. That issue of quality really comes down to the effectiveness, knowledge, training, and competencies of our direct support workforce, and continuing to improve the quality of that workforce and create better opportunities in terms of career, pay, are critical to maintaining and sustaining a system that will effectively support people with IDD.

Finally, and I know that Liz is going to talk a little bit more about this in terms of some things that we have learned over the course of the past year, 2020 brought a lot of challenges for people with IDD, as it has for many others. But people with IDD have struggled in ways that have received less attention than individuals in nursing

facilities and older adults. Research has demonstrated that people with intellectual and developmental disabilities are three times more likely to have very severe outcomes, including death, due to COVID-19, and yet we are still very limited in understanding the state-level data around the impact of COVID-19 on people with IDD.

Additionally, the need for ensuring that people with IDD are able to continue to maintain their supports and those relationships throughout the pandemic has proven both an opportunity for states and providers who have done some very creative things. The flexibilities that CMS moved quickly to implement has been very beneficial for this population and for states in ensuring that supports could be delivered remotely, that people were able to find other ways to meet their needs throughout this pandemic. At the same time, we know that interruption of day-to-day life for people with IDD is often incredibly challenging and may result in additional needs in terms of behavior or supports.

And finally, this past year has really brought to light the challenges within the IDD system, same as, I think, much of our culture, around equity issues and

disparities and ensuring that people of color are able to fully participate in our systems and that our systems are culturally, linguistically, and otherwise responsive to people with a range of backgrounds.

So with that I will turn it over to Melissa, and we will continue our presentation. Thank you.

* MS. STONE: Hi. Thank you. Thanks for having me. It's an honor to be able to talk to you all today. I was just going to speak for a couple of minutes about programs that we are doing here in Arkansas, kind of pre-COVID and then in relation to things that we learned during the pandemic for the population with intellectual disabilities.

In 2019, we launched a spin on managed care in Arkansas. We went live in March of 2019. And it is a unique model where we did not put out a procurement for managed care companies. We designed a model in-house that mandated that 51 percent of the companies had to be owned by Arkansas Medicaid providers, and then we outlined the type of providers that you had to be. So we mandated that you had to be a DD provider, a behavioral health provider, a hospital, and a pharmacist, for each one of the

organizations that stood up. And we opened it up to whoever wanted to do the work, as long as you met the requirements.

We ended up moving forward with three companies. And so we have moved all of our clients that have high IDD and high behavioral health needs into this managed care model. Right now we have about 45,000 members. We give them around $1.7 billion a year to care for them, because as you know that's a population that's very expensive for Medicaid programs. It was a change, because in Arkansas we don't have any other population really in a managed care model, in terms of our regular Medicaid program is straight fee-for-service. So this has been a big change to put those two specialty populations into a managed care type system.

But what the design was, was a care coordination model where each of the organizations, which we call PASSEs, which I did not name these groups, but it's called Provider-led Arkansas Shared Savings Entities. And when you type that it autocorrects to passé, but it's called PASSE. And we have three of them.

It's been a unique model where clients get

independently assessed, and if they tier a 2 or 3 we move you into the model. And regardless of whether you come in, because of your behavioral health diagnosis or your IDD diagnosis, we look at your functional needs and then all services under the model are available to you through your care coordination and your PCSP.

So it's been a huge change, because like many states we only pay for services for Medicaid based on your diagnosis before. So if you had a behavioral health diagnosis you could not bill us for IDD services, and vice versa, which has caused -- you know, it's very hard because you can't put people into these boxes based on just a single diagnosis.

It's all based on functional needs. I think we were a little naïve, and I've said this on previous presentations, that we thought, okay, we've put all these people under this umbrella and offer all of these services, and this is going to be a fix to the holes we were seeing in what people can receive. Well, I think that it improved, but what it's taught us over the last year, and especially with the pandemic, is that people really still like to stay in their own lanes, meaning behavioral health

providers really just want to serve behavioral health members, and IDD providers really just want to serve IDD clients.

And I'll back up. I had about 7,000 IDD clients in the model, and the remainder of the 45,000 have behavioral health needs. So we knew going in that we had approximately 1,000 people in the model that had both IDD and significant mental illness, so we were really trying to build a model so that they could get exactly what they needed. But we could not, and still cannot to some extent, get behavioral health providers to serve clients with IDD.

So when the pandemic arose, we had a service on our side called "supplemental supports," and it's a support that the definition is you can use it for unforeseen circumstances to keep people from being institutionalized. So it was a great service for the pandemic, right? So we added some modifiers on it. We allowed people to do it even telephonically because we were very concerned because people were really scared in the beginning. They didn't even want to go out to the house, even if they stood outside. And so we were really worried about people, and we needed it available for the behavioral health members.

So for the first time, we turned on that code so if you were a behavioral health provider, you could provide a historic developmental disability service, and it's been fantastic and it's been working. And so we've had providers kind of cross over and start doing another service that they were not used to.

So we've been working I guess over the last six months to launch a new provider type to try to make this concept broader. So we stood up on January 1st of this year a provider type called "community support system provider," and it's opened up to anyone who can meet the qualifications, but it is a provider that's going to have staff specially trained in both DD and BH members to incentivize providers to come into the space, get highly trained paraprofessionals who can serve both sets under the PASSE.

And so what we're really hoping to see -- we have, I guess, six providers right now in the process of becoming enrolled, which we knew was going to be low because it's really scary. We didn't sense that they're old staff, so they can choose. I mean, this was completely by choice. You know, we didn't want to totally get rid of

their old book of business. And an aside, we started the legislative session on January 11th, and I would have been killed if we would have gotten rid of their old provider track. So we're going to ease into this.

So we have got six who want to get into this space so they can serve both, and what we're really hoping is that we have this population, like I said, that has intellectual disabilities but they really need some significant behavioral health services. And we're looking to this new provider type to come in and do that for them.

We thought, like I said, that putting the services in the package would fix our problem, but what we've seen is the way these managed care companies work, there still continues to be a disconnect between the care coordinator that works for the PASSE and their utilization management arm that approves the service. And what we envisioned when we designed the program was a circle that, you know, they would meet with their care coordinator, and they would say, you know, here is what's going on with me, and the care coordinator would help them, you know, pick out appropriate specific services. And they do that, but that care coordination arm is so separated right now in

these companies, so unless something comes down to utilization management asking for the service, it's just dropping, right?

So if you have an IDD provider and you need behavioral health services, unless the behavioral health provider goes and sends something in to utilization management saying this person needs it, they're not getting it.

So our next step we're trying to do right now is really make that a circle and not this wall that's up so that really the care coordinator does what we envision them doing, which is helping them better connect to services. And then if utilization management says, no, that's not right, then it goes back to the care coordinator, and they pick something else. Does that make sense? Because what's happening now is almost like a Christmas wish list happening in these PCSP meetings, right? And then real service is happening based on what the utilization management of these companies is deciding which is appropriate and not. So we're still seeing major gaps.

So that's another reason for this one provider type that can do this wide array of both sides of services.

We hope they will get to know the members more, and they know these members need both IDD and behavioral health services, and we're going to make the request to utilization management for both. And so I should know more in, I guess, about six months once we get these up and running, so like I said, we should have some starting in the next few weeks. And we're really hopeful that this -- we know it won't be a complete fix, but we hope it will be better than what we are working with right now.

And then, lastly, I'll just say Sharon had mentioned this huge deficit of lack of direct care workers, and we have that in Arkansas, especially right now during the pandemic. But we were really hoping that we could maximize this workforce by bringing in and combining these two provider types, because we do know that a lot of the IDD direct service workers, they work for multiple agencies, right? They might do waiver during the day. They might do some personal care. They might work at an institution at night, one of our ICFs. They work multiple shifts at multiple organizations. Well, same thing with the behavioral health paraprofessionals. They work at, you know, day treatment clinics for people with behavioral

health during the day. So what we keep thinking is we're not growing more bodies here in Arkansas, right? I mean, we're not growing this workforce right now, especially during the pandemic. So we're trying to maximize it so we can cross-train this set that's already doing this work only with a different population.

So that's also the goal, is to try to work with the people that we have and get them to cross over to serve both IDD and BH.

So I will end there, and I look forward to questions when we get finished with the presentation. Thank you.

* MS. WEINTRAUB: Thank you. Before I begin, I would like to say hello to Brian Burwell. I had the pleasure of working with him in the '90s, and you might not remember me because --

COMMISSIONER BURWELL: Oh, Liz, I definitely remember you. You were great. And in the [inaudible] days, right?

MS. WEINTRAUB: Yes.

COMMISSIONER BURWELL: Right.

MS. WEINTRAUB: Thank you for listening to me

today, and thank you to the staff for understanding that plain English is important and for making a plain version to make this happen so that everyone can join the conversation. It's really important for all people to understand the conversation, and that dealing with --

[Telephone ringing.]

MS. WEINTRAUB: Sorry about that. Working from home isn't always easy.

And the plain language version is important for everyone to find, including my friends. So thank you.

This year hasn't been the easiest year for everyone. I understand that, and I think Sharon and Melissa have said that. But for my friends, people with disabilities, it has been especially very difficult, and I'll tell you why. As Sharon said, people with ID/DD have more risk of getting sick and, unfortunately, dying of COVID. I think Sharon has said it's three times higher or five times higher. The research so far is really scary. We know younger people with IDD are three times more likely to die than other people the same age.

In some states, hospitals have policies that discriminate against people with disabilities, and

advocates have to fight for fair access to treatment. Sometimes people can't bring their friends or their supporters to the hospital, and sometimes when you're in the hospital, it can be scary for anyone, but especially for people with disabilities.

There has not been enough support from home and community-based services workers, need PPEs and providers can't access to keep people working and safe. I can tell you that our counselor, our supporter, can't come into our house, and that's a problem right now when I want to learn how to cook or when I want to learn how to do something. It's really hard for her to help me and my husband to live on our own.

We don't have enough information about how many people with IDD have been diagnosed with COVID or have died. There has been a lot of focus on nursing homes, but not enough on HCBS, and that's a shame.

CMS should be asking for the state and states should be making it public. Lots of times people say, well, nursing home, nursing home. Well, what about the DSPs and health plans? That's a problem.

People with DD are sometimes very isolated, and

we all know that loneliness -- and I can't pronounce that word very well, sorry. We know that loneliness can kill people. According to the research, it can kill more than cancer. And I'm not saying that lightly because I know that cancer is a very serious disease, and I'm sorry that people die of that. But people can -- it's more deadly than cancer, and especially for people that can't drive. And during this time when you can't be with people, it's really hard. I can tell you that both my husband and I don't drive, and we can't see our friends. We can't communicate. And sometimes being on Zoom calls, we can't -- people don't know how to use the Webinar. I'm very lucky because I know how to do that, but a lot of my friends don't know how to do that. It's hard to be part of activities like that.

There's a story around self-determination. During Thanksgiving my family, we were wondering how to celebrate the holidays, and my one family member said, "Well, you can't go here or there" -- "here because of the rules of COVID," and there's so many rules that come with COVID that it's really hard to keep track of how to keep safe. And it's my husband and my decision where to go and

how to keep safe. I know the rules, and I worked for an organization that has been drumming into my head about the rules. I don't need my sister or my family to tell me, well, a family gathering with 15 people versus six people is not good. So we, my husband and I, chose to go to the event with six people with opening the window versus gathering with 15 other people. We knew that it was the safest way to go. And families need to trust that we know how to make that decision. We know. We have gotten the information from different Webinars, from different gatherings. People have told us. So why do our families need -- why can't our families trust that we'll make the right decision? And then if we need help, we can always ask.

Being able to balance the safety and health with the need for family and avoiding loneliness, I wanted to go to celebrate the holiday. I wanted to be with family rather than just sitting home and doing nothing. I wanted to do that. It's very lonely. And I know that it has probably been very lonely for everyone else, so I'm not saying that people with disabilities are any different, because sometimes it's really -- sometimes we just don't

understand that.

We have a lot of work to do to make the system fair for everyone, especially people who are Black or Brown or come from other countries or culture. This needs to include supporting people of color with disabilities, to be advocates and leaders. I hope that we learn all the important lessons from this year, and there are a couple of lessons I would like to leave you with. All means all. I like to say that. We often don't see -- we often don't say "all means all." All, if we are truly meaning -- if our country was built on justice for all, then all means -- all has to mean all. It can't be all means some.

When we think about inclusion, we need to consider everyone and do a better job including people with different races and culture. Sort of like plain language, we need to include all people, and that means all people from races and cultures, too. Technology and computer options need to be available, and we -- available to everyone, and that means we need to learn from -- we need to have the ability to teach us that technology. You can't just say, oh, use the computer, but teach us how to use that computer.

Relationships matter, and we need to keep -- we need a relationship to keep healthy and happy. My former boss at CQL would often say that if we have a good-quality life, we'll be happy and healthy.

Thank you very much for listening to me today.

DR. VARDAMAN: Thank you again to all the panelists. We appreciate your comments and am excited to hear the Commission's discussion.

So, with that, I'll turn it back to Melanie.

CHAIR BELLA: Yes. Let me reiterate our thanks to all three of you and for the report and especially for the plain language report. I think that might be a first of a kind and something that's an important practice for us to continue. So thank you for starting us down that path.

I'm going to open it up for questions or comments from Commissioners starting, Kit, with you, and then Kisha and Brian.

COMMISSIONER GORTON: Yes. Thank you, everybody, for taking time with us, and thank you for helping with the plain language report. I agree it's important if we're going to be respectful of the principle, nothing about me without me. We need to think about how we make our -- how

our work product accessible to people who use them.

I could talk all day, and I don't have all day. I'd love to drag this out, but I know there are other things to talk about.

I just want to focus on two things starting with part of what Liz said. So Liz talked very movingly about the right to risk, and we need to remember that people get to make choices. And sometimes their choices are not what we would choose for them, but that's no different from anybody else. And so they get to choose if they want to go to a gathering or whatever, so important that as we think about policy, we don't create policies that are restrictive in that way.

Many of the policies have been historically very parental. Keep people safe, keep people safe, keep people safe, well -- you know, Bilbo Baggins said it's dangerous to walk out your front door, and we need to let people walk out their front doors.

What I want to focus on more, though, in Liz's comments is she talked movingly and accurately about discrimination in health care, and the Commission has had an expanded aperture in terms of talking about racial and

ethnic bias. And I want to be sure that we hear Liz's feedback to encourage us also to think about bias and discrimination against people with disabilities.

It is common, and we have seen a lot of it in COVID, of people with disabilities being deprioritized, put farther down on the list, not admitted to hospitals, or if they are admitted to hospitals, not admitted to ICUs.

And I can tell you when I was in government in the '90s working in the IDD program in Pennsylvania, about every Friday afternoon, I would have to sit with some doctor who did not want to provide -- or hospital administrator who did not want to provide standard of care to somebody with a disability simply because they have a disability.

And so to the extent that we think about our programs and access, right? -- and we're the Payment and Access Commission -- this discrimination in health care is ongoing not just with respect to COVID care, with respect to transplantation and other things.

And so my takeaway from that is as the staff have become far more sophisticated in identifying access issues for people of color and people of different ethnic and

origins, we need to also figure out how we can distinguish particular access issues for people with disabilities.

And then very quickly, I just want to jump to an observation that Melissa made about siloes, particularly BH and IDD silos, and I would add physical health in that as well. All of those things are very, very siloed, and it's not just in Arkansas. Every state that I have worked in over the course of decades has had this problem.

And you go to a provider, you know, a behavioral health provider, and you say, "What services do you do?" And they say, "I'm a red crayon," and you say, "Well, what do you do for your patients who need blue crayons and yellow crayons?" And they look at you blankly and say, "I'm a red crayon." We need to figure out how to give people access to all 8 or 64 colors, and we need to help them talk to each other. But we need to understand that there's a huge structural barrier.

So snaps to Arkansas for trying to think about how to break down those siloes, but it exists everywhere.

And I think as we look at workforce, which you've done some in terms of mental health and now maybe we can branch out in future years to consider mental health and

IDD, because that's a very common set of co-occurring conditions, how do we get people access to all the services they need, not just to the service which happens to be most important at any particular moment?

And the last thing I will say is that integration of service is necessary because in a situation like COVID, the more people you have delivering care, the more risk you have in terms of exposure to infectious agents. So this is all this huge big cycle of difficulties that leads to disparate impacts for people with disabilities.

So thank you to everybody, and thank you for being patient, as I probably overspent my time.

CHAIR BELLA: Thank you, Kit.

Kisha and then Brian, then Chuck and Leanna and Sheldon.

COMMISSIONER DAVIS: Kit, you had really good comments, though I will give you some of my time. I echo much of what you said on discrimination.

Liz, I really thank you for your comments, and just kind of doubling down on the nothing about me without me and wanted to circle back to Melissa and Sharon as well as we're -- Melissa, I really appreciated your honesty in

the benefit design, and we did this, it didn't work, so we tried this. There's siloes, there were problems, and we are working through them. I really appreciated that.

I'm curious to hear from you, and, Sharon and Melissa, maybe you can weigh in as well on your perspectives on it.

But, Melissa, specifically, how do you include that stakeholder voice in benefit design when you're thinking about these programs that are being designed specifically for folks with IDD and behavioral health? How does that influence the conversation and the design around it?

MS. STONE: Yeah. So that's a great question.

So, you know, Arkansas is small. I know a lot of these clients, families, personally just over the years in my job, but the PASSEs like I said, have to be set up with the Medicaid providers that, you know, we're very aware of here in Arkansas. And then each PASSE had to have a consumer advisory council that was made up of parents and advocates.

That still wasn't enough because they weren't including them enough when we were developing it, and so --

oh, my gosh. We did these around the state town halls, right, where I traveled the state with a group of other staff members, and we held -- and this is before COVID. So we were able to hold these huge, you know, hundreds of people meetings and just answer questions, right? Some of them were awful because people were really scared and mad, but, you know, I think people just need to get it off their chest. And they appreciated us coming and letting them yell at us, right?

We took a lot back from what they said to look to see how we could make changes, and a lot of what we're trying to do now with taking down that wall between utilization management and care coordination is us just seeing the same things happening over and over in terms of complaints we see on Facebook.

There's a really loud Facebook group here called Medicaid Saves Lives, and I have a staff member that monitors it every day. And I get a lot of feedback from it, right, of what's not working. So I know when someone's cut DME before they call me to tell me they've cut DME. So I know exactly what's going on with how many -- you know, with everything, gloves, prescriptions, everything.

So we just try from all avenues to get feedback. I'll tell you, with COVID, it's been really hard because these things go a lot better in person, and you lose a lot on those Zooms. I mean, you just -- you cannot connect with families, and, you know, you just lose a lot.

So I'm really looking forward to getting back once we're all vaccinated and ready to go next year to try to continue to meet in person, but yeah, it's a work in progress. And I feel like it's going to be a work in progress always.

MS. LEWIS: And I would just add that Melissa's experience is not unique to Arkansas.

I think one of the benefits of working with the IDD community and the field is that there is no shortage of people who will engage with systems, health plans, providers, and researchers, both in terms of formal structures, right? So the DD Act ensures that there is a developmental disabilities network in each state that consists of the DD councils, the protection and advocacy agencies, and the university centers. So you have -- every single state has that structure and that infrastructure that allows the health systems to get to people who receive

services and supports.

And additionally and importantly, there's a tremendous body of advocates and advocacy organizations that are also generally representative of people with IDD, people with autism. I think that most of the states that are most effective in their benefit design have -- whether they're consumer advisories or ongoing kitchen cabinets that involve people with IDD and family members, it's critical.

The field is evolving. The next generation of people with IDD want things that are very different than the population of people who came out of institutions in the '70s and '80s. We have a generation of people who have grown up under the Americans with Disabilities Act and being able to be included in our schools and our communities in ways that the previous generation had not been, and if we are not listening to them in how we develop benefits, whether they are health benefits or social services and supports, then we will miss the mark. So I think it's absolutely critical, and I think that most of us have found ways to do that.

MS. WEINTRAUB: And I would echo everything that

Sharon was saying.

I would also say -- and one of my other favorite things that I should have said, but somebody said it -- was nothing about us without us. And I think that's so important.

You can invite us to be at the table and make it good for you and say, "Oh, yeah, you have advocate with a disability or a self-advocate," whatever you want to call it. There's a lot of debate in the disability community about what to call people.

But if you're just inviting them to make you pretty, what I call pretty, to your bosses or to the state or whoever, that's a token. And I can't -- I know what a token looks like because I have been a token before, but if you really want to listen to me, which you are today, and -- but including the plain-language version is a wonderful step. And you've said that you would like to have more of them. That's a wonderful step, and that's what I call a meaningful engagement and will listen to me and my friends, whether it hurts you -- and I use "hurt" in quotes. Obviously I would not hurt you on purpose, but if I said something that you might think, "Oh, that would hurt my

feelings," whatever my bosses won't like it, that's what I call hurting for no reason or hurting -- that's a token because you really need to listen to me, regardless of what I have to say, me and my friends.

CHAIR BELLA: Thank you, Liz. It's really important for you to be stating that and reminding us all about the difference between token and meaningful input.

I want to check with our panelists because we're running close to the end. Do you guys have a hard stop at 11:30, or would you be able to say for maybe five minutes after that?

MS. WEINTRAUB: I'm fine.

CHAIR BELLA: Okay. Thank you.

Knowing that we are imposing on them, I would ask the Commissioners to keep that in mind. We have at least four of you who want to make comments, but I certainly don't want to cut off the discussion because it's really important.

So I'm going to go Brian, then Chuck, then Leanna, then Sheldon.

COMMISSIONER BURWELL: Okay. I'll try to be brief, and I just want to say, Liz, what a joy it is to see

you again. We haven't seen each other for over 20 years. So it's good to see you still making trouble, and I want to tell all the Commissioners that this is anything but a token and a privilege to work with.

MS. WEINTRAUB: Thank you.

COMMISSIONER BURWELL: And it's nice to see you again, Sharon.

One thing that I have gotten back from the IDD community is that with crisis, there is also opportunity. One area where the system seems to be changing is in the area of day program services, moving from a model where everybody just left home and came to a centralized place, providers were given $50 per person per day or something, and it was a group setting. It was relatively inexpensive, but now with COVID, there is much more of a push to serve people in their home or some other setting, you know, do yoga or something like that.

It has caused problems in terms of payment models when you break up a budget for a day program into multiple individualized services. Can you just talk a little bit how that dynamic has been working out in the states and whether -- I mean, there's also been resistance among some

providers who are just comfortable with the old model, and doing individualized services is a challenge to them.

I'd just like to hear a few comments. We don't have much time, but how you see the system changing with that influence.

MS. LEWIS: Sure. I'll jump in quickly, and I'm sure Melissa has some insight in terms of the kinds of things that she's seen in Arkansas.

Long before COVID, I mean, this issue of the day programs was bubbling up and of concern to many in the community. We've for a long time had service and supports that are primarily custodial care for individuals as opposed to supporting their goal and aspirations, and part of it has been a payment policy challenge. But part of it has also just been a challenge in changing culture and understanding of what's possible, supporting the ability to have a mixed day. Most of us don't have a day that looks like we're spending all of our time in one place.

And I think what COVID has done for a lot of providers is actually created what's possible. I mean, it's interesting in talking to some providers in Texas that have struggled with how to move away from sheltered

workshops and serving people in those congregate settings, and the state had passed legislation requiring the department to move forward on trying to begin to find alternative mechanisms for day community engagement and in pockets, because it's fairly uneven. But providers have found ways to get creative.

One said to me recently, you know, he thinks that we've begun to put the nail in the coffin on some of the sheltered workshops because COVID has forced us to think this through.

But to the core of your question, Brian, around how do you adjust payment policy to do this, I mean, I think that people are struggling with it, and they think that there are tradeoffs in terms of, in particular, for people who are living with families and for people who are in residential settings that payment policies, assuming that they're out of the home for a certain number of hours a day, and the distinction between having a structured transportation service that picks somebody up and they're gone from everyone's radar screen for a period of time and then they come back into that environment, whether that's a home or a residential setting. And I think it's been a

mixed outcome at this point in terms of the ability of providers and states to adjust.

I think the other thing that has made a big difference is the ability to bring technology into the fold. One of the more interesting approaches that I've heard from several different states is where providers are finding ways to pull people together using common interests and technology, support them remotely, and it can be more efficient, but it also is bringing people together based on what they're interested in and the skills that they're seeking to develop as opposed to simply by virtue of the place that they're in.

So instead of having people showing up in a day center and spending all day in the day center with whoever else happened to be assigned to that provider in that day center, finding people based on their strengths and common interests and bringing them together and supporting them around those interests that can be still efficient in terms of backing in. So it's a work in progress, but I think that it was work that was occurring. But it has accelerated it.

COMMISSIONER BURWELL: Thank you.

CHAIR BELLA: Chuck?

VICE CHAIR MILLIGAN: I do want to echo the other Commissioners' comments. Thank you all very much for enlightening us. I'm going to save, for our Commission discussion after this particular session, after the panelist session, some comments I wanted to make, and Kit, I really appreciated the context and tone you set for us coming into this.

I'm going to focus then just on one question, and Sharon, the question is for you. One of the things that I've been curious about is, you know, many states were subject to various consent decrees and litigation related to mistreatment of individuals with IDD in state facilities in the past. I have lost sight of the extent to which those consent decrees might have been closed out, the extent to which those consent decrees continue.

But my question really is, emerging from state oversight, or court oversight I should say, of state creation of opportunities for individuals with IDD, as part of those consent decrees, have we seen a broadening of and an improvement of options and flexibility? Have we seen retrenchment where states once received of a consent decree

have maybe been less generous because there's no judge watching over them?

I'm just curious in the policy and delivery environment what has occurred coming out of the fact that over 30 states, at one point in time, were subject to consent decrees in this kind of service area.

MS. LEWIS: So I think that most states that have participated in litigation related to their institutional care have moved the needle, and it's evidenced by the fact that we now are at a place where the IDD system is significantly more rebalanced than any other aspect of our long-term services and supports system. And that's not to say that there isn't continuing -- I mean, even with all of those older consent decrees there's still a fair number of states that are either currently under a DOJ settlement, you know, under the Olmstead decision, in terms of an overutilization of those institutional settings or are at that type of litigation. And you see that in those disparities.

We have three states that at this point do not even operate or have any ICF facilities in the state -- not private, not public, nothing. They are serving everyone in

the community. And those states have demonstrated what's possible. We also are seeing that as, frankly, populations age and states find ways to close that front door that they're building a community capacity and reinvesting those resources back into the community.

I think two things have been challenging. One has been that oversight question, when we have a dispersed and fragmented system, and that's been noted by the Office of the Inspector General, and the ability to ensure that people in these dispersed systems continue to be able to have their needs met and continue to be health and safe. States have had to work very hard, and there's been a big initiative by CMS [inaudible] to ensure that health and welfare is protected.

The other thing relates back to this question of access to specialized medical care, which I neglected, when I was reading my initial comments, I actually wanted to talk just for a second about the fact that, you know, people with IDD really have a hard time accessing physicians that are comfortable, have the resources that they need. And I loved your analogy, Kit, of the red crayon, because that is what people with IDD run into all

the time. And finding ways to maintain a primary care, behavioral health care, and specialty care system that will serve people with IDD has been very challenging because we just don't have the adequacy and capacity across our systems to continue provide that support.

And I think the community would say that the tradeoffs that we're willing to accept, to some degree, because we don't want our home- and community-based services to become medicalized, we don't want everything to be based on a measurement of quality based on health care, at the same time [inaudible] diminished.

CHAIR BELLA: Thank you. Leanna?

COMMISSIONER GEORGE: Yes. I don't have a question but I just wanted to comment that as a parent of children with IDD I found the report very accurate, both of them. And I also wanted to point out a little factoid. Four percent of our population, U.S. population, has an IDD, but 10 percent of our incarcerated population in jails and prisons are individuals also with IDD. And I'm wondering if there's some kind of intersect there where the struggle to provide services is somehow contributing to that unbalancing or disproportionality with IDD in the

general prison systems.

MS. LEWIS: So I would hate to say that I know that there's a research-based, data-based connection between those two things, but I think you make a really good point. And I think, you know, when you take a look at the behavioral health section of the report and some of the information that we know about who the people are that are still ending up in the large ICFs in our population -- I think it was 17 percent of the new admissions of individuals into the large ICFs are individuals who are coming out of a part of the judicial system, whether that's forensic or otherwise related to criminal justice.

So I think it's a really important area that certainly could use more attention and reflection.

MS. STONE: I would just like to add, if I had a second, the Division of Youth Services, which is the juvenile detention system in Arkansas actually falls under the Department of Human Services, so I have a lot of interaction with them. And one of the things that just so trying to deal with is trying to get their Medicaid reinstated. You know, they turn their Medicaid off when they get put in detention. We know they need the service.

And then trying to get their Medicaid reinstated in a timely manner, because I have to independently assess them, and then they have to be assigned a PASSE if they have IDD or behavioral health, and that just takes time. So the timing on that is just a nightmare.

And then working with a family who has been very disconnected, because their teenager has gone into detention, it's also very hard on them. It's just rough. They don't want to fill out the paperwork or do anything because we don't have custody of them, essentially, right. So it is frustrating. It's frustrating that we have people with IDD sitting at DYS. As a lawyer it's frustrating. They should have had a better public defender than that.

But Sharon is right, and then the rest of the clients that get referred, a large majority of the clients that get referred to the state-run intermediate care facilities that we have that I oversee here are from our state hospital. And, you know, they called the other day about someone who murdered his mom, but they're not going to charge him and go to forensics. They wanted to give him to me to put him in ICF. No. Completely inappropriate for the clients that I have. Very dangerous.

So that's still that gap we're seeing that there's a service missing for these people that are dangerous as well.

COMMISSIONER GEORGE: Thank you.

CHAIR BELLA: Thank you. We just have time for one more. We've kind of pushed our luck already. So Sheldon, that's you.

COMMISSIONER RETCHIN: Actually, I am going to save my comment for the next session. I want to thank the panelists, though. It's a riveting panel. Thank you, Kristal, for putting this together. I want to thank all of the panelists, and especially a shout-out to Liz. She kind of stole the show, and it was just a really great learning experience for me. I appreciate it.

CHAIR BELLA: Toby, since Sheldon deferred you have time for about a 10-second question if you'd like to take it.

COMMISSIONER DOUGLAS: Sure. I'll be quick. The one area we haven't really talked about is this managed care, and the report does cite reasons why it's been so challenging. But I'd like to hear from Sharon or Melissa what are the reasons why -- it seems so out of the

expertise of the plans, which has been the challenges. Why are states, so many states, interested in integration, and what are the benefits?

MS. LEWIS: So I think it's been a really interesting road over the course of the last decade. If you had asked me 10 years ago how many states would have their IDD population integrated into their MLTSS plans I would have said it would have been many more than there are at this point.

I think that there are -- you know, as the report notes there are several reasons for that, in part because, I think, some of the traditional thinking around utilization management and some of the issues that Melissa has faced in terms of how do we support this population when it's really about supporting people on an ongoing basis over many, many decades, as opposed to acute and short-term approaches that have distinct recovery-based outcomes. That's a huge culture shift for these plans. It really is. It's astounding sometimes when [inaudible] with health plans around how do we prioritize the needs of this population. And I think that's been a disconnect.

I think what's interesting is that the states

that have been very successful, and Wisconsin comes to mind, in terms of supporting people with intellectual and developmental disabilities in a managed care framework, did it bottom-up and really grew a managed care approach out of local communities and local needs, and have some distinct features in how they have structured that. I know in Wisconsin there are still struggles around integration of the medical care piece, but I think when you look at how their managed LTSS program works for people with intellectual and developmental disabilities it has been more successful.

I think the other piece, in the question that was asked earlier, that states have struggled with and we've seen this in the states that have come in and gone very, very quickly towards managed care in a mandatory, all benefits, all services overnight, has been that challenge of actually integrating the perspectives of the consumers and beneficiaries and families in that process in a way that's been meaningful. I think there is no substitute for that, and taking the time and the energy and the resources that are necessary to do that.

And then finally, the issue of inequities in

terms of the HCBS providers and their ability to participate in different financing structures. We have a field of very small, home and community-based providers across this country that have not benefitted from very much state or federal investments in their data or infrastructure capacities, and their ability to navigate managed care and cash flow issues and quality reporting issues are not small. That infrastructure has not benefitted from many of the investments that have been made related to meaningful use or electronic health records, and we still have a tremendous amount of work that needs to be done to ensure that that infrastructure, frankly, can survive on [inaudible].

MS. WEINTRAUB: And Sharon and Brian, and if I can jump in. From my point of view, I think that people with disabilities don't understand these words, and they're scary to people. I didn't know about managed care until I got -- yes, 20 years ago I was working with Brian on these issues and I had been around the block many times, working in this field for over 20 years. But most of my friends don't have that knowledge, and sometimes when you're using managed care it's scary for people. They're like, what are

you talking about? And we want to understand. So I'll let others answer.

MS. STONE: I would just add quickly, you know, they operate like an insurance. The managed care companies operate so much like an insurance. They want to code as much as they possibly can and get out of any kind of manual, you know, administration. Right? That's how they actually can survive, and it actually is feasible to make money off of some of this.

So with this population you can't do that. I mean, they went in at the beginning and they tried to tier benefit packages based on your diagnosis and your tier. Well, the way we set it up was that no, you can't base any service on your diagnosis or your tier, so we had to go in and uncode everything.

So it's a lot of manual review, if you're really looking on individual basis of a person-centered service plan, and you can't have a lot of edits in the system that are automatically denying a service, if that makes sense. So it's a totally different way of running managed care than I think a lot of companies are used to with a fee-for-service, with me and some of you guys, where they can see

exactly my demographic and put me into a package.

So I think that's part of the thing that we've had to go through over the last year, is just learning how to make it more individualized when they want to make it more IT automatic.

CHAIR BELLA: Thank you all. So thank you for coming, first of all. Thank you for letting us keep you longer than we promised. But I think you can see that there is a great level of interest, and this is an area that we want to continue to explore. So we will likely be coming back to you and asking for your thoughts and your input. And again, just to reiterate what an important step it is for us today to have the plain language, and hopefully we'll start that as a practice. So thank you all again very much, and we really, really appreciate it.

MS. STONE: Thank you all.

COMMISSIONER BURWELL: See you again.

MS. WEINTRAUB: You have a nice day.

COMMISSIONER BURWELL: Bye.

MS. WEINTRAUB: Be well.

FURTHER DISCUSSION BY COMMISSION

* CHAIR BELLA: All right. For the Commissioners,

that was well worth going over our time, but I am going to be a stickler about trying to get us to the votes at noon. So how many of you would like to make a comment right now, and I'm going to then use that to determine how much time you each get. Sheldon, Chuck. We only have two? Martha, is that your hand? Leanna? Sheldon, Chuck, Martha, Leanna. Okay. I'm going to ask that you each limit your comments to two minutes, two and a half minutes.

Go ahead, Sheldon. Sorry.

COMMISSIONER RETCHIN: Okay. Don't penalize me on the first few seconds. I appreciate that. That was really a terrific panel. I'm just going to sort of jump to in terms of next steps. Because I read the HMA report. You may predict that I naturally focused on workforce, which I believe, for the IDD population, the DD population, and behavioral health, there is a commonality, and that is a workforce shortage.

When I read the HMA report, I came away with some great ideas of making this an underserved population, where there might be some bonus payments, et cetera. One thing, in terms of the direct care workforce, however, and the behavioral health workforce that have in common is a

reliance on immigrants. And the immigrant population has taken a hit in the last few years. I think as we begin to look at that -- and as an example, one out of four direct care workers is an immigrant. And if you look at the population, they represent -- five of the legal non-citizens represent 5 percent of the population but 10 percent of the direct care workforce.

So I think it's policy relevant, and I'd like to see us look more carefully at the direct care workforce in particular, but also behavioral health, and maybe focus on that factor in terms of immigrant issues. I know there are ethics about international brain drains, et cetera, but I do think that's an important area for us to look at. Thanks.

CHAIR BELLA: Thank you, Sheldon. Chuck.

VICE CHAIR MILLIGAN: Thank you.

Two comments in terms of next steps and potential future work. One is I wanted to go back to a comment Kit made which is the right to risk, and I would like to better understand approaches that are being taken around reflecting autonomy, not being patronizing or

paternalistic, but at the same time trying to balance the issues of potential exploitation and abuse.

This is not limited to IDD. We see this come up with other forms of HCBS where there's elements of protective services. So I would like to understand better how programs are approaching balancing the right to autonomy and self-determination with risk and exploitation.

The second thing -- and it was related to come comments Melissa made in the Arkansas model -- is I would like to better understand approaches to what I think of as inter-rater reliability or trying, as much as possible, to treat common clients in common ways.

I recognize that everybody is an individual. Everybody's needs are unique, that there has to be some tailoring to individual circumstances and needs.

At the same time, historically, a lot of time, service providing is based on individual case managers or individual UM decisions that I don't think relate as much to individual needs as they do to who the case manager or who the determiner is of that person-centered plan and what services are included.

So I would like to better understand how to

balance the need to customize and tailor services to individual-level issues with some inter-rater reliability dimensions of treating similar people in similar ways.

Thank you.

CHAIR BELLA: Thank you, Chuck.

Leanna.

COMMISSIONER GEORGE: Yeah. I'm also with the workforce initiative for the direct support professionals, figuring out how to increase reliability for the person, for the beneficiary to be able access those individuals to workforce.

I'm also interested in getting the transition out of incarceration and the Medicaid interaction there. It just sounds like there's some issues going on there as well.

CHAIR BELLA: Thank you, Leanna.

Martha?

COMMISSIONER CARTER: I think this belongs here. A friend of mine several years ago raised my awareness about the need for assistive technology. We all think about wheelchairs and scooters, but she was instrumental in developing a baby crib that was accessible to people in a

wheelchair. So I want to hear more about how states are handling the need for assistive technology. Are people getting what they really need to be independent?

CHAIR BELLA: Great. I appreciate you all sticking to time. We have a little bit more time if anyone else wants to make a comment.

[No response.]

CHAIR BELLA: Kristal, I thought that the discussion was very well laid out as well. I think that there is reinforcement for the areas you mentioned in the memo that we might want to look at. Obviously, you heard that around behavioral health and also equity and disparities in addition to the things that have been raised here.

What else would be helpful for you at this point?

DR. VARDAMAN: The conversation was very helpful. I think another opportunity you'll have to talk about related issues will be hopefully in April. We'll have results of some work we've been doing on rebalancing that will also talk about some of the themes that we've discussed today.

CHAIR BELLA: Okay.

And there is, Martha, some great work being done with assistive technology that we can make sure everyone is aware of, that we can look further in. At least I know of some great work being done in Pennsylvania, and I'm sure there is -- I see some other heads nodding. So if folks know of some things that would be helpful, send those to Kristal as well.

Okay. Anne, kind of point of preference. We can do the votes right now. I don't know if it's an issue to do it before noon, or we can take public comment on this session right now.

EXECUTIVE DIRECTOR SCHWARTZ: Why don't you take public comment, and then I think that will be fine.

CHAIR BELLA: Okay. We're going to open it up to those of you in the audience who might want to make a comment based on the panel and the discussion that we just had. If you would like to make a comment, please hit your hand icon, and we will unmute you.

Okay. It looks like we have one. Great. When you are unmuted, please introduce yourself and the organization you're representing.

MS. HUGHES: Sheryl, you've been unmuted. If you

can unmute yourself now.

PUBLIC COMMENT

* MS. LARSON: Hi. I'm Sheryl Larson. I'm from the University of Minnesota and had an opportunity to contribute materials for the report. I just want to thank the panel for paying attention to the plain language report. I think there's a lot of work we need to do in that area, and it doesn't just apply to people with intellectual and developmental disabilities. It applies across populations that are served by Medicaid.

That's all I have to say.

CHAIR BELLA: Thank you very much. Thank you for your work in that and involvement in that.

Anyone else who would want to make a public comment at this time?

[No response.]

CHAIR BELLA: Okay. Well, then we will conclude this session, and we will move into the next part of our agenda, which is to vote on recommendations in three areas.

Anne, I will turn it over to you.

VICE CHAIR MILLIGAN: And, Anne, I'm happy to do the process that I think we need to --

EXECUTIVE DIRECTOR SCHWARTZ: Yes. Please go ahead with the conflict of interest remarks.

VICE CHAIR MILLIGAN: So because this is a voting meeting, MACPAC's conflict of interest policies apply. The policies, for this in the public, are posted on our website under the tab About MACPAC.

On January 5th, the MACPAC Conflict of Interest Committee met by conference call and determined that for purposes of our votes today under our policy involving whether the recommendations involve issues that are particularly directly predictably and significantly used, applying that standard that governs our deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest related to the various recommendations under consideration today.

So following the meeting and review conducted by the Conflict of Interest Committee, we've identified no conflict applying our policy that would implicate the votes to be held now.

VOTES ON RECOMMENDATIONS FOR MARCH REPORT TO CONGRESS: POSTPARTUM COVERAGE, ESTATE RECOVERY, AND AUTOMATIC COUNTERCYCLICAL FINANCING

ADJUSTMENTS

EXECUTIVE DIRECTOR SCHWARTZ: Thanks, Chuck.

So what I'm going to do is I'm going to go through each recommendation one by one. There are seven altogether, and we'll take a roll call vote on each. I will read each recommendation so that the wording is in the transcript.

I also just want to let folks know that the only recommendation that changed from yesterday is the first one we're going to vote on because you will recall it had bracketed 90 or 100 percent on the match for postpartum coverage, but otherwise the recommendation language is exactly the same as you saw yesterday.

To the extent that folks had concerns, we are going to make sure that when we write out the chapter, we'll say the Commission had a healthy discussion of X and ultimately decided to do Y for these reasons.

So just the final thing is that on each vote, Commissioners, you can vote yes, no, or abstain. We have a full house today, so we don't have to worry about people not at the meeting.

So can I have the next slide, please?

* So these are the three recommendations that relate to postpartum coverage. The recommendation reads "Congress should extent the postpartum coverage period for individuals who are eligible and enrolled in Medicaid while pregnant to a full year of coverage, regardless of changes in income. Services provided to individuals during the extended postpartum coverage period will receive an enhanced 100 percent Federal matching rate."

Okay. So now for the votes. Tom Barker?

COMMISSIONER BARKER: Anne, could I pass and come back to me?

EXECUTIVE DIRECTOR SCHWARTZ: Sure.

COMMISSIONER BARKER: Thank you.

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: Abstain.

EXECUTIVE DIRECTOR SCHWARTZ: Peter Szilagyi?

COMMISSIONER SZILAGYI: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. I'm going to

come back to you, Tom.

COMMISSIONER BARKER: I vote yes. Thank you.

EXECUTIVE DIRECTOR SCHWARTZ: Okay. And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay, great. That's 16 voting yes with one abstention.

Next slide, please.

Okay. On Recommendation 2, “Congress should extend the postpartum coverage period for individuals who are eligible and enrolled in the state Children's Health Insurance Program while pregnant if the state provides such coverage to a full year of coverage regardless of changes in income.”

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. Seventeen in favor.

Next slide, please.

Okay. This is the final recommendation related to the postpartum coverage period to pregnancy coverage: "Congress should require states to provide full Medicaid benefits to individuals enrolled in all pregnancy-related pathways."

EXECUTIVE DIRECTOR SCHWARTZ: 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: And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Okay, great. All right. So that concludes the votes for that chapter.

All right. Next, we'll vote on the recommendations on estate recovery, and here there are again three. And we'll take a vote on each separately.

Next slide.

* So the first recommendation is: “Congress should amend Section 1917(b)(1) of Title XIX of the Social Security Act to make Medicaid estate recovery optional for the populations and services for which it is required under current law.”

Tom Barker?

COMMISSIONER BARKER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: No.

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: Abstain.

EXECUTIVE DIRECTOR SCHWARTZ: Okay.

Chuck Milligan?

VICE CHAIR MILLIGAN: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Sheldon Retchin?

COMMISSIONER RETCHIN: Abstain.

EXECUTIVE DIRECTOR SCHWARTZ: Bill Scanlon?

COMMISSIONER SCANLON: No.

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. So we have 2 no votes, 2 abstentions, and 13 yes votes.

Next slide, please.

Okay. The second recommendation in this chapter is: “Congress should amend Section 1917 of Title XIX of the Social Security Act to allow states providing long-term services and supports under managed care arrangements to pursue estate recovery based on the cost of care when the cost of services used by a beneficiary were less than the capitation payment made through a managed care plan.”

I think actually it should read "when the cost of services was less." Does anybody have a problem with that, just from a grammar perspective? Or we could say "costs." Any objections to the minor grammatical change in the language?

[No audible response.]

EXECUTIVE DIRECTOR SCHWARTZ: I see heads nodding no. I want to clarify that, so we can make that minor

change.

Okay. I'll call the roll again. 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: Seventeen votes in favor.

Next slide, please.

* Okay. So the final recommendation for this chapter: “Congress should amend Section 1917 of Title XIX of the Social Security Act to direct the Secretary of the U.S. Department of Health and Human Services to set minimum standards for hardship waivers under the Medicaid estate recovery program. States should not be allowed to pursue

recovery for, one, any asset that is the sole income-producing asset of survivors; two, homes of modest value; or three, any estate valued under a certain threshold. The Secretary should continue to allow states to use additional hardship waiver standards."

Okay. Taking the roll. Tom Barker?

COMMISSIONER BARKER: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR SCHWARTZ: Brian Burwell?

COMMISSIONER BURWELL: No.

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: Abstain.

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: That's one abstention, one no, and 15 yeses.

Okay. That completes estate recovery.

* Then our final recommendation is on the automatic countercyclical financing adjustment. If I could have the

recommendation? Thank you.

Okay. So this one is a little bit of a mouthful. “Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model, using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission also recommends this policy change should also include: an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment; an upper bound of 100 percent on countercyclical adjusted matching rates; and exclusion of countercyclical adjusted federal matching rate from services and populations that receive special matching rates(e.g., for the new adult group), or are otherwise capped or have allotments(e.g., disproportionate share hospital payments, territories).

COMMISSIONER CARTER: Anne, would anybody object to taking one of the "alsos" out of the main section there?

EXECUTIVE DIRECTOR SCHWARTZ: Everybody thumbs up on that? I see thumbs up. Great. Thank you.

Thank you, Martha.

Okay. Last go-around. 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: Seventeen yeses.

Okay. That concludes the voting, and those will appear in the report.

Melanie, I turn it back over to you.

CHAIR BELLA: I feel like we should all go out and celebrate that we just gave Congress more stuff to do. Hopefully, they won't be so busy with COVID that they can't take this great work.

Thanks to Anne, and thank you to the staff and also to the Commissioners. We've worked on these issues

that we just voted on for a long time, and everyone has been very dedicated to participating and having meaningful discussion and respectful of other's voices, and so I feel like we've made great strides today and want to personally thank all of you for getting to this point.

We are going to take a break. I'm sure everyone could use a little break. We will be back at one o'clock, and we will talk about a study on non-emergency medical transportation.

So thank you again, everybody. Great work, and I'll see you back here at one o'clock.

* [Whereupon, at 12:13 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: Welcome back, everyone. Thanks for getting back promptly. We're going to start the afternoon of our session, and I'm going to turn it over to Chuck, who is going to lead this session.

VICE CHAIR MILLIGAN: Thanks, Melanie. So our afternoon session is going to begin with a mandated report on non-emergency medical transportation. We look forward to the presentation. Aaron, although I'm disappointed you're not with another Erin on this particular panel this particular meeting, because it will create a lot of clarity, I look forward to the presentation, Aaron and Kacey. It's all yours.

MACPAC STUDY ON NON-EMERGENCY MEDICAL TRANSPORTATION

* MS. BUDERI: Great. Thank you, Chuck. Sorry my name is not also Aaron/Erin. I hope you're not too disappointed.

So like you said, Chuck, today we're going to continue our discussion of non-emergency medical

transportation, or NEMT. The Senate Appropriations Committee has asked MACPAC to do a study on this topic. At our October 2020 meeting, we discussed the work plan for the study and shared some preliminary findings, and today we'll be sharing some additional findings.

I'm going to start by reviewing the congressional request. I'll go over some recent changes to NEMT requirements and then provide a brief overview of the NEMT benefit. Then I'll turn it over to Aaron to discuss the findings from our analysis of administrative data on NEMT utilization. Then we'll turn it over to Mike Perry, of Perry Undem, who is with us today, to discuss the findings from focus groups we held for beneficiaries who have used NEMT.

This slide shows the language of the congressional request. The request has no due date and does not require recommendations, but staff anticipates that the results from the study could be public in MACPAC's June 2021 report to Congress.

At the October meeting, I noted that unlike other mandatory Medicaid benefits, NEMT was required by regulation, not statute. This changed with the enactment

of the Consolidated Appropriations Act for 2021, which codified the requirement into statute. This means that NEMT can no longer be made optional through a revised regulation, as the Trump administration had proposed. So although we're continuing our study on NEMT as planned and as requested by the committee, the context has changed.

Just to refresh your memory, the NEMT benefit generally covers a broad range of transportation services and can be delivered through a variety of different arrangements, including an in-house fee-for-service arrangement, a third-party transportation broker, or through Medicaid managed care.

MACPAC's study on NEMT has three primary components, which are outlined here. At the October meeting, we shared the findings from the first component, an environmental scan of state NEMT policies in all 50 states and the District of Columbia, and structured interviews with stakeholders in six states and at the federal level. Today, as I mentioned, we're sharing findings from the two additional components, focus groups with beneficiaries who have used NEMT and analysis of administrative data on NEMT utilization and spending.

Now I'm going to turn it over to Aaron.

* MR. PERVIN: Thank you, Kacey. This study represents MACPAC's first attempt to publish service-level estimates using data from the Transformed Medicaid Statistical Information System, or T-MSIS. Rides were identified using non-emergency medical transportation codes within the Healthcare Common Procedure Coding System, which is a standardized coding system that bill for medical devices, supplies, transportation services, and other auxiliary items.

To help standardize our findings so we could make apples-to-apples comparisons, we limited the sample to full benefit Medicaid enrollees in fiscal year 2018. Furthermore, due to variation in state billing practices, we also present findings as ride-days or days where we can find a claim or encounter related to NEMT.

The impact of this is that an individual may have multiple rides to multiple destinations. Under our method, this would count as a single ride-day. Therefore, we see our findings as a floor of NEMT use while the number of door-to-door rides is likely much higher. You will find a detailed discussion of our T-MSIS methodology within your

reading materials.

Using our methodology, our sample yielded 61.5 million ride-days and 3.2 million NEMT users, which brings us to an important finding which you will see reiterated in subsequent slides, and also was something that was largely confirmed within our stakeholder interviews. All NEMT use is concentrated. It's used extensively and by a small number of beneficiaries. While use does vary by eligibility group, mode of transport, diagnosis, we consistently find that among NEMT users transportation is a highly used benefit.

We also looked at spending within T-MSIS. Total Medicaid spending on NEMT was $2.6 billion, and this estimate excludes payments by all managed care plans to NEMT providers.

Our first chart presents the rates of ride-days on the basis of eligibility. The left side of the chart shows ride-days per full-year equivalent enrollee, while the right side of the chart shows ride-days per NEMT users. As you can see, we have a smaller ride-day amount among overall users, but among NEMT users, transportation is used extensively. As an example, for all those who are within

the disabled eligibility group, the rides per full-year equivalent was 3.7 ride-days in 2018. However, among NEMT users within the disabled eligibility group, rides were 24.4 ride-days in 2018. Again, this is a common theme throughout the presentation, low ride-days overall but high ride-days among NEMT users.

Overall, we found that for both full-year equivalents and for NEMT users, both the aged and disabled eligibility groups used NEMT the most frequently.

Moving on to individuals who are dually eligible for Medicare and Medicaid services, again, you can see low NEMT use overall but extensive use among NEMT users. When looking at the entire dually eligible population there were 3.6 ride-days in 2018, compared to only 0.5 ride-days for the Medicaid-only population. Among NEMT users, the dually eligible had 24.1 ride-days compared to almost 16 ride-days among the Medicaid-only population.

We were able to stratify our results by urban or rural residents based on the beneficiary ZIP code. Overall, we found minimal variation in frequency of NEMT use by urban or rural residents, though we did find that among NEMT users beneficiaries in urban locations had

almost 20 ride-days, while beneficiaries in rural locations had almost 16 ride-days in 2018. We find that the relatively lower use of NEMT in rural areas to be consistent with stakeholder interviews, and noted that there is often less transportation availability in rural areas because of a lower supply of NEMT providers.

This chart displays our findings for NEMT use among selected diagnostic categories, some of which were conditions that were defined in the statute mandating this report. To define each of these diagnoses we pulled the billing codes present within CMS's algorithm for identifying certain chronic conditions. Specifically, these conditions were chronic kidney diseases, with and without end-stage renal disease, or ESRD; intellectual or developmental disorders; opioid use disorder; and serious mental illnesses. We compared each of these diagnosis groups to beneficiaries who have none of these conditions.

Overall, we found that each of these diagnosis groups use NEMT at a higher rate compared to beneficiaries with none of these conditions. The range of NEMT use was between 32.6 ride-days for ESRD-diagnosed beneficiaries to 0.4 ride-days among those with none of these conditions.

Again, consistent with overall findings, transportation use was noticeably higher among NEMT users, but again, that use does vary by diagnosis group.

Among NEMT users with ESRD, there were 70 ride-days, compared with 12.8 ride-days among users with none of these conditions. It should be noted that we are likely underestimating the total number of ride-days among those with opioid use disorder, as methadone is not explicitly included in CMS's algorithm for identifying opioid use disorder.

We were also able to report out the share of ride days with each mode of non-emergency transportation. We also want to restate that beneficiaries can use multiple modes of transportation in a single day. A patient in D.C. might take a taxi for a primary care visit, public transportation to visit a specialist, and then take a taxi on their way back home. We found that both vans and taxis are the most prevalent forms of transportation. Forty-six percent of all ride-days reported a trip with a van, while 36 percent of all ride-days reported a trip with a taxi. The least frequent mode of non-emergency medical transportation was an airplane, which we found were only

used frequently in states with issues related to geographic access, such as Alaska.

For certain states we were able to report out the share of ride-days that went to a specific destination. Again, just to reiterate, beneficiaries can have multiple destinations specified in a single ride, a round-trip to their primary care physician and back home as an example. There are a few states that follow a standardized way of reporting transportation destinations, and we limited our sample to six states where 95 percent of NEMT claims had an identifiable destination. The most frequent destination was to a beneficiary's residence and to a physician's office, at 41 and 20 percent of ride-days, respectively. The least frequent destination was nursing homes, at 0.5 percent of all ride days.

We wanted to end our presentation with a few key takeaways for Commissioners. NEMT use is highly concentrated. It's used extensively by a small number of beneficiaries. Secondly, those who qualify for benefits under an aged or disabled basis are the most frequent users when compared to the other eligibility groups. Those with chronic kidney disease, with and without ESRD, intellectual

or developmental disorders, opioid use disorder, or serious mental illnesses use NEMT more frequently than those who are diagnosed with none of these conditions. We found that the ESRD population used NEMT particularly frequently.

Also, NEMT users primarily ride in a van or a taxi. These taxis can also include transportation network companies such as Uber or Lyft. And finally, within our sample of six states, the most common NEMT destination was to a home or a physician's office.

I can now turn it over to our colleague, Mike Perry, who will present findings from the beneficiary focus groups.

MS. BUDERI: Great. Mike, so whenever you're ready feel free to go ahead.

* MR. PERRY: Great. Hi, everybody. I'm in this square. Thank you for having me and thank you to MACPAC for commissioning this study. What I'm going to do is give you some highlights from eight focus groups that we held with diverse Medicaid beneficiaries who use NEMT services.

Why don't you go to the next slide, Kacey, and I'll tell you more about the study.

These are different times. It's hard to do the

kind of research that I normally do in person, and which I've done in the past with Medicaid beneficiaries on transportation services. So we had to do this online. We wanted to make it as accessible as possible so whatever way the beneficiary could participate in the study we supported. So whether it was just a telephone, phoning in to the focus group, whether it was on a laptop using Zoom, or whether it was on their mobile phone using Zoom was how they participated. These were 90-minute conversations. They often went longer. The individuals in this study came from Arizona, Connecticut, Georgia, Indiana, Massachusetts, and Texas.

I will say that, just as an aside, it was very important for these individuals to have a voice on these services. They really wanted to engage in this study and went to great lengths to do it. For example, we had one participant who was actually having dialysis and participating in the focus group holding up her phone. We had individuals who were using the transportation services as they participated in the focus group. We had individuals in rural areas who had to be outside to get enough internet access to participate. So it was a big

deal for them to participate in this study, and I commend MACPAC for actually trying so hard to hear the voice of beneficiaries.

So here are just some of the conditions that individuals had. We had, we felt, a wide range of conditions and challenges that people were dealing with: end-stage renal disease, we had a number of participants who were dealing with that; cancer; high blood pressure, back problems; some individuals who had been in car accidents and were recovering from that; cirrhosis of the liver; asthma and other respiratory issues; heart disease; PTSD; bipolar; anxiety; depression; substance use disorder. We had a number of individuals who have mobility challenges and use wheelchairs and were dealing with spinal cord injuries participate as well.

It was important to us to include all kinds of people and participants and lived experiences in this study. Another aside, although you are seeing me share the results it was a collaborative research process. We had researchers of different racial and ethnic backgrounds and experiences do this research. I only led one of these conversations. So this report is our shared effort. We

had 31 women, 10 men. We had a good split of younger beneficiaries and older. We had 27 Medicaid enrollees and 14 dual eligibles. We had 14 residents of urban areas, 7 suburban, 14 in small town, and 6 in rural areas. We really wanted to hear from that small town rural point of view and we had that, and there were some really compelling findings. We thought we had a lot of racial and ethnic diversity at 14 white participants, 13 Black, 9 Latinx, 2 APPI, 1 indigenous, and 2 mixed race individuals. And then in most cases these were actual participants in NEMT themselves, but sometimes we had a caregiver or parent participate.

So let's share with you some of what we learned from them.

We spent some of the conversation finding out what life was like before they had access to these services, and it was challenging. Some of the challenges they had around getting to and from appointments and health care were related to not having a car, not having a driver's license. Some were just unable to drive because of their health condition. Some found public transportation just not feasible, given their health

conditions they were dealing with. A few needed specialty vehicles, a wheelchair van, for example, that they didn't have access to, couldn't afford on their own.

Many could not afford the cost of transportation, particularly an issue for those living in rural areas. We had individuals who traveled an hour, hour and a half, and in one case it was three hours to and from appointments. So imagine the cost of public transportation or hired taxis to go back and forth.

For some, even if they weren't in rural areas and they were in small towns, public transportation just looks different. So you would have four buses, for example, that you could choose from in the day to make your appointment, and so a whole day would be spent going back and forth from appointments.

And then just the difficulty of relying on family and friends and neighbors to get you to and from appointments. It wasn't a reliable way for people to access care. So this was life before NEMT.

Here are just some of the ways, and it really varied, on how they used services. We had a Georgia woman with quadriplegia and she was using these services to get

spinal care, back and forth to a spinal care center three days a week. This therapy was critical to maintaining her strength and mental health.

I haven't mentioned it but the context of all of this is COVID and the pandemic, and this woman, in particular, could not get the therapy she needed for a number of weeks, even into months, and really talked a lot about feeling that her progress stopped, and the difficulty in accessing care during the pandemic. There were a lot of those kinds of stories.

We had an Arizona man who had been in a car accident, and he used transportation services for occupational therapy to get his mobility back. We had an Indiana woman. She had a number of health conditions. Her mobility was limited. She went to physical therapy two to three times a week and saw other specialists. She was one of the ones who lived furthest, in one of the most remote areas, and had a lot of challenges accessing her care.

We had a Massachusetts woman with end-stage renal disease. She was getting back and forth on her own to her appointments, but then she broke her hip, and she needed to use these services. So for her it may be more temporary

use.

We had a Massachusetts man with substance use disorder, and he used it to go back and forth to methadone clinic seven days a week and to assist in his recovery.

We had an Arizona mother of a child with autism. She used these services to take her daughter to see developmental specialists, and her daughter also participated in a respite and living skills program, and the mother had to travel quite far.

I'll give you an aside with that mother. That mother, before NEMT, she lived about two to three hours outside of Phoenix where she needed to go, and she was looking to move because she couldn't access her care to Phoenix, even though she really couldn't afford to before she accessed these services. So now that she has the services, she was able to stay in her more affordable community that she had grown up in.

Next slide.

So the next three slides are about what these services means to these participants, why they matter, and then we'll go on to some other issues.

So why do these services matter to them? What do

they mean? What value do they bring? We found that some participants viewed these -- their access to these services and to their care as a matter of life or death; that without this kind of regular care to treat the very serious health conditions, they thought that they would risk death if they were taken away or lost them. So it was very important to them.

We also found that just the difficulty of managing care, having consistent care for multiple conditions, these services allowed for that consistency. They allowed for people to feel they were improving, to their mental behavioral health, emotional health, to see it improve. That's what these services provided.

There was a lot of before and after in this conversation. Before services, after services, what was life like? And prior to NEMT, we heard a lot about missing appointments, being unable to receive necessary treatments. People who just could not cope with or access public transportation, just not even making appointments, not scheduling them, not getting care they needed. There were a number of health conditions that were unchecked. There were a number of hospitalizations that could have been

avoided prior to these services.

Many also talked about quality of life, and that's probably the biggest takeaway, and we'll get more into that on the next slide. But access to these services improved their health, yes, but their mind-set, their relations with family, their mobility, their self-agency, all of those were impacted through these services.

Next slide. Kacey, next slide?

MS. BUDERI: There you go.

MR. PERRY: There you go. Great.

Okay. So isolation was a big theme; mental health, big theme. During the pandemic it's something everyone can relate to. It is even more difficult for many of the people in our study. They had already felt isolated pre-COVID. They already felt in many ways trapped in their homes. COVID only made those feelings worse. So NEMT made them feel less isolated. Just on the very raw kind of level, it made them feel more connected.

They talked about the emotional toll of being confined and not feeling power or in control and how these services help address that.

Many were relying on services to treat their

mental health conditions or substance use disorders, and that was a day-to-day kind of thing, and it allowed them to function, get through their life, get through daily life, and they attributed their ability to move forward to these services. And then, you know, some of the insights we received from those who were being challenged with mental health needs was what it was like for them to have to negotiate public transportation and how hard that was for some, just could not do it, and how, you know, riding alone to and from their appointments using NEMT was really the only way they could access care.

Next slide.

So this is the last slide of what the value they see to these services. We talked about freedom. We talked about independence. One thing to keep in mind about these services is not only the beneficiary who benefits or their caregiver. It ripples through the whole family. So family relationships improved because there wasn't this dependency on other family members to get me to and from care. So they talked a lot about that. Whether it was their parent, their grown child, their spouse or partner, tensions seemed to be less because they could now be independent and did

not have to rely on them.

There was also a big impact on the family income because often it took someone out of the job market or out of a job to be able to get someone to and from appointments. And so the family economically benefitted when it freed up other family members.

We've talked about and heard a lot from those with mobility challenges, those in wheelchairs, about being able to get out of the house was so important, and this allowed them to get out of the house.

Lastly, it was just the coordination, navigation of transportation beforehand was so complicated that one of the values of this service is how it simplified their commutes back and forth, and that was important.

Next slide.

So the nature of these kind of focus group conversations is that people want to give feedback on how to improve these services. I don't want to lose sight of the fact that these services were not taken for granted, highly valued, made a huge difference in their life. But their feeling was that they could be improved.

Now, this varied greatly. It varied from

suburban, urban, rural, what state people were in. There was a lot of variance in their feelings around what needed to be improved and not.

So some of the things that came up more consistently are around drivers arriving too early, too late, not at all. It was sometimes difficult for beneficiaries to know who was to blame. Was it the driver? Was it the dispatch? They could never in many cases sort out where the breakdown was, but that was an ongoing challenge for a number.

Another thing they mentioned is just general customer service deficiencies, how they were treated by drivers, by dispatch, when they called to make complaints. They didn't always feel like they were treated well, respected, were heard, so that was an ongoing challenge.

Feeling that there was little recourse to hold drives or transportation companies accountable, this was almost a bigger factor for those in small towns and rural areas because they had such few choices for transportation services. There was a fear that, "If I complain, my service would go down or I would be banned from using these services." So there was this dynamic here in more rural

areas about the ability to hold these services accountable because they didn't have a lot of choices.

And then, lastly, there were a number of frustrations around policies that impacted how they use these services, so policies around sharing rides, using public transportation, more difficult particularly during the pandemic, and there was, you know, a desire to push back on some of those. Also, scheduling three days in advance was a pressure point for a number of participants just because their care was so unpredictable, and it was always hard -- it was just hard to plan care always three days out, and if they had to break that protocol, it was very hard to get the kind of services they need.

And then, lastly, any policies that precluded parents from bringing their children along on rides was challenging for them.

Next slide.

I'm almost done. These are some of the improvement ideas that they had. It was important to them for me to share on their behalf what they would like to see improved. So improving dispatch processes, preventing overcrowding on shared vehicles, reducing excessive wait

times, implementing stronger background checks for drivers. Some talked about drivers being reckless and scaring them, and so they wanted better background checks.

On shared vehicles, just by the way, there were a lot of issues there. They were actually coming from women about feeling uncomfortable in a van full of all men or those kind of issues were issues for the shared vehicles.

They wanted more flexibility in rules so beneficiaries can use NEMT services for non-medical purposes. They think things like access to healthy food, for example, improved their health, should be considered as part of this. They want to some flexibility around the policies I mentioned on the previous slide.

They mentioned wanting to use Lyft and Uber. This was the younger beneficiaries. They really felt it was easy to use the app. There was more accountability. They could rate the driver. They could see when they're showing up, and that they really liked all of those kind of technology advances.

We raised the idea of introducing new technologies in NEMT. They really liked a similar kind of app that they could use. It wasn't for everybody. It

wasn't for the older beneficiaries, but the younger ones in particular liked that idea.

So let's go to the last slide here. So we ended these focus groups asking participants what it would mean if their services were cut back or dramatically changed or taken away. I regret ending every focus group with that because there was an emotional response and a lot of fear that this could happen. They really do rely on these services, and they don't want them changed, so many got anxious about it. They rely on these services for care, for improvement, for progress, life and death for some. So that's their fear, that the services would be taken away.

They all thought there would be mental health consequences. That came up really early. Their well-being is very much tied to their access to the health care system, and if that were limited or taken away, then they thought it would have a lot of consequences and ripple throughout their family. They family would lose income. Family relationships would decline. Their own mental health and sense of agency would decline.

And then, lastly, there was another financial impact, which is just having to assume the cost of the

transportation. For some it's just not feasible. They live on very meager incomes and could not afford to pay for these services on their own.

SO those are the highlights. I spoke really quickly about a lot of important things, and the full report is much larger, and hopefully you'll have a chance to look at it. But I'll end there. Kacey, is there anything you want to add?

MS. BUDERI: No. Thank you, Mike. Thank you so much for that.

Commissioners, you've heard the findings from the focus groups and from the other two primary components of the study at this point. Like I said, our plan is to pull the information together for a chapter in the June report.

Although in October we had discussed the possibility of recommending that NEMT be made a mandatory benefit in statute, Congress has since already taken that action, so our conversation about that is moot now. And our chapter is going to be descriptive, laying out the findings that I, Aaron, and Mike have all shared with you.

So, with that, the three of us will listen to any questions. You can answer them, and we look forward to

hearing your feedback.

VICE CHAIR MILLIGAN: Thank you very much, all of you. I have Martha, then Tom, then Sheldon. I hope I can keep up with everybody. Martha, then Tom, then Sheldon, then Fred, and we'll go from there.

COMMISSIONER CARTER: First, thank you so much for this in-depth report and for listening to beneficiaries. It's really important. I have two questions.

In my state, which is West Virginia, they contract with a transportation vendor, and one of the options open to beneficiaries is gas mileage reimbursement. And I actually did see that used fairly often because of some of the problems associated with scheduling the NEMT and, you know, having sometimes to dedicate a whole day to transportation. So I wondered how often that's used, whether you captured that in your report, that people were, in fact, relying on family and friends and needed that gas mileage reimbursement to make it possible. That's one question.

The second question is sort of a general policy question. Even though this is now a mandated benefit, as

in some of the other things we've been working on, can it still be waived? And are there -- you know, what's the sort of read on how that might go?

MS. BUDERI: Sure, so I can take both of those questions, Martha. The first question about gas mileage reimbursement, that's definitely used. We did hear from a couple focus group participants who had used that.

From the stakeholder interviews, we also heard that that was being used. A lot of the brokers in the states in managed care, whoever's administering the benefit, a lot of times they will use mileage reimbursement, especially in rural areas where there's not a lot of transportation options, as you said.

There are some challenges. I think it just depends on whoever's administering it. For example, one state we talked to said that they have really a small number of people doing that because of the lengthy forms and approval process it takes to get through the approval for mileage reimbursement. So I think it's definitely a great tool that's being used. I think sometimes there are burdensome application processes. And I know we heard from one focus group participant who ran into some of those

issues.

So we can definitely highlight that in the report and use that as an example.

COMMISSIONER CARTER: That would be great.

MS. BUDERI: Yeah. And to answer your second question about whether it can still be waived, it's under Section 1902, which generally means that it can be waived, although, you know, with this administration, this new administration, I'm not sure of their willingness to continue doing that.

MR. PERVIN: And I would also just like to add, we did include mileage reimbursement within the T-MSIS analysis. We generally put it on the spending side and decided not include it on use just because there was a lot of state variation in that. But we can also change how that's reported within the chapter, depending on whether or not you want to see that specifically as NEMT use or just on the spending side.

COMMISSIONER CARTER: I think it's an important -- well, in my area it's definitely an important aspect of NEMT services. So to the extent that you can bring it out, I think it would be helpful.

VICE CHAIR MILLIGAN: Thank you. I have Tom, Sheldon, Fred, and, Tricia, I did see your hand earlier as well. Tom?

COMMISSIONER BARKER: Thank you, Chuck, and, Aaron, Kacey, and Mike, thank you very much for your presentation. Mike, as Martha said, I think it's great that you talked to beneficiaries as well. I think their perspective was really important, so thank you for that.

I had the same question that Martha did about waivers, and I just maybe wanted to follow up a little bit. My understanding -- and maybe I'm wrong about this, but my understanding was that the whole reason that Congress made it a mandatory benefit in the year-end package was because there had been some suggestion early on in the Trump administration that CMS was going to make it easier for states to waive the benefit even by allowing states to just do a SPA rather than having to go through the 1115 waiver process.

So I'd be curious if the data exists -- maybe it doesn't, but if it does, I would be interested in getting a sense as to how many states were waiving the benefit prior to -- well, the benefit's not yet in effect, or if it is,

it's only been in effect for a couple of weeks, but how many states had waived the benefit, and I'm using waiver not just from the 1115 sense but also if a state was able to just do a SPA that said that they weren't going to cover NEMT. I'd just be curious to know what those numbers are. But, Martha, I thought that was a great question, and I'm glad you raised it.

Thank you.

VICE CHAIR MILLIGAN: Thank you.

MS. BUDERI: So -- oh, sorry.

VICE CHAIR MILLIGAN: No. Go ahead, Kacey.

MS. BUDERI: I didn't know if you wanted me to answer that now or if you just meant to put it in the chapter.

COMMISSIONER BARKER: If you know, that would be great, and I would like to see it in the chapter, yes.

MS. BUDERI: Yeah, so it's a couple of states -- there are two that had 1115s. I don't believe any state has been able to do that for a SPA. There are 1115s -- there was an additional state that got one, but then it was part of the Kentucky package that got remanded back to -- yeah, vacated. The approval was vacated.

So I can definitely include that information in the chapter. I think we can acknowledge some of those states have actually been in place for quite a while, including Indiana, that waiver has been in place for quite a number of years now. So we can definitely include that in the chapter.

COMMISSIONER BARKER: Thank you.

VICE CHAIR MILLIGAN: Okay. So let me just run through the list I have right now. Sheldon, then Fred, then Tricia, then Peter, then Brian. Sheldon?

COMMISSIONER RETCHIN: Thanks, Kacey, Aaron. I really appreciated the report, and, Mike, thanks for your presentation as well.

As I read it, I actually almost thought to myself that, well, that maybe there's -- if I was doing a report on non-emergency medical transportation a year ago, I would have said this all makes sense. But then a tsunami hit, you know, with the pandemic, and as the tsunami recedes, I think we're going to have -- I know we're going to have a new water level on using telehealth, and it's hard for me to think about the balance in using NEMT and what I might recommend, and without telehealth they're now almost

inextricably tied. And so finding that balance on when NEMT is necessary, expedient, and medical care versus telehealth would be a really important contribution, I think.

To that end, Kaiser reported on NEMT I think five years ago. Maybe you know, Kacey or Aaron. In their study, they showed that 40 percent of trips were for behavioral disorders, which was far more than the disease graph that you have, although it was for serious mental illness, which is much less of -- more important to know if that other category included less serious mental illness, but still behavioral, which could be conducted with telehealth. So just in terms of that, I was interested in that.

Then a recognition that there are also still 6 percent of Americans who have no access to broadband, balancing that in the NEMT fills that in. So I think discussing this in the report, I don't see how you pull out telehealth anymore. I think they're ham and egg.

MS. BUDERI: We can definitely acknowledge that in the report, and we definitely have some anecdotal and qualitative findings to that end that we could include. We

heard a lot from our stakeholder interviews on that. We also heard -- you know, Mike, I don't know if you want to elaborate on this, but we heard from a couple of beneficiaries that they had tried telehealth, but, you know, I think for the most part they're a little bit wary of it because of either bandwidth issues or just because they have not -- they're not used to it. And, Mike, I don't know if you have anything to add on that, but it doesn't seem that telehealth has completely replaced NEMT rides for beneficiaries, even in the pandemic.

MR. PERRY: Thank you, Kacey.

From the beneficiaries, I think it's going to take a while because, generally, they were negative about their experiences with telehealth. Even on behavioral health issues and their therapists on the screen with them was not a replacement for them. They were glad it was there, but they just couldn't wait to go back in person. They felt that they were missing something as a result.

And then we had the bandwidth issue. We heard it from a number of our rural. They just could not access it, or even they could access it inconsistently. So even if they had thought they could access it, they found out later

they really couldn't, and they missed a lot of appointments.

So it was hit or miss, but generally, the feeling was a frustration with it, that it wasn't quite working well, that they were losing their progress. So it is going to take a while, I think, for this population to full embrace it, if they can.

VICE CHAIR MILLIGAN: So, Fred, you're up.

COMMISSIONER CERISE: Thanks.

And I'm going to follow up on Sheldon's point. I'll start with I think it's a bit of irony that, Mike, you were able to adapt and do your focus group virtually, which is unusual, and have good success with that. One of the outcomes that we talked about was virtual health care services which, as Sheldon said, in the past year, we've gotten, very quickly, very good at it in a number of areas. So I think we really do have to blend that telehealth component into this discussion.

Beyond telehealth, we have to think differently. This is still a very differently. This is still a very provider-centric model. You go pick the person up and you bring them to the provider, and then you bring them back

home. And I'll use the dialysis example. Hemodialysis is a provider-centric driven model that's based on a payment methodology, and there is another method, peritoneal dialysis, that's cheaper and safer and more convenient for patients.

I think for all of these programs, we need to look to see what are we moving people around for and is there a better way to do it that's going to be more convenient for the people that we're trying to serve and not more convenient for the providers.

So I do think telehealth is an important piece to put in here, and I would go a step beyond that and say let's look at what services people are accessing and is there a way that we can help them do that at home.

VICE CHAIR MILLIGAN: Is there any response?

COMMISSIONER CERISE: As fun as the trip in the van might be for most people.

[Laughter.]

MS. BUDERI: I think that's a really important point, and we can include some discussion of that in the chapter.

VICE CHAIR MILLIGAN: Thank you, Kacey.

Tricia?

COMMISSIONER BROOKS: Thanks, Chuck, and thanks, Kacey, Aaron, and Mike, for this.

I have a question and a comment. You indicated in terms of the folks that were part of the focus groups that seven were caretakers for people using NEMT. How many of those were parents of children?

MS. BUDERI: Mike, do you know that off the top of your head?

[No response.]

MS. BUDERI: Mike, I think you're on mute.

MR. PERRY: Yeah, yeah. Sorry.

The bulk, the majority were -- I'll get the count. My colleague is texting me as we're talking, and so she'll tell me the answer, but I think the majority -- okay. She's correcting me. Only one or two were parents.

COMMISSIONER BROOKS: Okay. Thank you.

So that really leads to my comment. I was happy to see in the background of the material that you gave us that you called attention to the fact that states are required to provide transportation to children and their, quote, "families" as part of EPSDT, and this is a sticking

point in a number of states where there's a single parent or a parent who's a caretaker of multiple children, and services are not allowing siblings to accompany the parent when they're taking the other child in.

I just would like to see this, and of course, now the focus group findings don't really tell us about parent experience and wouldn't have pulled that out. So I'd really like for us to think more about how we could gather some information on that but also to lift up.

The way the regulations read, they read differently for caretakers of adults than they do for parents of children who are eligible for EPSDT.

MS. BUDERI: Right.

VICE CHAIR MILLIGAN: Sheldon, did you have a comment on that point, or are you getting back in line again for something else?

COMMISSIONER RETCHIN: Back in line.

VICE CHAIR MILLIGAN: Okay. So I have Peter, then Brian, then Kit.

COMMISSIONER SZILAGYI: Thank you, Chuck, and thanks for a really interesting and important session.

I have a question for Mike and actually maybe the

rest of you and also maybe a suggestion for the chapter.

Mike, that was a really excellent presentation of qualitative results, by the way.

My question has to do with healthy individuals, and this is related to Tricia's point. Particularly, I'm a pediatrician, Mike, for parents and for children. For 30 years, I helped run the largest pediatric practice in Rochester, New York, which took care of very high-risk urban patients. Our patients, for them to come to us, if they didn't have NEMT transportation, they almost always have to take one bus to get downtown, switch, take another bus to get to our practice.

In the winter -- I just looked it up today -- it's 15 degrees in Rochester. They have to bring their other kids because most parents were single parents. So if they didn't have this transportation, many of them didn't come in.

So my question for you -- and if they did have a car, they had to pay parking costs. So we had parking passes. We often paid out of our pocket because we ran out of parking passes for our patients to come in. So there are just so many barriers for low-income parents to bring

healthy children.

My question was, how important did it feel in the focus groups for this service for healthy individuals? My comment about the chapters, there's a lot of emphasis about individuals who are very sick or who have emergent needs, but it feels to me that NEMT is extremely important for healthy individuals who are very low income. And if you just think about the alternatives, I think it kind of becomes obvious in my mind, so both a question and a suggestion for the chapter.

MR. PERRY: I would say that your own experience was played out in these focus groups as well. Even for health individuals, the multiple -- and like you mentioned, multiple buses. So it's not as easy as taking one bus to one location. It was never direct for most of the participants in our study. It was multiple buses, the cost of that, the challenges of that, the time, all of that, the inability to balance employment with doing all of that.

If there were a depression or mental behavior, emotional health issue overlaid over on top of that, all of that became that much harder. So, yes, we heard exactly what you said, which is the difficulty of it prior to these

services was not even making appointment. So it's not even that they miss and not even making appointments and not want to deal with it, and then even when making appointments, not showing up for them, missing them, so yes, we heard that as well, just as important for healthy individuals.

COMMISSIONER SZILAGYI: And two to her very quick comments, we -- thank you for that, Mike. We had a program where we would have medical students and residents go visit our patients, but they couldn't drive. We forced them to take the bus back to their patients' houses, and it was extraordinary how challenging that was for our medical students and residents.

Finally, I was in a leadership position in a Medicaid managed care organization in Upstate New York. There was a rival organization. We focused very strongly on transportation, and we had the sense that making transportation easy through a lot of beneficiaries to our program instead of the other Medicaid managed care program, where transportation was much more challenging.

Thank you.

VICE CHAIR MILLIGAN: Thank you, Peter.

Brian?

COMMISSIONER BURWELL: I have two questions. The first one is to Aaron.

You mentioned in one of your initial slides that the expenditure data excluded managed care. Was that also true for the utilization data, or were you able to use managed care utilization data? And if you were -- had difficulty using managed care encounter data, did that skew your results for the fee-for-service population?

MR. PERVIN: So we actually did have encounter data for managed care, and that's included in our calculations.

What we did not do when we calculated spending was just include those managed care payments to the NEMT providers because we didn't want to allow for some double counting in spending.

But I guess your larger question, yes, all these analyses do include encounter data.

COMMISSIONER BURWELL: Thanks.

Mike, you mentioned some of the barriers to using Uber and Lyft for your focus group participants, and you focus primarily on their technical ability to use -- to

order those rides. Were there other limitations or barriers in Uber and Lyft for the focus group participants like some states not cover Uber or Lyft? Are they not available in some areas? Was it the technical ability that was the primary barrier?

MR. PERRY: I think all the above, and I think, Kacey, you can probably answer this better than I.

MS. BUDERI: Yes.

MR. PERRY: It wasn't an option in a number of the states we went to, but go ahead, Kacey.

MS. BUDERI: I think for most of the participants, it was not an option for them to use Uber or Lyft for NEMT, although in some cases for some of them, it was kind of a backup method. The state or whoever was administering their benefit, Uber or Lyft was sent if the initial ride was late or if something went wrong.

I think a lot of the participants, when they talked about wanting to use Uber and Lyft, they were referring to their experiences just whenever they're using it normally, like you or I would. They wanted to be able to do the same thing for NEMT, but then some of them, as you mentioned, felt they wouldn't be able to, you know,

because of their technical abilities or their internet access. They wouldn't be able to use it.

But for the most part, I think it wasn't available to them as an option for NEMT for the participants.

COMMISSIONER BURWELL: Sorry to follow up, but is that often a cost issue? I mean, states won't pay for it because it's more expensive than their other options or other reason?

MS. BUDERI: I don't know that it's a cost issue. I think it's a new introduction as a new type of option that more and more states and brokers are adopting. We heard from brokers who we interviewed that they were all looking to adopt greater use of Uber and Lyft and other TNCs, transportation network companies. So I think it's just kind of new to the NEMT space, and it's definitely -- I think the expectation is that it will continue and will be playing an even bigger role in the future. So I think it's just newer.

VICE CHAIR MILLIGAN: And, Brian, I'm going to have an example of a barrier to Uber and Lyft when it gets to my turn.

Kit, and, Kisha, I did see you and added you to the list. Kit?

COMMISSIONER GORTON: So with respect to Uber and Lyft -- and Chuck told you his -- in Massachusetts, Brian, the state didn't allow it? Part of it is that Uber and Lyft have to become state Medicaid providers in order to get paid, and in Massachusetts, as you know very well, Brian, there's a big furor about Uber and Lyft competing with the medallion taxis. And I think that's true in other urban centers as well. So the taxi drivers put great pressure on the state not to allow Uber and Lyft to be used in the Medicaid program.

I think, to Kacey's point, eventually, it will wear down, but I do think there are other factors in letting people have access to that.

Getting to the observation and then the question that I have for Aaron, so my observation, which I think I made before, is in the years that I ran Medicaid MCOs in various states, the number one cause of complaints among beneficiaries was about transportation. So it's not only an irritant to members and providers. The plans spend a whole lot of time on it, and it's hard. And there are no

easy fixes, and particularly the biggest of the vendors has a predominant position in many places, and so there's market issues at play there as well.

So my question for Aaron, question/suggestion, is it seemed to me from the data -- and if I'm saying this wrong, if I'm interpreting this wrong, tell me, but it seemed to me from the data, such as the stuff you did on ride days among select diagnoses on Slide 13, that there are holes in the data, as there always are, and gaps. And you did what seemed to me to be heroic work to try and fill them in, but what you came up with was an incomplete picture.

If for ESRD, the ride days are 70 per year, if you're on dialysis three days a week, that's not 70 ride days. That's more than that. So either people are filling in with other sources, or as Fred said, there's a good number of people who are using peritoneal dialysis so they don't have to go to dialysis three days a week or two days a week.

But I think we're going to have to be more crisp and precise in talking about where the data issues are because this is how a mandatory benefit -- and people --

you know, people like Tricia and others who are watching the performance of the program very closely, they're going to want to know is this working right or is it not.

So I think -- and you tell me if I'm wrong -- that the current state of the data is far less than perfect, and so to the extent -- here's my suggestion. In the report, that we can actually have on other topics, point out to CMS or the states or whomever where are the ways that they need to shore up the data here. Then it strikes me that that's important guidance to them going forward.

VICE CHAIR MILLIGAN: Anne, did you want to comment on this point?

EXECUTIVE DIRECTOR SCHWARTZ: Data issues are always an issue, but I also just want to draw the distinction between what we see in T-MSIS and what states may be using for program management and contractor management.

Our purpose here is to show a national picture. Some day we hope to be able to show state variation, but these aren't the data that states are going to be relying on to manage their day-to-day operations.

COMMISSIONER GORTON: Thank you.

VICE CHAIR MILLIGAN: We're almost at time. I've got Kisha, then Sheldon. Then I had a little bit. We might run a couple minutes over.

Checking with Melanie. We're good with that, running a couple minutes over?

[No response.]

VICE CHAIR MILLIGAN: Okay. Kisha.

COMMISSIONER DAVIS: Thanks, Chuck, and I'll make my comments brief. It's more of a comment than a question, anyway. A theme that we kind of keep coming around to at MACPAC yesterday and today is around this kind of where health care dollars are spent or where the best dollar in health is spent, and that that best investment in health isn't always in health care. And I think this really emphasizes that a lot. So how are we shoring up our transportation system so that we are helping patients be able to access care in ways that are validating, keep them independent, shoring up mental health, and giving them the independence and the flexibility to manage their own care? And investing in transportation networks and Uber and Lyft and taxis and all of those things for people really support

their independence.

I also want to go back to something Fred was saying about bringing care to people, and while it's really great to be -- you know, we want folks to be able to have their independents and get out, there are some of these services that we can bring to patients.

I'm a doc that did house calls up until last year, and I think that there are still a few of us out there who do those and able to do that, especially when you're looking at that mom who has to drive all of her kids across town because there is no babysitter for the doc to be able to come and do a home visit that is often much less invasive for the mom and the families both, thinking about ways that we are integrating care delivery so that we can bring things to the patient when that makes sense.

VICE CHAIR MILLIGAN: Great. Thank you, Kisha. Sheldon?

COMMISSIONER RETCHIN: I yield my minutes back to my colleague from New Mexico.

VICE CHAIR MILLIGAN: That would be me. So I had three -- I was going to ask three questions, and maybe I'll turn them into three comments for you all to take offline

and see what you can do.

One comment is, Aaron, on your Slide 15 you kind of talk about where people were transported. One of the services I didn't see reflected here was the pharmacy, and I would like to know if that data is available, and if it is, if it could be extracted. Because I think one of the elements I've seen is the importance of somebody getting to get their prescription. Mail order isn't always possible. Delivery isn't always possible. So I wanted just to flag that for you as a service that I expected to see here. I didn't.

The second comment I wanted to make, to go back to Brian and Uber and Lyft, in New Mexico, Uber and Lyft would be required to get a completely different kind of license from the entity that authorizes transportation vendors. It's sort of the, you know, like New Mexico's version of a medallion system, if you will. And it required something that was akin to medical transportation, you know, short of an ambulance but including requirements around getting trained in first aid, getting trained in CPR. The drivers had to do these other things.

I'm curious to the extent we can find this

information in time for the June report, whether these different forms of transportation are subject to different forms of licensure standards, separate from the Medicaid provider enrollment piece, because that criteria became an entry barrier, that Uber and Lyft and their drivers weren't going to go do that stuff.

And the final comment I wanted to make is really around dual eligibles and maybe helps us segue into the next agenda item. I had a lot of conversations with CMS a few years back about whether Medicaid transportation was permitted to go to a Medicare service for dual, like to a doctor's appointment, because my read of the rules was Medicaid transportation was to get to a Medicaid service. And I went round and round with a lot of the leadership at CMCS at the time. It seems, from the fact that ESRD was such a prominent part of this, and so many people with ESRD are duals, that maybe this issue has been resolved and maybe Medicaid NEMT is overtly permissible to get to a Medicare-covered service. And if so, I would like to reflect that, because I think that was an area where Cindy Mann didn't know the answer to that question when I put it to her a few years back. So I just want to see if we can

be explicit about that in this report.

That's all I had. Kacey and Aaron, you've gotten a lot of great feed. Does it feel manageable to you, and do you have any questions for us before I hand it back to Melanie to close us out?

MS. BUDERI: It definitely feels manageable to me. I really appreciate all of your thoughtful feedback, and we can definitely make sure all of this gets put in the chapter, highlighted in the chapter. So thank you. Aaron, any questions?

MR. PERVIN: No. I think these are clear. Thanks.

VICE CHAIR MILLIGAN: And Mike, thank you very much for your work on our behalf and your excellent presentation, as Peter noted. So thank you.

Melanie, handing it back over to you.

CHAIR BELLA: Wonderful. We are going to transition into the next session -- thank you all -- which is about duals, integration of care for duals, continuing on that theme. We have some new analysis, and the purpose of this discussion is to get an update on the new work and gauge our continued interest in this subject. And then it

could come back to us in March for potential recommendations in June. Again, this is separate from what we discussed yesterday, which is much more forward thinking, sort of longer term. But with that I will turn it over to Kirstin and Ashley, and I'll say welcome, Ashley. I think that this might be your inaugural presentation to the group, so welcome.

INTEGRATION OF CARE FOR DUALLY ELIGIBLE BENEFICIARIES: NEW ANALYSES

* MS. SEMANSKEE: Thank you, Melanie, and good afternoon, Commissioners. Kirstin and I are going to talk about the results from recent analytic work on integrating care for dually eligible beneficiaries.

Today we'll be discussing findings from two contracts, the first on the role of Medicare agents and brokers and the second on state opportunities to maximize their contracts with Medicare Advantage, dually eligible special needs plans, D-SNPs, to better integrate care. We want to thank the teams at Health Management Associates and Mathematica for their work on these analyses. We hope to get feedback from Commissioners on policy options that could lead to recommendations in the June report.

We'll start by discussing the findings from our work on Medicare agents and brokers. As D-SNPs have become more common in recent years, many health plans have contracted with independent Medicare agents and brokers to increase their business. However, there is concern that Medicare agents and brokers may steer dually eligible individuals away from integrated plans like Medicare-Medicaid plans, MMPs, and toward non-integrated products like D-SNP lookalikes. This is in part because Medicare agents and brokers are not permitted to sell MMPs in most states and are not compensated for enrollments. This is especially concerning in states like California, where lookalikes have grown rapidly.

We contracted with Health Management Associates to examine the role of Medicare agents and brokers in enrolling dually eligible beneficiaries into different products. For this project, they interviewed stakeholders in seven states, including Medicare agents and brokers, Medicaid enrollment brokers, Medicare Advantage plans, and federal and state officials.

There were three key findings from this work. First, we found that Medicare agents and brokers are

increasingly interested in marketing and selling D-SNPs. Unlike other Medicare beneficiaries, dually eligible individuals can change their health plans once a quarter, and brokers benefit from being able to market to them year-round. As interest in D-SNPs has risen, broker training on integrated products has improved.

Second, we found that views were mixed on the value added by Medicare agents and brokers. Medicare Advantage plans told us that agents and brokers do a good job educating beneficiaries about both their integrated and non-integrated options. Further, we heard a more mixed reaction from beneficiary advocates and federal officials. On one hand, advocates acknowledged that brokers are a trusted resource for dually eligible individuals because they often live in the same community and speak the same language.

On the other hand, they were concerned that Medicare agents and brokers are not impartial advisors and may market certain products without respect to the level of integration. This was because agents and brokers are paid directly by the Medicare Advantage plans they contract with.

Medicare Advantage plans and federal officials, however, believe that existing regulation and broker compensation structures are sufficient to discourage inappropriate behavior.

Third, we found that dually eligible beneficiaries often lack access to an impartial source of information on all the coverage options available to them. Information comes from a number of different sources but is not typically coordinated.

Dually eligible individuals receive information on their coverage options from three different sources. Medicaid enrollment brokers who work under contract to the states help Medicaid beneficiaries who are newly eligible for Medicare and educate them on Medicare-Medicaid plans, MMPs, but do not discuss other integrated options available, including D-SNPs, HIDE-SNPs, and FIDE-SNPs. Medicare agents and brokers may interact with the very same beneficiaries to discuss their Medicare options but have minimal coordination with Medicaid enrollment brokers around integrated options, and do not sell MMPs in most cases.

State health insurance assistance programs, known

as SHIPs, can help educate beneficiaries on all of their options but they have limited reach. SHIPs offer free benefits counseling to Medicare beneficiaries but rely on small staffs and volunteers, and would likely need additional funding and training to take on a greater role in assisting all dually eligible beneficiaries.

We went into this project wanting to get a clear idea about whether Medicare agents and brokers are creating barriers to enrollment in integrated plans but we did not get a definitive answer. However, this analysis showed that dually eligible beneficiaries often lack access to an independent advisor that can educate them on all of their integrated coverage options. While advocates suggested that SHIP counselors could help fill this gap, their limited resources and training would make it difficult to support the whole dually eligible population.

Future work in this area could explore whether there are ways to increase coordination between Medicare agents and brokers and Medicaid enrollment brokers in hopes that this could improve beneficiary understanding of their integrated coverage options and enrollment into integrated plans.

Now I'll turn it over to Kirstin to discuss findings from our work on D-SNP contracting.

* MS. BLOM: Thank you, Ashley. Good afternoon, everyone. I'm going to walk through our work on the other contract, which was looking at opportunities for states to use contracting authority that they already have under current law to promote integration of care through D-SNPs. We'll go over key findings and some opportunities for policy changes that we identified.

Before we get to the analysis I wanted to do a quick review of current law authority. States have authorities to contract with D-SNPs under MIPPA, as you all know, but they also can go beyond those minimum requirements. D-SNPs must at least coordinate Medicaid benefits. They must have a contract with the state. But there are a number of other options that states can use to go beyond sort of that starting point.

And just for a little bit of context, in 2020, 42 states were contracted with D-SNPs but fewer than 10 states were using a number of contracting strategies that are available.

As Ashley said, we contracted with Mathematica to

look at opportunities for states to promote enrollments in integrated care by maximizing the authorities that they have currently to work with D-SNPs. Mathematica interviewed stakeholders in five states, in talking to federal and state officials, health plan representatives, and beneficiary advocates, and they focused on 10 specific contracting strategies, which we split into two groups, based on which states could use them.

There are strategies that all states can use and strategies that are only relevant really to states that already enroll the dually eligible population in Medicaid managed care. These are the strategies that all states can use. There is a lot of information here. I'm just sort of putting this in here for you guys to refer back to if you need to during this presentation, but I'm not going to go through all of these. And the second column, just as a note, is just example states. That's not meant to be a comprehensive list.

So these strategies, again, all states can use. The strategies on this slide are most usable or doable in states that have Medicaid managed care for duals, and that's because they involve coordination between the

person's Medicaid managed care plan and the D-SNP.

We identified a number of changes in state policy for Commissioners to consider, some of which you'll see here. These are changes that states could make in their contracts with D-SNPs to take fuller advantage of the authorities that are available under MIPPA today. Sometimes the change we're going to talk about here is just to adopt one of the strategies that were listed on a couple of slides previously, and sometimes the change is more about making it easier to adopt one of those strategies.

For example, states interested in restricting D-SNP enrollment to full benefit dually eligible beneficiaries, which is Strategy Number 1 on Slide 13, but who are concerned about disrupting care for the partial benefit population that might also be enrolled in that D-SNP, could instead require D-SNPs to enroll the two groups into separate plan benefit packages. Each plan benefit package within a D-SNP contract has its own set of covered benefits, cost-sharing structure, et cetera. A single contract can contain multiple plan benefit packages and they may operate in a single state or in multiple states.

So when a state requires a D-SNP to use separate

plan benefit packages to enroll the full or partial populations, both populations would then be enrolled through the same parent company but effectively in a different plan from an administrative perspective. D-SNPs can design separate enrollee materials for each of those, and this allows some of the same levels of simplification of enroll materials that limiting enrollment to just full benefit duals would, while, of course, avoiding a potential disruption in coverage, that there is a concern about for the partial dual population.

In addition, one interviewee suggested that to make the process of using separate plan benefit packages easier, CMS could allow D-SNPs to crosswalk current enrollees into the plan benefit package that's most appropriate for them rather than having those individuals disenroll and then manually reenroll in the new plan benefit package to avoid a disruption for them. This is not something that's allowed under current law.

Another option, the second one on this slide, is to require D-SNPs to submit any Medicaid information in their marketing materials or otherwise for other communications with enrollees for the states to review it.

This way, states could ensure that the information is clear and accurate for the beneficiaries. Another option is that states could develop template language for the Medicaid coverage portion that D-SNPs could use in their contracts.

And also states could require D-SNPs to use specific or enhanced care coordination methods. When plans are developing their models of care, which all MA plans must have, states could require that they incorporate specific care coordination provisions, such as requiring D-SNPs to specify how they'll train general coordinators to help beneficiaries coordinate delivery of LTSS. And states could also require the D-SNPs to submit the models of care for state review.

And then sort of as an aside, two interviewees also suggested that states could work to provide their data to D-SNPs in a more timely manner, including eligibility information and other data on where D-SNP enrollees are enrolled for their Medicaid benefits, to help D-SNPs coordinate their coverage.

So states could allow or require D-SNPs to default enroll Medicaid beneficiaries who are new to dual status into the D-SNP that's going to be affiliated with

their Medicaid managed care plan, provided that the individual retains that Medicaid eligibility after dual status. Of the strategies that we looked at and that we're talking about today, this is the one that offers the greatest potential to increase enrollment in integrated care. It works best when a state has both dually eligible beneficiaries and individuals who will become dually eligible enrolled in Medicaid managed care. States must also have D-SNPs that are operated by the same parent company as the Medicaid managed care plan.

And then we also heard from interviewees that it would be good if states could minimize benefit carve-outs, and this was something we've talked about before, and we understand this is not an easy lift. But obviously benefit carve-outs do limit the potential for integration and they do limit the D-SNP's role in managing Medicaid benefits for that individual. So the interviewees that we spoke with talked about the idea of minimizing the carve-outs rather than eliminating them, as a way of sort of taking a step in that direction.

And then finally, on this slide, CMS could encourage states to align their managed care open

enrollment periods with Medicare. This is also something we've talked about before. This actually came out of a discussion with stakeholders around aligning procurement policies, which is one of the strategies available under MIPPA, but we didn't include that here because we heard a lot of concern around the feasibility of doing that. So this was sort of run up as an alternative to that. This is something that if Commissioners are interested in we'd have to do a little more digging on to see how many states might be affected by this and where it could be used.

Okay. So then these are switching a little bit over to Medicare policy changes. Obviously, the Commission can't make recommendations on these but we can comment on them, so we wanted to flag them for Commissioner discussions since we heard about them in our interviews.

We heard from one interviewee in particular that CMS could require eligible beneficiaries to enroll in D-SNPs or prohibit them from enrolling in other non-integrated plans, like regular MA plans. This would promote enrollment in integrated options and reduce the number of options that beneficiaries have to choose from. Because they pointed out that while selective contracting

can limit the number of D-SNPs in a state, it does not change the number of non-integrated plans that are operating out there or the number of choices for beneficiaries in cases where those choices might be overwhelming.

We heard from people we talked with that the number of options has become something that might be detrimental to beneficiaries actually because they're really not able to compare all the available plans and meaningfully differentiate between them. I think we heard yesterday about one area in California that had like 90 options, and nobody is going to be able to compare all of those and make an informed choice.

And then another topic that came up in these interviews, that we also sort of touched on yesterday, was related to contracting in rural areas and the issue of network adequacy. We heard concerns from states and health plan representatives around CMS's network adequacy requirements, who noted that although they have made recent changes, we are not sure what the impacts of those are going to look like, but that rural areas are dealing with a different set of circumstances, including fewer providers

and fewer dually eligible beneficiaries, in many cases. One state in particular asked about the potential for a waiver of Medicare network adequacy requirements from CMS in areas with too few providers. They talked about this in the context of a waiver they got from their states, in a couple of counties that had sort of limited providers, and they were wondering if that would be something that could be done for them on the Medicare side.

So in terms of next steps, what we're hoping is that today Commissioners will use the discussion time to identify any of these changes we've talked about that are of interest to you, and then we would go back and develop those into draft recommendations. We would then bring those draft recommendations to the March meeting for discussion, and then depending on how that goes, we would bring the recommendations to the April meeting for a vote.

So that concludes our presentation. We're happy to take any questions. I know that was a lot of information, a lot of detail, so happy to answer any questions. Thank you.

CHAIR BELLA: Thank you both.

For Commissioners who don't live and breathe dual

eligible issues, I know there is a lot here. I always find it kind of helpful to think of things on a continuum, so a continuum of integration starting with fee-for-service, building our way up through different acronyms, D-SNPs, FIDE-SNP, HIDE-SNP, MMPs, you've heard thrown out to you.

Also, some of the policy considerations that have been raised have to do with different contracting strategies, and just going from more or less in terms of requiring the plan to be doing the same thing in the same geographic area for the same population, if we had a Venn diagram, some of these would start out this plan can serve anybody, this plan can only coordinate, this plan can only be in Medicare if it's also in Medicaid, this plan can only serve the same people in Medicare and Medicaid. I'm not sure that's making a lot of sense, but there is a relationship here, depending on how much we want to sort of push the whole integration. And the challenge with it, the tradeoff with some of that is it displaces people who are in current plans, and it just changes the environment. We meet our goal of integration, but we end up in some situations where plans are no longer able to operate in certain markets because they don't have a Medicaid contract

or because they don't have the same service area.

I just want people to understand there is a relationship here, and perhaps if it's helpful, we could also, Kirstin, sort of show some of that in the text as we work on this to understand that the more you go sort of this way, you get more people in a fully integrated product, but you also have some other after effects. I'm probably just making that worse the more I talk.

Why don't we open it up and see where people's heads are and what might be of interest? Stacey?

COMMISSIONER LAMPKIN: Thanks, and thanks, Kirstin.

I have a technical question and then a broader, more substantive question. My technical question, I think, goes back to one of the opportunities for changes made from Slide 15, where you were talking about restricting the SNP enrollment to just full-benefit duals versus not and kind of the disruptive situation that could occur for partial duals if they're already enrolled in a D-SNP.

So other than disruption, continuity of coverage, what other advantages are there for partial duals in being enrolled in a D-SNP versus a regular MA plan? Could you

highlight those?

And then my second, more substantive question is, can you remind us of some of the major barriers that have kept more states from using some of these contracting strategies that we see just a handful of states using?

MS. BLOM: So I think the advantages to the partial duals are limited. I think there's concern that there are some other benefits on the Medicare side, especially, that might be helpful to partial duals, that they might lose if they move to a different plan.

I think it's more about the detriment to integration that might occur with partials being in a plan where they are not going to have anything to integrate. So there's this idea that it sort of dilutes the integration of it. That's possible under that plan because you'll have to have sort of separate -- you'll have a model of care that isn't specific to a group that can have a fully integrated option.

In terms of the major barriers, I think one thing we've heard is around Medicare expertise. I think there's a sense that states don't sort of know where to start on some of these topics. There's technical assistance

available through the Integrated Care Resource Center, but I don't know that all states are necessarily taking advantage of that.

Then, of course, there's competing priorities or things obviously going on with COVID and other things, but I think that the main thing we've heard is around the Medicare expertise.

CHAIR BELLA: Yeah. I think, Chuck, I'll get to you.

I want to just say I think it's a really important point because -- Kirstin and Ashley can correct me if this is wrong, but most of these things, states, if not all of them, can be doing today. There are many things in this world that Congress needs to change, but most of these things, the state could be doing.

So for me, it goes back to our recommendation from last year, which was to support states and their ability to build capacity and expertise. One thing we might consider is if we like some of these things, we see that they're working in certain states and certain circumstances, we could reinforce the need to give assistance to states, and we could say for a certain type,

for a list of activities, including default enrollment or selective contracting or whatever it might be that we're interested in, if we wanted to give more definition around assistance but reinforce that need that there is still a great need to support the states.

Chuck?

VICE CHAIR MILLIGAN: Thank you.

So I want to disagree a little bit with Kirstin. Apologies to disagree a little bit about the response to the partial-dual question, Stacey, and then I've got some other things I want to mention.

There are partial duals that would meet a nursing facility level of care if they were assessed and were identified as having functional ADL-type limitations, and there are Medicaid eligibility pathways at higher income levels if you are a nursing facility level of care in terms of 300 percent of SSI and some of those components.

In other words, there are people who are partial duals who, if identified and assessed, would have a pathway into becoming full Medicaid beneficiaries in a different eligibility category in Medicaid that is at a higher income level and is dependent on nursing facility level of care.

So I think one of the things having operated a D-SNP in New Mexico, we identified individuals as partials that we then helped obtain full Medicaid benefits for because they qualified under that kind of HCBS waiver-type eligibility income level, if they had that nursing facility level of care. So I wouldn't want to omit that people move in and out of partial- and full-dual status in those kinds of ways.

There's a couple of other things I wanted to comment on. One is I wanted to make a couple of points about the agent and broker piece. One of the benefits that I've seen with agents and brokers -- and I don't think it fully came out in the conversations that happened -- is agents and brokers don't get a commission if the individual doesn't stay with the D-SNP for 90 days. I mean, there's a retention component to earning the commission, and during that period of time, often the D-SNP member will call the agent or broker if they're having issues. They didn't get their ID card or they're having trouble getting a doctor's appointment or something.

The D-SNPs in any Medicare Advantage plan are supposed to service their members, have support call

centers, all of that, but agents and brokers also were very helpful in that early onboarding servicing component, partly because their commission was dependent on that retention. That work and then the referrals they would make into the plans to resolve issues helped create stickiness that, I think, was important.

The other agent and broker comment I wanted to make is more philosophical, and I want to build this with one other point. And then I'll stop. I believe in integration. I've said that with this group many times. I believe it's the best model for dual eligibles to be in the same plan, aligned incentives, single plan of care, good coordination between Medicare and Medicaid services. I believe in integration.

Having said that, I don't think we should make a value judgment or be pejorative if an agent or broker is placing somebody in a non-D-SNP that, in fact, is better for them, because a lot of D-SNPs are only three or three and a half star plans compared to other non-D-SNP Medicare Advantage options in those markets that are four, four and a half, or potentially five-star plans. Those higher star-rated plans often by how Medicare finances Medicare

Advantage, those plans often then have $60 to $80 per member per month in additional supplemental benefits that they offer those members, including vision benefits, dental benefits, over-the-counter drug benefits, meals benefits, et cetera, et cetera.

So if there's a factual statement that an agent and broker is potentially placing a dual in a non-integrated Medicare Advantage plan, I think it's a mistake to assume that that is a negative outcome for that dual-eligible individual if they end up getting a tremendous amount of additional benefits that they would not get in a poor-quality, lower star-rated D-SNP.

Then the final comment I wanted to make -- and this, I think, Kirstin, gets more directly to kind of where our work might be going -- one of the things I see as a value in leveraging the MIPPA or the SMAC, depending on the acronym you like, for that contract between the D-SNP and the state is how in a model in which a member is in a D-SNP with one company and a Medicare MCO for a different company, how that MIPPA agreement imposes more care coordination obligations that go beyond the CMS integration rule.

And by that, I mean not just information about admissions, discharges, and transfers, but case conferences, IDT, interdisciplinary teams, a single HRA, passing information on HRAs back and forth, warm handoffs from call centers if somebody calls the D-SNP line, but it's a Medicaid question or the other direction. There are lots of tactical operational ways of imposing coordination of care, which isn't integration, but coordination if somebody is enrolled in one organization for D-SNP and a separate organization for Medicaid and how they can be obligated to work together in care planning, care coordination, dealing with high-risk members through case conferences. There are those elements to build out care coordination, and that, I think, would advance some of the discussions around how to leverage those MIPPA or SMAC agreements.

So I'll stop there. I took more than my fair share of time. Thank you.

CHAIR BELLA: Thank you, Chuck.

Brian, and then, Darin, I think I saw your hand.

COMMISSIONER BURWELL: Thanks, Melanie.

I have three comments and I guess one suggestion.

One, I thought that your table, Kirstin, of different D-SNP contracting options was really good, but I think even for the person who is not probably immersed in duals, it's a lot to kind of take in and kind of know the variations. I thought that table would be helped by specific examples of how those D-SNP contracting strategies have been executed in some of the states that have taken that strategy. Just on a ground level, Arizona did blah-blah-blah. Something like that would go a long ways to help people understand the implications of the different options.

Secondly, as we develop -- I know you've been talking to a large number of stakeholders, but as we develop recommendations that we may want to include in our June report, I would recommend continuing conversations with stakeholders, particularly the big ones, NGA, NAMD, et cetera, just to give them an opportunity to have early input into how we're moving in this area to promote integrated care models, so between now and June.

My third comment is I have a specific recommendation that I want to lay out there. I'm not sure if it's feasible, but one idea I had was as there are a number of states, as we know, that have MLTSS programs and

there may be a number of states that are now considering shifting their LTSS system from fee-for-service to managed care, I was wondering if a requirement of their filing for renewal of their existing program, which is usually 1115 or a (b)(c) combo, they would have to include a component in the application that lays out their intention to promote enrollment in integrated care models as part of their resubmission or renewal of their waiver.

It could include a requirement of how many of your MLTSS enrollees are in Medicare products, either aligned or unaligned. It would just produce a lot more information about the current state of the world and to how many people are actually in integrated products.

That would apply to states that want to move to MLTSS too as part of their 1115 or (b)(c) combo application, that they would have to include a section on how they intend to promote enrollment in integrated care models.

It wouldn't say that you have to. They could say we're not going to do anything. People could enroll whatever they want. That way, it could be in line with local market conditions, if there are not D-SNPs in all the

areas where the state has MLTSS, things like that. They could accommodate what they intend to do with the local Medicare market.

So I just thought that was a good idea that we could use to further promote integrated models.

CHAIR BELLA: Thank you, Brian.

Darin?

COMMISSIONER GORDON: Yeah. Kirstin and Ashley, thank you for this.

I think the thing that I continue to wrestle with -- and I don't really have a great answer for -- when I think about the state policy options that you laid out here, you acknowledge -- and these are things that some states are doing. These are available to states today. There's a hurdle there. In some cases, it may be that they don't believe that the effort is going to benefit in the long run, so they may just not move. In other cases, my sense is that it is the lack of Medicare expertise and knowledge and understanding of how to effectuate some of these policies. That's always a difficult thing.

So you have policy levers available to you, and there's different reasons why you don't choose to do them.

But some of them are having a sufficient knowledge base and bandwidth, quite frankly, to do something here. I just don't have a good answer on how.

I know that we've talked about some of that in our prior meetings about match for folks with that kind of expertise.

I think the ones that are really truly kind of true stretches here are your opportunities for changes in the Medicare policy side, which I'll comment on the network one first, network adequacy.

We've seen that, and we've discussed that in prior meetings. When you think of Medicare network adequacy, it's not thinking about the transportation benefit, which is available to us in Medicaid. So we're failing to recognize that when we think about this in an integrated fashion, Medicaid is bringing a different service to the table that would allow you to think about network adequacy differently. I think there's really true practical benefits from that, and I've experienced that personally.

CMS requiring eligible beneficiaries to enroll in D-SNPs, that, I think, is the most ambitious thing that we

have out here as far as considerations.

And I think going back to my earlier comment about why some states have or haven't pursued this, if it is because they don't believe in the value that integration is truly going to matter in the end, then something like this would be problematic for them. And without knowing that, I feel that as much as I think there's tremendous benefit with that type of policy recommendation, because I do believe in integration, the value of integration, I do think that's something we have to better understand before we could get to a recommendation.

Thank you.

CHAIR BELLA: Thank you, Darin.

Kit?

COMMISSIONER GORTON: So I want to follow up on Chuck's point about using a non-integrated approach isn't necessarily a bad choice. A choice is only choice if it's a choice. And so people get to make them that make sense to them.

I want to take us back an hour to Liz in the IDD conversation talking about how her friends are afraid of managed care because they don't understand it. And I have

said this before and I'll say it again. I don't think we as the policy community and sometimes state executives and federal executives who have been responsible for operationalizing these policy objectives. And I believe in integrated care. It's better care. But I don't think we've sold it very well, and I don't think people understand it, and I think people find it scary.

What I will say from personal experience in a Financial Alignment Initiative, these people who find themselves unbeknownst to them auto-assigned to a managed care program who didn't want to be in a managed care program, who don't understand a managed care program, the first thing they do is opt out because they feel victimized. And so I think we have a lot more work to do to convince providers -- and that's the other group of people we have not convinced -- as well as beneficiaries that it is in their interest to choose this, and if it is offered to them, they should think about accepting it.

So I think we should -- you know, we've said this to CMS before and said it to the states, but -- and I don't know that MACPAC necessarily has a role, but I think we at least have to acknowledge that an awful lot of

beneficiaries out there don't understand why we think this is better for them. And whether we need plain language reports for people with IDD, whether we need more focus groups, whether there needs to be -- if you look at the kind -- if you look at what happened to the ACA enrollment when the advertising and community outreach stopped -- right? -- and the enrollment dropped. That's for people with a lot less complex care than many of these duals.

So I do think that there's a level of investment that has to go into helping people understand that these are better choices. And then I think there's -- I think we owe everybody transparency and a level of humility. Some of these programs are pretty new, and a lot of them are fairly rough around the edges, right? So as Chuck pointed out, some of these integrated programs have pretty mediocre star ratings. They don't do all that great a job yet.

And so I do think that we need to be honest about where we are in the state of transition here. We need to be open about the fact that these are not alternatives in many communities where many duals live. And we need to be respectful of that dual and the people supporting them in the decision might choose another option because they don't

understand why the option that we think they should choose is a better choice.

CHAIR BELLA: So, Kit, I want to respond to one thing because I think the notion of who opts out is a little overgeneralized in what you just said. In some of the demonstration states like Ohio, their retention rate was very high, and it has to do with those -- the way -- the sequencing of the passive enrollment and adding the Medicare when somebody already had a relationship on the Medicaid side, similar to how we see in default enrollment. If I remember correctly, default enrollment in Tennessee and Arizona, you don't get many people opting out because they have -- there's a relationship there, right? And so I don't -- I think that we can't just say that all passive enrollment results in opt-out. I think there are very -- there's a lot of nuance there. And if there's a relationship there, we've seen that there's a much stickier outcome. And that's happened in some of the demos, and it's happened in the default enrollment states.

COMMISSIONER GORTON: Yeah, so I don't disagree with that, but the nuance of that is in the cases of Ohio and Tennessee, the relationship you're talking about is a

mandatory relationship. You know, so that's a little different, right? That's really not choice.

And so the extent that we want to get to a place -- I mean, I think we want people to choose this. That's my point. I'm not picking on auto-assignment. I'm saying people should want to choose this.

CHAIR BELLA: Yeah, but choose it so -- so there's a body of work, and this came up a little bit yesterday, around choice: what choice is, how people make choices, right? That has to do with the agents and brokers conversation. It has to do with providers. And while -- Kit, you know, providers sometimes are just not wanting to deal with managed care. It's not that it's in the beneficiary's best interest to stay out of this product. And so I think we have to look at making sure all the people that we think would benefit from this understand.

You know, if you go talk to providers in -- let's take L.A. that has so many choices. I'm sure the providers don't -- we haven't done a good job of educating them on what these various options are and why it might be good for their patients and them to be in some of these things. And so I just think that there's a whole bucket of work around

choice, and lots of people are looking at this -- the SCAN Foundation, Community Catalyst, the Arnold Foundation. A lot of people are looking at this -- CMS in the evaluations that they do. So there's -- but we do have to tackle that.

So I have a couple other comments, but they're not specific to Kit, so let me go and see who I've missed.

You guys are like, "Quit talking about this. I'm tired of this subject." Well, I'm going to say a couple last things.

One is I do -- back to the relationship thing, Kit, though, they've got -- to me, it speaks to a lot to these what I'll call "contracting options" that we're looking at about do you restrict a D-SNP to somebody that only has a Medicaid managed care plan? Do you restrict or promote people that are exclusively aligned? That has to do with existing relationships or trying to put those relationships together as a plan from the Medicaid and Medicare side. And so I think that would be helpful to think of it with that lens.

And then, lastly, I think we would be remiss not to make another recommendation around state support, and we also -- we've all talked about the disproportionate impact

of COVID on duals and on states, and if anything, this is another opening for us to highlight that and use this -- maybe use a terrible situation as a way to come out better on the other side for this population. And if we wanted to, we could -- the problem is in my mind -- and let me just say this, and then I will be quiet. I see sort of three buckets of states. We have states that are doing nothing today. We have states that have a D-SNP or they have something but they're not using these levers that you guys have pointed out about selective contracting or default enrollment. And then we have states that are kind of maximizing things with FIDE-SNPs and duals demos and PACE and all those things.

It's going to be different -- the policy options that you've laid out seem different for different states. It's hard to say like across the board we should require all states to do selective contracting, because that's not going to help the state that hasn't even gotten a start, right? And states that might be in that middle bucket, that have something but not a lot, then maybe the recommendation there should be you should do default enrollment as a start. I'm just giving examples.

So I think we have to think about it in terms of where states are, and there might be different recommendations. And one of the recommendations might be every state has to have an integration strategy, right? And that starts with like what they have now and where we think they need to build to. And, also, you know, if we wanted to come back to the state support, we could tie it to these kinds of things, including having an integration strategy. And so that we're actually -- if we're saying we want to get them resources, we're now adding a component of some sort of accountability or expected outcome on behalf of the states in return for those resources.

So I will stop there and see if anyone else has any comments.

[No response.]

CHAIR BELLA: Okay. I think we'll go ahead and take public comment -- oh, Brian, did I see your hand? Yes?

COMMISSIONER BURWELL: A quick comment. I just don't think a recommendation to require beneficiaries to enroll in D-SNPs is feasible. It never has been. We've never done that, get CMS or the federal government to

require people to enroll in managed care. So I just -- I don't know if we want to move forward with that, but I just don't think it's a feasible option.

CHAIR BELLA: And I think that was just something they were considering including in the chapter since we couldn't make a recommendation on that because it's Medicare.

MS. BLOM: That's right

CHAIR BELLA: Okay. I am going to turn to the audience now to see if anyone in the audience would like to make a public comment about this or about the NEMT session.

MS. RESPASS: Camille Dobson, I'm enabling your mic. Please unmute yourself to make a comment.

PUBLIC COMMENT

* MS. DOBSON: Thank you again for the work -- sorry. Camille Dobson, Deputy Executive Director of ADvancing States. We represent the AG disability directors that manage long-term services and supports for older adults and people with physical disabilities. Thank you again for your focus on dual eligibles. I don't have much to say today except to reiterate what I've said, I think, in the last three or four sessions about the need for

assistance to states to build the Medicare knowledge and capacity to address these issues. It's the number one barrier that our states who have not moved forward on integration have said is a barrier. And the complexity of the Medicare program, all of the initials, it's something that someone can't just learn on the fly in any -- the states who have done well at it have dedicated resources in their Medicaid agency.

The second is the unbiased information recommendation I think is really important. The fact that in the Medicaid space we have prohibited plans from doing any kind of marketing at all to potential beneficiaries has, I think, led to -- I'm not saying in states the best outcome, but at least the enrollment brokers in those managed care states do provide unbiased options, help people go through their options. It continues to baffle me that for the most vulnerable people we leave them open to all kinds of marketing strategies in general, and the fact that there could be incentives away from integrated care because of the self-interest of brokers and agents. And so I'd love for the Commission to go further and recommend to Medicare that they build an enrollment broker function for

Medicare beneficiaries, all of them or, in particular, dual eligibles, at least to help them get better information. We work collaboratively with the SHIP TA center, and I'm spending most of this year doing technical assistance and training with them on integrated care options to help them be better equipped to provide expertise on integrated care options, but that's a very heavy lift, and you all know that they're underfunded and mostly volunteer. And integrated care training is not required for them to do their job. So I think that would be really helpful and I think encourage the uptake.

In addition to all the things that the states can do, I think they just need help figuring out how to take advantage of those flexibilities.

Thank you.

CHAIR BELLA: Thank you, Camille.

Anyone else who would like to make a public comment?

[No response.]

CHAIR BELLA: Just to add to what Camille said, since we did make our recommendation, there have been new models that have come out that involve duals and the direct

contracting role, which is just one more thing states are going to have to understand. And so I think it just reinforces the need to continue to beat the drum that we need to get resources to help states.

Okay. Kirstin and Ashley, where's your head? What else do you need from us?

MS. BLOM: So I think it sounds like there's some interest in maybe like a recommendation for support for states. We can think about that. And then I don't know if there -- like Camille mentioned, this idea of an impartial adviser, I don't know what level of interest there is in that, but that's something else that we could develop. I definitely -- to Chuck's point from earlier, we are not -- we're trying to capture that nuance of brokers being, you know, trusted community advisers in a lot of cases and not necessarily, you know, acting in bad faith, that an individual might choose something that's not integrated, and they're free to do that. So we'll definitely try to convey that in the chapter. But I guess that's what I'm hearing from you guys. I don't know if there's anything else.

In terms of like the number of things we listed

here, it sort of sounds like the focus is more on state support, and that's fine with us.

CHAIR BELLA: I think it's important to keep talking about the levers that are out there and some levers states are doing. It's just hard to see that -- I don't know what that recommendation looks like, but we recommend states to continue to maximize the levers they have. There's just -- they don't apply uniformly across all the states, so I don't want to leave you thinking there's no interest there. It's just maybe we need to be really creative about how we think about what we're recommending and what we're signaling as important.

Chuck?

VICE CHAIR MILLIGAN: Sorry, yeah, I thought the better of it. Never mind.

CHAIR BELLA: Okay. So, Kirstin, I don't think all the work -- like all the information that's here about what states are doing is really important, and figuring out a way to share that with other states and promote the adoption of it is really important. That's different than like a recommendation to Congress, but I still think it's important for us to have voice. And so if you want to

bring something like that back, I think it's something we could consider.

MS. BLOM: And those are definitely things we'll be -- we can talk about in the chapter rather than put into an actual recommendation. So we'll work on that.

CHAIR BELLA: And Sheldon was kind enough not to raise his hand for some reason, but let's make sure we get the workforce -- or the provider integrated piece and the workforce, alongside the financial integrated piece.

MS. BLOM: Will do.

CHAIR BELLA: Okay. Thank you very much, everyone.

We're going to take a break until 3:15, and when we come back, we're going to talk about high-cost specialty drugs. So thank you. See you in 15 minutes.

* [Recess.]

CHAIR BELLA: Welcome back, everyone. Thank you for being prompt. We are going to go right into the session on high-cost specialty drugs. Chris, I will hand it over to you to lead us through it. Welcome.

PAYMENT AND COVERAGE OF HIGH-COST SPECIALTY DRUGS: REPORT FROM TECHNICAL ADVISORY PANEL

* MR. PARK: Thank you, Melanie. This presentation will summarize findings from our technical advisory panel on high-cost drugs. First I'd like to thank Amy Zettle, even though she's not here today for the presentation, as an integral part of the work. I would also like to take a moment up front to thank Caroline Pearson and her team at NORC for helping us pull together the panel and moderating the discussion.

Last October, we presented the findings from the pipeline analysis and first panel meeting. Today I'll focus primarily on results of the second and third meetings, held in November and December. While many models were considered, the panel ultimately settled on two potential models, a differential rebate for accelerated approval drugs and a new benefit for cell and gene therapies. I will walk you through the key design elements of these models and considerations from various stakeholder perspectives.

In 2019, we held an expert roundtable to help us better understand the unique challenges that high-cost specialty drugs present and how different policy options may be used to help manage utilization and spending for

these products. Many Commissioners thought it would be helpful for us to continue this work and expressed their strong interest in better understanding what drugs were in the pipeline and the specific challenges those drugs may present over the next three to five years.

Our goal for this year is to move beyond just identifying potential models and really dive into the issue and find targeted models that address the specific challenges presented by these drugs. To do this, we convened a technical advisory panel of state and federal officials, legal and drug pricing experts, and stakeholder groups over the course of three meetings. The first meeting was to review the drug pipeline and identify specific types of drugs that present the greatest challenges to Medicaid in the near term. Based on this pipeline analysis, the panel used the second meeting to narrow down the range of possible coverage and payment options to a preferred choice and to consider how such a model should be designed and implemented. In the final meeting we brought in stakeholder groups to refine the design of each model and to get their representative viewpoints on the pros and cons of each model.

In October, we presented the findings from the pipeline analysis and summarized the findings of the first meeting. As a refresher, we reviewed all drugs in clinical trials likely to have the greatest effect on Medicaid over the next three to five years, looking at costs and size of the intended population. After discussing all of the types of drugs in the pipeline, the panel decided to focus on three groups of drugs: cell and gene therapies, drugs receiving accelerated approval, and specialty drugs that are used to treat sensitive populations, such as HIV/AIDS, cancer, or debilitating childhood conditions.

For the next step, participants began to identify potential models that could be used to address the particular challenges of these priority groups. For accelerated approval drugs, the biggest challenge is that these products can be approved based on surrogate endpoints that are reasonably likely to predict a drug's clinical benefit. As a result, these drugs come to market with less clinical evidence than drugs approved in a standard pathway. Additionally, while the FDA requires the manufacturer to continue trials to confirm the drug's efficacy, these trials are often delayed or sometimes not

completed. The panel discussed several potential models but ultimately chose to move forward with a differential rebate, that is a higher statutory rebate for accelerated approval drugs.

Next, for cell and gene therapies, they tend to have extremely high up-front costs. For example, one current therapy is priced at $2.1 million for the course of treatment. Many of these therapies are indicated for conditions that affect a small population, creating uncertainty in the number of individuals seeking treatment in any given year. This combination of uncertainty in utilization and high cost can cause significant budget volatility year to year. In addition to the high up-front costs, states have questions about the certainty of the long-term benefits these therapies are supposed to provide, and the possibility that the benefits could accrue to other payers.

Due to multitude of challenges and potential solutions needed, the participants decided to focus on a new national benefit to cover cell and gene therapies outside of the Medicaid Drug Rebate Program. This would allow for new coverage, payment, or rebate requirements

without disrupting the existing structure of the MDRP.

Finally, states have limited ability to manage drugs for sensitive populations, and as a result have limited negotiating power with manufacturers. There has been a reluctance from state and federal policymakers in limiting access for these products, with some states having laws that explicitly prohibit restrictions on some of these products. While the panel discussed different options, they ultimately decided that the problem with sensitive population drugs remains a challenge due to strong political pressures to preserve beneficiary access to the products, and didn't think a new model would be particularly helpful at this time.

To summarize, the two models that participants felt most strongly about were differential rebates for accelerated approval drugs and developing a new national drug benefit for cell and gene therapies. For each of these models, we asked the participants to think about how these models should be designed and implemented around certain design elements. These elements are shown here, and I will walk through them as I describe each model over the next few slides.

For the differential rebate for accelerated approval drugs, the panel ultimately decided that the rebate could apply to accelerated approval drugs to reduce what Medicaid programs pay for these products while there is limited clinical evidence of the effectiveness, and to create a financial incentive for manufacturers to complete confirmatory trials. This additional rebate could be added through a statutory change to the MDRP.

Some participants also suggested that the inflationary rebate could be increased if confirmatory trials are not completed after a set number of years. They thought this would create additional incentive for manufacturers to complete the trials in a timely manner and further mitigate any price increases.

This slide quickly summarizes the design elements for the differential rebates. Because this would be a statutory change to the MDRP it would apply for all states. While there was some discussion about whether some drugs that have more clinically validated endpoints should be excluded, the panel ultimately agreed that this would be challenging to implement and that the model should apply to all drugs that have been approved through the accelerated

approval pathway.

Participants agreed that a higher rebate on accelerated approval drugs would lower the cost to Medicaid and could encourage manufacturers to initiate and complete confirmatory trials. As mentioned before, some participants suggested that additional inflationary penalty be added to the already increased statutory rebate should the manufacturer not complete the confirmatory trial at their set period of time, for example, five years.

For the supply chain, this model would not disrupt the existing supply chain since it is going through the rebate process. The rebate would revert back to the standard MDRP amount once the manufacturer completes the confirmatory trials and gets full FDA approval, and the panel also discussed increasing federal funding on these products but ultimately just decided to rely on the increased rebate to reduce overall spending on these products.

From the stakeholder perspective, the panel discussed a lot of things. For beneficiaries, one reason the panel thought this model was effective is that beneficiaries would maintain the mandatory access to these

products under the MDRP. Some panelists expressed some concerns that this higher rebate may discourage some manufacturers from pursing the accelerated approval pathway and beneficiaries may lose the early access to these products.

However, many participants thought the additional rebate would only play a small part in the manufacturer's decision-making process and that they still had plenty of incentives to pursue the accelerated approval pathway. Manufacturers would need to weigh the cost of the additional rebate for the benefit of early market access. Manufacturers could still decide on early access to establish the product prior to competitors entering the market and would be willing to pay the additional rebate.

Participants agreed that having the additional confirmatory trial would provide payers with more information on clinical effectiveness and help in setting utilization management guidelines. And finally, the panel also agreed that the new rebate would be unlikely to affect provider prescribing patterns.

For cell and gene therapies, the panel thought it would be helpful to carve these products out of the MDRP

into a new national benefit. The new benefit would allow for new coverage, payment, or rebate requirements without disrupting the existing structure of the MDRP for all other outpatient drugs. Depending on design, such a model could allow for more flexibility in coverage that exist under the current Medicaid drug coverage rules, and this model could also be designed to help address state concerns about high up-front costs and budget volatility by increasing federal funding for these products, and pooling utilization nationally to increase predictability and consolidate purchasing power.

In terms of design elements, participants ultimately determined that mandatory participation would create a larger risk pool and create a better opportunity to reduce up-front costs and budget volatility. This new benefit could also be expanded more broadly to include other payers such as Medicare. This would help address concerns from states about bearing the cost of the gene and cell therapies that end up showing durability and prevent future disability or reduce long-term treatment costs.

Most participants agree that the model should be narrowly targeted to cell and gene therapies only and

should be limited to those therapies that are expected to have durable or long-term benefits. Some participated supported including certain clinical conditions such as hemophilia entirely. They thought this could address concerns about encouraging use of gene therapy over other alternatives. However, participants ultimately thought this would broaden the model too far and it would be hard to determine which conditions to include.

On price, participants did not agree on a single mechanism. The panel discussed creating a standard minimum rebate for Medicaid, separate but similar to the MDRP, negotiating outcomes-based contracts, and establishing a value-based price in which the government sets a maximum reimbursement amount based on an independent assessment of product value.

Participants discussed at length whether a value assessment framework is the right approach for this model. Some participants argued in favor of the value-based price, nothing the importance of moving away from the existing payment and rebate models that ultimately tie price to what the manufacturer determines. Some stakeholders opposed this option entirely, suggesting that upper limit price

would be too low and deincentivize investment.

The value-based payment model could affect providers in the supply chain. In the current supply chain, states pay providers for drug costs, not manufacturers, so a value-based payment would go to the providers who would then need to negotiate with the manufacturers to ensure that their acquisition costs are lower than the program reimbursement rate. A rebate model, such as the MDRP, would not disrupt the existing supply chain.

Participants agreed that this should be a permanent change due to the complexity. Some participants suggested that CMS could conduct routine evaluations about beneficiary access and assessments of whether drugs should move in or out of the benefit. Others also suggested that the model could include a mechanism so that drugs would no longer qualify for the program if generics were developed or if other sufficient competition becomes available.

And finally, participants generally agreed that a national model should include increased federal funding. Full federal funding would reduce the volatility within and across states, and if not fully funded than an increased

FMAP would help alleviate some of the budget pressures on the states.

From the stakeholder perspective, many participants thought a national benefit could improve access to gene and cell therapies by creating a unified approach to coverage and payment, rather than the piecemeal and sometimes delayed approach that occurs in states today. Participants suggested implementing a strong patient appeals process for beneficiaries, particularly if coverage of all the drugs is not mandatory.

From a drug manufacturer perspective, they stressed the importance of maintaining beneficiary access in Medicaid and similar coverage requirements of the MDRP. Manufacturers were receptive of ways to better link the price of a drug to its effectiveness and value, but preferred that a new benefit program rely on the existing pricing model and incorporate outcomes-based contracts to arrive at a value-based net price. They thought that third-party value assessments should be used as part of the negotiation but should not be used to set a price ceiling. They also had concerns that a different pricing structure under the new benefit could penalize cell and gene therapy

manufacturers in a way that differs from manufacturers of traditional products.

Some participants worried that the authorization process under a national program could be challenging for physicians. However, many noted that there are already many requirements in place for cell and gene therapies, so it shouldn't have that much of an effect on decision-making. There were also some concerns about disrupting the existing provider revenue stream under a value-based payment approach, but many participants noted that most cell and gene therapies currently are going through a small number of providers considered centers of excellence, and that the buy-and-bill model is not typical.

So to wrap up, staff would appreciate any feedback on the findings from the panel, in particular the two model options. We would like to know whether Commissioners would like to move forward with either model as a potential recommendation and if any additional information would be needed to proceed toward a recommendation.

With that I'll turn it back over to you.

CHAIR BELLA: Chris, thank you for breaking that

down into understandable chunks of a complex subject.

I'm going to ask Stacey to kick us off, because I know she participated in a couple of these. So Stacey, enlighten us, please.

COMMISSIONER LAMPKIN: Ha, yeah. Well, first I'd like to just say what a privilege it was to get to sit in and listen to much of the work of this TAP. The Commission is really benefitting from a thoughtful consideration of these solutions from a group of highly knowledgeable individuals. If any members of the TAP are listening today, I want to thank you all again for helping deepen our understanding of the challenge that is in the nuances of some of these solutions. And, of course, thanks to Amy and Chris for excellent staff support, as always.

This is just such a critical area for us to be talking about. It's facilitating access to therapies that can transform quality of life for some Medicaid enrollees, but severe challenges with state budget implications from volatility and magnitude and availability of finite Medicaid resources for all Medicaid enrollees.

I'd also highlight implications for existing service delivery models. This is the other side of the

comment I was making yesterday, with respect to the pandemic. You know, especially as currently designed, it's volatile at the state level for many states, but substate level for managed care plans and smaller regional plans, provider-owned plans, the size of the risk pool is really not designed to deal with this kind of volatility. And of course there are risk-sharing techniques that can help some, or reinsurance, but those have their own complexity, administrative burden, and so forth.

So for all those reasons, I am personally very supportive of continued Commission conversation on these two models, potentially leading to recommendations. The accelerated approval subject to higher rebates, to me that one seems a little more straightforward. The protection for the state purchasers, spending a lot of money for an unproven product, and it also has the right incentive for the manufacturers to complete the clinical trials. For me, I'm interested to hear what other people think, but it just feels like, to me here, we just need to make sure that we vetted the potential for unintended consequences of something like this.

Much more thorny is the cell and gene therapy,

potential for the new benefit. It seems like a much bigger lift, but a lot of potential value to this. Unfortunately, I missed the TAP discussion of this particular model. It was the very last session and I wasn't able to attend. But I would like to hear more about some of the specific model design elements, particularly thinking about how would this impact care coordination, implications for existing services, better delivered alongside these therapies or superseded by these therapies, to make sure that the care provided isn't skewed by having a different funding source.

But in general I think there's a lot of great potential with both of these models.

CHAIR BELLA: Thank you, Stacey. Peter?

COMMISSIONER SZILAGYI: Thanks, Chris and Stacey.

Chris, you're so great at making unbelievably complex problems a little bit more clear for me, although I fear that I still am not really understanding some of this.

I'm still confused by why the group chose a differential rebate for accelerated approval drugs and a new national benefit, because I actually see a lot of similarities. I mean, it seems to me that accelerated approval drugs have high up-front costs and budget

volatility and uncertain long-term benefit, which was the challenge that was listed under cell and gene therapies, and it seems to me that cell and gene therapies have limited evidence.

I'm just not clear about why one type of solution was recommended for the accelerated approval drugs and the other for the cell and gene therapies.

I must admit I'm kind of really intrigued by the new national benefit because many of these are for unbelievably rare pediatric conditions. They're all taken care of in large children's hospitals. There's only a few centers that deal with many of them, and why would there be disparities or inequities, depending on which state you're in, if you're a child with one of these incredibly rare conditions?

So my main question was I'm not following the reason for one solution for one of these classes and another solution for the other class.

MR. PARK: Sure. Certainly, there could be some overlap, and if I go back to a few earlier slides, I think you'll see that a lot of the models, they discussed. They discussed a lot of models for both of those, and they

overlap quite a bit.

I think, ultimately, they saw accelerated approval drugs is that not all of these are -- you know, they might not be particularly high priced. They may be lower priced but target a lot -- large population, and their main concern was the limited evidence.

So they thought that it would be better to try to reduce the cost of these drugs up front until that evidence becomes more clear, and the rebate model would be the simplest model for that than like an outcomes-based contract. It might be hard to know what kind of outcomes you could expect if you don't have the full information on the clinical trials.

So that's kind of where they fell on that. So that was the benefit. As Stacey mentioned, this is a pretty discrete option.

For cell and gene therapies, because of the really high up-front costs, it might be a small population, and if they're not accelerated approval, they have at least gone through the regular FDA approval process and demonstrated some clinical benefit. The uncertainty might be in terms of how long the benefit lasts.

So I think all of these models could be used, and a differential rebate model could be used for the cell and gene therapies as well.

I think where they went to is a new national benefit would provide like a clean framework. You take these out of the MDRP so that you can treat them a little differently. So you could create a different rebate process in the MDRP. So instead of the 23.1 percent, you could create a different amount. Instead of best price, you could do something else. So you could use the value-based payment approach to kind of create like a best price instead of what's available in the market.

Even like pay over time, particularly if this is fully federal funded, that would become easier to implement something like that.

So I think because they didn't really narrow it down to any particular solution, that's kind of why they went with a new national benefit is because it would provide a new framework where you could use one or more of these strategies, and I think, to Stacey's point, there probably needs to be some more work done to kind of get more specificity on the ground, on what we think would be

the best solution.

COMMISSIONER SZILAGYI: That's helpful.

So the accelerated approval drugs, some of these are for common conditions?

MR. PARK: Potentially. One of the examples that we provided is there's a preterm birth drug, Makena, that went through the accelerated approval process, and so that one is not necessarily like a specialty condition per se. But it was a high-cost drug compared to existing treatments. States, before that was approved, were compounding that particular drug for the use of -- you know, to try to prevent preterm birth.

COMMISSIONER SZILAGYI: Thank you.

CHAIR BELLA: Sheldon and then Fred and then Chuck.

COMMISSIONER RETCHIN: Thanks. Can you hear me okay? I think I'm off mute now.

CHAIR BELLA: Yes.

COMMISSIONER RETCHIN: So, first, Chris, I must say that, like Peter, I'm blown away by your expertise in this area. I think there are seven clinicians on the Commission, and honestly, I'll take a little guess that you

could run rings around us in terms of your knowledge of pipeline development and specialty drugs.

But that said -- and don't take this offensively, but I'm just wondering in terms of the expertise, pipeline medications, the application of genomics to new blockbuster breakthrough therapies we're witnessing now, it's not going to go away. And I wonder if you have given any thought -- or Anne have thought about continuing with the panel in the future to allow some institutional memory and reassembling on an annual basis, just a thought, so just something to consider.

I'll make another couple comments. On the accelerated approval pathway, the example given on Makena for preterm births kind of puzzled me. It was approved on an accelerated basis, and it actually took 10 years for a very common condition, preterm birth, to get sufficient number of cases to realize, oh, gee, the drug doesn't work. In fact, it's not only ineffective, it even may be harmful. So I didn't really understand that.

Another comment I thought I'd make is on the value that was mentioned there from a third party to provide some utility in terms of the true costs, and I

don't know if that's been tried or is it merely to codify the pricing strategy that's in place. But in some ways, I was attracted at least as part of a toolbox for looking at this very difficult problem if someone could tell us, "Gee, those R&D costs are built in. They're reasonable."

I'll just make one more comment. Somewhere in there, for almost every strategy, there was a fallback on terms of new benefit, whatever, to increase the FMAP. I understand that these are very extensive costs, but it's the fastest-growing cost. Having the states involved, just another area where I don't want to get on that slippery slope where the default is an increase in the FMAP.

Thanks.

CHAIR BELLA: Fred and then Chuck.

COMMISSIONER CERISE: I'll add my voice to the chorus saying, Chris, thanks and great work. It really is very helpful the way you lay things out.

First off, I think it is something that we should continue to pursue because these things are not going to go away, and it's just too complicated, I think, for the states to solve this, particularly things like cell and gene therapies. To imagine every state coming to grips

with this, it's just hard to think about.

I think where you landed with some national solution here with expertise -- and Sheldon said somebody that can point to what's the R&D cost, who paid for the R&D, what's the slope to recover those costs, because when you're getting into millions per thing, it's just going to be really important to have a great understanding of that and have the experts be able to help try to figure that out. But I do think a national solution is going to be in order for that.

On the other one, the accelerated approvals, I think the recommendation seems to make sense. I don't know the mix of drugs that are involved there, but I would just say what I got from the reading is once Medicaid starts buying this, the pressure may be off to finish the trials. So if there's a policy that makes those rebates substantial or keeps the pressure on to finish the trials, if there's pressure to use an accelerated drug, I would make sure there's enough incentive to do that.

Essentially, like Sheldon said, in Medicaid, you should be able to accumulate those numbers, particularly for something like that hydroxyprogesterone, pretty readily

if they want to accumulate those numbers and finish the trials. So I think I would err towards substantial rebates on something that has not yet finished the trials that Medicaid is now paying for.

CHAIR BELLA: Thank you, Fred.

Chuck and then Darin.

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

One of the things that I just wanted to better understand is how to think about Medicaid compared to other payers as these same therapeutics come to market. With hepatitis C, very expensive early drugs, Sovaldi and Harvoni and those sorts of things, it was very disproportionally a Medicaid population that would benefit from those particular medications.

With some of these other drugs in the pipeline, I think many of them do correlate to disabilities that are probably disproportionately represented among Medicaid beneficiaries. I think that's probably not true for some of the other ones.

I think I had two questions coming out of that thought process. One is, do we have a sense, either at a

drug or therapy level or at a more aggregate level how much Medicaid as a purchaser is impacted as these drugs and therapies come to market? And second, do we have a sense of how other purchasers, large employers or Medicare or others, are thinking about this pipeline from their own purchasing vantage points?

MR. PARK: Sure, Chuck. Some of that, I think we did present in October in the pipeline. One particular area of focus would be cell and gene therapies for children for conditions like SMA, cystic fibrosis. Certainly, there is concern among the participants for like sickle cell disease therapies. That would probably be a lot of Medicaid beneficiaries. Also, there is a gene and cell therapy in the pipeline for hemophilia, which actually may not be a large increase in cost because states already spend a lot of treatment on hemophilia factor already. So those were some of the kind of primary conditions that stats were really focused on based on what's in the pipeline right now.

Other cell therapies that may be targeted, cancer, that might affect other payers a little bit more than Medicaid. Medicare, that might be more of a Medicare

issue or commercial payers than for Medicaid.

We can certainly look into how other purchasers are trying to approach these products. We know that on the commercial side, one of the payers -- and I can't think off of the top of my head -- had kind of proposed -- one of the PBMs had proposed a model to its customers where essentially it would be kind of like the new benefit in that they are going to pool together the risk, and so that they would cover the risk out of this pool. And each particular customer of that PBM maybe would pay like a couple of dollars PMPM to the PBM, for cell and gene therapies, and then they would cover the cost of cell and gene therapies out of that pool.

There's some consideration of similar models of like pulling risk across a broader population than a single payer that's out there on the commercial side.

VICE CHAIR MILLIGAN: Thanks, Chris.

As we move toward whatever form of publishing this work or any of the reports down the road, I think contextualizing this with how much of it is a Medicaid-specific issue versus how much of it isn't and how that observation might drive some policy recommendations down

the road or policy thoughts, I think that just would be helpful context, personally.

Thank you.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: Chris, great job, as usual.

The one thing that I'm wondering if you can provide more clarity for me, if it was discussed by the group, when we talk about a new national benefit, the thing that I'm struggling with -- and again, I'm not saying that that whole thing was designed and drawn out in the discussions, but did it come up? One of the things you see, I think of some of the transfusions that take place. It's the cost of the drug, but it's also the hospital experience as well that tends to be you get the drive covered, but you can't figure out how you're going to pay for the hospital care, that it's not necessarily helpful.

So was there any discussion about how? I mean, it's not just the therapy itself. So if there was a new national benefit to cover the therapy, would it cover -- in this example, I'll just use like CAR T or something similar. Would that also encompass all of the additional services around the therapy itself like hospital care

that's required?

MR. PARK: Yeah. So there was discussion about that, and using the example of CAR T, there was quite a bit of discussion about whether you should include all of the ancillary services that kind of surround the therapy into the benefit.

I think where the panel got kind of stuck was how far do you go. What services are attached to the particular therapy? They thought it kind of led down a slippery slope of maybe how far after the infusion should you consider maybe rehospitalization and things like that.

Ultimately, they kind of settled on just covering the therapy itself into the benefit, but certainly, that was part of the discussion. If it's something the Commissioners are interested in, we can certainly think about it more.

COMMISSIONER GORDON: Yeah. I think it's an interesting solution, and thanks for clarifying because that was just one thing. I saw where they gave comments about how you're separating the therapy and the administration, and I didn't know if it went as far as, in some cases, the hospitalizations as well. So that's

helpful because that will be something that could create an odd dynamic where Medicaid is paying in one situation and the national benefit is paying another. That creates another dual program where we need to work on integration.

It's helpful. Thank you.

CHAIR BELLA: Fred?

COMMISSIONER CERISE: Yeah. Chuck reminded me about a point I wanted to make, and that is to deal with the private payers and the commercial payers and the opportunity or potential to include them in whatever national work we're doing.

You mentioned in the paper that incentive to sort of shift people from the commercial side to the Medicaid side for some of these very expensive things. If there's a solution that includes everyone for these rare and very expensive things, it seemed like it makes sense to consider all the payers. I don't know how practical that is, but I'd throw that out for your thoughts.

CHAIR BELLA: Thanks, Fred.

Sheldon?

COMMISSIONER RETCHIN: Yeah. I was going to cycle back actually from the last presentation, last

meeting, a point that I thought Fred made was an outstanding one. It was the ability to get a bioethicist to sit as part of the TAP.

I'm looking at that really valuable chart here or the flow in accelerated approval drugs. The single challenge of limited evidence just sticks out at me. I have a very vivid memory, as maybe some of you do, that in the 1990s, women with breast cancer -- there were 41,000 women with breast cancer who got bone marrow transplants and that had no clinical advantage, and the pressure was put on systems to do it but long before there was any evidence that it worked. And it didn't, and we are all guilty of doing that out of a preponderance of hope.

But I still go back to the Makena, if there's some motive there to not get into what is called Phase 4 of a clinical trial, to get that evidence as soon as possible with accelerated approval. I think there's a real weakness here.

But what about the bioethicist? Was that person included?

MR. PARK: Yes, we did find an ethicist for the last meeting where we brought in all the stakeholders.

CHAIR BELLA: Okay. Any other comments from Commissioners? Tricia.

COMMISSIONER BROOKS: So my colleague, Edwin Park, served on the TAP and was not able to be part of the last meeting when the stakeholders came in. I think he's going to be able to join for public comment at 4:30.

And this is not my area of expertise but a couple of points that we feel are important to make is that the open formulary is a beneficiary protection and going to a targeted, closed formulary is counter to that. Additionally, a federal negotiated price strategy doesn't have to be outside the rebate program. It just would mean doing special treatment within the drug rebate program and then making sure that we would get the better price, whether that's the traditional rebate program or the negotiated price, including the inflation-related factor, because there's not a guarantee that the federal government will negotiate prices that would be lower than what could be accomplished through the rebates.

So hopefully Edwin is able to join us at 4:30 so he can share more in that regard, and I wanted to make sure it got in the record.

CHAIR BELLA: Thanks, Tricia, and he can always submit comments online as well, if he's not able to make it.

Okay. I have a question. I'm trying to read the will of the Commission. It definitely sounds like there's interest in continue work on the cell and gene therapies. What I'm looking for a little bit of signal is, is there interest in Chris bringing us back a recommendation on the accelerated approval, because that one seems to be a little more straightforward. Stacey, can I put you on the spot, and see, is that something we'd like to bring back more in recommendation form or do we want to keep it in exploration mode?

COMMISSIONER LAMPKIN: I don't want to rush it, so I want to make sure people get to a comfort level with it. But to me it seemed more straightforward and have aligned incentives. I would just like to make sure that we kicked the tires on any kind of unintended consequences, you know, just have cleared that hurdle. But other than that it seemed to me like a relatively straightforward potential recommendation, so not on as long a timeline as the other, for example.

CHAIR BELLA: Chris, what does that look like to you, in terms of what you might bring back to us when and what other sort of signals you need from us?

MR. PARK: Sure. Certainly the accelerated approval one is pretty discrete, and we do have a lot of feedback from the various stakeholder groups. I think the biggest concern of maybe unintended consequences is where that additional rebate amount is set, and if it's set too high, maybe it creates some disincentive for manufacturers to pursue certain drugs, and particularly a lot of these accelerated approval drugs, one of the criteria for the pathway of that is that it needs to treat kind of like a condition of high need.

So there was some concern right there but they thought that if the rebate were set appropriately that there's a lot of other incentives for the manufacturers to still pursue the pathway, and it really puts the onus on the manufacturer to kind of weigh that additional rebate versus early market access. And in terms of like for manufacturers, since they're not completing that last particular trial before they get approval, there are some reduced costs up front before they hit the market. So some

of that will be taken up by the additional rebate.

And then also I think they thought that it was important for the rebate to provide that incentive, for the manufacturer to complete their trials, because they're often delayed. When they submit their proposal to the FDA it's usually like two to three years, a lot of times, but we don't see necessarily results until like five years or later. So I think they really thought that was important to create that incentive.

And another thing I can bring up is that for both accelerated approval drugs and cell and gene therapies there was talk among the participants about kind of creating a national registry to kind of consolidate the evidence, and they thought that would be helpful. So this might be another place where, along with the additional rebate we could either make a recommendation or at least include in the rationale and support for trying to create a national registry to collect the evidence across states. So that also would benefit the manufacturer in kind of collecting real-world evidence to help with their confirmatory trial.

CHAIR BELLA: Okay. Stacey, any last comments to

Chris, on what he just said?

COMMISSIONER LAMPKIN: No. I think that all sounds good. I guess the only other one would be just to make sure that we have an assurance that moving the lever over here doesn't just push the cost into a higher list price, or there's not just some other lever that just drives the cost to a different part of the process. I don't understand the nuances well enough to know where that might happen, but is it real, a real incentive, or is it just on the face?

MR. PARK: That was another thing the participants discussed, and I think it kind of depends on -- there's certainly some concern that manufacturers can raise list price to counter any new rebate. The counter-argument is if they already, like a lot of economists think if they already have that ability to raise the price then that probably should have already been built into the list price already.

You know, I'm not sure we'll ever get to a point where we can say that this will or will not create an increase in the list price.

CHAIR BELLA: Okay. My closing comment or

request is just for you to make sure that we're -- I don't think we can ever go wrong talking to states, and I know you have been talking to states, but continuing to make sure we've got their input as we move forward on this, which I know you do.

Okay, Chris, thank you very much. I really appreciate the work.

CHAIR BELLA: We are in the home stretch and Chuck is going to take us through our last session. So I'll turn it to you, Chuck.

VICE CHAIR MILLIGAN: Thanks, Melanie. And we are now going to learn more about parity, mental health parity, and Erin is going to be leading us through this. So Erin, it's all yours.

MENTAL HEALTH PARITY IN MEDICAID

* MS. McMULLEN: Thanks, Chuck. Yeah, as Chuck said we're going to be discussing the implementation of the Mental Health Parity and Addiction Equity Act of 2008 today. I'm going to just wait until my slides pop up.

Commissioners, you might recall that we first discussed protections afforded under mental health parity when we were working on our report on oversight of

institutions of mental diseases.

Today we're going to provide a brief background on mental health parity before discussing the policy questions and the approach that staff took to analyze the implementation of mental health parity in Medicaid and CHIP. Your meeeting materials kind of do a deeper dive of mental health parity requirements. I'm going to just try to hit the high notes today. And then we're going to present some findings related to outcomes and challenges that states and MCOs encountered when conducting their parity analyses, as well as perceived shortcomings associated with mental health parity.

The findings that I'm going to discuss today will be incorporated into an issue brief that's going to be published in the spring of 2021.

In 2016, CMS clarified the application of the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid and CHIP in a final rule that addressed aggregate lifetime limits, financial requirements, quantitative treatment limitations, non-quantitative treatment limitations, and availability of information. It also required states and MCOs to perform an analysis of limits

placed on mental health and substance use disorder treatment benefits. And although these regulations went into effect in October of 2017, little is known about how mental health parity has been implemented at the state level.

So we set out to learn how these regulations have been implemented since they took effect. In examining their implementation, we sought to address the four policy questions that are listed on this slide. As you can see, MACPAC sought to understand the challenges that were experienced by state MCOs in complying with parity, whether the Mental Health Parity and Addiction Equity Act increased access to behavioral health services, and if specific changes to mental health parity were needed.

To answer those questions that I discussed on the prior slide, we conducted a series of semi-structured interviews with Medicaid officials in Hawaii, Maryland, and Oregon. We also interviewed MCOs were applicable, beneficiary advocates from these states, as well as officials from CMS and other national organizations, such as the Bazelon Center and the National Association of Insurance Commissioners.

Your meeting materials do go into deeper detail about mental health parity requirements, including the evolution of mental health parity at the federal level. I'm just going to hit the high points today.

Generally, parity requires group health plans and health insurance issuers that provide behavioral health benefits, including MCOs, to provide coverage for substance use disorder and mental health benefits that are no more restrictive than the coverage generally available for medical and surgical services. I just want to make a note, though, that parity did not mandate coverage for a specific behavioral health benefit, but if a state does cover physical health services in any classification, like outpatient, inpatient, pharmacy services, or emergency services, then some type of behavioral health benefit must be covered in every classification in which medical and surgical services were covered.

More recently, the ACA did apply parity requirements to individual health insurance coverage. It also required individual and small group plans, including those in the state and federal marketplace, to provide coverage for mental health and substance use disorder

services as one of ten essential health benefits.

In accordance with CMS rulemaking, parity requirements apply to all behavioral health benefits for Medicaid beneficiaries enrolled in an MCO, regardless of whether that plan provides mental health, substance use disorder services, or both. Once an individual is enrolled in an MCO their entire benefits package is subject to parity, including services that might be delivered through fee-for-service, through maybe a behavioral health carve-out. Such requirements are not applied to beneficiaries who receive Medicaid fee-for-service state plan services only.

Federal rules require that states that use an MCO to deliver some Medicaid benefits to provide documentation of compliance with parity to the general public. This is commonly referred to as a parity analysis. That analysis has to be posted on the state's Medicaid website, and states were required to comply with that by October of 2017.

Through our work, we found that many states requested an extension for this deadline, and as of November 2020, CMS was still working with five states on

their parity compliance documentation. I just want to caution that this isn't really due to lack of effort on states' or CMS's part. These analyses, as we'll discuss momentarily, are incredibly complicated.

Parity analyses must compare limitations placed on behavioral health benefits with those used for medical-surgical services. So states and MCOs are required to examine behavioral health services that fall into the four categories listed on this slide. Ultimately, this analysis requires states and MCOs to place each mental health and substance use disorder benefit as well as each medical and surgical benefit into one of these classifications for the purpose of their parity analysis.

Once they've done that, the state or MCO is then required to identify and test each benefit classification for each individual benefit, based upon applicable parity requirements. So each individual benefit has to be tested in the five areas listed on this slide. So that's aggregate lifetime and annual dollar limits; financial requirements, including co-pays; quantitative treatment limitations, so that could include day limits on the scope or duration of benefits; non-quantitative treatment

limitations, which could include medical management standards, provider network admission standards, payment rates, fail first policies, and other limitations on a benefit; and then the last one is the availability of information, and that includes criteria for medical necessity determinations regarding behavioral health benefits.

So generally, the limitations placed on behavioral health benefits may not be more stringent than those placed on medical-surgical benefits. Moreover, those limitations must be applied using the same factors in both writing and operation.

States have to document and post their findings from their parity analysis, including any follow-up activities applicable to the benefits provided to MCO enrollees. They must also make any changes to meet parity requirements that were discovered during their analysis. Either the state or the MCO must complete the parity analysis, depending on how benefits are administered in the state.

States must also document in their Medicaid or CHIP state plan and the ABPs and CHIP plans that they

comply with parity requirements. For certain CHIP plans and ABPs, the state doesn't have to complete a full parity analysis.

So once their initial parity analysis has been conducted, CMS reviews parity provisions in MCO contracts during their routine contract review process. As of November 2020, all states with MCOs have updated their managed care contracts to adjust parity provisions.

Now we're going to go over our findings from our interviews in more detail. Interviewees from states and MCOs generally identified similar challenges when conducting parity analyses. Those challenges were consistently cited in two areas. Perhaps not surprisingly, how states went about doing these analyses varied greatly. CMS did provide states with a toolkit to assist with parity analyses, including the data collection process, but states weren't required to use the materials that CMS provided. In fact, all of the states that we spoke with did develop their own data collection processes. For example, one state we spoke to hired a contractor to assist with the data collection process, while another state ultimately required MCOs to purchase a tool to collect the data needed

for parity analysis.

Depending on a state's delivery system, states had to collect and review information from multiple MCOs for all behavioral health and medical-surgical services. And one state that we spoke with, this included compiling information from 16 different managed care entities. Many stakeholders, including CMS, noted that these analyses were incredibly resource intensive and required a wide range of staff expertise.

When initiating their parity analyses, states, MCOs and stakeholders expressed concern that they had limited expertise and underestimated the scope of federal parity requirements. One state noted that it took significant time for staff to understand the level of specificity and depth of what was required of them. Moreover, getting state staff to recognize how programmatic changes, such as modifying the state plan or making major delivery systems changes, affect parity compliance, and that remains kind of an ongoing process concern for that state.

CMS did acknowledge a lot of these challenges and that states and MCOs struggled to conduct these parity

analyses.

So the most common difficulty that states or plans faced when conducting parity analyses was documenting compliance with non-quantitative treatment limitations. In part, this was because states and MCOs had to examine numerous policies for each behavioral health benefit, including utilization review strategies like prior authorization, medical necessity criteria, written treatment plan requirements, and various standards related to network design.

Collecting and summarizing these policies for each behavioral health benefit was challenging for states and MCOs, particularly since it was a new process and required a review of a high level of information about multiple complex policies.

CMS and states also indicated that data collection was difficult due to the complexity of state treatment systems. For example, states that have a high number of MCOs or multiple benefits carved out were required to analyze significantly more information.

In addition, if MCOs subcontract certain functions out, the state must understand the role of the

subcontractor, not just the MCO, and how the subcontractual arrangement affected parity compliance.

States also noted that in some instances, MCOs did not always provide the state with sufficient detail to assess parity compliance, requiring the state to go back to their MCOs several times with additional data requests.

In some instances, stakeholders and state staff had different opinions on what constituted a non-quantitative treatment limitation, and these non-quantitative treatment limitation analyses could be even more complex if payment methodologies used for behavioral health services differed from those that are used for medical and surgical benefits.

It's important to note that interviewees did cite similar challenges in assessing non-quantitative treatment limitations within the private insurance market, but despite these shared challenges related to mental health parity implementation and compliance, we did find that collaboration between insurance commissioners and state Medicaid agencies was limited.

Next slide. You can skip ahead. Thanks.

Finally, we're just going to wrap up with

discussing some perceived shortcomings related to mental health parity. The stakeholders that we spoke with agreed that parity has helped raise awareness and generated state-level conversations regarding access to behavioral health care, but some interviewees did note that they were concerned that many consumers didn't understand the protections afforded to them by mental health parity.

Generally, the states and MCOs that we spoke with noted that they had not made any large-scale changes to their behavioral health benefits as a result of their parity analysis.

Some state officials questioned whether much has changed as a result of parity. One state noted that it didn't have any data to demonstrate that parity implementation has improved access to behavioral health care in Medicaid and CHIP. They theorized that there may have been some minor improvements but overall no major systemic changes. Two other states that we spoke with had similar responses.

One advocacy organization did note that providers continue to be challenged by vastly different non-quantitative treatment limitations across MCOs, and

availability of information still remains a challenge.

Since parity doesn't mandate coverage of behavioral health services, one stakeholder noted other policies were more relevant in ensuring access to community-based services. Specifically, they noted that the community integration mandate under the ADA and the subsequent Olmstead decision was a more effective legal mechanism to ensure access to behavioral health care.

Next slide. So that concludes our findings related to parity. As I noted earlier, we'll be taking the information that was presented today and incorporate it into an issue brief that we will publish later this spring.

I do want to just take a minute to talk about what we have looking forward. In March, we're going to turn our focus back to some of the access issues we discussed in the fall. We'll be presenting some policy options to you to improve access to behavioral health care for both adults and youth.

In addition, Aaron and I will be back -- so you'll have another shot at the Erin/Aaron(s) -- to discuss policy options to improve clinical integration of behavioral health services via electronic health record

use.

So I'd be happy to answer any questions you have at this time. Thanks.

VICE CHAIR MILLIGAN: Thank you, Erin. It's always challenging being the last one on the formal agenda. So I appreciate you doing such a nice job with it.

Do we have anybody who has questions for Erin?

Martha, then Sheldon.

COMMISSIONER CARTER: Thank you, Erin.

One of my bugs is prior authorizations, and I wondered where that fit in here. Just in personal experience, running services that included medical and behavioral and substance use disorder, there were at least earlier on in the opioid epidemic more problems with prior authorizations and the need to continually reauthorize services. I wonder where that falls in here and what sort of barriers you're finding. Maybe that doesn't fit exactly into here. Maybe it goes into the access cover station later, but that's an important topic, I think.

MS. McMULLEN: Yeah. So within the mental health parity analyses, prior authorization and concurrent review policies would fall under that non-quantitative treatment

limitation bucket. So states and MCOs were required to look at those as a part of their analyses.

We did hear from CMS that some states did wind up changing some of their prior auth policies as a result of their parity analysis, but it seems like that was kind of at the margins. It might have been like some small tweaks here and there.

If you recall, we did a report on utilization management for medication-assisted treatment. It was issued in the fall of 2019, and we did see that some states were opening up their prior auth requirements as it related to medications to treat opioid use disorder.

So it does seem like states have made some changes, but I can't say whether that's because of parity or because of increased attention on the opioid epidemic. It's kind of hard to say.

COMMISSIONER CARTER: Thanks.

VICE CHAIR MILLIGAN: Sheldon, you're up, and then Toby after that.

COMMISSIONER RETCHIN: Yeah. Thanks. Thanks for that report. I'm disappointed if it's going to occur in the fall, listening in as a citizen back in my street

clothes. I'm sure the Commissioners will be shocked that I might think that this has anything to do with inadequate behavioral health workforce, but it does.

Since 2010, the participation rates from psychiatrists -- and I only just mention psychiatry not because it's by any means the only access for a behavioral health workforce, but that participation rates have gone from 47 percent down into the low 30s. That means that more than 65 percent of psychiatrists in the U.S. don't participate in Medicaid.

Yesterday we talked about extending the postpartum coverage to a year. The most common complication that was mentioned in the postpartum period is postpartum depression. So we can mandate coverage, but we can't mandate or guarantee access unless we look at that.

Maybe one last point to make is most metropolitan areas separate out diversion from behavioral health from the other aspects of the clinical enterprise, those that have psychiatric beds. Those at least in Columbus, that's not just diversion in a single hospital. Very regularly, they go to bed control over the city because the demand is so large and unfulfilled.

So I'm looking forward to trying to come up with policies to get at this with opioid disorder, and the pandemic has maybe given us a respite from thinking about it. But rest assured, the problems with mental health and addiction access have mushroomed during the pandemic.

VICE CHAIR MILLIGAN: Thank you, Sheldon.

Toby?

COMMISSIONER RETCHIN: Yeah. Just briefly, more of an observation of reviewing this and thinking back to some other topic on the duals is how complicated some of these new requirements and the expertise and need for resources. On the duals work, we were noting a lot of these requirements or opportunities and options within the dual space have been there for a while, yet states don't have either the expertise, the resources. So I'd just again applaud that we just need to keep on remembering how do we, within all of this work, think through the state resources and needs and what can we be examining to build, whether it's bench or more centers of excellence, to help states with the complexity of the new requirements and the need for new services, whether it's behavioral health or whether it's integration of care.

VICE CHAIR MILLIGAN: Thank you, Toby.

I didn't have anybody else on my list. Does anybody want to add yourself to the list now?

[No response.]

VICE CHAIR MILLIGAN: Okay. Erin, we look forward to the issue brief that you referenced and looked forward to, I think, probably seeing quite a bit of you next month or I should say in March.

Do you have any questions for us or anything else you need from us at this time?

MS. McMULLEN: I don't think so. Thanks.

VICE CHAIR MILLIGAN: Thank you, Erin.

So, Melanie, turning it back over to you.

CHAIR BELLA: Thank you, Chuck.

We will take any public comment now on the discussion we just had on parity or on the high-cost drugs, the discussion we had prior to this. If you'd like to make a comment, please hit your hand icon. I see one so far.

Please introduce yourself and your organization.

MS. REPASS: Paul Locke, you have been unmuted. Please make your comment.

PUBLIC COMMENT

* MR. LOCKE: MY comment being what my organization is and what my -- hello?

CHAIR BELLA: Go ahead.

MR. LOCKE: Would you please repeat the statement or just the question?

CHAIR BELLA: Paul, I'm sorry. We're having a really hard time hearing you.

VICE CHAIR MILLIGAN: Paul, we asked you to identify yourself and the organization that you're with. That's the part you didn't hear from us.

MR. LOCKE: Thank you. I'm from United Health Group, and I'm the policy writer for the Policy and Teams Division.

CHAIR BELLA: I'm sorry. We're still having trouble hearing you.

MR. LOCKE: I'm on a cell phone, and I can't -- my microphone didn't work. I'm from United Health.

CHAIR BELLA: Yep, that's great.

MR. LOCKE: I am from United Health. Okay.

CHAIR BELLA: Please go ahead with your statement.

MR. LOCKE: I am from United Health. I am a

policy -- on the Policy and Teams Division. I have performed Medicaid policy and research, and I'm just happy to learn. I've worked there since September, and I'm happy to grow my knowledge base.

CHAIR BELLA: Okay. Thank you very much.

MR. LOCKE: Thank you.

CHAIR BELLA: I think we can go to Edwin, please.

MR. REPASS: Edwin, I'm enabling your mic. Please unmute yourself to make your comment.

[Pause.]

CHAIR BELLA: Edwin, we need you to unmute your phone, and then we'll be able to hear you.

MR. EDWIN PARK: Oh, here we go. It took me a while to get unmuted. Sorry about that.

This is Edwin Park, Georgetown Center for Children and Families. I want to comment on the payment coverage of high-cost specialty drugs. As a disclosure, I was a participant on the Technical Advisory Panel.

I just had three comments on this issue. First, I think it's critical that the open formulary protections that currently exist under the rebate statute continue to apply in both models for both the accelerated approval

drugs and for the gene and cell therapy drugs to ensure beneficiary access.

For the second model related to cell and gene therapy, to ensure that Medicaid does better than under the current Medicaid Drug Rebate Program, that the minimum rebate or the rebate that's obtained under the value-based purchasing agreement should be the higher of the existing MDRP rebate and not just the minimum rebate but the full base rebate, the higher of the minimum rebate, or the rebate -- provider best price plus any inflation-related rebates. That will ensure that Medicaid can do better in dealing with the very high-cost gene and cell therapies that are coming down the drug pipeline to ensure affordability and sustainability for Medicaid programs, whether the federal government is picking up all these costs or just a greater share than current law.

And the last is I don't think it's necessary that the new model be entirely separate for the Medicaid Drug Rebate Program for the cell and gene therapies because that will help ensure -- if it's integrated to some degree, it will help ensure better enforcement of requirements for the manufacturers and ease of administration.

So just those three clarifications and I would argue key elements for these two models to deal with this important issue.

CHAIR BELLA: Thank you for taking time to participate in the panels, and thank you for the comments today.

MR. EDWIN PARK: Thank you.

CHAIR BELLA: I think we have one other person who would like to speak.

MS. REPASS: Nataki, I am enabling your mic. Please unmute yourself to make your comments.

MS. MacMURRAY: Hello. Can you hear me? Hello. Can you hear me?

CHAIR BELLA: Yes.

MS. MacMURRAY: Great. Thank you.

This is Nataki MacMurray. I'm with the Office of National Drug Control Policy. I actually had a question about the parity report, especially when it comes to the CHIP piece of it. Were you able to find greater accessibility to services for SUD for youth under either CHIP provisions or the EPSDT provisions that were on par with services for mental health issues for youth?

We usually talk about parity of behavioral health in general, and we often mean both mental health and substance use. And we compare that to medical, but we're often finding we're hearing that there's some disparity between the mental health services and substance use services, especially when it comes to youth. So were you finding any challenges with mental health and substance use being on par with each other as they try to be on par with medical and surgical benefits?

CHAIR BELLA: Erin, thank you for reappearing. Do you want to take that one?

MS. McMULLEN: Sure. So, unfortunately, the way these parity analyses are designed, states aren't required to demonstrate that they're facilitating access to services. Some of the work we presented at our December Commission meeting highlighted some of the concerns you brought up around access to behavioral health services for youth, and we did see a clear disparity in access to substance use disorder services that was much greater than what we were seeing on the mental health side.

That's not to say that there isn't an issue on the mental health side. We just found it was particularly

concerning around access to substance use treatment for youth.

So I would encourage you to go back and look at those, but unfortunately, the parity analyses don't lend themselves to the type of analysis you're alluding to.

CHAIR BELLA: Thank you for your comment, though.

Thank you, Erin.

I don't see -- one more second. I don't see any other hands raised.

Anybody else on the Commission have any final questions, comments, words of wisdom?

[No response.]

CHAIR BELLA: All right. Thank you for a jam-packed two days. Thank you again to Anne and the team. Thank you to all of you who joined us virtually. We will be back March 4th and 5th. So the time will fly. We'll be back very quickly, and again, thanks to all the Commissioners. Have a great weekend, everybody.

COMMISSIONER SZILAGYI: And thanks to Melanie for conducting a wonderful meeting for two days.

CHAIR BELLA: Thank you, Peter.

COMMISSIONER BURWELL: Agreed.

* [Whereupon, at 4:31 p.m., the meeting was concluded.]