PUBLIC MEETING

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CHAIR BELLA: Good morning, everyone. Welcome to the March MACPAC meeting. We are going to kick the morning off with a couple sessions on behavioral health, and with that, I'm going to turn it over to Chuck to lead us through the sessions.

VICE CHAIR MILLIGAN: Thank you, Melanie. So, as Melanie mentioned, we're going to have two back-to-back sessions to star the meeting, the first session regarding adults and the second session regarding children and youth.

Erin, it's all yours to kind of lead us into this discussion.

### BEHAVIORAL HEALTH SERVICES FOR ADULTS: PLAN FOR THE JUNE CHAPTER AND POLICY OPTIONS

* MS. McMULLEN: Thanks, Chuck

So during the past meeting cycle, the Commissions discussed access to behavioral health services on several occasions. Today's presentation builds off that prior work as well as some panel discussions that we had over the fall and winter by offering policy options to help states
navigate, design, and implement a behavioral health continuum of crisis services.

While much of this presentation is geared towards adults with mental illness, the policy options that are presented here would also apply to children and youth in Medicaid.

So today we're going to have a brief summary about the work we presented this fall and offer some new findings related to racial disparities among Medicaid beneficiaries with mental illness. Then we'll turn our discussion to current efforts to address behavioral health crises.

The Substance Abuse and Mental Health Services Administration, or SAMHSA, has established national guidelines for crisis care. Additionally, the implementation of 988, a new national three-digit dialing code for the National Suicide Prevention Lifeline, is expected to go live by 2022. However, the role of Medicaid remains undefined in both of these initiatives. Moreover, current Medicaid and CHIP guidance doesn't fully address how to pay for certain crisis services.

We'll conclude our discussion with policy options
for the Commission's consideration as well as next steps.

So at the September meeting, staff presented results from an internal analyses of federal survey data. Among other things, we found that in 2018, adults with any mental health condition who were enrolled in Medicaid were nearly four times as likely to receive inpatient treatment for their mental health condition as those with private coverage. Our findings for children and youth were similar.

In addition, adult beneficiaries with mental health conditions were more likely to experience interaction with the criminal justice system when compared to their privately insured peers.

Since we met in September, we've done some additional analyses to quantify health disparities among Medicaid beneficiaries with any mental health condition. Key findings are listed here on this slide.

Among other things, we found that Black beneficiaries experience mental illness at twice the rate of white beneficiaries, yet white beneficiaries with mental illness are more likely to receive treatment when compared to their Black peers. Similar disparities were observed
Among adolescents enrolled in Medicaid, Black beneficiaries who experienced a major depressive episode with severe role impairment were less likely to receive treatment in the past year when compared to their white counterparts.

Before I move on to the next slide, I just want to acknowledge that these are some pretty concerning findings. The draft chapter that we bring to you in April will include this information as well as other findings related to our work on health disparities among beneficiaries with mental health conditions.

Commissioners also heard from two expert panels in October and December that focused on access to mental health services for adults in Medicaid and access to behavioral health care for children and youth. During these panels, we have discussed demonstrations states can use to improve access to mental health care. That includes Section 1115 demonstrations as well as the certified community behavioral health clinics or CCBHC demonstration. While these demonstrations are promising, both panels highlighted access to behavioral health crisis services as
a particular concern, noting that the current system to pay for these services is fragmented and unstable. Part of the challenge with designing crisis services stems from the fact that multiple state agencies likely need to be involved because Medicaid cannot fully fund a crisis continuum by itself.

Now we'll turn our attention to national efforts that are currently underway to support individuals in crisis.

Until recently, the core components of the behavioral health crisis continuum had not been fully defined by a federal agency. In February 2020, SAMHSA issued National Guidelines for Behavioral Health Crisis Care, establishing the three core elements of a crisis system that are listed on this slide.

The first component is a regional or statewide crisis call center. Crisis call centers connect to the National Suicide Prevention Lifeline and operate 24 hours a day, 7 days a week. Using a caller's area code, calls to the National Lifeline are routed to the closest certified local crisis call center. These call centers are staffed with trained clinicians who provide crisis intervention
services via telephone, text, or chat. We'll discuss the National Lifeline and its network of crisis call centers more on the next slide.

The next two components of the crisis continuum, mobile crisis response and crisis receiving and stabilizing facilities are organized around the call center which coordinates crisis care in real time. Both mobile crisis facilities and stabilizing centers are available 24 hours a day, 7 days a week. States including Arizona and Georgia are playing a growing role in implementing comprehensive crisis programs that are funded through Medicaid, other state revenues, county and local dollars, and other funding. But the continuum outlined here is not available in many parts of the U.S., and when it is available, Medicaid may not support each of these components.

So before we discuss 988 implementation, I just wanted to remind the Commission why the National Lifeline and its network of crisis call centers is a necessary component of a continuum of care for Medicaid beneficiaries.

Beneficiaries experience mental illness at a higher rate than their privately insured peers. Often
connections to mental health care do not occur, and many beneficiaries indicate that they needed but did not receive mental health treatment.

Recently, the National Association of Medicaid Directors highlighted the role of the National Lifeline and its network of crisis hotlines, noting state Medicaid agencies needed to leverage and support these call centers to connect individuals in crisis with appropriate care.

Recently, the FCC designated 988 as the national three-digit dialing code for the National Suicide Prevention Lifeline. This new national dialing code will be implemented by July 2022, but some stakeholders are concerned that the National Lifeline and its network of local crisis hotlines will not have sufficient capacity to meet increased demand. It's important to note that once the national 988 number does go live, calls will still be answered by the nearest crisis hotline as they are now with the National Lifeline and its 1-800 number.

Funding for individual crisis hotlines that link to the National Lifeline is often a state or local responsibility, and some states, including Arizona, have been able to successfully use Medicaid funding to support a
portion of hotline costs. However, few other states are using this approach to build capacity for state crisis systems. In part, this might be due to limited federal guidelines and the fact that Medicaid can't be used to fully fund the hotlines.

So current federal guidance does identify some ways Medicaid can pay for crisis services but often falls short of providing enough detail to states or to offer a roadmap to support the three components of a crisis continuum. This includes how to use Medicaid administrative funding to support crisis hotlines. Many states currently access federal and Medicaid dollars to support tobacco quit lines. Similarly, CHIP Health Services initiatives can be used to access CHIP-administered funding to support poison control centers. Given that so few states use Medicaid to support crisis hotline, it would be helpful for CMS to further advise states on how to properly allocate a portion of crisis hotline calls to Medicaid under these authorities.

Current CMS guidance also identifies Medicaid authorities to pay for crisis stabilization services. However, it notes two components of multiple crisis --
provider cost for outreach and team supervision -- may not be covered by the state plan.

Because crisis services require a multi-payer approach, additional guidance would be useful to assist states in braiding funding to support crisis-related outreach and engagement activities that Medicaid can't pay for.

Moreover, guidance could further clarify whether states can pay for these activities through other Medicaid authorities.

On the next few slides, we'll provide three policy options to address these issues. The first policy option is really aimed at improving coordination between CMS and SAMHSA. The policy option reads: "The Secretary of HHS should direct the Assistant Secretary for Mental Health and Substance Use and the Administrator of CMS to work together to support states in developing and implementing a crisis continuum to support children and adults with behavioral health conditions."

The rationale for that policy option is listed here. Ultimately, increased coordination between these two agencies could improve access to behavioral health
services. Both CMS and SAMHSA play important yet very
different roles in improving quality and availability of
behavioral health services.

Improved coordination between these agencies is
needed for a number of reasons, including those listed here
on this slide, but it's also necessary to ensure that as
new evidence-based behavioral health initiatives are
identified, CMS can properly support states with additional
guidance and technical assistance.

I just want to note that this policy option could
be directed either towards the Secretary of HHS or
Congress.

The second policy option is geared towards
providing improved guidance for crisis services. That
option reads: "The Secretary of HHS should direct relevant
agencies to issue joint sub-regulatory guidance that
addresses how Medicaid and CHIP can be used to fund a
crisis continuum for beneficiaries experiencing behavioral
health crises."

So the rationale for that is listed here, and it
goes into further detail in your meeting materials. Sub-
regulatory guidance could be used to further clarify how
Medicaid and CHIP can be used to pay for the three components of a behavioral health crisis continuum outlined earlier. That guidance could identify some of the things I discussed on the previous slide, including how to create funding and what authorities would be appropriate to pay for different components of the crisis continuum.

In developing new guidance, the Secretary should invite the participation of all relevant agencies with a role in implementing the National Lifeline and agencies affecting children and families. So that would include but is certainly not limited to the Administration for Children and Families, CMS, FCC, and SAMHSA.

And then the final policy option really builds off Option 2. It would provide technical assistance and planning support for crisis continuums. That option reads: "The Secretary of HHS should direct a coordinated effort by relevant agencies to provide education and technical assistance on the implementation of a behavioral health crisis continuum that coordinates and responds to people in real time. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of crisis
services."
The rationale for that option is listed here. In addition to guidance, states really need technical assistance and dedicated planning efforts to coordinate the multiple state agencies and delivery systems that are involved in the provision of behavioral health services.

Existing funding could be used to support planning and technical assistance efforts. Congress has recently increased the Mental Health Services Block Grant. Specifically, the Consolidated Appropriations Act of 2021 included a new 5 percent set-aside in the block grant for evidence-based crisis care. Moreover, Congress is considering additional increases in block grant funding. The most recent stimulus bill that passed the House includes $1.75 billion in additional funding for the Mental Health Services Block grant.

Among other things, participation in the block grant requires all states and territories to submit a plan to SAMHSA every two years explaining how they will use block grant funds to provide comprehensive community-based mental health services. Such planning could include the Medicaid agency to improve access to crisis services.
As with the second policy option, the Secretary should work with all relevant agencies that I listed previously.

So that takes us to next steps. These recommendations really, if the Commission chooses to make them, would serve as a first step to address access to mental health care. If the Commission is interested in casting these as recommendations in the June report, we'll return to you in April with specific language, at which point, Commissioners can vote on recommendations.

We'll also bring a draft chapter that includes three complementary analyses that we presented in the following winter, combined with these analyses, examine prevalence and treatment rates among adults with mental illness and coverage of and access to mental health services for adults in Medicaid.

As you'll hear later from Melinda, there will also be a chapter on children and then a third chapter that's descriptive around behavioral health integration and EHR for adoption and among behavioral health providers.

If the Commission is not ready to make recommendations, we can still include a chapter in the June
report that includes this material.

So, with that, I'll turn it back over to you for a discussion.

VICE CHAIR MILLIGAN: Thank you, Erin.

Martha, if you could get us started, and I'll look and see if other Commissioners want to comment.

COMMISSIONER CARTER: Thank you, Erin. This was great and a great overview, and I really appreciate that we've pulled out the disparities.

I think one of our policy questions is what are the actions that Medicaid agencies could take to address and reduce these disparities.

I have actually a question, just a clarifying question. Not so much anymore, but sometimes substance use disorder services are included in the definition of behavioral health services, and I was assuming that this is solely behavioral health and not substance use disorder.

I know in my state, there are quick response teams to respond to people who recently had an opioid overdose, but we're not talking in that whole realm right now. This is just behavioral health?

MS. McMULLEN: Yeah. So I think when we use the
term "behavioral health," we're including people with mental illness but also people who experience substance use disorders. SAMHSA kind of sketches out the crisis kind of continuum in the work they put out this last year.

COMMISSIONER CARTER: Thank you. That's important, then. I think we may want to pull out in our chapter if this does apply to substance use disorder services, and like I said, I know in my state, they've got quick response teams, medical provider, behavioral health provider, social worker, teams that go out and quickly interact with people who have recently had an overdose. That kind of funding maybe would then fall into this conversation. So I think that's important to highlight.

VICE CHAIR MILLIGAN: Thank you, Martha.

I have Kisha, then Fred, then Sheldon, then Kit. Kisha?

COMMISSIONER DAVIS: Thanks, Erin. I really appreciated this, and I agree with the policy recommendations that you've laid out.

Two things that I wanted to highlight. First is around 988, which I really applaud the FCC and SAMHSA for creating. One thing I think would be important for us to
highlight in the chapter is in the creation of this new crisis support, having the ability for texting and telehealth. When you're looking at the next generation, they are much less likely to call for help as they are to text for help and so in the development of a new system creating opportunities for that.

I also really appreciate calling out the disparities, the racial disparities in mental illness and mental health treatment. Also recognizing as we call out in the chapter that the staffing for those crisis support centers really need to have training and understanding and cultural competency in how mental illness shows up in different communities. Sometimes depression in some minority communities shows up as anger as opposed to sadness, so dealing with that. And I think this is an important next step in helping folks get out of the legal system and into mental health treatment.

I think we don't need to get into the whole politics of police funding, but I think police officers would agree that they do not enjoy being called to mental health crises and would much rather have a mental health professional be the one who is dealing with that, so to the
extent that we can continue to encourage and promote our
youth and adults who need mental health crisis services for
that to be available to them.

VICE CHAIR MILLIGAN: Thank you, Kisha.

Fred?

COMMISSIONER CERISE: Thanks.

Erin, I appreciate the great report. I mean, you
outline it well. It's easy to understand and incorporating
a lot of input.

My comment will be, though, it's heavily focused
on crisis management at this point, and I think that's
important. And I think we do need to move forward with
recommendations around that, but I also think there's
another body of work that addresses the rest of the
continuum.

Kisha commented on some of it already, which I
appreciate. How do we improve access to services in
general? Decriminalize behavioral health, address social
determinants. So there's another body of work that I think
is important that is not going to get captured here. So
that's one big comment.

More specifically to the options outlined here, I
agree with the options. I wonder, number one, if there's a place, as you look at including different agencies, if HUD or whoever is dealing with housing options needs to be pulled into this discussion because that becomes such a critical piece, even in the acute setting. So I would consider that.

Then the hard part on these crises, 988, and then you're putting the crisis teams together is, as you reference, Medicaid owns a piece of that, but it's just a piece of it. But the crisis system supports people in all categories. You're not getting Medicaid-eligible people only that are accessing it, and so how do you include other payers?

You referenced this in your number two, but can we go broader and say Medicare has got to be in this, other commercial payers have to be in this? So when the recommendations go forward to Congress to say everyone is benefitting from this and so how do you get everyone to pitch in to support the crisis services that go well beyond Medicaid, and I think the reason a lot of locales don't put this together is because they can't just do it with a third of the funding. They need the rest of the piece.
VICE CHAIR MILLIGAN: Erin, did you have any response to that?

[No response.]

VICE CHAIR MILLIGAN: Erin?

COMMISSIONER CERISE: And I don't know that I'm looking for a response other than just to say --

VICE CHAIR MILLIGAN: Okay.

COMMISSIONER CERISE: -- you know, is there a way to broaden our recommendations to include other payers.

It's one thing to go administratively to say within the agency, but then if you go to commercial payers, then you're going to Congress to say it's got to be broader than Medicaid and even broader than Medicaid and Medicare and SAMHSA.

VICE CHAIR MILLIGAN: Yep. Thanks, Fred. After I collect everybody's feedback, I want to circle back to the specific options themselves.

So I have Sheldon, then Kit, then Bill.

COMMISSIONER RETCHIN: Well, I just want to echo what everybody said about the report. Erin and Melinda, you did a tremendous job, and I think this is one of the most important areas for the Commission. We have an
epidemic within the pandemic for mental health and
substance abuse.

I'll just make a couple of comments. One is an
observation. Maybe this is what others were talking about
as well. So the memo describes the severe disparities
among underrepresented minorities. That's great. I mean,
we need to do that and be sure that we have that lens wide
open in whatever we're looking at.

But then we're making recommendations that appear
to be agnostic about solving this sort of major issue of
disparity. Can't do everything, but I think it just sort
of -- it's kind of, I guess, highlighted for me that we're
recognizing a problem first step, but then we really should
be thinking about how do we attack that.

Erin wrote me that some of this may be in
previous -- the previous discussions we've had.

Let me also sort of echo a little bit about what
Fred was saying, that we're talking about crisis services
for a continuum, and I understand the value of that. But
would this be the same thing we would do for physical
conditions focusing on a crisis service? We could send
diabetics to the emergency room and get them out of crisis,
which would be ketoacidosis, but no one would accept that
as good care.

At a minimum, I think it would be good policy for
us to at least acknowledge that some of the reason for the
crisis services that we need is because we won't have
comprehensive care, and to that end, I thought the
anecdotal information on the CCBHC model was promising.
But we ought to recognize that we need more comprehensive
care to avoid the crises rather than just creating crisis
service.

On Option 1, if you don't mind me jumping into
that while I've got a little air time, it just struck me as
odd that a recommendation for two agencies to work together
might be really useful, sort of like what we just suggested
that Medicare and Medicaid work better together because we
don't need an coordinating office to do integrated models
of care, but actually, we did and we made tremendous
progress in integrated models for duals under our Chair's
leadership.

Maybe they should jointly appoint a czar over
mental health and substance abuse. It does strike me that
we have very fragmented policies across those, but just
admonishing the agencies to work better together sounded a little stretch, but thanks.
Again, Erin and Melinda, you did a great job.
This is so important.
VICE CHAIR MILLIGAN: Thanks, Sheldon.
Erin, did we lose you for a minute somewhere in there?
MS. McMULLEN: Yes.
VICE CHAIR MILLIGAN: If we did, did you capture Fred's comments, or is that when we lost you toward the end of that?
MS. McMULLEN: My internet went out in the middle of that, but I believe it was mainly focused around kind of my comments earlier around multi-payer and the need to address other payers when trying to develop a crisis continuum. Is that a safe --
VICE CHAIR MILLIGAN: Yep, that captures it, Erin. I just wanted to check.
MS. McMULLEN: Thank you.
VICE CHAIR MILLIGAN: Sure.
Kit, then Bill, then Darin.
COMMISSIONER GORTON: So I agree with everybody
else. it's an important topic, and the work you did is well done.

I would like to -- and I'm supportive of converting the options that you've outlined, Erin, into --

EXECUTIVE DIRECTOR SCHWARTZ: Kit, we can't hear you very well.

COMMISSIONER GORTON: You can't hear me very well. Can you hear me now?

COMMISSIONER BARKER: That's better, Kit.

VICE CHAIR MILLIGAN: Yeah.

COMMISSIONER GORTON: Okay. I apologize for just mumbling.

So I support the three options. I support converting them into recommendations for the Commission to vote on, and I just have -- and I want to endorse the comments that other people have made with respect to shining that spotlight on behavior health equity, which I think is very important. And I do think it was Sheldon's comment about shine a light on the fact that you have a problem, but at some point, we might want to think about recommending something for the problem. Just saying that there's a health equity problem hasn't helped in any other
realm of health care to get things better. You need to focus solutions at the people who are disadvantaged, and so we ought to think about that, maybe not in this scope of work, but as we go forward.

I wanted to just -- in Option No. 3, you talked about -- and in the paper -- and maybe I missed it when I listened to the paper, but it seemed like in Option No. 3, you referenced the state and the territories. And this is somewhat of a bridge to this afternoon's conversation.

You didn't mention the territories in the other options and in the earlier parts of the paper, and it may just be implied. But I would like to understand whether the territories will benefit from 988, whether the territories are in a position to do the crisis things, and particularly since territories are funded differently for Medicaid and presumably are funded differently for all of the other things, whether that creates special challenges for the territories in doing all this.

And I don't know that we necessarily need to deal with that all in this chapter, but if those are -- if you have answers to those questions, that's swell. And we should probably put them in the chapter. If the answer is
the territories are just the same and we didn't forget about them, that's good too.

If we have more thinking to do about the territories in the context of behavioral health services in general and crisis services in particular, then we ought to, in my view, in this chapter at least put a placeholder, and then maybe in the work that Kacey is doing further on, we deal with the issues of that, the specifics of that in that piece of work. I don't think we need to say everything twice, but I think we need to acknowledge that the territories are different and if they have particular challenges, particularly with funding, right? Because as I understand it, their funding cliff applies to behavioral health services as well as everything else for Medicaid.

So I just want to raise that and make sure that we are thinking about that going forward so that in some pieces of work, we can shed a little light on that. If today is appropriate for asking questions about that to the territories in the time we have with the Medicaid directors, then I would be happy to have that conversation as well.

Thank you.
VICE CHAIR MILLIGAN: Thank you.

I have Bill, then Darin, then Brian.

COMMISSIONER SCANLON: Actually, Chuck, I was trying to adjust my screen, so I wasn't really raising my hand, but given the opportunity, I will say that I'm very supportive of the recommendations because this is a very important area that's been too long under, sort of, invested in and, to a point, almost neglected.

I think that the options are very positive, but I would also think, at least in our narrative about these, that we sort of underscore the need for follow-up. It's not just a question of initially giving out directions, but the fact that these intended actions occur is critical here. I would observe that we will follow up in the future but also encourage the Secretary to be following up in the future.

Thank you.

VICE CHAIR MILLIGAN: Thank you, Bill Darin?

COMMISSIONER GORDON: Erin, great, great work, and I echo many of the comments that have already been made.
I agree with Sheldon's comment about we'd like these two agencies to work together seems a bit soft. Whether it's -- I don't know about a czar, but a task force or something that can help give greater clarify to states around this, because when we had to modify our crisis system in Tennessee, it really was us on an island and to figure it out, working with some providers that were interested, willing, and I'm trying to figure what role Medicaid agencies, you know, funding we could have to support it. So I think this is definitely needed.

On the discussion around having other payers participate, I think that's a great concept. I don't know how you pulled that off. If we waited to get everyone on board, we probably would have never stood up some crisis centers, but I think at the very least, as recommendations, I think if states can have greater clarify about how Medicaid can play a role, then they can work with different providers to actually stand up some of these crisis centers. It's not just the mobile crisis unit, the crisis centers. We've seen some really dramatic success in the role that they can play as well.

So, again, I applaud the recommendations, and I
think just other than maybe taking an additional step about
the agencies working together, I suppose them.

VICE CHAIR MILLIGAN: Thank you, Darin.

Brian?

COMMISSIONER BURWELL: I want to jump on kind of
Martha's question on clarification, and that is
distinguishing between crisis response systems for people
with substance use disorders who have overdosed and crisis
response systems for other types of behavioral crises, I
think, we're primarily talking about.

Suicide prevention. Those response systems in my
mind look quite different, and I just want the chapter to
acknowledge that we're not just talking about uniform
crisis response systems to deal with all kinds of
behavioral issues but systems that can respond to different
populations in different types of crises.

I don't want to create bureaucracies that aren't
necessary, and I want them to build upon -- our
recommendations to build upon what we already have out
there and helping them work more effectively.

VICE CHAIR MILLIGAN: Thank you, Brian.

I didn't see anybody else who wanted to jump in,
Erin, I had a couple questions and some comments too. Do we have any indication whether the July 2022 go
drive is in jeopardy if it is on schedule? Do we have any
indication of the likelihood of achieving that deadline?

MS. McMULLEN: It is my understanding that it is
on pace for July, by July 2022.

VICE CHAIR MILLIGAN: The second thing -- and I
want to come back to some of the options that we were just
talking about and see if I can synthesize some comments I
heard. But I wanted to ask a question about the first
option. Do we have any indication that there is a
hesitation or lack of urgency in the conversations between
CMS and SAMHSA within HHS? In any of our work, was there
an indication of an issue that merited getting addressed by
us?

MS. McMULLEN: Sure. So I think over the past
few years, there has been maybe less collaboration between
the two agencies. There's maybe a few examples that I can
point to. So the National Guidelines on the crisis
continuum that came out this time last year really don't
mention Medicaid much, and just by the fact that Medicaid
is the largest payer of mental health services in the U.S.
and playing an increasing role in the payment for substance
use services.

In our conversations with panelists in the fall
and kind of staff conversations with different national
experts, I think we heard similar, similar things. I think
stakeholders really appreciate the joint guidance, and when
it's done well, I think it's received very well and it
takes evidence base and how to actually turn that into
payment in the Medicaid program.

I think some of our conversations highlighted
that there has been a little bit less of that in recent
years. This kind of policy option was aimed at addressing
that some.

Also, I just wanted to kind of maybe tease out
some of the nuances here. So Congress was also kind of
concerned about the role of the SAMHSA administrator, and a
few years ago, they created this new Assistant Secretary
position for substance use and mental health to really
elevate the role of the SAMHSA Administrator.

Part of that statutorily defined role includes
dozens of different things. One of them is kind of
coordinating with other agencies that play a role in behavioral health care.

This was kind of our way of trying to maybe address that role and how it related across the agency, just because SAMHSA really does play such a strong role in providing that evidence base for CMS.

VICE CHAIR MILLIGAN: Thank you. That's really helpful.

Martha, I'll come back to you in a second.

My next question, Erin, is Fred mentioned potential other agencies being included in a collaboration recommendation, including HUD. I might want to add the Department of Labor in that to the extent that they're -- if we're going to try to involve the commercial payer world, ERISA and DOL issues could potentially be a barrier and potentially be a solution.

I wanted to ask -- and, Anne, feel free to jump in on this, but do we have any concerns about whether our recommendations touch on agencies that are really kind of a little bit more afield from Title 19 or Title 21? Do we have any concerns about that?

And I would assume -- I would hope not if it's
more of a collaboration recommendation, but I wanted to check.

EXECUTIVE DIRECTOR SCHWARTZ: So I don't think there's a concern with respect to statutory authority. I do think that we would want to suss out what the role of those agencies are with respect to supporting the development of a crisis continuum. It might be more appropriate to talk about a variety of other agencies in the text rather than in the recommendation itself. I think that's something that we'd want think through a little bit further.

I also don't think having a laundry list is a great idea, just for the sake of us being able to say, oh, geez, all these guys should be involved. I think we should think it through a little bit, and I think there's always the option of referencing those issues in the narrative as opposed to the recommendation.

VICE CHAIR MILLIGAN: And I just had, I think, one or two more brief comments, Martha. Then I'll come back to you.

Erin, I think you're hearing a lot of support for kind of the chapter and some good comments for inclusion on
the chapter, and I would just for my -- my request would be
to include a little bit of context about the CMS-SAMHSA
working relationship and some of -- I want to make sure
that we better develop that background before we maybe lean
into that kind of recommendation.

And I personally support the point of view that
we've heard from a few Commissioners around -- you know,
Darin mentioned a task force or some sort of working group
between SAMHSA and CMS and, you know, the czar or whatever,
but I do think that the more we can articulate what it is
we would hope to see as opposed to more generic
collaboration which is a form of recommendation I've seen
between CMS and SAMHSA going back since the dawn of time, I
think that would be helpful.

I have heard general consensus about support for
the options. My request and suggestion would be that when
you bring things back to us in April, I think it would be
in the form of a recommendation and to give some thought to
whether and how to include other agencies that we've heard
about and also how to address the comment Fred started us
with but others kind of piggybacked around guidance that
would involve or have implications for the commercial and
Medicare and other payer components being brought to the
table, and maybe that could be an element of what CMS and
SAMHSA help address in guidance is the proper way to get at
this. And might also lend itself to what we might want to
say to Congress. But my suggestion would be for you all to
figure that out and bring it back to us kind of respecting
the intent that you've heard from folks here.

But I want to go to Martha now. Then I want to
just do one more sweep and see -- and Martha, then Kisha --
and one more sweep to see if anybody has any final thoughts
or comments.

For the public, just to let you know, we will
take comments, but we'll take comments after the next
session that Melinda will lead on children and youth. So
if you could hold off on the behavioral health comments
until we've gotten through both of these sessions, that
would be appreciated.

Martha?

COMMISSIONER CARTER: Thanks, Chuck.

Just listening to reports from the field in an
area of maybe further exploration about integration or
collaboration between SAMHSA and CMS is around the area of
the CCHBCs, because I've heard that there isn't such good
collaboration there, and that might be something to talk to
the CCHBCs more about.

VICE CHAIR MILLIGAN: Thank you.
Kisha?

COMMISSIONER DAVIS: Just as we're thinking about
collaboration and encouraging that, there has been this
theme from several of the Commissioners around the
disparities piece that's highlighted very well in the
narrative portion but doesn't come through in the policy,
and is there a way to, in our policies, also encourage that
or encourage collaboration with Office of Minority Health
and the development of the behavioral health network and
crisis hotline to be a part of that conversation, so we're
starting to address more of the disparity piece?

VICE CHAIR MILLIGAN: Thank you. Good
suggestion.

Anybody have any final comments among the
Commissioners?

Peter.

COMMISSIONER SZILAGYI: Yeah. I agree with what
has been said, and I'd like to make one final point linking
this part to the next one.

The evidence shows that a very high proportion of parents who have serious mental health problems have children who develop serious mental health problems. So to the extent that we can work on the crisis and mental health services for parents, there will be a beneficial spillover on children and adolescents.

VICE CHAIR MILLIGAN: Thank you. Really good point.

Okay. So, Erin, do you have what you need for now?

MS. McMULLEN: I do. Thanks.

VICE CHAIR MILLIGAN: Melanie, do you have any comments or thoughts as Chair before we move on to the next panel?

CHAIR BELLA: No. I mean, I support bringing it back to us in recommendations.

I'm on the fence about a task force because I think oftentimes those are not as effective either, but maybe we can come back with some ideas on how to strengthen the collaboration and work the other points in.

VICE CHAIR MILLIGAN: Great. Thank you.
Thank you, Erin, and we'll look forward to seeing you again at our next meeting.

MS. McMULLEN: Okay. Thanks.

VICE CHAIR MILLIGAN: All right. So we'll turn next to Melinda to lead us through a related discussion with respect to children and adolescents. Melinda, it's all yours.

### BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH: PLAN FOR JUNE CHAPTER AND POLICY OPTIONS

* MS. ROACH: Great. Thanks, Chuck.

So, in December, the Commission discussed access to behavioral health services for children covered by Medicaid and CHIP. Staff presented data showing that a significant percentage of adolescents with behavioral health conditions do not receive treatment.

Commissioners also heard from an expert panel about state initiatives and other opportunities to improve access to behavioral health services for this population. Panelists agreed that states generally have Medicaid authorities needed to improve access but may lack the awareness and capacity to use them.

This session builds off that discussion by
presenting policy options to address the identified need for additional guidance and technical assistance. These policy options focus on children and adolescents with significant mental health conditions who are at greatest risk for out-of-home placement and poor outcomes. If the Commission is interested in including these as recommendations in the June report, we'll return in April with specific language for you to vote on.

We'll also bring a chapter that provides context and background on access to behavioral health services for children and adolescents, including previously discussed work on the availability of behavioral health providers serving this population. If the Commission is not ready to make recommendations, we can still include a chapter in the June report with this material.

Let me just try to advance the slide.

Today's presentation will include background information on various agencies that are involved in the care of children and adolescents with behavioral health conditions. We'll also revisit data presented in December on access to treatment for children and adolescents with significant mental health conditions and discuss challenges
that were highlighted by panelists and other experts. That will lead us into the two policy options, and then we'll close by discussing next steps.

In December, we presented data showing that Medicaid is a major source of coverage for adolescents with significant mental health conditions, covering one in every three youth with a past-year major depressive episode resulting in severe role impairment.

These adolescents and children with significant mental health conditions are often at risk for out-of-home placements as well as involvement with child welfare and the juvenile justice system.

They are also more likely to have an SUD and to die by suicide.

Access to home- and community-based behavioral health services can prevent these children and adolescents from being removed from their homes and communities.

Such services have been shown to improve clinical and functional outcomes, school attendance, and other measures of well-being. They can also reduce rates of attempted suicide and contacts with law enforcement, yet these services are often not available to children and
adolescents with significant mental health needs and their families.

Multiple federal, state, and local agencies play a role in serving this population, and therefore, addressing the needs of these children and adolescents requires collaboration with multiple partners.

At the federal level, this includes CMS and SAMHSA as well as ACF, which administers federal funding for child welfare. At the state and local level, key partners beyond the Medicaid agency include behavioral health, child welfare, and juvenile justice agencies.

This slide summarizes federal requirements affecting access to behavioral health care for children and adolescents in Medicaid and CHIP. Medicaid must cover medically necessary health services for enrollees under age 21 under the Early and Periodic Screening, Diagnostic, and Treatment benefit. This is true regardless of whether the required services are covered under the state plan.

CHIP is required to cover behavioral health services, and the Americans with Disabilities Act requires that services for individuals with disabilities, including those with serious mental health conditions, are provided
in the most integrated setting appropriate to their needs. Despite these requirements, the behavioral health needs of many children and adolescents covered by Medicaid and CHIP go unmet. One panelist at the December meeting noted that while access to behavioral health services is a challenge across the life span, the problem is more acute for young people. This is particularly true for those with significant mental health conditions. The data we presented in December showed that only half of adolescents enrolled in Medicaid who experienced a past-year MDE received some form of treatment. Among those with MDE resulting in severe role impairment, only 60 percent received treatment. Having looked further into differences across racial and ethnic groups in Medicaid, we found that Black beneficiaries with MDE with severe role impairment were less likely to receive treatment than their white counterparts.

Recently, this unmet need has been exacerbated by school closings, social distancing, and other consequences of COVID-19. As we've noted in many instances, children and adolescents with significant mental health conditions
covered by Medicaid and CHIP lack access to services that help prevent hospitalization and the use of residential treatment.

In several class-action lawsuits, courts have found that states were not providing sufficient access to these services to meet their obligations under EPSDT, leading to more potentially avoidable out-of-home placements.

In 2018, while adolescents with Medicaid coverage received mental health treatment at similar rates as their peers with private coverage, they were more likely to be served in inpatient and residential settings.

In December, panelists noted that states often face challenges determining how to use available Medicaid authorities to structure benefits that meet the needs of this population. While there are a number of options states can pursue such as 1915(c) waivers and 1915(i) state plan authority, the process can be difficult to navigate, and states have received minimal federal support for their efforts in recent years.

National experts, including panelists at the December meeting, have highlighted the need for additional
federal guidance and technical assistance to expand home- 
and community-based behavioral health services for children 
and adolescents with significant mental health conditions. 
The next several slides outline policy options and in many 
ways mirror those that Erin presented in the last session. 
The first option is focused on additional 
guidance. It reads: "The Secretary of Health and Human 
Services should direct CMS, SAMHSA, and ACF to issue joint 
sub-regulatory guidance that addresses the design and 
implementation of benefits for children and adolescents 
with significant mental health conditions covered by 
Medicaid and CHIP."

New guidance could facilitate state adoption of 
home- and community-based behavioral health services that 
permit children and adolescents with significant mental 
health conditions to live in their communities and avoid 
institutional placements.

Previous guidance issued in 2013 was useful but 
is now out of date.

Among other things, new guidance could identify 
additional evidence-based services, including those 
addressing trauma; promote coordination with other child-
serving agencies; and provide clearer guidance on how states can pay for these services in Medicaid and CHIP. In developing such guidance, coordination between CMS, SAMHSA, and ACF is needed to address the role of state Medicaid, behavioral health, and child welfare agencies in serving children and adolescents with significant mental health conditions, particularly as states continue navigating the intersection between Medicaid and new child welfare requirements under the Family First Prevention Services Act.

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

In addition to sub-regulatory guidance, technical
assistance and planning opportunities are needed to enhance state capacity and jumpstart efforts to expand the continuum of services for children and adolescents with significant mental health conditions. Such technical assistance coupled with planning support could help states establish cross-agency partnerships, engage stakeholders, design new Medicaid and CHIP benefits, and overcome other barriers such as limited state resources and capacity.

Existing funding could be used to support these efforts. As Erin noted, Congress recently increased funding for SAMHSA's Mental Health Services Block Grant and is considering additional increases in the latest COVID relief package. A portion of this funding should be used to help state agencies dedicate staff time needed to engage relevant partners and develop a coordinated plan to address the behavioral health needs of children and adolescents with significant mental health conditions.

As a next step, we're hoping to get a sense of your interest in developing these policy options into recommendations for the June report. In April, we'll return with a draft chapter, and again, should you decide to move forward with these policy options, we'll also bring
specific language for you to vote on.

Thanks for your time, and with that, I will turn it back over to you, Chuck.

VICE CHAIR MILLIGAN: Thank you, Melinda. Really good work and appreciate it.

We'll start with Peter.

COMMISSIONER SZILAGYI: Thanks, Melinda. I really appreciate this and very much appreciate the focus on mental health.

Just sort of at the high level, I agree with these two policies, and I feel strongly that they by themselves are a first step. They're great, but they will do a limited amount to really solving the mental health problems of children and adolescents, but it's an important first step.

So just to set the context, prior to the pandemic, we were already facing a crisis of mental health problems in children and adolescents with insufficient providers, not enough payment, long waiting lines. We sometimes in California have to wait six months to get a mental health provider for mental health in children and adolescents, and there were really two systems of care
prior to the pandemic.

As Sheldon said with respect to adults -- and it's perhaps even more so with children -- that the pandemic has created an epidemic of mental health problems. Two weeks ago, I saw a seven-year-old with major depressive problems, and it was clearly triggered by the pandemic. In addition, as we've talked about, social factors play a major role for mental health problems in children.

So I agree with a policy of guidance and a policy of technical assistance, but I do think that in the future, we need to go much further in improving the health care for children on Medicaid.

Payment and real parity is such a concern that I worry, then, until we reach true parity in payment and parity in the quality of the mental health systems, we're not going to be able to solve this problem overall.

A couple other thoughts. Integrated mental health care has been shown to work in many settings where you integrate mental health and pediatric care together and pay appropriately, and I think that may be something worth highlighting.

I think Kisha mentioned telehealth care in the
adult world. There are many adolescents who would prefer mental health services by telehealth rather than in person, because they're adolescents, and I think highlighting that in parity in payment for telehealth, I think is important. Somebody mentioned mobile health or pairing police with mental health services, and that's absolutely true in the pediatric and adolescent world. There have been some high-profile cases just in the last couple of months about children and adolescents with major depressive problems who were engaged by police because there weren't mental health mobile crisis units available, and there are settings where mobile crisis units have worked very, very well.

One other point is justice-involved youth. As you mentioned, Melinda, many, many children and mostly adolescents with major mental health problems are involved with child welfare and end up being justice-involved youth and incarcerated, and some states have laws now that there's automatic Medicaid. If they had Medicaid going in to incarceration, they automatically have Medicaid going out. That's not the case everywhere, I believe, and that would improve care.
So my basic points is that I think these are two good steps, but I think there's a lot more that we can do. And I'm really glad that we're in this space right now.

VICE CHAIR MILLIGAN: Thank you, Peter.

I have Sheldon, then Brian.

COMMISSIONER RETCHIN: So I am just delighted with the report. I think this is a tremendous area as a companion piece, and I appreciated Peter's remarks.

I was hoping -- I was really hoping I could get through an hour of the Commission without saying anything about the workforce, but I failed.

As I read this, I was struck by the remark or the statement, which was highly accurate, but it said "while adolescents with Medicaid coverage received treatment at similar rates as their peers with private coverage," and I thought wow. That's a tremendous statement that really there's -- it's inequitable. Actually, it's equitable that those with private coverage also have tremendous unmet needs.

In a recent Kaiser report, I was looking at the column where they went through states about needs met, and there were states that have, in terms of unmet needs, 80 to
90 percent in terms of mental health.

Then I'm struck by the cutoff for mental-health health professional shortage area, and I'm sure everybody else realizes. But to be designated as a HPSA for mental health, you have to have a population-to-provider ratio that's actually 30,000 to 1, and with that, we have hundreds of mental health professional -- health professional shortage areas.

So I just want to be sure that we include the workforce, and I know I reached out. Melinda and Erin were both generous in responding and will include that, but HRSA has a major study on this. This is just a crisis; I think a major part of the barrier. It's just an inadequate workforce.

VICE CHAIR MILLIGAN: I have Brian, then Tricia.

COMMISSIONER BURWELL: Melinda noted, and also our background materials note that there are provisions in the COVID relief bill to enhance Medicaid funding for crisis intervention services, and I just want to make sure that we stay on top of that in the next few weeks, before the next meeting, and perhaps issue some kind of memo or summary of what is eventually enacted. I don't know if
they're going to stay in there or not. I just believe that both our chapters and our recommendations should include that information and kind of what's been done already. I don't want our recommendations to go Congress and then have people think, well, we've already dealt with that, you know, in the COVID relief bill. So it's just a request to try to stay as informed as possible about what could happen in Congress over the next few weeks.

VICE CHAIR MILLIGAN: Thank you. Tricia?

COMMISSIONER BROOKS: I want to thank you and, and Melinda, great report. I just want to echo, actually, Peter and Sheldon, and Sheldon, if I'd raised my hand first I would have raised the workforce issue for you, so you could have avoided it, but I think that's an important element. And Peter, you know, indicating that it's an important step, but it really is just a baby step forward. And one of the things I hope we can begin to convey is just the urgency within the child space for behavioral health. The reality is that we keep filling up the pipeline of adults with mental illness that started, that was rooted in childhood, and if we're ever going to stop that cycle we really have to focus on kids and make
sure that the system is working for them.

So I really would like to see the connection in terms of the share of mental illness that is initially diagnosed in teen or early adulthood to really help convey the urgency that all we're doing is filling up the pipeline if we don't address it back with children and youth. Thank you.

VICE CHAIR MILLIGAN: Thank you. Toby, then Martha.

COMMISSIONER DOUGLAS: Great report, and I agree with all of the recommendations.

One thing I do want to make sure we keep on the radar is just the growth in technology-abled solutions that are out there, and how is Medicaid reimbursed, whether it is through managed care rate setting, or in a fee-for-service. Some of these are going to be very different and different models for reimbursement. Similar to what we did with telehealth and really got ahead of that, and obviously that has become a very valuable piece of the Medicaid program, we need to think through the evolution of how we will be engaging beneficiaries differently and definitely for behavioral health there are a lot of applications.
coming out that could prove to be effective.

VICE CHAIR MILLIGAN: Thanks, Toby. Martha?

COMMISSIONER CARTER: Thanks. I had noted, when reading the chapter, the scarcity of information by race and ethnicity, and I think, Melinda, you all responded that there really weren't a lot of data available in this area. But I think we need to keep calling this out and then keep asking the question, what is the role of Medicaid programs in addressing and reducing disparities by race, ethnicity, and I'm going to add geographic, because that also gets to the workforce issue that Sheldon brought up. I think there are geographic disparities in urban and in rural and in frontier areas that I would add to the disparities list.

VICE CHAIR MILLIGAN: Are there any other Commissioners that wanted to jump in? Fred?

COMMISSIONER CERISE: Sorry. I was on mute. Yeah, I'll just make a quick comment, and that is Peter talked about some of the practices integrating behavioral health into the pediatric practices and other modalities, and Melinda, I thought you did a great job of outlining different services that need to be considered. And I would just emphasize that for complex populations
like this, they need systems to be able to address those needs. And so as we look for guidance, I would also include the need to understand how we address the continuum of services, because we don't want a menu of options that states may support half of them or something, but how that guidance would point to the full continuum of services that health plans would ensure, or providers would ensure. But it really begs for systems of care to address these complex cases.

VICE CHAIR MILLIGAN: Thank you. So, Melinda, I had a few myself. I wanted to start with the first option. When you went through the materials in the slide deck you mentioned the guidance is out of date and you referenced 2013. Is the primary -- and I think it was the next slide, in terms of the rationale, the second bullet there -- is the primary reason that the guidance is out of date now is that there are a lot more evidence-based practices and a lot more proven models of care? I wanted to better understand this, and, you know, you can touch on it briefly, but in the chapter itself, to the extent that we might be moving in the direction of a recommendation on Option 1, I want to make sure that we're really pretty
clear on what we mean by that bullet. I recognize that some of the materials got deeper than this particular deck. For the sake of the public and for the sake of building out the case for this recommendation, could you just elaborate on why this is out of date?

MS. ROACH: Sure, and that's something certainly we can flesh out in the draft chapter.

You're right. Part of it is including these evidence-based practices that experts have recommended should be highlighted in federal guidance. I think therapeutic mentoring is one that comes to mind that states are increasingly offering to this population.

I think there are a plethora of newer state examples that other states would benefit from having access to. The 2013 guidance highlights a variety of states, but even the links that are offered in that guidance are no longer live, so it's just less of a useful tool for states now that are trying to learn about how to move forward in this area. And I think there may be some updates that CMS may want to make in terms of discussion of available Medicaid authorities, so that something that we can detail further in the draft chapter for April.
VICE CHAIR MILLIGAN: Yeah, thank you, because, as I said when we were doing the section that Erin walked us through, I think recommendations about collaboration have been around for a while, and I think the more we can make the case for why we're weighing here, I think the better.

My second question relates to the second option, about TA, and you did, in the next on the slide and in the recommendation, you touched on existing federal funding. So the second-to-last line on this is to use existing federal funding. I had a question around your thoughts about CMMI as an element here, and to the extent to which maybe they've underfunded or underscoped pilots and demonstrations using CMMI authority around the behavioral health gaps needs. And this might come back to the technology piece that Toby touched on, is I think CMMI could have a role here in how they consider using their authority and some of their funding sources to help pilot improvements in care and outcomes and access. And I was curious about whether we know much about CMMI involvement to date, and whether that, in your view, Melinda, is ripe for what we mean by using existing Federal funding here as
MS. ROACH: I think that's something that we can explore further. One CMMI model that comes to mind, and I'm blanking on the full name, but the InCK kids model that launched recently I think is relevant in this space. I'm not sure of other investments being made on the part of CMMI, but there may be opportunity there. I would hesitate to sort of speak to that now without looking into it a little bit further.

VICE CHAIR MILLIGAN: Yeah, and my request is maybe by the time we come back in April if you could just dig a little bit into that. I think CMMI, historically, has leaned more toward Medicare and toward aging populations and some medical primary care improvements, but I think they've probably not focused their work and portfolio quite as much on behavioral health for children and adolescents.

My, I think, last question and comment is we heard a couple of things in this discussion from the Commissioners around areas where we might want to include language in a recommendation, one having to do with workforce, one having to do with race and ethnicity data
collection, and maybe a recommendation around using our bully pulpit here in a recommendation to urge collection and dissemination of information along those lines.

I'm curious about whether you think those can be incorporated in the existing recommendations that we've talked about in this meeting, whether they might be separate recommendations, whether you think they are appropriate for consideration. And we can come back to this in April, but I did want to call out that the workforce and the race and ethnicity piece I think merit some form of explicit call-out, when we get to it. That's my own personal opinion. And I just wanted to get your sense of if we might want to approach that when we come back in April.

MS. ROACH: I think certainly there is a good amount of descriptive information that we can provide in terms of background and context to help set up the recommendations. You know, one idea is to think about how we could sort of incorporate those issues into the existing policy options in terms of things that CMS and SAMHSA and ACF should be working to address in helping states address. So that could be one avenue in terms of building it into
the work.

VICE CHAIR MILLIGAN: Yeah. And I defer to you and Anne kind of between now and April about maybe the best way to address it. But I think you've heard from several folks, and I think there is more consensus even than the folks who spoke that being a little bit more explicit would probably be worthwhile.

I want to just check and see if there's any other Commissioners that want to kind of jump back in with any final comments.

Seeing nothing, I'll check with you, Melanie, about any final thoughts on your part before we wrap this up, and then we will turn to public comment after this session.

CHAIR BELLA: No. Melinda, thank you. Just similar to the adults, I support the recommendations. I think I'm still trying to think about how we put some teeth into the agencies working together and kind of what's stopping them from working better together today. But certainly these are important signals, and we can consider them first steps if we can't figure out the teeth in time for you to bring it back to us in April.
Thank you for the work.

VICE CHAIR MILLIGAN: And so let's now turn to public comment on both of the two sessions, and just to help set expectations for the public commenters, please identify yourself and your organization. Please offer any comments you wish to offer. This is not intended to be a Q&A session for the Commissioners. So, please, anybody who wishes to make some comments feel free to raise your hand in the Chat function and the operator can kind of walk us through who might be queued up to offer comments.

And I see a couple, so if we could --

MS. HUGHES: David Woodlock has been unmuted, so he can just unmute his own line.

VICE CHAIR MILLIGAN: Thank you. David, it's up to you to unmute, and you have the floor.

### PUBLIC COMMENT

* MR. WOODLOCK: All right. I think I just did. Can you hear me?

VICE CHAIR MILLIGAN: Yes.

Mr. WOODLOCK: Great. Great. Thank you. Good morning, everybody, and thank you for an impressive conversation. So I'm David Woodlock. I live in New York
State and currently run a large not-for-profit here that serves overwhelmingly a Medicaid population, so by quick background.

A couple of things, if I can say. I just saw this morning an impressive study on the commercial side of things, that having reviewed 92 billion claims on the commercial side that there has been a 90 percent increase in self-harm claims for young people 13 to 18, and a 94 percent in overdose claims, year-to-year, March-to-March, from 2019 to 2020.

So I think as we were just discussing, the urgency of better attending to young people, I think the data is absolutely overwhelming in that, and I think if we don't do something fairly soon we are going to have a wounded generation on our hands that is not ready to be successful in school or be healthy in the broadest way.

Forgive the familiarity here, but Fred mentioned the importance of a continuum of care on the adult side, and I think a little bit later in the kids conversation Peter mentioned the importance of pediatrics. So I would really underscore, as we think about both the workforce issue and the access to care issue that primary care across
the age continuum is a critical issue. So I think payment incentives and collaborative guidance from CMS on ways to encourage and promote care and attention from the primary care community is critically important. So that is one point, if I may.

The second, really, we talked a little bit about workforce development, and I think it's important also in the access issue that we think broadly about how we define the workforce. And somebody mentioned the inclusion of the Department of Labor in these discussions, which I would strongly support myself. But all the way from peer supports, family supports, and the professional community, so whether those are community health type workers that can address behavioral health needs and the like, I think is critically important, as is school-based mental health initiatives.

And then, lastly, if I may, I think when thinking about young people, in particular, and the issues of race and ethnicity and the confluence of poverty, the young people, particularly, I think, are very comfortable with and amenable to the use of digital technologies for communication. We here rolled all of our services -- we
take care of about 10,000 people a year with pretty serious mental health problems -- we rolled to tele-mental health intervention pretty quickly, and it became painfully apparent that the more the distressed folks were, the less access they had to digital technologies.

So whether that's smartphones or computer-based, or it's the fees associated with being online, I think as we think about all of the wonderful benefits of telehealth and tele-mental health and substance use issues, the digital divide is very real and painfully apparent the more you use the digital technologies. There are an awful lot of people who are some of the most needy, who simply don't have access to that. So an expansion of telehealth could inadvertently be another example of escalating health disparities.

So that's my two cents. Thank you for listening.

VICE CHAIR MILLIGAN: Appreciate the comments, David.

Operator?

MS. HUGHES: Kirsten Beronio? I'm sorry if I'm pronouncing that incorrectly. You're unmuted.

MS. BERONIO: Thank you. Hi. I'm Kirsten
Beronio. I am the director of Policy and Regulatory Affairs for the National Association for Behavioral Healthcare.

I just wanted to make a few suggestions regarding the guidance that you are thinking about recommending CMCS forward on crisis services. One recommendation I wanted to make was that you specifically encouraged CMCS to address how states can access federal Medicaid match for administrative costs. As has been discussed, some of these services can be tricky to directly cover via Medicaid, but a lot of the activity that needs to take place at the state level, to really stand up the infrastructure that's needed to address these crisis calls, to crisis call centers and mobile crisis units, et cetera, are activities that could potentially be reimbursable as administrative costs, as long as that was properly allocated to take into account the degree to which Medicaid beneficiaries are taking advantage of those services. So that would obviously be an important part of that.

Some states have already been doing this. So there are examples that CMCS could look to, to how to properly do the cost allocation, et cetera.
I would also encourage you to call out specifically, to make sure that it's addressed, the availability of enhanced administrative match for some of the technology that needs to be put in place. Again, some of the challenges in this area is that sometimes you don't know if someone is on Medicaid. Obviously, we want to make these services available to all people, regardless of payer. So how do you properly cost allocate? How do you make sure all payers are participating?

I would encourage that this guidance not just address commercial, how to incorporate commercial payers in supporting this, but also Medicare and so making sure that CMCS is working with the Center for Medicare Services, and what more Medicare can do in this space, I think would be important as well as CCIIO to think about how the marketplace systems can help support access to crisis services.

Finally, I wanted to just point out I think it's really important that we call out and offer more support for the three areas that SAMHSA's guidelines focus on, namely the call centers and the mobile crisis units and the crisis receiving centers and stabilization centers. Those
are severely under-resourced right now, and so we do need to pay attention to those.

But I think we also need to keep in mind that a lot of the people accessing these services may need access to inpatient care. So if you're suicidal, a 23-hour program is really not going to be sufficient, and you may need inpatient care. For the Medicaid beneficiaries accessing these services, they do face a big barrier, which is the IMD exclusion for accessing that inpatient care. So I think it is relevant to these discussions and should be called out in the guidance.

At CMCS, there is an 1115 opportunity. There has been legislation introduced over the years to try to address this one recent bill. It's either introduced or will be introduced soon that creates a state option that's similar to the 1115 opportunity.

So there are potentially opportunities there, but it continues to be a big challenge for accessing that level of care. So thank you very much.

MS. HUGHES: Hilary Daniel, you may unmute to make your comment.

MS. DANIEL: Hi. Can you hear me okay?
VICE CHAIR MILLIGAN: Yes.

MS. DANIEL: Great. Good morning, and thank you for a great discussion thus far. My name is Hilary Daniel. I'm with the Children's Hospital Association. CHA works to advance child health through innovation in equality, cost, and delivery of care to Children's Hospitals across the nation.

We are grateful the Commission has taken up the vital issue of access to children's behavioral health care services and appreciate the opportunity to share our perspective.

While mental and behavioral health conditions can occur at any age, children are especially vulnerable. Approximately 15 percent of adult mental illnesses occur by the age 14 and 75 percent by age 24.

As mentioned before, the pandemic has exacerbated an already worrisome trend in the mental health of children and youth, as social isolation has limited kids' access to school, friends, and other support systems. For Children's Hospitals, this means seeing children who are in crisis.

In communities across the country, Children's Hospitals have seen increases in suicide attempts, self-
harm, and violent outbursts. From April to October 2020, hospitals saw a 24 percent increase in the proportion of mental health emergency visits in kids ages 5 to 11 and a 31 percent increase for kids and teens ages 12 to 17. This crisis is further exacerbated by racial inequity and those in underserved or under-resourced communities.

In addition to the increase in crisis care, preliminary data from CMS shows a marked decline in outpatient mental health for children during the pandemic, with 44 percent fewer outpatient mental health services between March and May of 2020 compared to the same period in 2019.

The rapid expansion and adoption of telehealth has helped to offset some of these services and connect children with the care they need. Audio-only telehealth has been particularly beneficial in reaching children who may face unique barriers to accessing video visits, like children in lower-income homes who may not be able to access their own devices, or children living in group home settings who may not feel comfortable being on video due to privacy concerns or feeling stigma. Although telehealth has helped to offset, some of those challenges remain.
The Commission should examine ways Medicaid can address the acute inpatient crisis by better supporting alternatives to inpatient care. This includes options such as partial hospitalization programs, day programs, or step down programs to offer a bridge between inpatient and traditional outpatient settings.

It is also important to advance policies and legislation that support and strengthen the pediatric health care system. This includes broader support for sustainable Medicaid payments for the behavioral health workforce, including primary care, through enhanced provider rates and through enhanced Medicaid matching funds, as well as investments in training pediatric mental health and behavioral health care providers.

There are immediate and long-term needs to create sustainability across the spectrum of children's behavioral and mental health care. We recommend the Commission examine ways to better support care in the community and invest in upstream interventions such as prevention surveillance to enable timely diagnosis and treatment, potentially avoiding more intensive care and costs down the road. Further strategies should include increased federal
funding for children's health care research, ongoing awareness in research in deliveries reform, support for community-based resources to address key social determinants of health, identification and ways to evolve and enforce existing provisions of the EPSDT benefit to ensure children are receiving comprehensive pediatric care, and additional guidance to state Medicaid programs on the ability to provide necessary Medicaid coverage for behavioral health services to children in school settings.

We further recommend MACPAC detailed support for children's mental, emotional, and behavioral health needs across the federal government and explore how these resources could be better coordinated and leveraged together to improve care and services across Medicaid and other federal programs such as those under HRSA and SAMHSA.

Children's Hospitals and their affiliated providers stand ready to partner with you as you continue your work focusing on the behavioral health needs of children. We will provide follow-up with more detailed comments and welcome the opportunity to work with Commissioners and Commission staff to support access to the pediatric behavioral health services.
Once again, we thank you for the opportunity to provide comments on this critical issue and for your attention to children's mental, emotional, and behavioral health care needs.

VICE CHAIR MILLIGAN: Thank you.

Just as a quick check, I see three more folks lined up to speak, and after we get through the three, Anne, if you could just help remind everybody on how to submit comments in writing. I don't happen to remember offhand, but that is another opportunity that we will take into consideration.

So let's have these three individuals offer their comments, and then we'll wrap up this session.

MS. HUGHES: Andrew Sperling, you may unmute your line.

MR. SPERLING: Good morning. My name is Andrew Sperling. I'm the director of Legislative Advocacy for the National Alliance on Mental Illness. I want to thank the Commission for a very rich discussion this morning, particularly around crisis management and crisis intervention.

It was briefly mentioned that there is a
provision in the American Rescue Package to Medicaid and the health crisis intervention. It's something called the CAHOOTS Act, which actually stands for the Crisis Assistance Helping Out on the Streets Act. It was actually introduced in the last Congress by Senator Ron Wyden and Senator Catherine Cortez Masto from Nevada. It is in the American Rescue Package that passed the House early Saturday and is in the Senate bill. They're still making some adjustments to it. This bill provides 80 percent FMAP for states to fight crisis intervention for mental health crisis. It's a bill that NAMI is vigorously supporting. This is a model that was originally developed in Eugene, Oregon, which accounts for Senator Wyden's strong interest in this, and we're hopeful that the way this is structured, it's really going to incentivize states to engage in using Medicaid to finance evidence-based crisis intervention services for mental health.

I'd also draw the Commission's attention to a provision that was in the American Rescue Package but was removed last week because of a ruling of the Senate Parliamentarian under the very byzantine and complicated budget rules that govern the budget reconciliation process.
that this bill is being written under. This is the Medicaid Reentry Act, which would create an eligibility category under Medicaid for inmates 30 days prior to release. We believe this is also a part of crisis intervention. We know that when people leave prison or jail and don't have a valid access to Medicaid, falling into crisis, not getting the treatment they need, and ending up in recidivism is quite high. This bill unfortunately because of the budget rules was stripped. We think there's enormous attention being paid to this in Congress because of the challenges at the level that all Members of Congress and policymakers hear about with respect to mental health crisis, so a lot of attention here in addition to 988, but we appreciate the Commission's support on this and look forward to helping you further down the road with your deliberations. Thank you.

VICE CHAIR MILLIGAN: Thank you.

I think one or two folks jumped on the line after I mentioned it before. So if the remaining folks could please try to be brief with your comments.

Operator?

MS. HUGHES: Dorothy Dupree, you've been unmuted.
You can unmute your own line.

MS. DUPREE: Can you hear me okay?

MS. HUGHES: Yes, we can.

MS. DUPREE: This is Dorothy. Okay. Thank you. This is my first time. So please bear with me.

I think this is a wonderful discussion. I've really enjoyed the first two presentations.

I can't agree more. Well, first of all, my name is Dorothy Dupree. I am from Montana. I have worked in health policy for many years, 10 years in Centers for Medicare and Medicaid Services, and I'm not back working for tribes in Montana. I work primarily for the Rocky Mountain Tribal Leaders Council.

We represent a number of tribes in Montana and Wyoming. It's the Assiniboine, the Sioux, the Gros Ventre, Blackfeet, Confederated Salish and Kootenai Tribes, Crow, Little Shell Band of Chippewa, Rocky Boy Tribe of Chippewa Creek, Northern Cheyenne, Northern Arapaho, and Eastern Shoshone, very important tribes, all considered to be Plains tribes. We're very rural, and we suffer a high level of health care disparities.

Racial disparities, I can't agree more with what
you are discussing. I think it's really important for us to understand the racial disparities, and one comment was made about data, that it's difficult to get data for minority populations. And I know it's nearly impossible to get data for the Native American population.

We have an EpiCenter in Billings, Montana that's part of the Rocky Mountain Tribal Leaders Council that I work for, and it's difficult for the EpiCenter, even though legislation states to provide data, provide the access to data, that it's been difficult for our EpiCenter to gain access to data. And that makes it then almost impossible to develop reasonable policy for how we reach out, how we treat, how we recognize what our disparities are and what our individuals are suffering from. So without data, then you begin to rely on basically horror stories.

We have an epidemic of suicides amongst our youth, and we see that somewhat like a rollercoaster. It will go away for a while, and then it comes back with a vengeance. So we're in an epidemic situation right now with suicide, but I think part of that can be related to the pandemic. But I think a lot of it, we've seen even before the pandemic set in.
I agree. We have looked at the social
determinants of health. We're developing our policies
within the framework of the social determinants of health,
and I cannot agree more that agencies absolutely need to
work together. It's more than just what I say -- it's more
than just a lack of access to health care services. It's
more than that. It's transportation. It's housing. It's
access to data, as I said. It's working relationships.

So I encourage you to keep on the path that
you're working on. I will continue to participate and
observe in these meetings. I think it's very good to see,
and it gives me hope that you are intending to go down the
right path.

Some of you may think that we have the Indian
Health Service and the Indian Health Service is going to
step up and assist us, but the Indian Health Service is
woefully underfunded.

Plus, I think equality -- the difference between
equality and equity is one size does not fit all. We're
very different in our traditions and our practices. Our
cultures in Montana are very different, and we also have to
accommodate the differences between tribe to tribe, among
tribe to tribe. So it's challenging to say the least to ensure that there's equity that we have without data, without analysis, and without a lot of working partnerships. It's difficult to get to that equity position where what we're designing will fit this tribe and what we design will fit another tribe and so forth. So we realize very clearly that one size does not fit all.

So thank you for this time. I appreciate it, and I'll end my comments there.

VICE CHAIR MILLIGAN: Thank you, Dorothy.

MS. HUGHES: Patricia Johnston, you may unmute your line.

MS. JOHNSTON: Hi. This is Pat Johnston. I am the director of Public Policy for the National Association for Children's Behavioral Health. Our members provide home- and community-based and institutional services for kids and families, and I will be brief.

I want to make a pitch for the Commission to take a look at how the Medicaid IMD exclusion affects kids, which it does significantly, and it hasn't seemed to fit into any prior reports or this report that the Commission has done.
Just to mention several connections with the presentation and earlier comments, EPSDT does not trump the IMD exclusion. So kids may be identified as needing a level of care that the IMD exclusion prevents Medicaid for paying for.

Out-of-home placements that are made to the child welfare system or the juvenile justice system are to a unmeasured degree, in some cases, a result of the appropriate level of care not being available. So there's a couple of things that were in the presentation that connect directly with the IMD exclusion.

Then as far as some of the Commissioners' comments, obviously, it also connects with parity. The IMD exclusion is the greatest parity violation, at least the spirit of parity that we have in this country, and as far as making the case for collaboration between ACF and CMS, I think the biggest barrier there is a reluctance to deal head on with the IMD exclusion. As Melinda noted, with the Family First Prevention Services Act, this is really coming to a head as a barrier for states to fully implementing that child welfare reform law.

So that's it. Thank you very much for your
attention, and I'll follow up with specific comments to staff.

VICE CHAIR MILLIGAN: Thank you.

I think that leaves Marisa.

MS. HUGHES: Yes. Marisa Aguilar, you've been unmuted. You can unmute your own line.

MS. AGUILAR: Thank you, Operator. If you can also unmute Laura Wilson-Slocum and Shery Blyth. They are with me and will be also making brief comments as well.

VICE CHAIR MILLIGAN: Yes, please do be brief if there are three of you about to comment. Thank you.

MS. AGUILAR: Yes. Thank you, everybody, for having us. My name is Marisa Aguilar. I am the practice manager over at the Expanded Mobile Crisis Outreach Team in Austin, Texas. I work for the local Mental Health Authority, Integral Care. We provide a strong foundation for well-being. We support adults and children living with mental illness, substance use disorder, and intellectual and developmental disabilities.

We are proud to share our experience as a CCBHD, as it's really led the framework for the work that we've been doing. Our program launched in 2013, and we partner
with first responders who have the ability to request us
for co-response when they've identified someone that's
experiencing a mental health crisis.

Our goal is to connect people to treatment in the
most appropriately least restrictive option, diverting them
from emergency rooms, case officers, emergency detentions,
and jails.

What we did in FY20 is we integrated clinicians
into our 911 call center, wherein when the call takers have
recognized and identified that someone is experiencing a
mental health crisis, they can immediately transfer the
call to our clinicians on the floor in the absence of a
public safety or a medical emergency so that we take over
and provide support and figure out the most appropriate
resource for that individual, diverting police response
where it's not necessary.

We've had a lot of successes that have come with
this integration at the 911 call center, wherein prior to
this, if someone called 911 and was experiencing a mental
health issue, a first responder would go to the scene to
begin with and then call out an expert clinician to do that
assessment that is needed. This provided us with an
opportunity to divert more upstream, diverting police when
it was not necessary to get the most appropriate care at
the right time for that individual.

On February 1st of this year, our community added
a fourth option when somebody calls 911. So the script now
reads, "Are you calling for police, fire, EMS, or mental
health services?" This provides earlier identification of
signs and symptoms of mental health, wherein we've been
able to divert 86 percent of the calls transferred to our
clinicians from police response when it was not necessary,
connecting people to timely intervention and the right care
at the right time.

I will now pass it over to my colleague Laura
Wilson-Slocum so she can provide additional information.

MS. HUGHES: Laura, you've been unmuted, and if
you could also tell me the name of the other person so I
can find her while you're making your comment.

MS. WILSON-SLOCUM: Yes. Thank you, Operator.
Our colleague is Sherry Blyth. She's the director of
Crisis Services. Thank you so much.

I will keep my comments brief at the request of
the committee. My name is Laura Wilson-Slocum, and I'm the
administrator for Crisis Services and Justice Initiatives at Integral Care.

I mainly wanted to share with you all that about six months after the EMCOT team began their work with Austin Police Department, one of their assistant chiefs administered a survey to their patrol officers, of which there's over 800 patrol officers. They had a fantastic response for patrol officers. I think about 60 percent of the officers took the time to fill out a survey about how they felt the EMCOT team was serving the community and assisting the department.

What we found in particular that one officer said that struck us is he said that EMCOT is a force multiplier. It keeps more police on the street.

As all of us reimagine what public safety actually means and reimagine how we want to monetarily invest in public safety, this is a sentiment that we can all keep in mind. Of the many years that we've worked with Austin Police Department and the Travis County Sheriff's Deputies Office, we've never encountered a deputy or a patrol officer who has said, "No. We want to handle all mental health crisis calls ourselves. We don't want mental
health clinicians to assist." They all want to work with mental health clinicians because a mental health crisis deserves a health care response, and police officers are trained in public safety. And they're public safety experts.

We've been thrilled with the collaboration we've had with Austin Police Department, and we're thrilled to be the first city in the country, according to Texas Meadows Mental Health Police Institute to add the fourth option on a 911 script.

Thank you, and I pass this over to our director of Crisis Services, Sherry Blyth.

MS. BLYTH: Hi, everybody. I'm Sherry Blyth. I'm the director for Crisis Services. I will be very brief.

I think you've already heard what we're doing in Austin. I think a good example that people can relate to is one of the first calls we received was from a mother who was calling from out of state about her adult son living in Austin who does have a serious mental illness. She called 911 for a welfare check. She hadn't heard from him, and she was very, very concerned about him. That was the first
call that our -- that call was moved to our clinician at the 911 call center. We were able to dispatch the mobile team directly and not involve police, and that person was linked to care. And we were able to let his -- and we were able to connect him with his mother so that she knew he was safe.

That is a great example of the kind of situation that does occur on a daily basis, and I'm sure many of you are familiar with these kind of scenarios.

I work at the 911 call center. I think that is the furthest upstream you could get in terms of linking people to care and when there's not an unnecessary law enforcement involvement.

Thank you so much for your time. We appreciate it.

VICE CHAIR MILLIGAN: Thank you all, and just for your awareness, we did receive the letter that David Evans from your organization sent. And we've had an opportunity to read it ahead of this meeting as well.

Anne, if you could maybe just let folks know how to submit comments by writing, and then, Melanie, turning it back over to you for whatever concluding remarks you
want to make before the morning session ends.

EXECUTIVE DIRECTOR SCHWARTZ: Sure. The email address is comments@macpac.gov, and every comment that we receive through that, we share with all the Commissioners, so rest assured that all comments are shared.

CHAIR BELLA: I don't have anything to say except thank you for this morning's sessions. We're going to break now. We'll be back at one o'clock to start the session on specialty drugs. Thank you, everyone. Thank you, Chuck.

VICE CHAIR MILLIGAN: Thanks.

* [Whereupon, at 12:16 p.m., the Commission was recessed, to reconvene at 1:00 p.m. this same day.]
CHAIR BELLA: Welcome back, everyone. I'm going to it like 30 seconds, and then, Chris, we'll hand it over to you to get started.

[Pause.]

CHAIR BELLA: Okay. Let's get going. Thanks, everyone, for rejoining. We're going to start off with high-cost specialty drugs, and Chris, take it away.

### HIGH-COST SPECIALTY DRUGS: MOVING TOWARDS RECOMMENDATIONS

* MR. PARK: Thanks, Melanie. As you recall, over the past year, MACPAC contracted with NORC at the University of Chicago to conduct an analysis of the drug pipeline and convene a technical advisory panel, or TAP, to look at issues with high-cost specialty drugs more closely. The TAP met three times over the fall to examine drugs in the pipeline that are particularly challenging for states to manage and to identify design coverage, payment, and rebate models to address the challenges these drugs present and to assess the potential effect of these models on various stakeholders.

At the January meeting, staff presented findings
from the TAP's work, and in particular two possible models to address challenges for cell and gene therapies and with drugs approved through the accelerated approval pathway. Commissioners expressed interest in moving toward a recommendation for the differential rebate model for accelerated approval drugs, but they were not ready for a recommendation on cell and gene therapies but wanted to continue work on this issue.

So today I will review the U.S. Food and Drug Administration, or FDA's accelerated approval pathway for prescription drugs and the issues these drugs present to state Medicaid programs. I will then describe the proposed differential rebate model and the rationale for increasing the rebate on accelerated approval drugs, as well as the implications for different stakeholder groups. Finally, I will present two potential recommendations to implement the differential rebate model on accelerated approval drugs.

The first recommendation that increases the minimum rebate is the primary recommendation. If the Commission decides to proceed with that one it can then decide whether or not to include a second recommendation as well.
In order for any recommendation to be included in the June report, the Commission must reach a decision on which options it prefers at this meeting, so that staff can draft the chapter and specific recommendation language to be voted on at the April meeting. The chapter will also provide context for MACPAC's work on high-cost specialty drugs, including the work of the TAP on the pipeline analysis and cell and gene therapies. We will not move forward with a recommendation on cell and gene therapies but we can include a discussion of the design framework that the TAP discussed, and that will serve as a marker for our continuing work on this topic.

The FDA allows for expedited approval pathways for products that demonstrated substantial improvement over other available therapies or that fulfill an unmet medical need. One pathway, the accelerated approval pathway, allows the FDA to approve a drug based on whether the drug has an effect on a surrogate endpoint that is reasonably likely to predict a clinical benefit. The use of surrogate endpoints means an accelerated approval drug enters the market before the clinical benefit has been definitely demonstrated. In some cases, accelerated approval has been
controversial when the relationship between surrogate
epistases and the clinical benefit have not been well
established.

For example, for Exondys 51, a drug used to treat
Duchenne muscular dystrophy, the FDA approved a drug even
though its advisory committee did not think there was
enough evidence presented at the time to demonstrate that
the drug was reasonably likely to produce clinical benefit.

As part of the approval, the FDA requires
manufacturers to conduct post-market trials to verify the
clinical benefit of the product. If the confirmatory trial
does not provide evidence of clinical benefit, then the FDA
can withdraw the product from the market. However, in many
instances, the confirmatory trials are delayed and it can
take several years before the trial is completed. One
study found that results of confirmatory trials for over
half of the indications granted accelerated approval
between 2009 and 2013 were not available after a median of
five years of follow-up.

Although there are some practical reasons for the
delays, drug manufacturers do not have the same financial
incentives to complete the confirmatory trials that they do
with Phase III clinical trials under the traditional
pathway. These products are already generating revenue and
negative findings could result in the drug being pulled
from the market.

The Medicaid Drug Rebate Program, or MDRP,
requires drug manufacturers to pay a statutorily defined
rebate. In exchange, states are generally required to
cover all of the participating manufacturers' products as
soon as they have been approved by the FDA and enter the
market. This means that states must cover accelerated
approval drugs, unlike other payers who have the ability to
exclude coverage.

Many states have expressed concern in being
required to cover and pay for these drugs, while additional
studies are still needed to verify the clinical benefit,
and that the high price for many of these products is not
supported by the existing evidence. In some cases, states
may end up paying for a product that ultimately does not
demonstrate a clinical benefit. For example, Makena, a
drug used to reduce the risk of preterm birth, received
accelerated approval in 2011. In October of 2020, the FDA
proposed that the drug be pulled for the market because the
post-market study failed to show a clinical benefit. As we discussed in January, the TAP proposed a differential rebate model for accelerated approval drugs that would increase the rebate on these products. This increased rebate would be added as a statutory change to the MDRP and increase the minimum rebate above the current 23.1 percent of average manufacturer price. Participants felt that increasing the rebate struck a balance between maintaining coverage of these products in Medicaid while addressing concern that manufacturers are charging prices that are not supported by the existing clinical evidence. Increasing the rebate would provide a lower net price to help account for the uncertainty that the product will produce the anticipate clinical benefit. Medicaid will pay less while there is a limited amount of evidence. Additionally, the higher rebate would create a financial incentive for manufacturers to complete confirmatory trials in a timely fashion.

Another option is to add an additional inflationary penalty should the manufacturer not complete the trial after a set period of time, for example, five years. This additional inflationary penalty would help
mitigate any increase in the list price while there is a limited amount of clinical evidence, and provide even more incentive for manufacturers to complete the confirmatory trial in a timely manner. However, because this option is tied to the inflationary rebate, it would not have any effect if the manufacturer does not increase the product’s price faster than inflation.

The increased rebate would apply until the manufacturer completes the confirmatory trial and verifies the clinical benefits. The FDA has an existing process to convert accelerated approval to traditional approval. Once the FDA grants traditional approval, the rebate would revert back to the standard amount under the MDRP. This would effectively be increasing the net price for the manufacturer.

Manufacturers are likely to oppose this policy, and they argue that additional Medicaid rebates may discourage research and development on drugs and delay market availability for these drugs. Manufacturers would need to decide whether to bring their product to the market early under the accelerated approval pathway and incur the additional cost of the increased rebate. Manufacturers
already take into account several factors, including Medicaid rebates, when making decisions on a product's launch. Medicaid is not the sole payer for these drugs, and an increased rebate would not necessarily have a significant influence on a manufacturer's decision to pursue the pathway. They may also try to build the new rebate into the price.

Manufacturers still have the incentive to get accelerated approval and establish the product prior to competitors entering into the market and generate revenue as soon as possible.

Because this rebate would be implemented under the MDRP, states would still be required to cover accelerated approval drugs. The beneficiary would still maintain similar access to accelerated approval drugs that they currently have. If a manufacturer decides to forego the accelerated approval pathway then beneficiaries may have to wait longer for the drug to come to market. The increase rebate will reduce net spending for both the Federal Government and states. We have requested a score from the Congressional Budget Office and will provide this at the April meeting.
But to get a sense of potential scale, prior MACPAC analysis found that Medicaid spend about $686 million before rebate in fiscal year 2017 for 27 drugs approved under accelerated pathways since 2014. If the rebates were increased 10 percent, for example, then this could potentially be savings close to $1 billion over ten years, depending on the cost of the accelerated approval drugs in that time frame.

We are presenting two potential recommendations today. Recommendation 1 is the primary recommendation, which would be included if the Commission wishes to proceed. Recommendation 1 would increase the minimum rebate, and it reads:

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

Recommendation 2 would increase the inflationary rebate, and it reads:

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

So the next steps, the Commission should decide today whether to proceed with recommendations that would be included in the June report. If you wish to proceed you have two options to choose from. You could choose Recommendation 1 only or you could choose both Recommendations 1 and 2. Staff will bring back the recommendation for a vote at the April meeting, along with
a draft chapter for the June report.

This next slide is not the full recommendation language but provides a summary of the two options to help with your deliberations, and with that I will turn it back over to the Commission.

CHAIR BELLA: Chris, thank you. That was a lot of information to get through very succinctly, and I think you've really clearly articulated what we need to decide here. I would remind the Commissioners that there was a general level of comfort with this, such that we asked Chris to bring this back to us as a recommendation. So I think I would first start out by asking just for a straw poll show of hands, of Commissioners that are in support of Recommendation 1.

[Show of hands.]

CHAIR BELLA: Okay. Can you keep your hands up, please? So it looks like everybody is in support of Recommendation 1. Is that correct?

COMMISSIONER BARKER: Melanie, this is Tom. I am in the camp of I think we should maybe hold off a little bit before moving forward.

CHAIR BELLA: Okay. Sorry, Tom. I thought I
saw your hand. Okay. Why don't you then -- can you say a little bit more about your concerns?

COMMISSIONER BARKER: Yeah, but can I ask Chris a question first, before I do?

CHAIR BELLA: Sure.

COMMISSIONER BARKER: Chris, on Recommendation 2, that recommendation, as I understand it, would only kick in if a manufacturer increased the price of the drug more than CPI, right? In other words, there would be an enhanced inflationary rebate but it would only be enhanced if they increased the price beyond CPI. But if they didn't increase the price beyond CPI, only Recommendation 1 would apply.

MR. PARK: That's correct.

COMMISSIONER BARKER: Okay. Thanks.

So I guess, Melanie, I would just say I'm just a little bit concerned -- Chris, can you go back maybe three slides? I guess my concern is that Congress has created this pathway for accelerated --

MR. PARK: Is this the slide?

COMMISSIONER BARKER: Let me finish my point first.
MR. PARK: Okay.

COMMISSIONER BARKER: Then I'll find the slide.

Congress has created this pathway for accelerated approval for a set of drugs for which there is an unmet medical need, and I guess my concern is that an enhanced rebate might create a disincentive for manufacturers to go through that pathway, and it would therefore delay access to drugs for which there is a clear medical need.

So one of the slides -- I'm sorry, Chris -- one of the slides, you made that point, and that's the concern that I have.

CHAIR BELLA: Okay. I'll open it up to --

COMMISSIONER BARKER: I'm sorry to interrupt, Melanie. This is the slide. Sorry. I apologize for interrupting.

CHAIR BELLA: No problem. No problem. Okay. I just wanted to get a sense of where we are on Recommendation 1, in particular. I will open it up for comments and also for folks to weigh in on Recommendation 2. I see Kit and Stacey. Okay. Kit and then Stacey, and then Chuck.

COMMISSIONER GORTON: I just want to respond to
Tom with a clarification. So its access to unproven drugs with demonstrated need. And, you know, for me that's a whole big difference, right? So you're exposing people -- yes, they have a need, I get it, but let's get it proven as quickly as we possibly can. I'm sensitive to that. I've lived with a child in a wheelchair. I've buried a child who used a wheelchair. So I get the implications of this. But to expose people to unproven drugs is simply not what we are supposed to do in the Medicaid program. There's a role for experimentation. It's one thing if there is evidence behind the drug, but Exondys is a great example of a place where the experts said, "We don't think so," and the agency went in another direction. And not only did that expose young adults and families to an unproven treatment, it also generates enormous costs for taxpayers.

And so that's why I'm in a different place from you. I think if we had proven therapies, yeah, we ought to get them out there as quickly as possible. But access to unproven therapies, I mean, what is that access to, exactly? And I just think we need to raise that question because the manufacturers always push the need, and I don't
think people who are suggesting that there be some level of
circumspection in putting these potential therapies out
there -- you know, nobody is saying there isn't a need.
The issue is, is this stuff any good, or is it even
potential harmful, as we found with autologous bone marrow
transplantation for breast cancer, where folks were pushed
to authorize the therapy for women, which, in fact, turned
out to be harmful to them.

So I just think that, you know, I get it, but if
we're going to talk about this we need to talk about the
fact that we're talking about unproven therapies. Thanks.

CHAIR BELLA: Thank you, Kit. Anne, you had a
clarification?

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just
wanted to quickly make sure that we're careful about our
language here, and also make clear that we are staying out
of FDA's business. The point is simply about Medicaid
payment policy.

So I'm not going to argue your point with you,
Kit, but I think there are people who will argue about the
word "unproven." And so I just want to caution folks to be
careful about the language that we're using to make it
clear what we're doing here. I hear what you're saying, Kit, but I think the FDA watchers would push back on your choice of words.

CHAIR BELLA: Stacey, then Chuck, then Martha, then Sheldon.

COMMISSIONER LAMPKIN: Yeah. Thank you. I have a comment or two, and then maybe a question for Chris. So I'm very supportive, conceptually, of Recommendation 1, because it feels like a nice compromise between preserving some access but also providing some incentive and some relief. But it feels a little bit like an article of fate that there is a rebate increase percentage that is significant enough to be meaningful to states, significant enough to provide the incentive to encourage the clinical trials, and yet not so high that it discourages manufacturers from doing the research or making the product available through this avenue.

And so, you know, the TAP thought, I guess, Chris, that there could be an increase that would kind of meet all those goals, help address all those goals, that they didn't have a particular recommendation of an increased amount. Am I recalling that correctly? Did they
have any sense of order of magnitude that they were able to suggest or anything that they used to have some confidence that there was a sweet spot here?

    MR. PARK: They didn't identify a particular amount, but as like kind of a starting point, the moderator had put out the 8 percent increase that was included in the ACA, that took the minimum rebate of 15.1 to 23.1, and most of the TAP members felt like it needed to be higher than that 8 percent, but they didn't say it should be, like, 15 or 20 or anything like that.

    So I think the feeling is it should probably be above 8 percent, so maybe like 10 percent or above, but they didn't kind of narrow in on a specific amount.

    COMMISSIONER LAMPKIN: And so how would we address that point, you know, in the rationale for our recommendation, do you think, Chris?

    MR. PARK: Sure. I think we can certainly point out, you know, with the caveat that it should probably be at least around 10 percent, but I don't think we have the ability to zero in on like a specific amount. And I think that will be up to legislators to try to figure out what that should be. I'm not exactly sure how they decided the
15.1 to 23.1. And so I can try to do a little bit more research on that to see how they came up with that estimate, but I'm not sure that we would be able to recommend a specific amount.

COMMISSIONER LAMPKIN: Okay. Thank you for that, and then, while I have the mic, Melanie, because you asked for feedback on the second recommendation, I would just say, from my perspective, I feel more strongly about the first recommendation and I feel a little ambivalent about the second one. But if others thought that that was the way to go, I think I would be fine with that.

CHAIR BELLA: Thank you, Stacey.

Chuck and then Martha.

VICE CHAIR MILLIGAN: Thank you.

Chris, I had just a few questions. The first question is, is every drug that is approved under the accelerated approval process required to -- is there any drug for which that's the end of the FDA process and there is not a confirmatory trial aspect? In other words, are there ever instances in which if we were to adopt this recommendation and it became law, there's no pathway for certain medications to complete the process because the
accelerator approval itself is the completion of the
process, and there is not a confirmatory trial?

MR. PARK: My understanding is that manufacturers
do need to complete that confirmatory trial, but I can
double-check that to make sure that that is the case.

VICE CHAIR MILLIGAN: Yeah. To me, if there are
instances in which the confirmatory trial isn't necessary —
or I guess if the accelerated approval is the endpoint in
any instances, it seems like we would be setting up that
particular medication for a permanent higher rebate if they
had no pathway or no element of confirmatory trial. So I
just want to make sure to understand that aspect.

The second thing I wanted to ask is, in the TAP,
did it ever come up around non-Medicaid payers and whether
they also have tools they use to try to get manufacturers
to go through a confirmatory trial? In other words, are
commercial payers or other payers — do they use tools like
PDL or tiering or cost-sharing provisions or any other
tools to try to incent manufacturers to complete the
confirmatory trial using the levers available to those
particular payers? Do we have any awareness of that?

MR. PARK: Sure. Certainly, other payers that
you mention have tools with formularies, tiering, cost sharing, where they can either not cover the drug if they don't believe it's effective or they could kind of strictly limit the use of the drug if they have very high prior authorization policies in place.

I don't know if those are necessarily put into place with a goal of creating an incentive for the manufacturer to complete the trial, but in some cases, I do believe they might classify these treatments as loosely using the word "experimental," and so that is part of their reasoning for not covering a drug, and therefore, that does maybe create the incentives for the manufacturer to complete the trial. But I don't think it's explicitly tied to that. I think it's more that they are trying to very closely manage the use of this product if they feel like it's not potentially providing the clinical benefit that they anticipate.

VICE CHAIR MILLIGAN: So my suggestion is when we get around to the chapter on this, Chris, whatever context you're able to incorporate around other payers -- you know, Medicaid doesn't have some of those tools. It doesn't have the ability to use a lot of differential cost sharing. It
doesn't have the ability to use some of the exclusion mechanisms because of the Drug Rebate provisions. I think contextualizing this around the fact that potentially other payers also have tools and use tools around accelerated approval, I think that context would be helpful that Medicaid wouldn't be an outlier in trying to use its levers to incent completion of the confirmatory trial.

One comment and then one final question. The comment is in the materials, one of the examples that I found most persuasive was the example that you referenced around medications that would receive accelerated approval because they showed evidence of shrinking tumors, but they had not yet shown evidence of actually improving survival rates for individuals with cancer. I think the more that we can differentiate in the chapter around not just the examples you referenced in the slide deck in your presentation today, but examples where a surrogate endpoint might demonstrate a meaningful impact, but that the ultimate health outcome that the medication is seeking to pursue, which in this case would be a higher survival rate or better quality of life or something else, that we don't yet have that evidence, and that the importance of the
confirmatory trial is aimed at getting to those deeper clinical -- evidence of clinical effectiveness.

My final question is, are we simply speculating about the increase in launch price? And it's actually on the slide that's on the screen right now. You mentioned that a potential effect might be manufacturers would bake in the higher rebate into the launch price. I assume you don't have any evidence of that, although I assume that if they were to do so, Medicaid wouldn't have a lot of tools to address that because, as we've seen, Medicaid doesn't have a lot of tools to address and negotiate launch price issues. I just wanted to ask whether it's pure speculation or whether we have any evidence of that launch price issue.

MR. PARK: Sure. I think a long time ago, CBO tried to do an analysis where they tried to see if launch prices changed after -- I think when the Medicaid rebate program came into existence. It seemed like they found a little bit of evidence of that, but I think this is a tricky topic, and that kind of depending on the particular economist you talk to, some of them believe that manufacturers already have every incentive to launch at the highest price possible that the market will bear. So kind
of regardless of where the rebate is for Medicaid, they are going to try to launch at the highest price possible. So I think we can't definitively say that this will or will not be an issue, but I think it's certainly something that several economists argue about as to whether or not there could be a change in their launch price because of this.

VICE CHAIR MILLIGAN: Okay. Thank you.

Thank you, Melanie.

CHAIR BELLA: Thank you, Chuck.

Martha and then Sheldon.

COMMISSIONER CARTER: Anne, I appreciated your comments about the FDA, and I just want to elaborate on that a little bit. I wondered as I read the materials. I think we need to be careful that we're not commenting on the effectiveness of the FDA's expedited approval pathways. That's not our role and acknowledging Kit's concerns that there perhaps have been drugs that didn't pan out the way they were intended. There are also a lot of drugs that have. So I think we just need to make sure we're focusing on the effect on the Medicaid program and whether
Medicaid programs need some assistance, some financial assistance as they evaluate and in most cases are required to cover new drugs.

CHAIR BELLA: Thank you, Martha.

Sheldon?

COMMISSIONER RETCHIN: There. Am I on?

CHAIR BELLA: Yep.

COMMISSIONER RETCHIN: Okay. Yeah. I'm going to circle back and just make a -- maybe ask two questions, Chris, or embedded in a comment.

The first was that I interpreted Tom's comment this way, which I thought was quite appropriate. It was a question of whether if the rebate level is too high, then the manufacturers will argue that they'll stay away from investing in the development of drugs that particularly disproportionately serve Medicaid beneficiaries. If it's too low, then we'll have drugs that have this accelerated approval, and there's no look back in terms of getting the results of the clinical trials. This is sort of a Goldilocks framework.

You know, but what concerns me -- and I'll ask this of Chris -- on several occasions and like on
Recommendation 2, can this be determined generically? That is, aren't some of these decisions in terms of rebate level, in terms of the number of years as embedded in Recommendation 2, the number of years that we would give a manufacturer, isn't that somewhat drug-specific? And if it is, is there something we should do in terms of a panel review? I mean, there are not that many novel therapeutics that would be following this.

I looked back, and it was startlingly low. Actually, only 11 percent of novel therapeutics actually go the accelerated approval pathway. So that was my first question: Is this drug-specific, and should there be some reference to that in Recommendation 2?

The second one was I'm just curious to circle back. We asked -- we wondered if you've included a bioethicist on the panel. Has the bioethicist made any recommendations or contributed any thoughts on any of this?

[No response.]

CHAIR BELLA: Chris, did you --

MR. PARK: Sorry. Clicked the wrong button. so I'll start with Question 2 first. The bioethicist did not make any specific comments on the
accelerated approval recommendation. I think the main concern is access, and by including it in the MDRP, Medicaid still is required to provide coverage for these products when they come to market. so I think they felt like that was a good balanced way to address the issue for this particular case would be to try to address the concern on the price side, and by lowering the net price for Medicaid, that could be a good balance to kind of address any concerns but still provide beneficiaries to have access to potentially very important medications.

Then to your first question about whether or not this should be drug-specific, not necessarily in terms of the rebate amount, but the TAP did have a discussion about whether all accelerated approval products should be subject to this increased rebate, only a handful of them, because certain surrogate endpoints maybe have a much higher degree of certainty in terms of predicting clinical benefit versus others.

And they thought it would get kind of messy, and that the decision process, which one applies and which one doesn't, they thought that was a slippery slope and potentially just complicates things. And it would be a
cleaner process to just apply this to all accelerated approval drugs. So I think that context would apply to having some kind of committee trying to fine-tune what the rebate should be for each specific drug.

COMMISSIONER RETCHIN: Thanks.

CHAIR BELLA: Does anyone have any strong feelings? I'm hearing general support for Recommendation 1. Does anyone have any strong feelings on Recommendation 2? We need to give Chris some guidance on what to bring back to us. Are most folks in a position of ambivalence?

Tom and then Fred.

COMMISSIONER BARKER: Thanks, Melanie.

I'm not going to reiterate my comments from before because you know what my position is.

I did want to just suggest maybe -- Anne, I'd be interested in your input on this. Would it maybe be worth mentioning if we did go forward with Recommendation 1 on the 340B program? Because 340B-covered entities would then get -- would get the benefit of a lower price. Is that something we would normally do, mention the 340B program?

EXECUTIVE DIRECTOR SCHWARTZ: I mean, we wouldn't mention it in the recommendation, but it could be something
in the implications section, because those are providers
that serve the Medicaid population.

COMMISSIONER BARKER: Yeah, that is what I was
thinking.

Then with regard to 340B, I think with respect to
the discussion that Chuck and Chris were having, I do think
if you were to look at the legislative history of the 340B
program, you would see that there is -- that the whole
reason 340B was enacted was because there was a concern
that manufacturers built the original Medicaid rebate into
a launch price. So I'd just point that out, Chris, when
you're doing the research that you are conducting.

CHAIR BELLA: Thank you, Tom.

Fred?

COMMISSIONER CERISE: Yeah. Just an observation
on one. We've had a lot of discussion about it, but in the
recommendation itself, there's not a real statement about
the amount of the rebate. I've heard that we don't want to
say an amount, but do we want to give some direction there?
We could default to a pharmacoeconomist or people like
that, that can look at it, but to say it should be of the
magnitude that is going to encourage completion of their
trials or something to push, because I think what we're all saying is right now the incentive may be to go slow and just drag feet. But if we put an added rebate there, the idea is to encourage to complete it. So I'd just throw out the thought that you might want to put a substantial amount or an amount to incentivize completion of trials and maybe even reference getting the expert help, to help determine what that would be.

CHAIR BELLA: Chris, do you want to take that as input, or do you want to respond to that?

MR. PARK: Sure. Are you talking about inserting the word "substantial" into the recommendation, or would it be more in the surrounding text, the rationale to say something simile like the TAP suggested that it should be above the 8 percent?

COMMISSIONER CERISE: Yeah. You know, maybe you've covered it in the text, and that's good enough. I just don't want to lose that.

MR. PARK: Okay.

CHAIR BELLA: Thank you, Fred.

Chuck?

VICE CHAIR MILLIGAN: I just wanted to talk about
the second recommendation for a second. I remember in the past, we got presentations around the magnitude of the inflationary rebate, and it tended to be very substantial for a lot of drugs, that in fact, inflationary rebate was worth more than the base rebate, if I'm recalling all of that previous work correctly, and we made recommendations a few years back along those lines.

I'm in support of Recommendation 2, although I think, like Stacey, it's probably not as strong as No. 1, but I am in support. If we go there when we take a vote in April, I want to make sure that we pull through some of that context in history of our previous work around inflationary rebates, because those can be quite substantial as time passes, and it's not a trivial financial impact to states and the federal government. I just want to make sure we pull through that previous work we've done on that topic.

Thank you.

CHAIR BELLA: Thank you, Chuck.

Are those the comments on Recommendation 2 in particular? Does anyone not want to see it come back in April?
CHAIR BELLA: Did you all eat stuff at lunch that made you sleepy? I'm not getting much activity here.

Chris, I think that, first of all, do you have -- well, my take on this is you should bring both of the recommendations back to us. There are a couple of questions to confirm, one about Chuck's, whether everybody goes to the confirmatory trial, a couple things to confirm. We know you're still waiting on a CBO score. I would ask that you also ponder whether we need to insert a word like "substantial" or whether the surrounding text and the rationale provide the intent that would allow folks to find that right balance of encouraging speed to the confirmatory trial.

Do you need anything else from us in order to do what you need to do to bring it back in April?

MR. PARK: I think I have enough to bring it back in April.

CHAIR BELLA: Okay. Any last comments from Commissioners? If not, we're going to move to the next session.

[No response.]
CHAIR BELLA: Okay. Chris, thank you. I think you're staying, though, correct?

[No response.]

CHAIR BELLA: Yep? Okay. We'll get moving to the next session, which is about the COVID vaccine. We've had lost of discussion about this, and this is obviously something that's top of mind, how we ensure access for folks on Medicaid.

So, Chris and Michelle, I will turn it over to you.

### MEDICAID POLICY ISSUES RELATED TO THE COVID-19 VACCINE

* MS. MILLERICK: Great. Thank you, Melanie.

Today Chris and I are going to provide an update on Medicaid policy issues related to the COVID-19 vaccine. This builds upon work presented by Chris Park and Amy Zettle at the September Commission meeting, which focused on Medicaid coverage of vaccines in general and explored a range of possible strategies to improve vaccine access for adult Medicaid beneficiaries.

In response to the urgency and public health importance of the COVID-19 pandemic, we narrowed the
immediate next step in our work to identifying if there are any particular issues in accessing the COVID-19 vaccine in Medicaid and to examining whether any of our proposed policy options are particularly well suited to address these issues or whether, perhaps, any new policy options are needed.

During the September and December Commission meetings, Commissioners raised several questions and concerns regarding the available supply of COVID-19 vaccines and policies for coverage and payment of the vaccine in the Medicaid program, which were established in the interim final rule published in November. A lot has changed since then, and the Administration and Congress have taken steps to address many of these concerns.

The purpose of today's presentation is to update you on the details of these developments.

As you see on this overview slide, we'll first take a look at Medicaid coverage of the COVID-19 vaccine, both under the ongoing public health emergency, or PHE, and going forward after the PHE ends.

Next, we will summarize key findings from stakeholder interviews that we conducted as part of this
work, including interviews with state and federal
officials, academic and clinical experts on vaccination,
and national organizations representing a wide range of
stakeholders.

Then we will describe administrative and
legislative actions that affect Medicaid coverage of the
COVID-19 vaccine, including the COVID-19 relief
reconciliation bill that is currently before Congress. As
you know, the House passed its version last week, and the
bill is currently under consideration in the Senate.

Finally, we will highlight two additional policy
issues for consideration before summarizing next steps.

We welcome any questions Commissioners might have
in response to this update and look forward to the
discussion.

First, with respect to Medicaid coverage of the
COVID-19 vaccine, the Families First Coronavirus Response
Act, or FFCRA, provides a 6.2-percentage-point increase to
the FMAP for expenditures on or after January 1, 2020,
through the end of the quarter in which the PHE ends if
states meet certain conditions.

Coverage of COVID-19 vaccines without cost
sharing is required as part of the terms of the FMAP increase included in FFCRA, and all states and territories are currently claiming the increased FMAP. However, the COVID-19 vaccine coverage requirement under FFCRA does not apply to certain limited-benefit enrollees.

At this time, the supply of COVID-19 vaccines has been purchased by the federal government, and states are only responsible for paying for administration of the vaccine.

At the end of the quarter in which the PHE expires, the FMAP increase and other conditions of the FFCRA will no longer be in effect, so vaccine coverage requirements will revert to those in place prior to the COVID-19 pandemic.

Many beneficiaries, such as children under 19, adults receiving essential health benefits such as the new adult group, and those in separate CHIP will continue to have mandatory coverage of all ACIP-recommended vaccines. However, coverage of vaccines, including the COVID-19 vaccine, will be optional for certain adult groups, such as those eligible on the basis of disability, parent and caretaker relatives, and pregnant women. For these adults,
states may also charge cost sharing for a vaccine or its administration within the existing cost sharing requirements after the PHE.

In addition, a Public Readiness and Emergency Preparedness Act, or PREP Act declaration, authorized qualified pharmacists to order and administer COVID-19 vaccinations. The PREP Act specifically provides immunity from any liability arising from COVID-19 countermeasures and preempts state and local laws that may otherwise prohibit a qualified pharmacist or pharmacy intern from ordering or administering COVID-19 vaccines.

CMS has expressed the expectation that consistent with Medicaid's freedom of choice requirement, all state Medicaid programs will make payment for a COVID-19 vaccine and its administration to all pharmacies or pharmacists who meet the qualifications under the PREP Act.

Next slide, please.

Over the last two months, MACPAC conducted 11 interviews with Medicaid medical directors, national organizations representing Medicaid managed care plans, pharmaceutical manufacturers, patient advocacy groups, and pharmacists, as well as officials from CMS and the Centers
for Disease Control and Prevention. The goal of these
interviews was to learn whether these stakeholders had any
concerns about Medicaid coverage of the COVID-19 vaccine
both now during the PHE and in the future once the PHE ends
and if there are any particular policies that are better
suited to COVID-19 vaccines compared to other adult
vaccines.

First, stakeholders commented that most of the
current issues with access to the COVID-19 vaccine are
supply and logistical issues that affect all payers and
populations and are not specific to Medicaid. There was
also general consensus that the immediacy of the COVID-19
pandemic could warrant a different approach from coverage
of other adult vaccines, particularly in the near term.
Many states and stakeholders reported that they have not
yet begun to contemplate long-term Medicaid coverage and
policy decisions for the COVID-19 vaccine after the PHE
concludes. While many believe it's likely that COVID-19
vaccination will become an annual occurrence, similar to
flu and other vaccines, it's difficult to engage in
planning until there's more evidence on whether boosters
will be required and if so how often.
Payment adequacy was one of the most common issues raised by stakeholders who expressed concern about the level of provider payment for administration of the COVID-19 vaccine, including the potential for low payment to discourage provider participation and increase barriers to vaccination for beneficiaries. Stakeholders generally recommended that vaccine administration should at least match the Medicare rate, which is $16.94 for the first dose and $28.39 for the second dose in a two-shot series.

Stakeholders also expressed support for PREP Act flexibilities that have authorized pharmacists as qualified providers to administer COVID-19 vaccines and believe this will help to increase vaccine access.

The importance of accurate and timely reporting on vaccine uptake was also a theme in our interviews. Reporting and functionality varies by state, but current CDC rules require vaccine administrators to report COVID-19 vaccinations and certain data into their medical records within 24 hours of a COVID-19 vaccination and into the relevant IIS, or Immunization Information System, within 72 hours.

Some stakeholders expressed concern about the
limited sharing of immunization information with entities involved in coordinating a member's care, such as Medicaid managed care plans.

With respect to health equity issues, states and stakeholders acknowledge the importance of addressing racial disparities in vaccine uptake. Experts emphasize the importance of addressing vaccine hesitancy and engaging in targeted efforts to increase awareness of the vaccine and its efficacy. It was also suggested that improved data collection reporting on vaccine update by race and ethnicity would be helpful to inform interventions that address disparities.

All stakeholders emphasized the importance of collaboration with community-based organizations and provider partners, such as federally qualified health centers, which typically serve populations who have been disproportionately affected by the pandemic.

Finally, stakeholders generally supported the policy options that MACPAC discussed last September but did not necessarily favor one option over the other. To address short-term issues, stakeholders expressed support for policies that would increase funding for the purchase
and administration of the COVID-19 vaccine, including enhanced FMAP for vaccine administration and continuation of federal purchasing of the vaccine for a temporary period of time.

I will turn it over to Chris now to talk about federal action on these issues to date, additional policy considerations, and next steps.

* MR. PARK: Thank you, Michelle.

Recent actions by the administration and Congress addressed many of the near-term issues that came up during the stakeholder interviews. The administration has signaled to states that it will extend the PHE through the end of the year, keeping the 6.2-percentage-point FMAP increase and the COVID-19 vaccine coverage requirement in place.

The administration has also recently executed new purchase agreements for the current vaccine and made it likely that the federally purchased supply will be enough to vaccinate the entire U.S. population.

Additionally, the administration recently announced that it would send vaccines directly to certain federally qualified health centers that would increase
access to vaccines for underserved communities.

The American Rescue Plan Act of 2021, the budget reconciliation bill that the House passed last week, has several provisions which address Medicaid and CHIP coverage and payment for the COVID vaccine. It extends coverage of the COVID vaccine to all Medicaid beneficiaries, including those with limited benefits. It would require mandatory coverage of COVID vaccine administration and treatment, without beneficiary cost sharing, and would provide 100 percent match for COVID vaccine and administration spending through one year after the end of the PHE.

Coupled with the likelihood that the PHE will be extended through the end of the year, this means that COVID-19 vaccine coverage would be mandatory and cost for the vaccine administration would be matched at 100 percent until at least the end of 2022. The same coverage requirement, and 100 percent match, is also included for CHIP through one year after the end of the PHE.

The bill also gives states the option to provide coverage of COVID-19 vaccination and treatment for uninsured individuals without cost sharing. It also provides additional funding for the CDC, HHS, and FDA to
advance vaccine distribution, uptake, transparency, and surveillance. This bill has passed in the House, and the Senate is expected to vote on it shortly.

While the federal proposals address most of the issues identified during our interviews, there were a couple of things that are not addressed that may warrant further consideration. First is the adequacy of provider payment rates for vaccine administration. Most of the stakeholders thought Medicaid should pay at least Medicare rates.

We did some research and found payment rates from 49 states, and the majority are paying Medicare rates, but 10 states are paying less than Medicare for COVID-19 vaccine administration. Presumably, states that are currently paying less than Medicare rates would be willing to increase payment rates up to Medicare levels if provisions for 100 percent matching for vaccine administration becomes law. However, the legislation does not require states to pay at Medicare rates nor does it set a minimum payment amount.

Stakeholders also emphasized the importance of timely and accurate reporting on COVID-19 vaccination data
to applicable state and federal entities as well as other organizations and individuals involved in patient care or member outreach. There may be opportunities to improve data reporting and sharing, particularly on race and ethnicity, and to target outreach for at-risk populations in communities with low vaccine uptake.

A study in January found that only 17 states were publicly reporting COVID-19 vaccination data by race and ethnicity and states vary in what data is collected and reported. An update to that analysis shows that reporting is improving and that 34 states now report data by race and ethnicity.

Furthermore, some of our interviews highlighted the need for better data sharing to coordinate care. For example, some states do not provide managed care plans with access to information from the state immunization information system.

Additionally, Medicare is not required to share immunization information on dually eligible beneficiaries when Medicaid providers and managed care plans also provide care for those individuals, such as managed long-term services and support plans.
At this time, the American Rescue Plan Act of 2021 appears to address many of the short-term issues that were identified in our interviews. We will continue to monitor the Medicaid payment and coverage of the COVID-19 vaccine, particularly as more information becomes available on the need for boosters or annual vaccinations to address variants and maintain immunity.

We will provide any updates to the Commission as needed if further action may be warranted.

Going forward, staff will continue to examine the issues of Medicaid coverage of adult vaccines more broadly, continuing the work we presented in September. Many of the stakeholders that we interviewed expressed general support for the policy options we presented last fall, and we will continue to explore those options.

And with that, I will turn it back over to the Commission for any questions.

CHAIR BELLA: Thank you, Michelle. Thank you, Chris.

Just to kind of highlight what was just said for Commissioners, this is not for any action on our part. This is trying to keep us as much real-time updated as
possible, as this thing is moving quickly, but several of the concerns we had had do seem to be addressed, which is reassuring.

So how about if folks have any comments or questions or things that you want to make sure we're keeping an eye on, that would be a good time to call them out now.

Peter and then Chuck.

COMMISSIONER SZILAGYI: Good. Thanks, Michelle and Chris. This was really an excellent presentation, very clear, and actually really exciting because many of the issues that we had talked about and that many other people had been discussing have been addressed by what the administration has done.

I mean, obviously, the pandemic has highlighted the vital importance of the vaccines. If you think about it, what the administration has done has been, in a way, a big variant of the VFC program. They purchased the vaccine. They have a good administration fee, tracking with the IIS. So I'm just planting that seed in terms of discussion for other adult vaccines.

And I do agree that the American Rescue Plan this
year addresses these short-term issues, and that the
barriers now are really supply, distribution, and
hesitancy.

I do think I am worried about the 10 states that
appear to be paying less or can pay less than Medicare
rates. With the pandemic, if there are surges in certain
states, they are likely to spread to other states. So it's
a national emergency, it's a national crisis, and I'm
worried about states -- if there is cost sharing, if
payment isn't Medicare rates, I am worried that there may
be lower vaccination rates in those states.

And I do agree with the -- I think you mentioned
sort of a second kind of concept of requiring both
reporting of race and ethnicity and data sharing, and I
think that's actually a good idea as well.

One last point about the equity issue. There
used to be enormous disparities in childhood vaccination
rates with people of color having -- children of color
having lower rates. That disparity has disappeared, and it
disappeared because major structural changes were done in
the immunization delivery system, including financing, and
it includes the VFC program and Medicaid. I think if we
can do something similar for adult vaccines, we might be able to -- and there are big disparities in adult vaccines -- we may be able to reduce those disparities.

For COVID vaccine, there is also a real concern about higher hesitancy among people of color for the COVID vaccine. So what that translates to in my mind is the need to do more work for public health, more efforts to engage individuals and including people of color for the COVID vaccine.

But overall, I do think that most of these concerns that we've talked about earlier have been addressed. I'm worried about the Medicare payment rates in those 10 states, and I would suggest reporting on race and ethnicity from the IIS's or the data repositories.

Thank you.

CHAIR BELLA: Thank you, Peter.

Chuck and then Sheldon. Thank you, Chuck.

VICE CHAIR MILLIGAN: Thank you.

I want to align myself with Peter's comments.

Chris, do you mind just going briefly to Slide 7? I'm just going to make a couple of very brief comments.

In that final bullet in terms of continuing to
examine strategies to improve access for adults, to me, one of the eye-opening things about this whole body of work that we've been doing over the last year has been to learn about the coverage and benefit rules and the extent to which vaccines were not really a required benefit for adults. I do think articulating to whatever extent we know or have confidence, articulating what we mean by continuing to examine strategies when we get to the chapter and when we get to next steps and to not have it entirely vague -- but I recognize there's going to be some uncertainty. But I want to just call out that I think keeping an eye on this over time is going to be important.

Whatever lessons we can draw from this particular experience with the pandemic, again, around hesitancy and some of the other things that Peter touched on, I would encourage that we examine what the future work may or may not look like and what we can commit to when we talk about continuing to examine strategies.

The other thing I want to add is I share Peter's concerns about the payment rate for administration and also supply and also hesitancy. I would add another element, which is to the extent that there are difficult-to-locate
and difficult-to-engage Medicaid beneficiaries, whether
it's homelessness or transience or other pieces, I think it
would be beneficial for MACPAC at some point in time to
catalog approaches and strategies around outreach and
engagement and location to capture best practices or
lessons learned or any of that kind of work in some
potential chapter or issue brief down the road.
So I will leave it there. Great work leading us
through this, during the course of this year, and,
Michelle, thank you as well as Chris.
CHAIR BELLA: Thank you, Chuck.
Sheldon and then Kisha.
COMMISSIONER RETCHIN: This is a great, great
report, Michelle and Chris. I really enjoyed reading it.
The's very comprehensive.
Let me bring up two issues and really circle back
and support what Peter said about communities of color with
higher vaccine hesitancy rates. This is historic,
historical, and we need to engage those communities more in
terms of determining some of the barriers. Some of the
barriers are well known, but also, let's not forget just in
terms of having providers, sufficient providers in some
communities of color means that there are unmet needs and
no relationships with or not active relationships
potentially with primary care physicians and other
providers that would be able to overcome that hesitancy.

So that's important.

The other group that I found puzzling, not
addressed by the administration -- and I don't know if this
is on your radar, Michelle or Chris -- that is that today
there are 12 million Americans who are homebound, who are
largely at home. They're not likely to get in lines to get
vaccinated in Dodger Stadium or whatever the name of the
stadium is now, and they have no access. Walgreens is
going to congregate living facilities and not to the home.

I don't know. Chris or Michelle, have you heard
that addressed at all -- and Peter?

MS. MILLERICK: It came up in our interviews of
both states and some provider organizations and managed
care entities having that issue sort of risen to their
level of awareness, who are actively working with their
states and partners to try to address that.

There weren't specific examples that folks gave
us of how the problem had been solved. It seemed like they
were really in the trenches of saying that we recognize the need for this. Some of them talked about trying to partner with more mobile types of providers like ambulance providers who might be able to be mobilized to go to people in the community where they are who are homebound, but it was certainly something that was on people's radar. And people were really still in the process of trying to solve it.

MR. PARK: And just to add on, I think the recent development of the Johnson & Johnson vaccine being approved and having much less requirement in terms of cold storage and things like that maybe will make it easier to kind of get the vaccine to the homebound population.

COMMISSIONER RETCHIN: Peter?

CHAIR BELLA: Peter, on this?

COMMISSIONER SZILAGYI: I will make a quick comment to that. There's a lot of discussion in the vaccine world about using the Johnson & Johnson vaccine for individuals who are homeless, homebound, for which a single dose -- it's difficult to track them down for a second dose or it's difficult even to get a first dose in, and as Chris says, I think that's one of the strategies.
And I love Chuck's comment about documenting kind of best practices. MACPAC has done that so well in so many different areas, whether it's best practices across states or within states, but documenting best practices for COVID vaccination and with respect to lessons for other types of either public health measures -- vaccines or other types of public health measures.

Just as an example, we at UCLA have incorporated the Social Vulnerability Index, the SVI, to actually help prioritize patients for vaccinations; in other words, patients who are in the highest Social Vulnerability Index are going to be prioritized earlier for COVID vaccination with special outreach. So there are, I think, interesting practices that might be generalizable to other settings.

CHAIR BELLA: Thank you, Peter.

Kisha?

COMMISSIONER DAVIS: Thank you.

I'd like to cosign on many of the comments that were already made, especially, Peter, your comments at the very beginning.

Two points that I want to bring up just around vaccination and using all available means to get
vaccinations in arms, shots in arms, some states are focusing on mass vaccination sites, some are focusing on pharmacies, some are focusing on community health centers. But I also want to make sure to highlight that including the primary care office and primary care doc and physicians, physician offices in that distribution, some states -- I know in Maryland, it's been very rare, if not impossible, for primary care offices to be able to administer vaccines. Even I know some offices who have gone to the extent of purchasing a deep-freeze freezer to be able to distribute and haven't been able to do so because they can't get supply from the state or from the federal government.

Many of these docs have already created that level of trust with their patients and the community, and so it's a way to get at that vaccine hesitancy. If they're not able to be part of the solution, then that's a barrier, and so making sure docs who have been -- clinicians who already have that established relationship with patients are able to be a part of the solution. They are effective every year in administering immunizations, so keeping them as part of the loop.
The second is around the racial disparity, and I echo many of the concerns that Commissioners have brought up around vaccine hesitancy in minority communities. I would actually really like the Commission to dig into that a little bit more. I appreciate collecting best practices, but also, I would love to see us specifically track the immunization rates in minority Medicaid beneficiaries and just to see where that is and then maybe using some of those best practices and sharing that out. It's a trend that concerns me. I think it affects our ability to get there, and we've already seen the disparities in Black and brown communities. I just want to make sure that we are continuing to pay attention to that.

Thanks.

CHAIR BELLA: Thank you, Kisha.

Have I missed anyone? Fred and then Martha.

COMMISSIONER CERISE: I'll be quick. I agree with all the comments that have been made, great comments, and it's really encouraging to see the federal proposals because it really does address a lot of the critical issues.
I just have a question for Michelle or for Chris. Do you know why in the American Rescue Plan Act that allows 100 percent coverage, coverage at 100 percent FMAP, that it's optional for states to apply that to the uninsured? Why wouldn't that just be part of the -- I mean, first off, maybe the option is meaningless because everybody is going to do it, but why wouldn't they just include that in the set of expectations? If you're going to do Medicaid and you take that up, you'll make it available to the uninsured too, since that's at 100 percent FMAP as well.

MR. PARK: Sure. I think it's primarily for the states who have taken up that option. Originally, it was to provide COVID testing for uninsured populations, and the bill in Congress right now would extend it beyond testing to include vaccines and treatment. I think another reason it's optional is that there is funding through HRSA, through the kind of uninsured pool, to provide payment for those who are uninsured to get the vaccine. So I think there is another mechanism for vaccine administrators to get payment when they do administer the vaccine to the uninsured population.

CHAIR BELLA: Anything else, Fred?
COMMISSIONER CERISE: No. It just seems like you're leaving a gap there of an important population from a public health perspective, but if the idea is there are other vehicles and states are taking advantage of it, I guess I understand.

CHAIR BELLA: Okay. Thank you.

Martha, then Darin.

COMMISSIONER CARTER: Thanks.

Since I think we're doing okay on our time, I wanted to highlight the current program between HRSA and the CDC to use the community health centers to distribute vaccine because the health centers are really providing care for the populations that we're really concerned about in terms of disparities.

So the health centers that were invited to participate are those that are already documented, because the health centers have great data, already caring for a large percentage of people experiencing homelessness, public housing residents, migratory and seasonal farmworkers, and patients with limited English proficiency.

I think there were 137 health centers invited and 113 currently participating. 137 doesn't sound like a lot,
but these are usually big health centers. This represents millions of people that are potentially reachable through the community health centers. Nationwide health centers care for 29 million people. So these are the large health centers in each state that have the organizational capacity to field a major vaccine push.

So I think it's really promising, and I think we need to track it. But also, we know there is going to be good data coming out of this group.

Thanks.

CHAIR BELLA: Thank you, Martha.

DARIN?

COMMISSIONER GORDON: Chris and Michelle, thank you for this.

I think your part on -- you know, you collecting the feedback on data is really important. As I think about not only on the race and ethnicity gaps in the data as being an issue, I also think the point you raised about the lack of visibility that health plans have into who's been vaccinated and who hasn't been vaccinated is an area of opportunity, because we basically have this resource in many states. Managed care covers much of that population,
and their ability to do effective outreach to those who
have yet to be vaccinated has been limited because of the
lack of that data sharing. So I'm glad you raised that
point. I think it's something that doesn't seem like it's
been addressed by any of the actions to date, but I think
it's something that is causing us to be somewhat sub-
optimized in our effort in really attacking this issue head
on.

CHAIR BELLA: Thank you, Darin.

Other comments?

[No response.]

CHAIR BELLA: Well, Michelle and Chris, I think
you can tell that we're very appreciative of this and
really reassured to know that you're keeping an eye on all
of this and you're letting us know of developments
especially in the areas that we're interested in and look
forward to having this pave the way for some of our
discussion on adult coverage of vaccines writ large. So
thank you very much.

We are going to move into the next session.

Sheldon, I'm not sure if that was the excitement
about the adult coverage in vaccines or something else you
do or do not want to share, but if you'd like to share, we have a second. If not, we'll just pass.

COMMISSIONER RETCHIN: I'm not sharing that, but it involved my daughter. Thanks.

[Laughter.]

CHAIR BELLA: Good. All right. Well, that level of excitement is always good to see.

All right. Just to kind of get level set on what we have left to do, Rob is going to talk to us about the Medicaid Innovation Accelerator Program. Then we are going to take public comment on these last three sessions. We are not going to run past three o'clock because at three o'clock we are taking a break, and we must promptly begin at 3:15 because we have guests from the territories joining us, and we have a very robust panel at that time. So we need to stick to our schedule.

So Rob is going to go through this. Then we'll take public comment, and, Rob, it's all yours. Thank you.

### BUILDING STATE CAPACITY: WHAT WE LEARNED FROM THE MEDICAID INNOVATION ACCELERATOR PROGRAM

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

So this afternoon, I'm going to speak about the
findings from the evaluation of the Medicaid Innovation Accelerator Program, known as IAP.

I'll first begin by providing some background about IAP and about the CMS Center for Medicare and Medicaid Innovation, known as CMMI, and then I'll discuss some of the findings from the evaluation regarding state interest and engagement in the program as well as some of the barriers that states encountered when implementing their IAP projects.

It's important to note that the Commission is not required to write a formal comment letter on this evaluation, and we're not planning to, since the Commission has already previously expressed its support for IAP. However, we're presenting these findings to you today because we're hoping that they will help facilitate a discussion about the Commission's future work on state administrative capacity and the role of CMMI in supporting state innovation.

So, as a result, I will conclude today's presentation with a few policy questions in those areas, and I'll look forward to your feedback on the future direction you'd like to take this work.
So first some background about CMMI. CMMI was created in 2010 as part of the Affordable Care Act in order to test new innovations to improve quality and reduce costs. Congress appropriated $15 billion for CMMI for the first 10 years and $10 billion every 10 years thereafter.

So far, about 10 CMMI models have focused on Medicaid beneficiaries or statewide innovation, totaling about $2 billion, which it's important to note it's much less than the number of models in the funding that has been devoted towards models for Medicare enrollees.

So the IAP is one of the main CMMI initiatives related to Medicaid, but it's a little bit different from other types of CMMI models. So rather than testing a specific policy change, IAP provided technical assistance to states and helped them implement payment and delivery system reforms using existing Medicaid authorities.

CMMI initially appropriated about $100 million for the initiative over five years. This amount represents a pretty large increase in federal administrative funding for Medicaid, but it's a relatively small share of state administrative funding and of course even smaller share when you look at total amount of spending on Medicaid.
benefits for the entire program.

IAP was initially scheduled to expire in 2019, but it was extended a year, and funding ultimately expired in September of last year.

So in terms of the structure of IAP, basically the IAP funding wasmostly used to hire consultants that worked with states in a variety of different program areas listed here. In addition, states could receive support for help in various functional areas such as data analytics and value-based payment, and they could use that support to work on whatever area they wanted. So other areas such as maternal health were addressed through those functional areas.

IAP offered TA through a variety of different modalities, including webinars that were available to all states and more intensive coaching that was provided one-on-one.

In addition, states that were implementing similar initiatives were grouped together in various program tracks, so that they could learn from one another as they went through the process.

Similar other CMMI projects, IAP was
independently evaluated to assess whether it achieved its goals. The final evaluation was published last December based on data collected as of September 2019.

Overall, the evaluation found a pretty widespread interest in IAP program activities. Of all the different program areas, the substance use disorder and LTSS tracks were two of the most popular. One potential reason may have been the fact that CMS introduced new opportunities for substance use disorder waivers and housing supports in LTSS at about the same time that IAP was first introduced. Ultimately, many states that were participating in IAP took advantage of the TA to help implement some of those new program options in their states.

The evaluation found that states rated all the different types of TA as useful, but they noted that the coaching was particularly helpful for states that were further along in their implementation process and could benefit more from the individualized support.

States also appreciated the opportunity to learn from other states participating in the same program area, suggesting that there were some benefits in CMS's approach to group similar states together throughout the TA process.
This figure shows the geographic reach of IAP program in functional areas as of September 2019. As you can see, most states participated in at least one program or functional area. In addition, not shown in this figure is the fact that virtually all states participated in the many webinars that CMS put together through IAP.

There were three main barriers that the evaluation identified. First, in some states, they faced challenges with staffing that prevented them from fully taking advantage of all the IAP opportunities. In some cases, it was difficult for coaches to get full engagement from state staff who are busy with many competing priorities. In other cases, states just simply didn't have staff with sufficient data analysis skills to really use and take advantage of some of the more sophisticated data models and value-based simulations that were created by the IAP coaches that they worked with.

The evaluation also noted that some states faced roadblocks because of changes in state priorities. So although the state Medicaid director was required to sign off on projects at the start, these efforts sometimes faced challenges as they were being implemented as they needed to
get buy-in from state legislatures or other state agencies.

Finally, because of state budget constraints, some states were not able to fully scale up the programs that they developed through IAP. Here, it's important to note that IAP only provided funding for federal TA, and it didn't provide any funding directly to states. So it was not directly intended to address state budget challenges.

So now that IAP funding has expired, the future of IAP is unclear. At this time, it's a bit too early to know where the Biden administration will focus its CMMI efforts. Using existing authorities, CMMI could choose to continue IAP with new funding or could create new IAP-like models that use some of the lessons learned from the program.

In addition, the administration will have an opportunity to take a closer look at the full range of models being tested by CMMI and consider whether there's a need for more investment in Medicaid-specific models more broadly.

The findings from IAP can also help inform future efforts for CMS to provide TA to states using its existing administrative funding as well as other efforts to support
state capacity. For example, as you'll recall, the Commission made a recommendation last year about providing funds for state capacity to implement integrated care models, and you all talked this morning about potential recommendations related to supporting state capacity around behavioral health.

The Commission has not commented specifically about how this type of support should best be provided or finances, but the IAP evaluation provides some insight into some of those questions.

So that concludes my presentation for today. As I mentioned at the outset, we're really looking for your input on how this evaluation can help inform our future work on state capacity and on the role of CMMI.

There are some questions here to help guide your discussion, and if you do want to pursue further work in this area, it would be particularly helpful to know what direction you want to take the work, what ideas we should develop further, and of course, ultimately, what information would be most helpful in your decision-making.

Thanks.

CHAIR BELLA: Thank you, Rob.
I feel like every session we've had or almost every session, it all comes back to a common theme of states don't have the bandwidth or states don't have the capacity, whether it's duals or behavioral health or COVID and on and on and on. So I think this is really important, and I appreciate you walking us through the findings of this.

We're going to turn it over to comments starting with Sheldon.

COMMISSIONER RETCHIN: Yeah, Rob, I really enjoyed your memo and presentation. I think it sort of amended the follow-on or segue from what Melanie just mentioned. It's kind of ironic -- it seems like a ton of logic -- that the barriers that exist for successful implementation of innovation are the barriers that exist, and there's a rationale for more assistance or we really can't do any more innovation.

I will say I was, however, taken aback by the fraction of CMMI funding that goes to Medicaid, and maybe I'm just missing something. But given the variation among the different Medicaid programs along with the thin administrative structure of most state programs, that
shouldn't be a reason not to innovate. That should be a reason to actually invest.

But I don't know. Maybe, Melanie, you could address this. Why did Medicaid get such a small amount of funding through CMMI? Or maybe, Rob, you can jump in too.

CHAIR BELLA: Well, Rob, you should elaborate.

Part of it is I think that CMMI authority to test isn't as broad in Medicaid as it is in Medicare, and I think that that's one of the reasons that would be given. It's more limited. So it has to be paired with another Medicaid authority, which perhaps the agency is much more familiar with Medicare. So having to pair them together maybe was a barrier internally, but that is definitely an issue, Sheldon, in terms of the reach of the innovation center on Medicaid and what it can waive. The wand is much smaller for Medicaid than for Medicare, I guess, is how I think of it.

And, Rob, I don't know what you would say to that.

MR. NELB: I think that's fair, and perhaps the converse of that is important to note too is that Medicaid under its existing authority has a lot of waiver authority
through 1115 to test new --

COMMISSIONER RETCHIN: Right.

MR. NELB: But it's interesting it's still about the CMMI sort of funding and this overall focus. I think IAP was an example of how CMMI kind of recognizing that there's a lot of flexibility in Medicaid, and so trying to use CMMI funding to help support and complement that is a bit different for approaches.

But we can take a closer look at that, thinking about those authorities, and perhaps we could talk to CMMI more about whether there are some barriers in their statute or why they're not focusing on Medicaid.

COMMISSIONER RETCHIN: I'll just end up and just say I know that there's -- Anne had mentioned having Liz Fowler come to the Commission, and I think it's an important area early on in our tenure to make that point. I know the 1115. There are other areas for innovation, but this CMMI was meant to be for both agency.

CHAIR BELLA: Yeah. I do think the point you started out with, though, like even if we still have to equip states with the ability to take advantage of these opportunities, which is something that we can't lose sight
COMMISSIONER RETCHIN: Right.

CHAIR BELLA: Brian, I saw your hand and then Toby.

COMMISSIONER BURWELL: Yes. And I apologize for my temporary absence. I had to go to a funeral this afternoon.

In the spirit of full disclosure, I was the project director of one of the two major contracts funded by CMS when I was at IBM Watson Health. From 2012 to 2019, I was the project director of the IT contract.

I would want to say three things. One is that I think there are much increased opportunities — and this is partly a result of the pandemic — to use via virtual technology as a technical assistance tool. For example, the technology that we use for this meeting here is significantly more advanced than any technology that was available during the contract. We did have some videoconferencing. We did do webinars, but the speed of development of these technologies just over the last two years is amazing, and I think there's a lot more that CMS could do with these technologies now that they couldn't do
before. There wasn't a videoconference in which there wasn't some kind of technical, logical glitch usually during that contract, not only at the federal level or at even IBM, but at the state level, people not being able to get on, all kinds of things. So I would encourage much greater investment. I mean, these things do cost money in those as part of a TA effort.

Secondly, the IAP-TA model was to put together cohorts of states to address certain policies of maybe relevance to the states, but they were fairly long-term engagements, usually a year or more. It often took an amount of time to get the states organized and on board and engaged and working on it, but I do think there's an opportunity to also provide technical assistance over the short term. I would support a pool of part of the investment to do things with much greater immediacy and quick turnaround to very short-term topics of immediate interest to the states. I think with these types of technologies, it would be a lot easier to form meetings, get consultants, address issues over a very short period of time.
Third was -- and Rob alluded to this in the chapter was the inability of the contractors and their consultants to provide technical assistance around the direct operation of the program. So there was this fine line that we cannot step over around advising states on how to put together 1115 waivers, for example, because the IAP organizational structure at CMS and other reasons was not part of the overall operation of Medicaid, and they didn't want people who didn't have that operational responsibility giving advice around operational issues.

I think there's an opportunity to integrate those two, the TA component organizationally with the direct program operations, so that there could be technical assistance that actually led to real policy and program change, state plan amendments, waivers, whatever.

I'll stop there. I just think there's a better opportunity to integrate those two functions.

CHAIR BELLA: Thank you, Sheldon.

Toby?

COMMISSIONER DOUGLAS: Yeah. I'll be brief.

First of all, I think that the TA is essential for states, but what was clear from the findings -- and I'd
say this is where we need to focus -- is on these emerging areas that are not where states have the expertise. We talked about it this morning that when we get into some of these new emerging areas around mental health, and we saw that the same wouldn't be recommended around duals.

But it needs to come, and one area, when I think back to the financial alignment demos, there was 100 percent federal funding for support for implementing those demonstrations. So if we could complement it with efforts, the TA with getting states some resources on their side where they don't have to put out state match, I think that could help with the infrastructure and building off some of those.

Am I remembering it correctly, Melanie, how you guys -- we did that?

CHAIR BELLA: Sort of, yeah. Every state got a million dollars, and they could use it for like implementation costs, including hiring staff to support the program.

COMMISSIONER DOUGLAS: Yeah. Because it's very hard, as we know, for states. Even with the TA, it's going to come down to bandwidth on the state side. So what do we
do or recommend around the TA coupled with some
infrastructure building for these unique emerging issues?

CHAIR BELLA: Thank you, Toby.

Fred?

COMMISSIONER CERISE: Yeah. I think it's an
important program to have. I think the ability to spread
good ideas is important. So I certainly would look for how
to be able to continue to facilitate it.

Rob, I have a question about the state
constraints. You mentioned three things -- the staffing
challenges which I get, and changing priorities. The third
one around state budget constraints is a confusing one
because if the program is designed to propagate models that
have been proven to improve quality and lower costs or at
least not increase costs, then perhaps a heavier focus on
those programs that we have, harder evidence that they
really do lower costs could help state uptake.

Do you have any insight? That explanation of why
states couldn't participate because of the budget
constraints seems a little hard to understand, given the
program is going to put forward ideas that lower costs.

MR. NELB: Sure. So to be clear, these were
states that did participate initially, and maybe through IAP, they developed sort of a small-scale model or they developed the concept for a new value-based payment arrangement or whatever. But then when they maybe went to their legislature to try to scale that up statewide or getting the funds to implement, they faced some challenges. Obviously, the goal is to do things that reduce costs and improve quality, but with some of these, there is still an up-front investment required and the savings aren't achieved until down the road. So in states with tighter budget constraints, it's harder to make that initial investment, even if you think it's going to lead to savings down the road.

COMMISSIONER CERISE: I guess that's an important point because everybody who spends money has people coming at them with ideas that are going to lower costs, but not this year. But it's going to come. You know it's going to come. So to be able to really focus on the ones that if you want update, there are some that really do have good evidence that they are going to lower costs as well. So maybe that would help.

CHAIR BELLA: Thank you, Fred.
So my comments will not come as a surprise, and depending on how we think about TA, I mean, it feels to me like we have to address the issue of state capacity and bandwidth and actual hands in the state to do things. Before, we're worrying about spreading best practices, because the TA that passes on best practices means nothing if they have nobody there to implement it. So I just don't want to lose sight of that as we think about where CMS should focus and how we get value. Honestly, like Medicare, it's easier in Medicare. So I think we do have to keep beating the drum, "Don't forget about Medicaid," and let's make sure states are at the table, particularly when decisions are made that impact the Medicaid programs. I think Liz Fowler will be very receptive to those comments and to brainstorming with us, and I know Anne has her on the list of folks that we'll talk with sooner rather than later. So I feel like this is -- we're all kind of aligned on the fact that we want to see more of this in Medicaid, and I think maybe we'll have receptivity from the folks that are going to be planning the next few years of activities at the innovation center.
Any additional thoughts? Anything else, Rob, that you want to add?

MR. NELB: No, that's all. Thanks. This is really helpful and will give us some ideas going forward.

CHAIR BELLA: Well, this is wonderful because it honestly is a theme in every single session, so thank you.

All right. We are going to move into public comment. We're going to try this a little differently. I would like to ask anyone who wants to make a public comment to please raise your hand. Then we are going to tally up the number of people that want to make a public comment and try to make sure we have enough time allotted for everyone.

So far, I see one person, two people. We'll just give it 10 more seconds. If you'd like to make a public comment, please raise your hand now.

All right. Every time I think I can predict where we're going to get public comment, I'm wrong. We just have a couple folks that want to speak. If you could start with Camille, that would be great.

MS. HUGHES: Camille, you're unmuted. Just unmute your line.

### PUBLIC COMMENT
* MS. DOBSON: Great, thanks. Good afternoon.

Thank you again to the staff for great work on these two topics. I wanted to briefly, on the COVID vaccine issue, let you know that we are working really hard with our states to gather best practices around getting vaccines to homebound individuals, and so we should have some materials to share, hopefully shortly.

There are not a lot of good practices. A couple of states are using their health plans to identify folks that are homebound and using care managers. The complexity needing to have the ultra-cold storage and being able to watch someone for 15 minutes after they have gotten the vaccine has really caused a lot of challenges, staff, manpower-wise.

One really interesting initiative is in Delaware, they're using their paratransit system to go to all of their known providers where the paratransit individual -- the buses actually will take four or five nurses and drop two off at one site and then hop forward to another site that can get those first two and forward to another two. So they continue to do this hopping, and they're making some really good progress.
I know Michelle mentioned EMS. That's happening in Kentucky and a couple of other states.

But, anyway, we'll be happy -- I'll let Anne know when we have that publication or that highlight document available to share with you.

On IAP, I have a lot to say too, but I won't spend a lot of time. I was a subcontractor through IBM Watson for the IAP LTSS track, and we have a lot of thoughts about the way it was structured.

I agree with -- I think it was Peter, maybe, who said -- or Sheldon, I think -- that talked about the lack of funding for Medicaid. It's horrific, actually, how little money from CMMI went to Medicaid, and I think back to Melanie's point, some of it is based on the waiver authority. But fundamentally, the way they evaluate, that was really the problem. They really wanted pre, post, or having control groups to evaluate the impact, and that's not how it works in Medicaid. So I think they were hampered by coming up with models that worked for Medicaid. So that's the structure of the CMMI evaluation criteria that I think is in the control of the agency, at least from my perspective, having been there when they started.
Then IAP, I think, in the health space, it was very frustrating that CMS did not take advice from the states on what they were most concerned about, and what they really wanted help with was meeting the HCBS settings rule. And they wanted help figuring out how to do different day services, for example, or on quality, and what we got was value-based payment. The reality is that the states -- value-based payment is very minimal in the HCBS space, except -- well, in the HCBS space, in nursing facilities in a number of states, real quality improvement and value-based payment, but it was a struggle to get states to evaluate, to come up with an idea that would work, because you need to have value-based payment. You need to have a value proposition, and that's very challenging in the HCBS space.

It was very valuable. State capacity was very hard. I think in the four years that I was working with Brian and IBM Watson, staff turned over every year. Every single year, we had new staff that were coming on board. So that's a challenge. But it would be great if the agency would dedicate some funding to the problems that states really have as opposed to the structure to sort of fit
everyone into one model, although the housing track, I know, is very successful.

So that's it. I appreciate the opportunity to comment today. Thank you.

CHAIR BELLA: Thank you, Camille, and thank you for the information you'll be sharing on best practices.

MS. HUGHES: Scott, you may unmute your line now.

MR. WOODS: Great. Thank you so much. Good afternoon, Madam Chair and members of the Commission. My name is Scott Woods, vice president of Policy and Research at PhRMA.

We submitted written comments to the Commission in advance of this meeting urging members not to advance the recommendations on the differential rebates for accelerated approval drugs and cell and gene therapies, but I do want to make two brief points about the differential rebates.

First, as an initial matter, the FDA has clarified in guidance that drugs granted accelerated approval must meet the same statutory standards for safety and efficacy as those granted traditional approval, and we cited the guidance in our written comments for your
Second, we believe that by raising the statutory rebate on drugs where only surrogate endpoints have been leveraged for approval and where confirmatory trials have not yet been completed, drug manufacturers could be potentially deterred from pursuing this pathway, especially as you consider the significant rebate level that has been discussed this afternoon, 8-plus percent. That differential rebate would come on top of the base statutory rebate, supplemental rebates that states may negotiate, and potentially other policy levers, including the removal of the AMCP that's currently under consideration by the Congress in the COVID reconciliation bill.

Given the vulnerable populations that Medicaid serves and the broad access to medicines that they are afforded, we believe that it's paramount that MACPAC not advance its recommendation to the Congress at its next meeting. We look forward to a further dialogue with the Commission and staff, and we're happy to help in any way that we can.

Thank you for your consideration.

CHAIR BELLA: Thank you, Scott, for submitting
comments and for being here today to make public comment.

MR. WOODS: Thank you, Madam Chair.

CHAIR BELLA: Anybody else like to make any comment?

[No response.]

CHAIR BELLA: It does not appear so.

All right. Anyone else on the Commission have any final words, questions, comments?

[No response.]

CHAIR BELLA: Okey doke. We are going to take a break. I think we need to stick with the time frame because we have the territories coming at 3:15. So we will not start earlier than that, even though we have a little bit more time. So you all have about a half an hour. We will see you back here promptly at 3:15. Thank you.

* [Recess.]

CHAIR BELLA: Okay. We're ready.

MS. BUDERI: Hi. Good morning.

CHAIR BELLA: Good morning for us and good afternoon to all of you.

### PANEL DISCUSSION: CURRENT AND FUTURE ISSUES

FACING THE TERRITORIES
MS. BUDERI: Hi, Helen.

Well, everyone, thank you. Today at this session, we are excited to welcome panelists from four of the five U.S. territories -- American Samoa, although I don't know if our panelist, Sandra, is on yet, but also the Commonwealth of the Northern Mariana Islands, or CNMI, Puerto Rico, and the U.S. Virgin Islands, or USVI. And our panelists will discuss several issues facing their Medicaid programs, including a major reduction in federal Medicaid funds, often referred to as the Medicaid fiscal cliff, that will occur this October without congressional intervention. Let me see if I can advance these slides. There we go.

Before I introduce our panelists, I'm going to go briefly over some background information on Medicaid and the territories and talk about the upcoming Medicaid fiscal cliff. I'll provide a refresher on MACPAC's prior work and statements on this issue, and then I'll turn it over to our panelists.

Territories are generally considered states for the purposes of Medicaid unless otherwise specified, but their Medicaid programs differ from states in several
important ways. Guam, Puerto Rico, and USVI have similar program structures as states. CNMI and American Samoa operate their programs under section 1902(j) waivers, which are uniquely available to them and allow the Secretary to waive almost any Medicaid requirement. And I'll just note that for anyone looking to learn more about Medicaid programs in the territories, there's a link on this slide to our fact sheets for each territory.

So territory Medicaid programs operate on a capped allotment financing structure. This means that unlike the states, which can access an unlimited amount of federal dollars at the applicable matching rate, territories may only do so up to an annual cap, which is specified in Section 1108 of the Social Security Act. This is called the Section 1108 cap or Section 1108 allotment. Moreover, the federal medical assistance percentage, or FMAP, is specified in statute at 55 percent, which is much lower than what territories would receive if their FMAPs were determined through the same formula used for states, which is largely based on per capita income. This arrangement has historically been insufficient to fund territory Medicaid programs, and as a
result, territories have had to rely on time-limited increases in federal Medicaid funds and FMAPs. Congress provided temporary additional federal Medicaid funds or enhanced FMAPs on several occasions in the last decade, including through the Patient Protection and Affordable Care Act.

Most recently, through the Further Consolidated Appropriations Act of 2020, Congress substantially raised each territory's Section 1108 cap for FY 2020 and 2021 and raised the FMAPs for these fiscal years as well to 76 percent for Puerto Rico and 83 percent for other territories. The Families First Coronavirus Response Act further raised these allotments to help respond to COVID-19 and also provided a 6.2-percentage-point FMAP bump during the public health emergency to all states and territories.

Along with the extra funding, Congress added several new requirements for the territories related to program administration, program integrity, and reporting. For example, all territories must designate a program integrity lead, and American Samoa, CNMI, and Guam must make reasonable progress towards establishing methods of reporting data to the transformed Medicaid statistical
information system and establishing Medicaid fraud control
units. And there were several additional requirements that
apply only to Puerto Rico.

So to help illustrate the Section 1108 allotments
with and without temporary increases, I've included this
table showing allotments from FY 2019 through 2022, with
and without the increases. I'll note that in FY 2019,
additional funds were available to territories, but they
are not shown here because they were structured separately,
in addition to the allotments rather than as part of the
allotments.

Congress has not provided any increases or
additional funds for FY 2022 or future years, and I'll draw
your attention to the last two columns here where we see
the amounts provided by current law for FY 2021 and the
amounts provided for FY 2022, when the allotments will
revert back to their statutorily specified levels. The
difference, as you can see here, is stark, dropping, for
example, from $85.6 million in 2021 to $13 million in 2022
for American Samoa.

This drop-off, as I mentioned, is referred to as
the fiscal cliff and will occur on October 1 without
congressional intervention. FMAPs will also revert from their current levels of between 82.2 and 89.2 percent down to 55 percent for all territories.

Territories have faced similar fiscal cliffs in several previous years, most recently at the beginning of FY 2020. In most cases, fiscal cliffs have been averted by last-minute action by Congress, but CNMI did experience a lapse in funds in March 2019.

MACPAC expressed concern about the territory financing arrangement in our June 2019 report to Congress on Medicaid in Puerto Rico, which we wrote in response to a congressional request.

In anticipation of the fiscal cliff expected in October 2019, MACPAC stated that an additional infusion of temporary funds would keep the Medicaid program afloat, but in the long term, reliable, sustainable access to care for the Medicaid population will likely require changes to the existing financing arrangement that provide a higher level of federal investment and over a longer period of time than past interventions. Although this work was specific to Puerto Rico, the Commission also noted implications for other territories.
Now I'm going to turn it over to the panel. We have asked our panelists to discuss the issues shown on this slide, including unique features of their Medicaid programs and circumstances affecting the programs, current and future priorities for program improvement, effects of new federal requirements, effects of COVID-19 and efforts to respond to those effects, the upcoming Medicaid fiscal cliff and level of federal investment needed for FY 2022 and future years, and other issues facing the program.

So to introduce our panelists, I am not sure if Sandra was able to join, but we have Sandra King Young from American Samoa, Helen Sablan of the Commonwealth of the Northern Mariana Islands, Jorge Galva Rodriguez of Puerto Rico, and Gary Smith from U.S. Virgin Islands.

So, with that, I'm going to turn it over to our panelists. I'm not sure if Sandra was able to join. Sandra, are you here? If not, maybe we can start with Helen. Would you be ready?

* MS. SABLAN: Yes, I am ready.

MS. BUDERI: Great.

MS. SABLAN: Okay. So the Commonwealth Medicaid Agency on behalf of the U.S. citizens in the Commonwealth
of the Northern Mariana Islands appreciates the opportunity
to provide an overview to the Medicaid and CHIP Payment and
Access Commission. We really appreciate the work of MACPAC
and wish we had the capability to analyze our Medicaid
program like MACPAC has for the nation.

The Medicaid program in the Commonwealth of
Northern Mariana Islands has approximately 16,000
beneficiaries. Under Section 1108, the Medicaid program
will receive $7.3 million for the medical assistance
program for FY 2022. This is the equivalent of 456 per
member at year at 55/45 percent FMAP.

The Medicaid program for the CNMI and U.S.
territories arrived at the Medicaid fiscal cliff in March
2019. No more funding for providers. Medicaid members
advised to go to our only hospital Commonwealth Healthcare
Corporation safety net health system for care. Congress
provides disaster assistance in 2019. Congress passes
Consolidated Appropriations Act FY 2020 and provides
accurate Medicaid funding for two years. So Congress funded
for 2020 and '21, so a fiscal cliff again by September 30,
2021.

Transition for the '19 Medicaid ACA all spent.
Medicaid disaster assistance, CNMI expand Medicaid funding, Consolidated Appropriation Act FY 2020, and the reports to Congress, PIE, T-MSIS and others.

Super-Typhoon Yutu on October 2018, ACA increase could have been un-expended, and in 2020 of December, got approved for Medicaid. Disaster assistance helped greatly -- following Typhoon Yutu and then 2020 COVID with the additional funding and eligibility.

We are the smallest U.S. territory, farthest and west, 8,900 miles from D.C., distance, travel, and time zone and a day zone is the challenges. Smallest Medicaid population, 16,000 Medicaid and 52,000 total population. Medicaid accounts for 46 percent of the U.S. citizen population. 2010 census, median income for a family of four, CNMI is $19,000 versus the U.S. at $62,000. Medicaid funding is critically important for health care system.

Commonwealth Heathcare Corporation does not have all specialties and travel immediately invokes air travel. Capacity in territory is limited. The Section 1108 ceiling today will provide about $7.3 million for the medical assistance program, and CHIP is about $11.3 million.

In 2018, the CNMI and Medicaid paid $54 million
in Medicaid and CHIP claims, MAP and IBNR but not recorded of $18 million total Medicaid expense of $72 million, and then CMS informs CNMI that FY 2020 would have received 7.2 for 2020 for MAP and $11.2 million for CHIP, leaving a major shortfall.

In March 2019, the Section 1108 cap funds and the final amounts left from the Affordable Care Act are completely expended. CNMI closed access to private providers and notified beneficiaries that care would only be provided by the Commonwealth Heathcare Corporation, a public corporation, and a safety net system.

1978 Medicaid program established in the Commonwealth with Section 1108 caps and 50 percent FMAP. 2010, Affordable Care Act provides 101 million to Section 1108 caps to be expended by 9/30/2019, increases the FMAP from 50 percent to 55 percent federal amount. 2011, certified public expenditures with the only hospital on the island, and there's no local match because of recession.

2018 October, hit by Typhoon Yutu.

2019 March, Medicaid exhaust Section 1108, ACA increase of 101 million from 2012 to 2019 and local funding. 2019 in March, Medicaid refers all beneficiaries
to CHCC. 2019, Congress provides disaster relief. 2019 in December, Congress Consolidated Appropriation Act increases cap to $60 million and FMAP to 83 percent.

2020, program works hard to meet congressional and statutory and program requirements, and then September, this coming September 2021, the fiscal cliff again.

Medicaid priority is to pray that Congress addresses the fiscal cliff and treats the territories as states. CNMI takes seriously the management of the program, and our goal is to manage program like the best states. CNMI has initiated Medicaid enterprise systems and is reviewing all statutory requirements and has plans to address issues from third-party liability to electronic visit verification and others. CNMI wants to review gaps in quality of care and appropriateness of all reimbursement rates and will review rates against private payers. CNMI would like to develop and apply waivers, but it's unable to do so because of caps and annual appropriations do not support option. No predictability on funding.

The CME, APD and IPDs for the decision support system, data warehouse, Medicaid management information system, health information technology is in the planning
stage, and we already have a plan that we're working on. Program integrity lead and joint operating agreement with unified program integrity contractor and submitted data from largest health care provider, designation of the attorney general, the office of public auditors, independent investigation unit and policy deliberation.

T-MSIS data, CMS approve advance planning document for EVV, MMIS, and T-MSIS project. CNMI to use the reuse provisions and partnerships to lessen cost of system.

CMS approved the decision support system so that CNMI is able to analyze costs, services, outcomes, waste, fraud, and abuse, among many others. CMS approve the HIE implementation plan, and CNMI is revisiting the need for the Health Information Exchange.

Reports to Congress and CMS, has submitted many others, compliance activities, which is third-party liability from private VA, DoD, private provider enrollment and eligibility, electronic visit verification, and then COVID-19 for some eligibility has increased Medicaid beneficiaries from 16,000 to 27,000. This means that over
50 percent of CNMI residents are currently covered by Medicaid.

CNMI has the uninsured rate highest in the nation. So fee is excellent. The inclusion of the compact of freely association, the co-financials in Medicaid is also good. Although the Commonwealth does not have many COFAs[citizens of freely associated states] as Guam and other states.

Fiscal cliff is priority number one, number two, number three, and number four; U.S. citizens of the CNMI are treated the same as in states; and eliminate the 1108 caps; and apply the FMAP formula as states. Local match, CNMI does not have the local match. COVID-19 has severely affected our tourism-based economy. Making reasonable and appropriate progress in compliance is a fundamental priority. Our goal is to manage program as well as any state.

Our many other issues are internal. Many bidding capacity deal with civil service. CNMI never get a pricing study. We openly acknowledge our own issues and then CNMI local budget issues and options.

All plans and activities are dependent on Section
1108 caps and FMAP. The health of the health system is dependent on Medicaid. The CNMI is unable to plan with any anticipation because of the inability to predict amounts over Section 1108 Medicaid, the grant. Purpose is to define state to include all states, the District of Columbia, and U.S. territories and eliminate the cap or increase the cap by CMS or MACPAC estimate, and maintain the FMAP at same level. The cap should increase based on any increase in percentage based on the latest CMS National Health Expenditures, the NHE, grow for the latest year published. The inability to predict the Medicaid grant in future years means that CNMI cannot plan any waiver program.

And this concludes my presentation. Thank you.

MS. BUDERI: Thank you so much, Helen.

Jorge, would you like to go next?

* MR. GALVA RODRIGUEZ: Sure. Thank you very much, Helen.

I'd like to thank the panel for the opportunity of letting you know the particularities and the challenges that we face at the Medicaid program in Puerto Rico.

Puerto Rico has a population insured by Medicaid,
which amounts to approximately 1.5 million insured. Of
these 1.5 million, approximately 275,000 are dual
eligibles. Representing Medicaid insurance represents 42
percent of all insured population in Puerto Rico, and it
represents a lifeline for our medically indigent
population.

The net effect of Medicaid for the island's
economy cannot be dismissed because of the huge impact it
has not only on the well-being of our population but also
on the viability of our health care system and the economy
as a whole.

In terms of particularities of our system, we are
one of the few territories or states in the United States
that has a 100 percent managed care system for the delivery
of medical and hospital services to our insured population,
and we also have a particularity of having the single state
agency separate from the agency that runs the managed care
operation that provides payment to our providers, both on
the hospital and medical side.

Under Public Law 116-94, Puerto Rico was able to
achieve the provision of funds for fiscal years '20 and '21
in the approximate amount of $2.6 billion for fiscal year
'20 and $2.7 billion for fiscal year '21. This amount was instrumental not only in operating the system as it existed at that time, but also providing enough wherewithal to fund what we called at the time "sustainability initiatives," and these sustainability initiatives included the following. Raising the poverty level in the Puerto Rico poverty level to 85 percent of the federal poverty level, raising the reimbursement to our medical providers under Medicare Part B at 70 percent of the Medicare fee schedule, providing supplementary reimbursement to hospitals -- and I will go into the hospitals in a minute when talking about COVID -- provide increases to physicians, primary physicians with sub-capitated arrangements, and of course, providing coverage for our hep C patients.

The total amount of money that was involved in the funding of these initiatives was approximately $700 million, which were added on top of the existing budget that we had developed under Obamacare, of Obamacare funding, and the VBA funding in the preceding years, and with the state matching funds, the total amount of our budget for fiscal '20 raised to approximately $3.4 billion.
and approximately $3.5 billion for fiscal '21, which is the year that we are handling now.

In terms of the sustainability initiatives, they were instrumental in strengthening both the ability of bringing new population into the Medicaid, into the Medicaid program. As you probably know, our population, around 50 percent of our population is currently under the poverty line. So the Medicaid program becomes the lifeline and the only means of providing medical and hospital services to this population.

But in addition to having a vulnerable and fragile population in terms of income and socioeconomic status, we also have a particularly weak position in terms of the reimbursement scheme for our providers of both hospital and physician providers.

In terms of our physician providers, the situation, as probably some of you know, has been quite dire in the past few years. Physicians have been emigrating from Puerto Rico at a very rapid rate. So having additional reimbursement for our physicians was instrumental in keeping them on the island and not de-populating our professional base for the treatment of our
Medicaid population and our population at large. In terms of hospitals, our first estimation when PL 116-94 was discussed revealed that hospitals were experiencing an operational loss in the management of our Medicaid population. It was originally estimated at approximately $46 million. We revisited that amount of money and estimated that the direct operational loss accruing on our hospital operations was closer to $106 million a year. Still, there are some of our hospitals that are experiencing an extreme weakness in their financial statements, which was only partially redressed with this additional reimbursement that was secured by PL 116-94.

The act also imposed on Puerto Rico, individual requirements that speak to oversight and accountability for the federal funds received by the program, and these requirements basically have to do with oversight and accountability measures to make sure that the expenditures of federal money in Puerto Rico are appropriately safeguarded and that we also have appropriate contracting practices to ensure the best deal possible for the program and robust systems to detect improper payments.
and allow for recovery and recoup of these improper payments.

I'm happy to say that at this point in time and ahead of schedule, Puerto Rico has either complied with some of the requirements in PL 116-94 or is ahead of the curve in complying with these requirements. So we feel pretty confident that in going before Congress this year asking for reauthorization of funds for the program, we are in a very strong position to show that substantive programs have been developed to account for the money that is sent over here and to account for the spending of this money properly.

We have engaged in substantial contracting reform. At this point, we have already performed an evaluation of some of the contracts that we were not letting out through RFPs or RFIs. We have corrected that issue, and we are ready to let out big contracts, especially for our PBM and our PPA. These RFPs are going out before this month is over, and in this sense, we're going to be addressing one of the biggest issues that was brought forth by the GAO when they audited our operations on the basis of a mandate, legal mandate in 116-94.
Of course, we also have to take care of PERM and the MEQC issues, and we are working closely with external consultants to make sure that our PERM and MEQC programs are up to par and that our reporting on both of those indicators are in accordance with the provisions of PL 116-94.

In terms of the effect that we received from the COVID pandemic for the program, we are affected basically because of a drop, a very severe and marked drop in utilization that affected two segments of a provider network. The first one was hospitals, and the second one that was very severely impacted by the COVID emergency was dentists. Our dentists basically were facing empty offices because of patients not arriving due to their fears of contagion from COVID-19, and the same effect was seen at hospitals.

As a matter of fact, our hospitals have not recovered their prior occupancy, their pre-pandemic occupancy levels, and at the present date, hospitals are still experiencing historically low occupancy rates, hovering around the mid-50s, which, of course, we know is not sustainable in the long run because of the preexisting
weakness of their financial statements and the effect that this has had on their operations.

An independent study commissioned by the Puerto Rico Hospital Association was instrumental in showing us that hospitals could have experienced a loss of between $700 million and $1 billion arising from the lockdown that Puerto Rico experienced in the first part of 2020 and the decrease, the sustained decrease on average occupancy.

So, in this respect and hospitals being -- almost all hospitals being private in the territory because of the health reform that was effected more than almost 30 years ago, it is imperative that we continue providing increased reimbursement under the program for the Medicaid patients. As I said prior, almost 42 percent of all insured population in Puerto Rico belongs to Medicaid, which means that at the hospital level, that same percentage holds in most of our hospitals. The book of business depends on a strong Medicaid showing, and of course, it also depends on strong Medicaid or stronger Medicaid reimbursement, which we don't have yet.

So this is an issue that we are going to be bringing before Congress, have them understand that given
the fact that most of our hospitals are private organizations, we cannot allow for the sustained weakness in their financials and the potential problems down the road that could even signify the closing of some of our hospital institutions.

In other elements of the effect of COVID on our operations, we were pretty fast in providing our normative letters that allowed for the coding of initially testing. We also provided for coding and the possibility of reimbursement for monoclonal antibodies from remdesivir, and when the vaccines came along, we provided for the expansion of our vaccination network, allowing the proper codes for pharmacies and other providers to be able to vaccinate and also providing for a fee schedule for the provision of the vaccines that equals the fee schedule that's used in Medicare.

We made an estimation of our actuarial situation, and we were satisfied that we could pay the Medicare fee schedule for the vaccination program. Why? Because we wanted to incentivize providers through a Medicare funding scheme for vaccinations instead of going for a lower fee, as is usual when we're dealing with Medicaid versus
The fiscal cliff is something we're looking at with a lot of trepidation. Of course, we are very confident that because of Puerto Rico's strong position in terms of complying with the oversight and accountability provisions in PL 116-94, we are going to receive a positive reception at Congress when we go over there to fight for reauthorization of the funds.

However, the effects of the cliff for Puerto Rico would be dire. We have already made the estimation along with the FOMB, the Fiscal Oversight and Management Board, which you know is kind of a receiver for Puerto Rico, given the fact that the Commonwealth government defaulted on its obligations, and it was placed under a special provisions, very similar to what you see in bankruptcy law.

The FOMB has put together their fiscal plan for Puerto Rico, and the fiscal plan for fiscal '22 reveals a gap that would be due to the disappearance of the extra supplementary money that we received for '20 and '21. This gap could be as large as 1,400 million dollars.

So what would be the effect of that gap on the operations of Medicaid? Basically, we would have to roll
back all the increases we provided to our medical and hospital providers. We would have to roll those back. We would have to disenroll the additional population that was brought in with the increase of the Puerto Rico poverty level, and that would take care of only part of the gap.

In addition to rolling back all the sustainability initiatives and the effect that that would have on our providers and the insured population, we would also have to disenroll anything between 350- and 400,000 beneficiaries from our Medicaid rolls. That would, of course, be a very severe blow to our health care system. That would reverberate through the entire system, with a drop in utilization, and mainly would affect the hospitals which are still trying to recover from historically low occupancy rates.

So we've made it a purpose of ours to go to Congress, and basically, we would like to receive a treatment similar to the states. We would like for us to receive an FMAP at 83 percent and, of course, do away with the Section 1108 cap. The cap is currently -- as you saw in the prior numbers that were shown to the panel, the cap is fixed at around $400 million a year. That is completely
insufficient to deal with the expenses associated with the program. At this point, we need at least $3.5 billion a year to run the program, provide adequate coverage for our beneficiaries, and maintain the increases that we did in our insured population and the increases provided to our medical and hospital providers.

In addition to this, in our search for parity, we have a few programs that are not being paid at this point, are not being covered at this point by Medicaid, and we are interested in starting to look at the possibility of bringing those into the Commonwealth, beginning with the Part B Medicare coverage for dual eligibles. We do not have a payment of the Medicare Part B for dual eligibles. That is a huge gap in care that affects one of the most vulnerable segments of our population, and we would very much like to be able to achieve enough funding to perform this purchase of Part B Medicare coverage for the dual eligibles.

In addition to that, another huge gap that Puerto Rico suffers at this time because of lack of adequate funding is the lack of long-term care coverage under the program. We do not fund long-term care, and as you might
understand, that causes a significant gap in the ability of providing a full complement of care to our beneficiaries and even increases the overall expenses to the system since we have people staying in hospitals that don't have to stay in hospitals. They would be in a much better venue, in a much more economically feasible venue of care, with long-term care instead of hospitals, but because of lack of funds, we are unable to fund this.

So, basically, in a nutshell, that gives you a high-level idea of the situation of the program in Puerto Rico. I'll be more than happy to entertain your questions or any other comments as the panel proceeds further. Thank you for your attention.

MS. BUDERI: Thank you so much.
Gary, would you like to go?
[No response.]

MS. BUDERI: Oh, I think you are on mute, Gary.
MR. GALVA RODRIGUEZ: He's on mute.
MS. BUDERI: There you go. Oh.
MR. SMITH: Yes, I am.
MS. BUDERI: There you go.

* MR. SMITH: My apology. Again, good afternoon.
I'd like to thank MACPAC for providing this opportunity for the Virgin Islands to provide you with an overview of our program, and, Kacey, you did an excellent job in outlining the variances and differences between the programs in the territories and the programs in the states.

So on behalf of Governor Albert Bryan and also my commissioner, Kimberley Causey-Gomez, welcome to the Virgin Islands in my virtual room. I'm Gary Smith, and I've been the Medicaid director for the past three years and seven months.

Our program is unique from the states, as we're located -- we're stationed on four different islands, separated by water, covering 133.73 square miles. Our total staff is 33, which is, I have 15 staff at my St. Croix location and 19 staff in my St. Thomas location which also covers the Island of St. John, which is approximately 10 miles east of us. St. Croix is approximately 20 miles south of us. So we connect by traveling via ferryboat to St. John, and we can catch the airplane sea shuttle to St. Croix on a small 7-seater or 15-seater airplane from airport to airport to St. Croix.

That 33 staff provides services to, as of today,
32,401 members. The territory of the Virgin Islands population is approximately is 105,000, which our membership is about 28 percent of our population.

Based on research and studies from the University of the Virgin Islands, which is our local university, there is approximately an additional 20,000 persons here in the territory eligible for the program. So if those members were in the program, it would be insuring approximately 50 percent of our population just as in Puerto Rico and also CNMI and my sister territories.

Our program is 100 percent fee-for-service. There is no managed care. We reimburse our private providers by utilizing the approved Virgin Islands Medicare rates.

Our two public hospitals receive per diem payments, which we establish based on cost reports that we collect on an annual basis as well as our two FQHCs, federally qualified health centers. They are on a fee-for-service basis. Then also we have the Department of Health who they have clinics as well that provide direct services.

In all of those facilities, presumptive eligibility is available, and that has assisted our
membership enrollment but only on average about 6 percent annually.

Goals and priorities currently for the Virgin Islands program is -- number one on the list is the Health Information Exchange implementation. We just completed the RFP process this Monday, and we received a total of 10 proposals for the Health Information Exchange, and I think about a week from now, which is next week, Thursday, we will begin the review process of those proposals.

Also what we're working on is expanding our benefits to the membership as we're moving towards a more community-based-type program, we're implementing a state plan amendment to include personal care attendant services, so we can reach those elderly persons, the blind and also the disabled, and then also those who because of COVID may be having to stay home.

We also are going to move to extending the home, community-based services by delving in more to long-term and support services, which will also help us address long-term services, which is very much needed by our elderly population, and then also behavioral health is a big challenge for us, which we're going to be utilizing those
services to address that challenge as well.

Other goals and priorities that are currently going on simultaneously is implementation of the electronic visit verification, EVV, implementation of cybersecurity, which is going to work simultaneously with the implementation of the Health Information Exchange, and also patient access and interoperability providing our members the opportunity to be able to access their information as far as formulary, Medicaid management, and payments to providers, so forth and so on.

With respect to COVID-19, as of today, we have 2,704 positive cases, and of the total that has been provided, we provided a total of 48,711 tests so far since the pandemic began. We have 46,007 negative tests. We currently have 113 pending cases. Of the confirmed positive cases, a total of 2,547 persons have recovered. We have 132 active cases and 25 total deaths.

Okay. Relative to the vaccinations, our Department of Health in conjunction with our Emergency Management Agency has rolled out a plan. All vaccinations through the Department of Health are free of charge. Physicians are being directed to utilize the program
through HRSA, the Health Resources and Services Administration, which is reimbursing our providers for the administration of the medications. So there's no charge for our citizens to obtain the vaccination.

We are currently -- our governor implemented a five-pronged program to get us back to the "new normal," as everyone is calling it. So the five-pronged steps for that program is total quarantine, which happened, I would say, about around April or May for us, and then after that, we move to the stay-at-home, which during the stay-at-home, all nonessential businesses are closed. Public and private sector, those businesses are closed. You only could do takeout orders at the restaurants. Schools and daycares were closed. Beaches on the weekends closed from noon and a suspension of effective medical and dental procedures. So during that time, a lot of telemedicine and telehealth was happening.

We received approval from CMS under a disaster state plan amendment to provide telemedicine and telehealth services, and implementing telehealth is another goal and priority that we are working on in conjunction with the governor's office.
Safer at home, which is the phase that we're currently under right now, that's the third phase. So right now, nonessential businesses are open. Bars are still closed. If you have a bar only, that's still closed. Hotel reservation systems are closed as well. Restaurants are still at takeout only. Indoor/outdoor recreation facilities are open. No food or drinks. Facial coverings are required. No gatherings greater than 50. Facial coverings are also required and social distancing. All commercial entities require facial coverings. Our schools and daycares are still closed during this phase. Our school children are still attending school virtually, and that has had a tremendous effect on a lot of our children. And I can attest to that personally. I have a grandson who he is not doing well at all. He said, "Grandpa, I want to be able to go to school and see my friends, and this is difficult." His attention span is short. So we're struggling with him, but we're trying to get him back on track and pray to God that will be opening soon so the kids can begin to interact with their friends, families. And I miss it as well. I would have preferred doing this presentation face-to-face with you guys rather
than virtually.

So the fourth phase is open doors, which all businesses will be open, indoor/outdoor recreation. Indoor and outdoor recreation facilities will open, but no food and drinks still. Still no gatherings over 50.

Then the last phase, which will be the new normal, mask, gathering, and social distance restrictions will be released.

Overall, the COVID has really have us adjusted our lives and lifestyles. My staff is, I'd say, about 60 percent teleworking. There are some of us that come in on a couple of days. Some come in every day. I'm an office guy. I have to come to the office every day unless it's absolutely necessary that I have to telework because of the building being shut down from an experienced positive case here in the building or whatnot.

So issues facing the program including the additional federal financial support needed for the years ahead. Congress had enacted a Consolidated Appropriations Act of 2020 to temporarily avert the fiscal crisis that we faced back in September of 2019, which increased our cap to $126 million for fiscal years 2020 and 2021. So we're
going to be facing another fiscal cliff come September 30th of this year. So these amounts were premised on our request for additional 100 percent federal funding for our program for FY 2020 and 2021. That was subsequent to the Bipartisan Budget Act funds expiring in September 30th of 2019.

So we would like to see a permanent solution to the issue for us and also our brethren and sistren in the other territories where we no longer have to rely on an arbitrary piecemeal fix to our health care system, which promotes uncertainty and also inequities for our citizens, which we are U.S. citizens, and how we are treated.

Also, it prevents us, as both Jorge and Helen have mentioned. It's just not available to us. We were not able to plan properly and appropriately as to how we move our programs forward, because from one year to the next, we don't know what's going to happen.

So this is the second time in the past couple of years we're going through this, having to decide, well, what services are we going to roll back, how many members are we going to have to take off our rolls because we're not going to be properly funded. So we would like to see a
permanent fix and not having to go through this on an every-year or every-two-year basis.

So it's even more critical now with the ongoing impacts of the physical and mental health of my citizens, brothers and sisters here on the Virgin Islands as well as the other territories.

The results from the impacts of the two hurricanes, which we're still recovering from, now has been exacerbated by the impacts of COVID-19.

So, as I had mentioned before, we have attempted to reduce the uncompensated care at our public facilities by implementing presumptive eligibility, which is available at both of our hospitals, the two federally qualified health centers, and also our Department of Health clinics.

This helps reduce uncompensated care, but we still need to have the ability to receive disproportionate share hospital payments to help with the truly uncompensated care costs, because undocumented immigrants or non-qualified immigrants do not qualify for presumptive eligibility, thereby that is still a large portion of the uncompensated care to our facilities.

As we have opened borders and everyone wants a
piece of the American way and life, we have a lot of folks coming in illegally, but we also want to be able to help them when they require health care and medical services.

So we believe that a permanent fix needs to be enacted which addresses, at minimum, the following areas for the Virgin Islands and the other territories and citizens to be treated like those in the states and the District of Columbia. One, remove the annual dollar cap on Medicaid funding and allow the funding to be open-ended based upon the needs of our program. Two, eliminate the artificially low Federal Medical Assistance Percentage, the FMAP, for Medicaid and allow our FMAP to be determined per the formula the states have. Three, provide for Medicaid disproportionate share hospital payments; and four, allow the Section 1902(j) waiver which currently applies only to American Samoa and the Northern Mariana Islands to apply to all U.S. territories.

And that's the conclusion of my presentation, and I welcome any questions that the Commission has.

CHAIR BELLA: Kacey, do you have anything else or should we launch right in?

MS. BUDERI: No, I think you can launch right in.
CHAIR BELLA: Okay. First, let me say thank you to our panelists. While we would prefer to be sitting across the table from you, that's not always convenient, so I feel fortunate that we have all three of you here with us today, so thank you for taking the time.

I want to be respectful of your time. We have a little over 20 minutes with our panelists, and so let's jump right in. Who would like to start with a question or a comment? Kit.

COMMISSIONER GORTON: Okay. Wow. Part of me is speechless, and it's not because we don't care but because you guys have laid out this incredible knot that I think most of us would like to help you untie, from a policy perspective. But it's pretty incredible. Special thanks to Helen for getting up in the middle of the night. By my check, it's like four o'clock in the morning there, or maybe not even? So thanks.

MS. SABLAN: It's actually seven o'clock in the morning.

COMMISSIONER GORTON: Oh, gosh. It's still early.

MS. SABLAN: Yeah.
COMMISSIONER GORTON: But I guess, so you've laid out all of these pieces, and I think we've heard common themes in terms of eliminate the caps, common themes in terms of you need a planning horizon that's more than a year out, common themes in terms of relatively small populations -- Puerto Rico is bigger in that regard, but the other territories are really quite small, in terms of the populations that they serve and the resources that are available.

You didn't talk about limited technical resources, and I can only imagine what an agency with 33 people is doing to try and figure out T-MSIS and PERM and COVID and DSH payments, although, be careful what you wish for with DSH payments.

So I guess my question is, how do we thoughtfully unpack that? I mean, what is your advice to us in terms of where to dig in first, understanding that it's a complex set of problems that is not going to go away fast. And we did weigh in with the last fiscal cliff, and certainly one option is for us to refresh those arguments and weigh in again.

But, you know, from your perspective on the
ground there, what are the most pressing things, and how do 
we triage? How do we organize our thoughts around what's 
happening there, in a sensible way? I'll stop there.

MR. SMITH: So, if I may, Jorge and Helen, I'll 
go and then you guys can add anything you may. So for us, 
the top priorities would be not to have these piecemeal 
fixes, and, you know, provide state-like treatment for us, 
and not give us two years at this increased amount, giving 
us two years at the increased FMAP, and have it be a 
permanent fix. If not a permanent fix, at least give us 
10- to 15-year span period. I would say that, let's say if 
the territories were to be funded at the current numbers 
that were provided to us in PL 116-94, the total for a 10-
year period for all territories -- and that would include 
Puerto Rico -- would not be the budget of, let's say, you 
know, Massachusetts or -- where is another small 
jurisdiction? -- possibly North Dakota. These states'
Medicaid budgets are $16, you know, $17 billion. And I 
don't think that if you combine all of the funding for the 
five territories for a period of 10 years, I don't think, 
mathematically -- that budget or that cost would be less 
than 85 or 90 percent of the states across the nation.
It provides us with such difficulty to decide and
determine how we plan, how we budget. You know, I finished
budget proposals for coming up in our territories,
switching from annual to biennial budgeting, and I had to
provide budgets based on 55/45 match, because I'm not sure
what's going to happen for the coming fiscal year and
beyond.

So for me, I think that would be the important
thing, and the other stuff will come after that, because
we're required to meet the same compliance measures and
requirements that States do. So allow us to have the same
latitude when it comes to our Medicaid budgets and our
FMAPs.

MR. GALVA RODRIGUEZ: I would like to add just a
few ideas that are unique to Puerto Rico, to what Gary just
said. I think that Gary already delved on the main themes.
For Puerto Rico, the 1108 cap makes no sense financially.
The size of the program and the demands of the program,
they are much higher than the amount of money allocated by
the caps, so those should have to go.

In addition to that, of course, we would like to
be placed on a formula for FMAP that would take us away
from the 55/45 percentage division that is coming down the pike, once 116-94 expires at the end of this Federal fiscal year.

But in addition to that, Puerto Rico has tools, particularities, that I want to put on the table because they are very important. One, as I mentioned a few minutes, we are under the equivalent of a receivership under the Fiscal Oversight and Management Board, because of the financial situation of our government. This means that we have the need for certainty in the flow of revenue that we receive from the program. We cannot possibly try to predict what the matching funds will look like, and we cannot possibly predict what the impact on the budget of the commonwealth will be if we don't have certainty. So this longer horizon that Gary just put on the table is something that is essential for the proper management of the program.

Second, the instability is having a profoundly deleterious effect on our provider network, and I want to stress this very strongly. We have suffered an exodus of physicians to the Mainland that is probably unprecedented in the other territories. We have lost literally hundreds,
if not thousands, of physicians, both specialists and
general practitioners. And I already mentioned the
situation of our hospitals, which are very weak at this
point and cannot tolerate another financial shock like the
one we suffered under the pandemic.

So in terms of the instability of our health care
system, having a longer time horizon, doing away with
artificially low caps, and giving our providers the
certainty that they are going to be paid at least a
reasonable fee for their services -- nobody is going to get
rich serving the Medicaid program; we know that -- but we
cannot tolerate that the Medicaid program implies an
operational loss for our providers, because under those
circumstances we won't be able to sustain either our
physicians, who are going to leave Puerto Rico for the
Mainland, or the hospitals, which will eventually go under.

So the longer planning horizon, doing away with
the caps, getting a formula for FMAP, and having at least
something similar to the access to the funds we need as
opposed to an artificial cap, those are themes that
resonate in the Virgin Islands, in Puerto Rico, and
anywhere else across the territories.
CHAIR BELLA: Thank you. Helen, did you want to add anything?

MS. SABLAN: Yes. Actually, I agree with Gary and also with Jorge. We actually, in the ancillary area, there is a parity act, H.R. 6495, and this bill would eliminate Medicaid funding limitations for the territories. However, we still need to address the FMAP, because it is not included in there.

So no matter how many deals, or no matter how costly or prolonged their treatment, that cap will always limit care in the territories, and this is coming from Congressman Sablan. We have to send our patients off-island because we have limited resources available here on-island. So some of our patients are actually in L.A., being treated, from cancer to cardiac, and then our children, also in San Diego, they are still there, and it's really costing us a lot of money. But we really need to address our cap and increase our FMAP, from the 55 percent, because we can't afford it. That's all I have.

CHAIR BELLA: Thank you very much.

MR. SMITH: I'm sorry. If I may, I just wanted to add a bit as to Helen just mentioned it, and I didn't
1 mention it during my overview. But, you know, we send
2 patients off-island on a daily basis, and just to give you
3 an example, FY2020 expenditures for services, our total
4 expenditures was $104 million, but total for services and
5 care was $96, $97 million, and almost 30 percent of that
6 $97 million spent was to off-island providers. That's what
7 we spent to obtain care for our members and citizens here
8 in the territory, having to send them to either Puerto Rico
9 and/or Florida, and sometimes as far as New York or Texas.
10
11 CHAIR BELLA: Thank you. Kit and Darin, is it on
12 this point or something else? If it's something else I'm
13 going to put you later in line. If it's this point, go
14 ahead.
15
16 COMMISSIONER GORDON: It's on --
17
18 COMMISSIONER GORTON: I just want to follow up on
19 what Gary said, real quick. Gary, what rates do you get?
20 Do you get the in-state Medicaid rates or do you have to
21 negotiate case-by-case rates?
22
23 MR. SMITH: I have to negotiate case-by-case.
24
25 Most of the facilities will not accept their state Medicaid
26 rates. I have been working with the Florida program to try
27 and work something out. Beth Kidder, who is the Medicaid
director there, she and I have plans to have continued conversations and see if we can work something out through their hospital association. But usually they'll accept the Medicare rate there. It's just one hospital, though. They're just egregious and they will not accept the Medicare rate, so they really hit us hard, and I won't call any names but, yeah, so we have to negotiate case-by-case.

MS. SABLAN: It's the same situation for CNMI, so we have to negotiate with them in order for them to take our patients.

CHAIR BELLA: Okay. Darin, is it on this?

COMMISSIONER GORDON: Yeah, that was what I was trying to understand how that compared to the rates they had at home. And so he explained it's significantly higher. Thank you.

CHAIR BELLA: Okay. Thank you. Chuck, and then Toby, and then Sheldon, and then Kisha, and we've got a little less than 10 minutes.

VICE CHAIR MILLIGAN: So, thank you all very much for joining us and sharing information, and Kacey, thank you for teeing it up so well. I do want to commend to everybody in the public, and others who read the
transcript, to track down those fact sheets that Kacey linked in the deck, because they are very helpful.

I have a question, just one question, but I was hoping the three of you would be comfortable answering, and it's a little bit of a hard question. In the past, when the issue has come up about eliminating the cap or using a more traditional FMAP that the States have, part of the tradeoff that people discuss is then whether the territories would also then feel willing to accept the other requirements that the States have. And so, for example -- and this is in the fact sheet Kacey linked to -- Puerto Rico and the U.S. Virgin Islands are not obliged to use eligibility standards that the states you. You all can set your local standards, and you're not tied to FPL and those sorts of things.

On the benefit side, for CNMI, the 1902(j) waiver means you're not required to offer mandatory benefits that the states are required to offer -- and I'm just referencing a couple of things on the fact that, that even though the U.S. Virgin Islands and Puerto Rico don't have that waiver and are theoretically required to offer the mandatory benefits, Puerto Rico apparently doesn't offer
transportation benefits, and Puerto Rico apparently also
doesn't offer coverage for nursing facilities. And, Jorge,
correct me if those are wrong, but I'm referencing what was
in the fact sheet. And for the Virgin Islands, there isn't
coverage for free-standing birth centers or rural health
care clinics.

So the broader question, not to get into the
specifics of those benefits, the broader question is, would
you be willing to adhere to the other mandates that states
have about eligibility and benefits in exchange for being
subject to the FMAP provisions and the lack of a ceiling on
overall allotments, because I think it's going to be
difficult to advocate for one without the other. So that's
the question.

MR. GALVA RODRIGUEZ: I'll go first. We have
been discussing this issue, and the answer, from the
Commonwealth of Puerto Rico, is yes, we want to provide
those mandated services. We know we are not providing
those at this point. So it would be a very acceptable
tradeoff to get those caps eliminated or substantially
revised, get the FMAP either placed on a formula similar to
the States or have it raised permanently. And we think it
would be a reasonable tradeoff in terms of the provision of these services for our population in exchange for those additional funds. I would gladly go down that road.

MR. SMITH: So for us, in the Virgin Islands, we would, as well, but, you know, I would say we are well on our way, because back in 2015, we implemented a new eligibility and enrollment system, and the rules are MAGI-related. That's the rules and policies, how the system was set up. It's also we hope to integrate the system. That's what the system, the Medicaid program, uses now. We hope to integrate our SNAP TANF, child care programs for that eligibility enrollment citizen, where it can be one-stop shopping for our members. You know, the only have to see one eligibility and enrollment case worker.

And then regarding the rural health clinics, I mean, we are a rural jurisdiction, and, you know, as far as I know there aren't many services that we don't cover at our Department of Health clinics or the FQHCs, and we do not have any freestanding birthing centers. But, you know, we would be willing to do that. St. Thomas is only 32 square miles. St. Croix is 84, and St. John is, I believe 26 or 28. So, you know, it's very small jurisdictions that
we have, and it doesn't take much time to get from one end
of the island to the next. But, you know, we're open to
that discussion and would do anything that the Federal
Government will require us to do.

So we have our T-MSIS stood up. We have a
certified MMIS system. We have an established MFCU
operating out of the Department of Justice. We just
received approval to hire program integrity staff, with a
program integrity director, quality control, and also fraud
investigators will be hired. So I think we're on a good
path, but, you know, whatever it takes for us to be able to
have those stipulations removed, we're in.

CHAIR BELLA: Helen, did you want to --

MS. SABLAN: Yeah. With CNMI we are also willing
to do that, you know, as a tradeoff, but the only problem
that we have here is the limited resources, the provider
resources, on the island. But then when they are referred
off-island, we will definitely cover it then.

We also are in the process of complying with the
requirements, the Federal requirements under the
Consolidated Appropriations Act. We are in the process of
having the eligibility and enrollment as well.
CHAIR BELLA: Okay. Thank you. Do the three of you have a few more minutes? We have two questions left.

MR. SMITH: Sure.

CHAIR BELLA: We will try to be quick. So Toby withdrew his question because of time, so that leaves Sheldon and Kisha. Sheldon?

COMMISSIONER RETCHIN: Yeah, thanks. I will address this actually to Director Galva, and I jumped off so I may have missed some of your presentation regarding the brain drain, the physician brain drain that the island is experiencing, which I am well aware of, dramatic, and in part because there's no stability in payment and the variables.

But maybe this is also for Kacey. You know, when I look on the website, the AAMC published state workforce data, and particularly around physicians. But if I look at Puerto Rico it says even after the brain drain, recently as the data of 2018, it says there are 250 physicians per 100,000 population. And then when I compare it to Virginia, in Virginia there are only 230 physicians per 100,000 population.

So there must be a mistake. I don't really
understand how Puerto Rico could have that kind of brain
drain and still have a higher density of physicians than
Virginia. Maybe that should be corrected, because I know a
lot of policymakers look at that website for state
workforce data. Do you have an explanation, or can you
figure out why that is?

MR. GALVA RODRIGUEZ: Yes. The intensity of care
in Puerto Rico is higher than the one that we typically
find in the States, because we have a much sicker
population. The incidence and prevalence of chronic
diseases in Puerto Rico is quite higher than in most
jurisdictions in the United States. For example, diabetes
tops basically any other jurisdiction in the States. We
also have a prevalence of chronic pulmonary disease and
also chronic heart conditions.

So this demands an amount of care that is unlike
what you find in jurisdictions where the population is
healthier and they don't have such a dire need of medical
and hospital attention. So that explains why, even though
the numbers seem, on the surface, to suggest that we don't
have a problem with our physician brain drain, the fact of
the matter is we are experiencing shortages of physicians,
especially on the specialist side.

COMMISSIONER RETCHIN: Thanks.

CHAIR BELLA: Kisha?

COMMISSIONER DAVIS: Thanks, and thank you, Chuck and Sheldon, for being in my head, which is a little bit scary, so I can cut my comments short. But I had a similar question around, you know, if the requirements on the territories to kind of meet some of the demands, if you were to be treated more like states, so thank you for answering that, and also around the kind of brain drain and provider access, specifically in Puerto Rico, is something that I was also really concerned about, and I would like us, as a Commission, to continue to follow that and dig into that a little bit more, especially in the wake of coronavirus.

I think now I'll just end with a comment. As Kit mentioned, you've really kind of presented us with this knot, and what strikes me and stands out to me is that you are all American citizens, and it bothers me the disparity that we see in the health care of our fellow American citizens, and recognizing that while you are not states, you are representing American citizens, and we want them to
have access to high-level health care. And so we just appreciate Kacey and the Commission for the opportunity and for you all meeting with us to continue to just dig in a little bit further into this, and hope that we continue to follow it.

CHAIR BELLA: Kisha, those were excellent closing remarks. Kacey, though, any last words to wrap up this panel, before we thank them?

MS. BUDERI: No. I just want to say thank you to all of our panelists for coming.

CHAIR BELLA: Yeah, I want to echo that. I can't tell you what is the value of hearing from you directly. And so this is an area of interest to us that we will continue to work on, and don't be strangers to us and to Kacey, as I'm sure you won't be. But thank you again for taking time out of your day to spend with us.

MR. GALVA RODRIGUEZ: Thank you very much for the opportunity.

CHAIR BELLA: Thank you.

MS. SABLAN: Thank you. thank you, too.

MR. SMITH: Good evening, everyone.

### FURTHER DISCUSSION BY COMMISSION
* CHAIR BELLA: Kacey, thank you for putting that panel together. We have the remainder of our time for additional conversations and discussion form the Commission about what we heard.

Toby, would you like to start?

COMMISSIONER DOUGLAS: Yeah. First I just want to echo --

CHAIR BELLA: You are very fuzzy.

COMMISSIONER DOUGLAS: Can you hear me better now?

CHAIR BELLA: Does everybody else think it's fuzzy?

COMMISSIONER DOUGLAS: Is it any better?

CHAIR BELLA: Okay. While Toby figures that out, other comments? Darin?

COMMISSIONER GORDON: Yeah. I appreciate Kisha's closing remarks. I really appreciate this. Obviously, the size of this cliff is not inconsequential. I do think some of the points that Chuck brought up about some of the requirements that aren't currently imposed upon the islands would likely be part of a conversation if you look at changing how you reimburse islands.
But one of the things that I think was a constant theme that kept coming up was also how expensive it was to receive services on the Mainland, and how rates were incredibly more expensive than what they were paying back in their respective islands. And I think it would be worth having a conversation about getting more information and data on that. I know we did hear kind of the general scale of how much services are provided, like for the Virgin Islands, back in the States, but it would be good to get a better sense of that, because I think that would be one area -- again, this is such a big, broader issues, but it is one area that I do think is worth exploring more and getting more data on, because that rate disparity is only taking those limited funds and extinguishing them at a much more rapid pace. So this is something that just stood out to me.

CHAIR BELLA: Thank you, Darin. Chuck?

VICE CHAIR MILLIGAN: I want to echo Darin's comment, and I was struck by that as well.

I'm not proposing that we get to this kind of recommendation any time soon, but there is a step Congress could take, which is requiring any provider that
participates in Medicaid, in its own state, to accept that state's Medicaid rates in providing services to the territories as a way of putting a ceiling on potential extortionary behavior.

And, you know, we've seen examples of this in the past around managed care services that cross jurisdictions, and I just do think that separate from the allotment, separate from the FMAP issue, separate from the cliff, some of these other pieces, there is another step that Congress could take, which is linking the rates charges to the territories to the rates the providers are willing to accept from their local Medicaid jurisdictions.

CHAIR BELLA: Thank you, Chuck. Fred?

COMMISSIONER CERISE: Yeah. It feels like I'm missing something, and I know there's got to be a bigger story here, because the problem is just -- it seems like it's just too obvious. And so I'm asking myself, what else was going on here, because, you know, you're getting these year-to-year fixes, so there's some acknowledgement that there's a real issue. There's no way you can plan a program with these year-to-year fixes. We're like a half a safety net program, because you've got Medicaid, but you've
only got it up to this level.
And it just feels like we're missing something,
and maybe there's a bigger issue around statehood and why
we're withholding this program, because, you know, you
can't run half a safety net program, and that's what we're
doing here. If you're going to do Medicaid you can't have
a cap, you've got to have reasonable match rates, and they
have got to have the ability to play year to year.

And if there are other concerns, then it would
seem like, you know, where those rest, in Congress or
wherever, those need to be put there to say these are the
concerns. But it just feels like we're running half a
safety net program, which doesn't work. You know, like you
hear these stories and it's very clear it's not a viable
solution as a safety net program. It breeds inefficiency.
You can't go year to year with a fix like that and try to
make a program that works.

CHAIR BELLA: Martha?

COMMISSIONER CARTER: At the risk of opening a
can of worms, I believe I heard one of the speakers say
that they don't get DSH payments. And I don't know. None
of them, get DSH payments, or some of them get DSH
payments? But that's got to also -- go ahead, Kacey.

MS. BUDERI: That's correct that none of them get DSH allotments.

COMMISSIONER CARTER: So that feeds into the instability of their safety net program. I mean, I don't know. I guess we might need to explore that more, but it seems like that's part of the picture that we would need to understand.

CHAIR BELLA: Kacey or Anne, do you have any comment -- thank you, Martha -- on what Fred was saying, which is how we got where we are? I know we've gone over it before, but anything else you want to say to the overarching comment about --

EXECUTIVE DIRECTOR SCHWARTZ: So the one thing I would say is that the 1108 amounts for each territory are not based on some notion of what it takes to run a program, that is, they're not necessarily scaled to what those territories are doing from a functional perspective. So I think trying to find a rationale for these amounts is probably not going to be a fruitful endeavor. The issue is more how do you get from the statutory amounts to whatever you think is a path to the future -- whether they need to
look exactly like states or something else-- would be more helpful. And we tried to do that a little bit with the work that Kacey did for our Puerto Rico chapter, in which we scaled the Puerto Rico program against the states, even taking out the LTSS.

From a budget perspective, Congress has to think about where we are now in terms of those caps. But I think from a policy perspective, and thinking about what those programs should be, those amounts doesn't represent some objective level of what it takes to run a Medicaid program.

CHAIR BELLA: Kacey, I'm sorry. Did you want to make a comment? And then I have just an overarching comment.

MS. BUDERI: No. I was just going to say what Anne said about how we don't know why the caps were set where they were set back in the '70s or the '60s, when the territories joined the program.

CHAIR BELLA: You don't know congressional intent back then?

[Laughter.]

CHAIR BELLA: No, just so my head is straight on what we think would be coming, we expect that Congress may
ask us to weigh in on what happens as the cliff is approaching. Is that correct? And so we will have this discussion again. So is there anything else? I think, Kacey, you've heard sort of the sentiment and the concerns and some of the questions. Is there anything else Commissioners want to ask Kacey to keep in mind in preparation for a discussion as we get closer to the cliff?

Kit, then Chuck. Kit, you're on mute.

COMMISSIONER GORTON: So sorry about that. I think we should have as much granularity as we can reasonably get along the lines of what the administrative resources the territories have to deal with. I mean, I think we have some level of insight into Puerto Rico and the FOMB and what goes on there, but the other four, they are running tiny programs. They have huge numbers of administrative demands that they are trying to live up to all of the other requirements of the program. They have limited staff. I mean, our theme for the year is that states lack resources, dot, dot, dot, right? If the states lack the administrative resources to run their programs, what on earth, you know, do these people have?

And I'm not suggesting that we make a normative
statement there, but will we be able to say this is an agency of 33 people, and here's where they get their extra teeth from, Zoom calls to the Mainland, and be able to talk about -- and do they have constraints, right? Do they have local constraints? Do they have to use their cap money to pay for their staff? I'm still a little hazy on that. Can they even get staff? Are they seeing the same kind of brain drain in Puerto Rico for technical staff as they are seeing for other kind of staff?

So I think that as much administrative detail we can get as to what it takes to run one of these programs, I can't imagine how you set actuarially sound rates for such a tiny program, in some of those cases. But what they have available to them now. So if we're going to say, okay, here's what it takes to run a Medicaid program, ticking off the form and boxes, and so here's the level of administrative support they would need, laying aside the whole services cost. Because otherwise I think it's going to just continue to cycle.

CHAIR BELLA: Thank you, Kit. Chuck, this is probably our last comment.

VICE CHAIR MILLIGAN: I will withdraw it,
Melanie. It's covered.

CHAIR BELLA: No, no, no.

VICE CHAIR MILLIGAN: No, no, it's fine. It's fine.

CHAIR BELLA: Look, I was joking. Make your comment, please.

VICE CHAIR MILLIGAN: The question that I posed, I think it would be helpful to have awareness of where Guam and American Samoa around that question, because to me, if MACPAC is asked to make some recommendations, it would be helpful to know whether there was a similar willingness to accept kind of a broader set of state-like treatment in exchange for state-like financing.

CHAIR BELLA: That's a good comment. Anybody else? Kacey, do you have what you need?

MS. BUDERI: Yeah. This has been really helpful. I think I'm all set.

CHAIR BELLA: Well, thank you for getting ahead of the game and getting this panel together and having it present today so that we might be prepared if and when we get asked.

Okay. We have wrapped up the day. Does anybody
have any final comments or questions? Or, Anne, do you have any final words?

[No response.]

CHAIR BELLA: I'm taking that as a no. Okay. As always, thanks, everybody, for staying engaged over, what are we using, not Zoom, GoToWebinar.

Our next meeting is April 8th and 9th, and at that meeting we will be going through recommendations and taking votes for the June report. And so for the public, thank you for attending. Look for our March report to come out, what, the 15th, Anne? March 15th?

And I want to say thank you to Anne and the MACPAC staff and to Jim and all the folks that keep us up and running with the technology.

CHAIR BELLA: And then I actually would be remiss -- sorry, false ending -- just to see if there's anyone in the public who wants to make any comments on this last session.

### PUBLIC COMMENT

* MS. HUGHES: No hands.

CHAIR BELLA: No hands. Then, for real this time, thank you, everybody, for staying engaged. I really
appreciate your participation, and our meeting is adjourned.

* [Whereupon, at 4:48 p.m., the Commission was adjourned.]