PUBLIC MEETING

VIA GoToWebinar

Thursday, March 3, 2021
10:30 a.m.

COMMISSIONERS PRESENT:

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KATHY WENO, DDS, JD

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1 P R O C E E D I N G S

2 [10:30 a.m.]

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

8 VICE CHAIR MILLIGAN: Thank you, Melanie.

9 So, as Melanie mentioned, we're going to have two
10 back-to-back sessions to star the meeting, the first
11 session regarding adults and the second session regarding
12 children and youth.

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

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

17 * MS. McMULLEN: Thanks, Chuck

18 So during the past meeting cycle, the Commissions
19 discussed access to behavioral health services on several
20 occasions. Today's presentation builds off that prior work
21 as well as some panel discussions that we had over the fall
22 and winter by offering policy options to help states

1 navigate, design, and implement a behavioral health
2 continuum of crisis services.
3 While much of this presentation is geared towards
4 adults with mental illness, the policy options that are
5 presented here would also apply to children and youth in
6 Medicaid.
7 So today we're going to have a brief summary
8 about the work we presented this fall and offer some new
9 findings related to racial disparities among Medicaid
10 beneficiaries with mental illness. Then we'll turn our
11 discussion to current efforts to address behavioral health
12 crises.
13 The Substance Abuse and Mental Health Services
14 Administration, or SAMHSA, has established national
15 guidelines for crisis care. Additionally, the
16 implementation of 988, a new national three-digit dialing
17 code for the National Suicide Prevention Lifeline, is
18 expected to go live by 2022. However, the role of Medicaid
19 remains undefined in both of these initiatives. Moreover,
20 current Medicaid and CHIP guidance doesn't fully address
21 how to pay for certain crisis services.
22 We'll conclude our discussion with policy options

1 for the Commission's consideration as well as next steps.

2 So at the September meeting, staff presented

3 results from an internal analyses of federal survey data.

4 Among other things, we found that in 2018, adults with any

5 mental health condition who were enrolled in Medicaid were

6 nearly four times as likely to receive inpatient treatment

7 for their mental health condition as those with private

8 coverage. Our findings for children and youth were

9 similar.

10 In addition, adult beneficiaries with mental

11 health conditions were more likely to experience

12 interaction with the criminal justice system when compared

13 to their privately insured peers.

14 Since we met in September, we've done some

15 additional analyses to quantify health disparities among

16 Medicaid beneficiaries with any mental health condition.

17 Key findings are listed here on this slide.

18 Among other things, we found that Black

19 beneficiaries experience mental illness at twice the rate

20 of white beneficiaries, yet white beneficiaries with mental

21 illness are more likely to receive treatment when compared

22 to their Black peers. Similar disparities were observed

1 among beneficiaries in other racial and ethnic groups.
2 Among adolescents enrolled in Medicaid, Black
3 beneficiaries who experienced a major depressive episode
4 with severe role impairment were less likely to receive
5 treatment in the past year when compared to their white
6 counterparts.
7 Before I move on to the next slide, I just want
8 to acknowledge that these are some pretty concerning
9 findings. The draft chapter that we bring to you in April
10 will include this information as well as other findings
11 related to our work on health disparities among
12 beneficiaries with mental health conditions.
13 Commissioners also heard from two expert panels
14 in October and December that focused on access to mental
15 health services for adults in Medicaid and access to
16 behavioral health care for children and youth. During
17 these panels, we have discussed demonstrations states can
18 use to improve access to mental health care. That includes
19 Section 1115 demonstrations as well as the certified
20 community behavioral health clinics or CCBHC demonstration.
21 While these demonstrations are promising, both panels
22 highlighted access to behavioral health crisis services as

1 a particular concern, noting that the current system to pay
2 for these services is fragmented and unstable.
3 Part of the challenge with designing crisis
4 services stems from the fact that multiple state agencies
5 likely need to be involved because Medicaid cannot fully
6 fund a crisis continuum by itself.
7 Now we'll turn our attention to national efforts
8 that are currently underway to support individuals in
9 crisis.
10 Until recently, the core components of the
11 behavioral health crisis continuum had not been fully
12 defined by a federal agency. In February 2020, SAMHSA
13 issued National Guidelines for Behavioral health Crisis
14 Care, establishing the three core elements of a crisis
15 system that are listed on this slide.
16 The first component is a regional or statewide
17 crisis call center. Crisis call centers connect to the
18 National Suicide Prevention Lifeline and operate 24 hours a
19 day, 7 days a week. Using a caller's area code, calls to
20 the National Lifeline are routed to the closest certified
21 local crisis call center. These call centers are staffed
22 with trained clinicians who provide crisis intervention

1 services via telephone, text, or chat. We'll discuss the
2 National Lifeline and its network of crisis call centers
3 more on the next slide.
4 The next two components of the crisis continuum,
5 mobile crisis response and crisis receiving and stabilizing
6 facilities are organized around the call center which
7 coordinates crisis care in real time. Both mobile crisis
8 facilities and stabilizing centers are available 24 hours a
9 day, 7 days a week. States including Arizona and Georgia
10 are playing a growing role in implementing comprehensive
11 crisis programs that are funded through Medicaid, other
12 state revenues, county and local dollars, and other
13 funding. But the continuum outlined here is not available
14 in many parts of the U.S., and when it is available,
15 Medicaid may not support each of these components.
16 So before we discuss 988 implementation, I just
17 wanted to remind the Commission why the National Lifeline
18 and its network of crisis call centers is a necessary
19 component of a continuum of care for Medicaid
20 beneficiaries.
21 Beneficiaries experience mental illness at a
22 higher rate than their privately insured peers. Often

1 connections to mental health care do not occur, and many
2 beneficiaries indicate that they needed but did not receive
3 mental health treatment.
4 Recently, the National Association of Medicaid
5 Directors highlighted the role of the National Lifeline and
6 its network of crisis hotlines, noting state Medicaid
7 agencies needed to leverage and support these call centers
8 to connect individuals in crisis with appropriate care.
9 Recently, the FCC designated 988 as the national
10 three-digit dialing code for the National Suicide
11 Prevention Lifeline. This new national dialing code will
12 be implemented by July 2022, but some stakeholders are
13 concerned that the National Lifeline and its network of
14 local crisis hotlines will not have sufficient capacity to
15 meet increased demand. It's important to note that once
16 the national 988 number does go live, calls will still be
17 answered by the nearest crisis hotline as they are now with
18 the National Lifeline and its 1-800 number.
19 Funding for individual crisis hotlines that link
20 to the National Lifeline is often a state or local
21 responsibility, and some states, including Arizona, have
22 been able to successfully use Medicaid funding to support a

1 portion of hotline costs. However, few other states are
2 using this approach to build capacity for state crisis
3 systems. In part, this might be due to limited federal
4 guidelines and the fact that Medicaid can't be used to
5 fully fund the hotlines.

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

20 Current CMS guidance also identifies Medicaid
21 authorities to pay for crisis stabilization services.
22 However, it notes two components of multiple crisis --

1 provider cost for outreach and team supervision -- may not
2 be covered by the state plan.
3 Because crisis services require a multi-payer
4 approach, additional guidance would be useful to assist
5 states in braiding funding to support crisis-related
6 outreach and engagement activities that Medicaid can't pay
7 for.
8 Moreover, guidance could further clarify whether
9 states can pay for these activities through other Medicaid
10 authorities.
11 On the next few slides, we'll provide three
12 policy options to address these issues. The first policy
13 option is really aimed at improving coordination between
14 CMS and SAMHSA. The policy option reads: "The Secretary
15 of HHS should direct the Assistant Secretary for Mental
16 Health and Substance Use and the Administrator of CMS to
17 work together to support states in developing and
18 implementing a crisis continuum to support children and
19 adults with behavioral health conditions."
20 The rationale for that policy option is listed
21 here. Ultimately, increased coordination between these two
22 agencies could improve access to behavioral health

1 services. Both CMS and SAMHSA play important yet very
2 different roles in improving quality and availability of
3 behavioral health services.
4 Improved coordination between these agencies is
5 needed for a number of reasons, including those listed here
6 on this slide, but it's also necessary to ensure that as
7 new evidence-based behavioral health initiatives are
8 identified, CMS can properly support states with additional
9 guidance and technical assistance.
10 I just want to note that this policy option could
11 be directed either towards the Secretary of HHS or
12 Congress.
13 The second policy option is geared towards
14 providing improved guidance for crisis services. That
15 option reads: "The Secretary of HHS should direct relevant
16 agencies to issue joint sub-regulatory guidance that
17 addresses how Medicaid and CHIP can be used to fund a
18 crisis continuum for beneficiaries experiencing behavioral
19 health crises."
20 So the rationale for that is listed here, and it
21 goes into further detail in your meeting materials. Sub-
22 regulatory guidance could be used to further clarify how

1 Medicaid and CHIP can be used to pay for the three
2 components of a behavioral health crisis continuum I
3 outlined earlier. That guidance could identify some of the
4 things I discussed on the previous slide, including how to
5 create funding and what authorities would be appropriate to
6 pay for different components of the crisis continuum.
7 In developing new guidance, the Secretary should
8 invite the participation of all relevant agencies with a
9 role in implementing the National Lifeline and agencies
10 affecting children and families. So that would include but
11 is certainly not limited to the Administration for Children
12 and Families, CMS, FCC, and SAMHSA.
13 And then the final policy option really builds
14 off Option 2. It would provide technical assistance and
15 planning support for crisis continuums. That option reads:
16 "The Secretary of HHS should direct a coordinated effort by
17 relevant agencies to provide education and technical
18 assistance on the implementation of a behavioral health
19 crisis continuum that coordinates and responds to people in
20 real time. Additionally, the Secretary should examine
21 options to use existing federal funding to support state-
22 level activities to improve the availability of crisis

1 services."

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

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

17 Among other things, participation in the block
18 grant requires all states and territories to submit a plan
19 to SAMHSA every two years explaining how they will use
20 block grant funds to provide comprehensive community-based
21 mental health services. Such planning could include the
22 Medicaid agency to improve access to crisis services.

1 As with the second policy option, the Secretary
2 should work with all relevant agencies that I listed
3 previously.
4 So that takes us to next steps. These
5 recommendations really, if the Commission chooses to make
6 them, would serve as a first step to address access to
7 mental health care. If the Commission is interested in
8 casting these as recommendations in the June report, we'll
9 return to you in April with specific language, at which
10 point, Commissioners can vote on recommendations.
11 We'll also bring a draft chapter that includes
12 three complementary analyses that we presented in the
13 following winter, combined with these analyses, examine
14 prevalence and treatment rates among adults with mental
15 illness and coverage of and access to mental health
16 services for adults in Medicaid.
17 As you'll hear later from Melinda, there will
18 also be a chapter on children and then a third chapter
19 that's descriptive around behavioral health integration and
20 EHR for adoption and among behavioral health providers.
21 If the Commission is not ready to make
22 recommendations, we can still include a chapter in the June

1 report that includes this material.

2 So, with that, I'll turn it back over to you for

3 a discussion.

4 VICE CHAIR MILLIGAN: Thank you, Erin.

5 Martha, if you could get us started, and I'll

6 look and see if other Commissioners want to comment.

7 COMMISSIONER CARTER: Thank you, Erin. This was

8 great and a great overview, and I really appreciate that

9 we've pulled out the disparities.

10 I think one of our policy questions is what are

11 the actions that Medicaid agencies could take to address

12 and reduce these disparities.

13 I have actually a question, just a clarifying

14 question. Not so much anymore, but sometimes substance use

15 disorder services are included in the definition of

16 behavioral health services, and I was assuming that this is

17 solely behavioral health and not substance use disorder.

18 I know in my state, there are quick response

19 teams to respond to people who recently had an opioid

20 overdose, but we're not talking in that whole realm right

21 now. This is just behavioral health?

22 MS. McMULLEN: Yeah. So I think when we use the

1 term "behavioral health," we're including people with
2 mental illness but also people who experience substance use
3 disorders. SAMHSA kind of sketches out the crisis kind of
4 continuum in the work they put out this last year.
5 COMMISSIONER CARTER: Thank you. That's
6 important, then. I think we may want to pull out in our
7 chapter if this does apply to substance use disorder
8 services, and like I said, I know in my state, they've got
9 quick response teams, medical provider, behavioral health
10 provider, social worker, teams that go out and quickly
11 interact with people who have recently had an overdose.
12 That kind of funding maybe would then fall into this
13 conversation. So I think that's important to highlight.
14 VICE CHAIR MILLIGAN: Thank you, Martha.
15 I have Kisha, then Fred, then Sheldon, then Kit.
16 Kisha?
17 COMMISSIONER DAVIS: Thanks, Erin. I really
18 appreciated this, and I agree with the policy
19 recommendations that you've laid out.
20 Two things that I wanted to highlight. First is
21 around 988, which I really applaud the FCC and SAMHSA for
22 creating. One thing I think would be important for us to

1 highlight in the chapter is in the creation of this new
2 crisis support, having the ability for texting and
3 telehealth. When you're looking at the next generation,
4 they are much less likely to call for help as they are to
5 text for help and so in the development of a new system
6 creating opportunities for that.
7 I also really appreciate calling out the
8 disparities, the racial disparities in mental illness and
9 mental health treatment. Also recognizing as we call out
10 in the chapter that the staffing for those crisis support
11 centers really need to have training and understanding and
12 cultural competency in how mental illness shows up in
13 different communities. Sometimes depression in some
14 minority communities shows up as anger as opposed to
15 sadness, so dealing with that. And I think this is an
16 important next step in helping folks get out of the legal
17 system and into mental health treatment.
18 I think we don't need to get into the whole
19 politics of police funding, but I think police officers
20 would agree that they do not enjoy being called to mental
21 health crises and would much rather have a mental health
22 professional be the one who is dealing with that, so to the

1 extent that we can continue to encourage and promote our
2 youth and adults who need mental health crisis services for
3 that to be available to them.
4 VICE CHAIR MILLIGAN: Thank you, Kisha.
5 Fred?
6 COMMISSIONER CERISE: Thanks.
7 Erin, I appreciate the great report. I mean, you
8 outline it well. It's easy to understand and incorporating
9 a lot of input.
10 My comment will be, though, it's heavily focused
11 on crisis management at this point, and I think that's
12 important. And I think we do need to move forward with
13 recommendations around that, but I also think there's
14 another body of work that addresses the rest of the
15 continuum.
16 Kisha commented on some of it already, which I
17 appreciate. How do we improve access to services in
18 general? Decriminalize behavioral health, address social
19 determinants. So there's another body of work that I think
20 is important that is not going to get captured here. So
21 that's one big comment.
22 More specifically to the options outlined here, I

1 agree with the options. I wonder, number one, if there's a
2 place, as you look at including different agencies, if HUD
3 or whoever is dealing with housing options needs to be
4 pulled into this discussion because that becomes such a
5 critical piece, even in the acute setting. So I would
6 consider that.
7 Then the hard part on these crises, 988, and then
8 you're putting the crisis teams together is, as you
9 reference, Medicaid owns a piece of that, but it's just a
10 piece of it. But the crisis system supports people in all
11 categories. You're not getting Medicaid-eligible people
12 only that are accessing it, and so how do you include other
13 payers?
14 You referenced this in your number two, but can
15 we go broader and say Medicare has got to be in this, other
16 commercial payers have to be in this? So when the
17 recommendations go forward to Congress to say everyone is
18 benefitting from this and so how do you get everyone to
19 pitch in to support the crisis services that go well beyond
20 Medicaid, and I think the reason a lot of locales don't put
21 this together is because they can't just do it with a third
22 of the funding. They need the rest of the piece.

1 VICE CHAIR MILLIGAN: Erin, did you have any
2 response to that?
3 [No response.]
4 VICE CHAIR MILLIGAN: Erin?
5 COMMISSIONER CERISE: And I don't know that I'm
6 looking for a response other than just to say --
7 VICE CHAIR MILLIGAN: Okay.
8 COMMISSIONER CERISE: -- you know, is there a way
9 to broaden our recommendations to include other payers.
10 It's one thing to go administratively to say
11 within the agency, but then if you go to commercial payers,
12 then you're going to Congress to say it's got to be broader
13 than Medicaid and even broader than Medicaid and Medicare
14 and SAMHSA.
15 VICE CHAIR MILLIGAN: Yep. Thanks, Fred. After
16 I collect everybody's feedback, I want to circle back to
17 the specific options themselves.
18 So I have Sheldon, then Kit, then Bill.
19 COMMISSIONER RETCHIN: Well, I just want to echo
20 what everybody said about the report. Erin and Melinda,
21 you did a tremendous job, and I think this is one of the
22 most important areas for the Commission. We have an

1 epidemic within the pandemic for mental health and
2 substance abuse.
3 I'll just make a couple of comments. One is an
4 observation. Maybe this is what others were talking about
5 as well. So the memo describes the severe disparities
6 among underrepresented minorities. That's great. I mean,
7 we need to do that and be sure that we have that lens wide
8 open in whatever we're looking at.
9 But then we're making recommendations that appear
10 to be agnostic about solving this sort of major issue of
11 disparity. Can't do everything, but I think it just sort
12 of -- it's kind of, I guess, highlighted for me that we're
13 recognizing a problem first step, but then we really should
14 be thinking about how do we attack that.
15 Erin wrote me that some of this may be in
16 previous -- the previous discussions we've had.
17 Let me also sort of echo a little bit about what
18 Fred was saying, that we're talking about crisis services
19 for a continuum, and I understand the value of that. But
20 would this be the same thing we would do for physical
21 conditions focusing on a crisis service? We could send
22 diabetics to the emergency room and get them out of crisis,

1 which would be ketoacidosis, but no one would accept that
2 as good care.
3 At a minimum, I think it would be good policy for
4 us to at least acknowledge that some of the reason for the
5 crisis services that we need is because we won't have
6 comprehensive care, and to that end, I thought the
7 anecdotal information on the CCBHC model was promising.
8 But we ought to recognize that we need more comprehensive
9 care to avoid the crises rather than just creating crisis
10 service.
11 On Option 1, if you don't mind me jumping into
12 that while I've got a little air time, it just struck me as
13 odd that a recommendation for two agencies to work together
14 might be really useful, sort of like what we just suggested
15 that Medicare and Medicaid work better together because we
16 don't need an coordinating office to do integrated models
17 of care, but actually, we did and we made tremendous
18 progress in integrated models for duals under our Chair's
19 leadership.
20 Maybe they should jointly appoint a czar over
21 mental health and substance abuse. It does strike me that
22 we have very fragmented policies across those, but just

1 admonishing the agencies to work better together sounded a
2 little stretch, but thanks.
3 Again, Erin and Melinda, you did a great job.
4 This is so important.
5 VICE CHAIR MILLIGAN: Thanks, Sheldon.
6 Erin, did we lose you for a minute somewhere in
7 there?
8 MS. McMULLEN: Yes.
9 VICE CHAIR MILLIGAN: If we did, did you capture
10 Fred's comments, or is that when we lost you toward the end
11 of that?
12 MS. McMULLEN: My internet went out in the middle
13 of that, but I believe it was mainly focused around kind of
14 my comments earlier around multi-payer and the need to
15 address other payers when trying to develop a crisis
16 continuum. Is that a safe --
17 VICE CHAIR MILLIGAN: Yep, that captures it,
18 Erin. I just wanted to check.
19 MS. McMULLEN: Thank you.
20 VICE CHAIR MILLIGAN: Sure.
21 Kit, then Bill, then Darin.
22 COMMISSIONER GORTON: So I agree with everybody

1 else. it's an important topic, and the work you did is
2 well done.
3 I would like to -- and I'm supportive of
4 converting the options that you've outlined, Erin, into --
5 EXECUTIVE DIRECTOR SCHWARTZ: Kit, we can't hear
6 you very well.
7 COMMISSIONER GORTON: You can't hear me very
8 well. Can you hear me now?
9 COMMISSIONER BARKER: That's better, Kit.
10 VICE CHAIR MILLIGAN: Yeah.
11 COMMISSIONER GORTON: Okay. I apologize for just
12 mumbling.
13 So I support the three options. I support
14 converting them into recommendations for the Commission to
15 vote on, and I just have -- and I want to endorse the
16 comments that other people have made with respect to
17 shining that spotlight on behavior health equity, which I
18 think is very important. And I do think it was Sheldon's
19 comment about shine a light on the fact that you have a
20 problem, but at some point, we might want to think about
21 recommending something for the problem. Just saying that
22 there's a health equity problem hasn't helped in any other

1 realm of health care to get things better. You need to
2 focus solutions at the people who are disadvantaged, and so
3 we ought to think about that, maybe not in this scope of
4 work, but as we go forward.

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

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

19 And I don't know that we necessarily need to deal
20 with that all in this chapter, but if those are -- if you
21 have answers to those questions, that's swell. And we
22 should probably put them in the chapter. If the answer is

1 the territories are just the same and we didn't forget
2 about them, that's good too.
3 If we have more thinking to do about the
4 territories in the context of behavioral health services in
5 general and crisis services in particular, then we ought
6 to, in my view, in this chapter at least put a placeholder,
7 and then maybe in the work that Kacey is doing further on,
8 we deal with the issues of that, the specifics of that in
9 that piece of work. I don't think we need to say
10 everything twice, but I think we need to acknowledge that
11 the territories are different and if they have particular
12 challenges, particularly with funding, right? Because as I
13 understand it, their funding cliff applies to behavioral
14 health services as well as everything else for Medicaid.
15 So I just want to raise that and make sure that
16 we are thinking about that going forward so that in some
17 pieces of work, we can shed a little light on that. If
18 today is appropriate for asking questions about that to the
19 territories in the time we have with the Medicaid
20 directors, then I would be happy to have that conversation
21 as well.
22 Thank you.

1 VICE CHAIR MILLIGAN: Thank you.
2 I have Bill, then Darin, then Brian.
3 COMMISSIONER SCANLON: Actually, Chuck, I was
4 trying to adjust my screen, so I wasn't really raising my
5 hand, but given the opportunity, I will say that I'm very
6 supportive of the recommendations because this is a very
7 important area that's been too long under, sort of,
8 invested in and, to a point, almost neglected.
9 I think that the options are very positive, but I
10 would also think, at least in our narrative about these,
11 that we sort of underscore the need for follow-up. It's
12 not just a question of initially giving out directions, but
13 the fact that these intended actions occur is critical
14 here. I would observe that we will follow up in the future
15 but also encourage the Secretary to be following up in the
16 future.
17 Thank you.
18 VICE CHAIR MILLIGAN: Thank you, Bill
19 Darin?
20 COMMISSIONER GORDON: Erin, great, great work,
21 and I echo many of the comments that have already been
22 made.

1 I agree with Sheldon's comment about we'd like
2 these two agencies to work together seems a bit soft.
3 Whether it's -- I don't know about a czar, but a task force
4 or something that can help give greater clarify to states
5 around this, because when we had to modify our crisis
6 system in Tennessee, it really was us on an island and to
7 figure it out, working with some providers that were
8 interested, willing, and I'm trying to figure what role
9 Medicaid agencies, you know, funding we could have to
10 support it. So I think this is definitely needed.
11 On the discussion around having other payers
12 participate, I think that's a great concept. I don't know
13 how you pulled that off. If we waited to get everyone on
14 board, we probably would have never stood up some crisis
15 centers, but I think at the very least, as recommendations,
16 I think if states can have greater clarify about how
17 Medicaid can play a role, then they can work with different
18 providers to actually stand up some of these crisis
19 centers. It's not just the mobile crisis unit, the crisis
20 centers. We've seen some really dramatic success in the
21 role that they can play as well.
22 So, again, I applaud the recommendations, and I

1 think just other than maybe taking an additional step about
2 the agencies working together, I suppose them.
3 VICE CHAIR MILLIGAN: Thank you, Darin.
4 Brian?
5 COMMISSIONER BURWELL: I want to jump on kind of
6 Martha's question on clarification, and that is
7 distinguishing between crisis response systems for people
8 with substance use disorders who have overdosed and crisis
9 response systems for other types of behavioral crises, I
10 think, we're primarily talking about.
11 Suicide prevention. Those response systems in my
12 mind look quite different, and I just want the chapter to
13 acknowledge that we're not just talking about uniform
14 crisis response systems to deal with all kinds of
15 behavioral issues but systems that can respond to different
16 populations in different types of crises.
17 I don't want to create bureaucracies that aren't
18 necessary, and I want them to build upon -- our
19 recommendations to build upon what we already have out
20 there and helping them work more effectively.
21 VICE CHAIR MILLIGAN: Thank you, Brian.
22 I didn't see anybody else who wanted to jump in,

1 just giving everybody another chance.

2 Erin, I had a couple questions and some comments
3 too. Do we have any indication whether the July 2022 go
4 live is in jeopardy if it is on schedule? Do we have any
5 indication of the likelihood of achieving that deadline?

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

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

17 MS. McMULLEN: Sure. So I think over the past
18 few years, there has been maybe less collaboration between
19 the two agencies. There's maybe a few examples that I can
20 point to. So the National Guidelines on the crisis
21 continuum that came out this time last year really don't
22 mention Medicaid much, and just by the fact that Medicaid

1 is the largest payer of mental health services in the U.S.
2 and playing an increasing role in the payment for substance
3 use services.

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

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

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

21 Part of that statutorily defined role includes
22 dozens of different things. One of them is kind of

1 coordinating with other agencies that play a role in
2 behavioral health care.
3 This was kind of our way of trying to maybe
4 address that role and how it related across the agency,
5 just because SAMHSA really does play such a strong role in
6 providing that evidence base for CMS.
7 VICE CHAIR MILLIGAN: Thank you. That's really
8 helpful.
9 Martha, I'll come back to you in a second.
10 My next question, Erin, is Fred mentioned
11 potential other agencies being included in a collaboration
12 recommendation, including HUD. I might want to add the
13 Department of Labor in that to the extent that they're --
14 if we're going to try to involve the commercial payer
15 world, ERISA and DOL issues could potentially be a barrier
16 and potentially be a solution.
17 I wanted to ask -- and, Anne, feel free to jump
18 in on this, but do we have any concerns about whether our
19 recommendations touch on agencies that are really kind of a
20 little bit more afield from Title 19 or Title 21? Do we
21 have any concerns about that?
22 And I would assume -- I would hope not if it's

1 more of a collaboration recommendation, but I wanted to
2 check.
3 EXECUTIVE DIRECTOR SCHWARTZ: So I don't think
4 there's a concern with respect to statutory authority. I
5 do think that we would want to suss out what the role of
6 those agencies are with respect to supporting the
7 development of a crisis continuum. It might be more
8 appropriate to talk about a variety of other agencies in
9 the text rather than in the recommendation itself. I think
10 that's something that we'd want think through a little bit
11 further.
12 I also don't think having a laundry list is a
13 great idea, just for the sake of us being able to say, oh,
14 geez, all these guys should be involved. I think we should
15 think it through a little bit, and I think there's always
16 the option of referencing those issues in the narrative as
17 opposed to the recommendation.
18 VICE CHAIR MILLIGAN: And I just had, I think,
19 one or two more brief comments, Martha. Then I'll come
20 back to you.
21 Erin, I think you're hearing a lot of support for
22 kind of the chapter and some good comments for inclusion on

1 the chapter, and I would just for my -- my request would be
2 to include a little bit of context about the CMS-SAMHSA
3 working relationship and some of -- I want to make sure
4 that we better develop that background before we maybe lean
5 into that kind of recommendation.
6 And I personally support the point of view that
7 we've heard from a few Commissioners around -- you know,
8 Darin mentioned a task force or some sort of working group
9 between SAMHSA and CMS and, you know, the czar or whatever,
10 but I do think that the more we can articulate what it is
11 we would hope to see as opposed to more generic
12 collaboration which is a form of recommendation I've seen
13 between CMS and SAMHSA going back since the dawn of time, I
14 think that would be helpful.
15 I have heard general consensus about support for
16 the options. My request and suggestion would be that when
17 you bring things back to us in April, I think it would be
18 in the form of a recommendation and to give some thought to
19 whether and how to include other agencies that we've heard
20 about and also how to address the comment Fred started us
21 with but others kind of piggybacked around guidance that
22 would involve or have implications for the commercial and

1 Medicare and other payer components being brought to the
2 table, and maybe that could be an element of what CMS and
3 SAMHSA help address in guidance is the proper way to get at
4 this. And might also lend itself to what we might want to
5 say to Congress. But my suggestion would be for you all to
6 figure that out and bring it back to us kind of respecting
7 the intent that you've heard from folks here.
8 But I want to go to Martha now. Then I want to
9 just do one more sweep and see -- and Martha, then Kisha --
10 and one more sweep to see if anybody has any final thoughts
11 or comments.
12 For the public, just to let you know, we will
13 take comments, but we'll take comments after the next
14 session that Melinda will lead on children and youth. So
15 if you could hold off on the behavioral health comments
16 until we've gotten through both of these sessions, that
17 would be appreciated.
18 Martha?
19 COMMISSIONER CARTER: Thanks, Chuck.
20 Just listening to reports from the field in an
21 area of maybe further exploration about integration or
22 collaboration between SAMHSA and CMS is around the area of

1 the CCHBCs, because I've heard that there isn't such good
2 collaboration there, and that might be something to talk to
3 the CCHBCs more about.
4 VICE CHAIR MILLIGAN: Thank you.
5 Kisha?
6 COMMISSIONER DAVIS: Just as we're thinking about
7 collaboration and encouraging that, there has been this
8 theme from several of the Commissioners around the
9 disparities piece that's highlighted very well in the
10 narrative portion but doesn't come through in the policy,
11 and is there a way to, in our policies, also encourage that
12 or encourage collaboration with Office of Minority Health
13 and the development of the behavioral health network and
14 crisis hotline to be a part of that conversation, so we're
15 starting to address more of the disparity piece?
16 VICE CHAIR MILLIGAN: Thank you. Good
17 suggestion.
18 Anybody have any final comments among the
19 Commissioners?
20 Peter.
21 COMMISSIONER SZILAGYI: Yeah. I agree with what
22 has been said, and I'd like to make one final point linking

1 this part to the next one.

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

8 VICE CHAIR MILLIGAN: Thank you. Really good
9 point.

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

12 MS. McMULLEN: I do. Thanks.

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

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

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

22 VICE CHAIR MILLIGAN: Great. Thank you.

1 Thank you, Erin, and we'll look forward to seeing
2 you again at our next meeting.
3 MS. McMULLEN: Okay. Thanks.
4 VICE CHAIR MILLIGAN: All right. So we'll turn
5 next to Melinda to lead us through a related discussion
6 with respect to children and adolescents. Melinda, it's
7 all yours.
8 **### BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND**
9 **YOUTH: PLAN FOR JUNE CHAPTER AND POLICY OPTIONS**
10 * MS. ROACH: Great. Thanks, Chuck.
11 So, in December, the Commission discussed access
12 to behavioral health services for children covered by
13 Medicaid and CHIP. Staff presented data showing that a
14 significant percentage of adolescents with behavioral
15 health conditions do not receive treatment.
16 Commissioners also heard from an expert panel
17 about state initiatives and other opportunities to improve
18 access to behavioral health services for this population.
19 Panelists agreed that states generally have Medicaid
20 authorities needed to improve access but may lack the
21 awareness and capacity to use them.
22 This session builds off that discussion by

1 presenting policy options to address the identified need
2 for additional guidance and technical assistance. These
3 policy options focus on children and adolescents with
4 significant mental health conditions who are at greatest
5 risk for out-of-home placement and poor outcomes. If the
6 Commission is interested in including these as
7 recommendations in the June report, we'll return in April
8 with specific language for you to vote on.
9 We'll also bring a chapter that provides context
10 and background on access to behavioral health services for
11 children and adolescents, including previously discussed
12 work on the availability of behavioral health providers
13 serving this population. If the Commission is not ready to
14 make recommendations, we can still include a chapter in the
15 June report with this material.
16 Let me just try to advance the slide.
17 Today's presentation will include background
18 information on various agencies that are involved in the
19 care of children and adolescents with behavioral health
20 conditions. We'll also revisit data presented in December
21 on access to treatment for children and adolescents with
22 significant mental health conditions and discuss challenges

1 that were highlighted by panelists and other experts. That
2 will lead us into the two policy options, and then we'll
3 close by discussing next steps.
4 In December, we presented data showing that
5 Medicaid is a major source of coverage for adolescents with
6 significant mental health conditions, covering one in every
7 three youth with a past-year major depressive episode
8 resulting in severe role impairment.
9 These adolescents and children with significant
10 mental health conditions are often at risk for out-of-home
11 placements as well as involvement with child welfare and
12 the juvenile justice system.
13 They are also more likely to have an SUD and to
14 die by suicide.
15 Access to home- and community-based behavioral
16 health services can prevent these children and adolescents
17 from being removed from their homes and communities.
18 Such services have been shown to improve clinical
19 and functional outcomes, school attendance, and other
20 measures of well-being. They can also reduce rates of
21 attempted suicide and contacts with law enforcement, yet
22 these services are often not available to children and

1 adolescents with significant mental health needs and their
2 families.
3 Multiple federal, state, and local agencies play
4 a role in serving this population, and therefore,
5 addressing the needs of these children and adolescents
6 requires collaboration with multiple partners.
7 At the federal level, this includes CMS and
8 SAMHSA as well as ACF, which administers federal funding
9 for child welfare. At the state and local level, key
10 partners beyond the Medicaid agency include behavioral
11 health, child welfare, and juvenile justice agencies.
12 This slide summarizes federal requirements
13 affecting access to behavioral health care for children and
14 adolescents in Medicaid and CHIP. Medicaid must cover
15 medically necessary health services for enrollees under age
16 21 under the Early and Periodic Screening, Diagnostic, and
17 Treatment benefit. This is true regardless of whether the
18 required services are covered under the state plan.
19 CHIP is required to cover behavioral health
20 services, and the Americans with Disabilities Act requires
21 that services for individuals with disabilities, including
22 those with serious mental health conditions, are provided

1 in the most integrated setting appropriate to their needs.

2 Despite these requirements, the behavioral health
3 needs of many children and adolescents covered by Medicaid
4 and CHIP go unmet. One panelist at the December meeting
5 noted that while access to behavioral health services is a
6 challenge across the life span, the problem is more acute
7 for young people. This is particularly true for those with
8 significant mental health conditions. The data we
9 presented in December showed that only half of adolescents
10 enrolled in Medicaid who experienced a past-year MDE
11 received some form of treatment. Among those with MDE
12 resulting in severe role impairment, only 60 percent
13 received treatment. Having looked further into differences
14 across racial and ethnic groups in Medicaid, we found that
15 Black beneficiaries with MDE with severe role impairment
16 were less likely to receive treatment than their white
17 counterparts.

18 Recently, this unmet need has been exacerbated by
19 school closings, social distancing, and other consequences
20 of COVID-19.

21 As we've noted in many instances, children and
22 adolescents with significant mental health conditions

1 covered by Medicaid and CHIP lack access to services that
2 help prevent hospitalization and the use of residential
3 treatment.
4 In several class-action lawsuits, courts have
5 found that states were not providing sufficient access to
6 these services to meet their obligations under EPSDT,
7 leading to more potentially avoidable out-of-home
8 placements.
9 In 2018, while adolescents with Medicaid coverage
10 received mental health treatment at similar rates as their
11 peers with private coverage, they were more likely to be
12 served in inpatient and residential settings.
13 In December, panelists noted that states often
14 face challenges determining how to use available Medicaid
15 authorities to structure benefits that meet the needs of
16 this population. While there are a number of options
17 states can pursue such as 1915(c) waivers and 1915(i) state
18 plan authority, the process can be difficult to navigate,
19 and states have received minimal federal support for their
20 efforts in recent years.
21 National experts, including panelists at the
22 December meeting, have highlighted the need for additional

1 federal guidance and technical assistance to expand home-
2 and community-based behavioral health services for children
3 and adolescents with significant mental health conditions.
4 The next several slides outline policy options and in many
5 ways mirror those that Erin presented in the last session.
6 The first option is focused on additional
7 guidance. It reads: "The Secretary of Health and Human
8 Services should direct CMS, SAMHSA, and ACF to issue joint
9 sub-regulatory guidance that addresses the design and
10 implementation of benefits for children and adolescents
11 with significant mental health conditions covered by
12 Medicaid and CHIP."
13 New guidance could facilitate state adoption of
14 home- and community-based behavioral health services that
15 permit children and adolescents with significant mental
16 health conditions to live in their communities and avoid
17 institutional placements.
18 Previous guidance issued in 2013 was useful but
19 is now out of date.
20 Among other things, new guidance could identify
21 additional evidence-based services, including those
22 addressing trauma; promote coordination with other child-

1 serving agencies; and provide clearer guidance on how
2 states can pay for these services in Medicaid and CHIP.
3 In developing such guidance, coordination between
4 CMS, SAMHSA, and ACF is needed to address the role of state
5 Medicaid, behavioral health, and child welfare agencies in
6 serving children and adolescents with significant mental
7 health conditions, particularly as states continue
8 navigating the intersection between Medicaid and new child
9 welfare requirements under the Family First Prevention
10 Services Act.
11 The second policy option addresses the need for
12 technical assistance and planning support. It reads: "The
13 Secretary of Health and Human Services should direct a
14 coordinated effort by CMS, SAMHSA, and ACF to provide
15 education and technical assistance to states on improving
16 access to home and community-based behavioral health
17 services for children and adolescents with significant
18 mental health conditions covered by Medicaid and CHIP.
19 Additionally, the Secretary should examine options to use
20 existing federal funding to support state-level activities
21 to improve the availability of these services."
22 In addition to sub-regulatory guidance, technical

1 assistance and planning opportunities are needed to enhance
2 state capacity and jumpstart efforts to expand the
3 continuum of services for children and adolescents with
4 significant mental health conditions. Such technical
5 assistance coupled with planning support could help states
6 establish cross-agency partnerships, engage stakeholders,
7 design new Medicaid and CHIP benefits, and overcome other
8 barriers such as limited state resources and capacity.
9 Existing funding could be used to support these
10 efforts. As Erin noted, Congress recently increased
11 funding for SAMHSA's Mental Health Services Block Grant and
12 is considering additional increases in the latest COVID
13 relief package. A portion of this funding should be used
14 to help state agencies dedicate staff time needed to engage
15 relevant partners and develop a coordinated plan to address
16 the behavioral health needs of children and adolescents
17 with significant mental health conditions.
18 As a next step, we're hoping to get a sense of
19 your interest in developing these policy options into
20 recommendations for the June report. In April, we'll
21 return with a draft chapter, and again, should you decide
22 to move forward with these policy options, we'll also bring

1 specific language for you to vote on.
2 Thanks for your time, and with that, I will turn
3 it back over to you, Chuck.
4 VICE CHAIR MILLIGAN: Thank you, Melinda. Really
5 good work and appreciate it.
6 We'll start with Peter.
7 COMMISSIONER SZILAGYI: Thanks, Melinda. I
8 really appreciate this and very much appreciate the focus
9 on mental health.
10 Just sort of at the high level, I agree with
11 these two policies, and I feel strongly that they by
12 themselves are a first step. They're great, but they will
13 do a limited amount to really solving the mental health
14 problems of children and adolescents, but it's an important
15 first step.
16 So just to set the context, prior to the
17 pandemic, we were already facing a crisis of mental health
18 problems in children and adolescents with insufficient
19 providers, not enough payment, long waiting lines. We
20 sometimes in California have to wait six months to get a
21 mental health provider for mental health in children and
22 adolescents, and there were really two systems of care

1 prior to the pandemic.

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

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

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

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

22 I think Kisha mentioned telehealth care in the

1 adult world. There are many adolescents who would prefer
2 mental health services by telehealth rather than in person,
3 because they're adolescents, and I think highlighting that
4 in parity in payment for telehealth, I think is important.
5 Somebody mentioned mobile health or pairing
6 police with mental health services, and that's absolutely
7 true in the pediatric and adolescent world. There have
8 been some high-profile cases just in the last couple of
9 months about children and adolescents with major depressive
10 problems who were engaged by police because there weren't
11 mental health mobile crisis units available, and there are
12 settings where mobile crisis units have worked very, very
13 well.
14 One other point is justice-involved youth. As
15 you mentioned, Melinda, many, many children and mostly
16 adolescents with major mental health problems are involved
17 with child welfare and end up being justice-involved youth
18 and incarcerated, and some states have laws now that
19 there's automatic Medicaid. If they had Medicaid going in
20 to incarceration, they automatically have Medicaid going
21 out. That's not the case everywhere, I believe, and that
22 would improve care.

1 So my basic points is that I think these are two
2 good steps, but I think there's a lot more that we can do.
3 And I'm really glad that we're in this space right now.
4 VICE CHAIR MILLIGAN: Thank you, Peter.
5 I have Sheldon, then Brian.
6 COMMISSIONER RETCHIN: So I am just delighted
7 with the report. I think this is a tremendous area as a
8 companion piece, and I appreciated Peter's remarks.
9 I was hoping -- I was really hoping I could get
10 through an hour of the Commission without saying anything
11 about the workforce, but I failed.
12 As I read this, I was struck by the remark or the
13 statement, which was highly accurate, but it said "while
14 adolescents with Medicaid coverage received treatment at
15 similar rates as their peers with private coverage," and I
16 thought wow. That's a tremendous statement that really
17 there's -- it's inequitable. Actually, it's equitable that
18 those with private coverage also have tremendous unmet
19 needs.
20 In a recent Kaiser report, I was looking at the
21 column where they went through states about needs met, and
22 there were states that have, in terms of unmet needs, 80 to

1 90 percent in terms of mental health.

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

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

15 VICE CHAIR MILLIGAN: I have Brian, then Tricia.

16 COMMISSIONER BURWELL: Melinda noted, and also
17 our background materials note that there are provisions in
18 the COVID relief bill to enhance Medicaid funding for
19 crisis intervention services, and I just want to make sure
20 that we stay on top of that in the next few weeks, before
21 the next meeting, and perhaps issue some kind of memo or
22 summary of what is eventually enacted. I don't know if

1 they're going to stay in there or not. I just believe that
2 both our chapters and our recommendations should include
3 that information and kind of what's been done already. I
4 don't want our recommendations to go Congress and then have
5 people think, well, we've already dealt with that, you
6 know, in the COVID relief bill. So it's just a request to
7 try to stay as informed as possible about what could happen
8 in Congress over the next few weeks.
9 VICE CHAIR MILLIGAN: Thank you. Tricia?
10 COMMISSIONER BROOKS: I want to thank you and,
11 and Melinda, great report. I just want to echo, actually,
12 Peter and Sheldon, and Sheldon, if I'd raised my hand first
13 I would have raised the workforce issue for you, so you
14 could have avoided it, but I think that's an important
15 element. And Peter, you know, indicating that it's an
16 important step, but it really is just a baby step forward.
17 And one of the things I hope we can begin to
18 convey is just the urgency within the child space for
19 behavioral health. The reality is that we keep filling up
20 the pipeline of adults with mental illness that started,
21 that was rooted in childhood, and if we're ever going to
22 stop that cycle we really have to focus on kids and make

1 sure that the system is working for them.

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

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

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

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

1 coming out that could prove to be effective.
2 VICE CHAIR MILLIGAN: Thanks, Toby. Martha?
3 COMMISSIONER CARTER: Thanks. I had noted, when
4 reading the chapter, the scarcity of information by race
5 and ethnicity, and I think, Melinda, you all responded that
6 there really weren't a lot of data available in this area.
7 But I think we need to keep calling this out and then keep
8 asking the question, what is the role of Medicaid programs
9 in addressing and reducing disparities by race, ethnicity,
10 and I'm going to add geographic, because that also gets to
11 the workforce issue that Sheldon brought up. I think there
12 are geographic disparities in urban and in rural and in
13 frontier areas that I would add to the disparities list.
14 VICE CHAIR MILLIGAN: Are there any other
15 Commissioners that wanted to jump in? Fred?
16 COMMISSIONER CERISE: Sorry. I was on mute.
17 Yeah, I'll just make a quick comment, and that is
18 Peter talked about some of the practices integrating
19 behavioral health into the pediatric practices and other
20 modalities, and Melinda, I thought you did a great job of
21 outlining different services that need to be considered.
22 And I would just emphasize that for complex populations

1 like this, they need systems to be able to address those
2 needs. And so as we look for guidance, I would also
3 include the need to understand how we address the continuum
4 of services, because we don't want a menu of options that
5 states may support half of them or something, but how that
6 guidance would point to the full continuum of services that
7 health plans would ensure, or providers would ensure. But
8 it really begs for systems of care to address these complex
9 cases.
10 VICE CHAIR MILLIGAN: Thank you. So, Melinda, I
11 had a few myself. I wanted to start with the first option.
12 When you went through the materials in the slide deck you
13 mentioned the guidance is out of date and you referenced
14 2013. Is the primary -- and I think it was the next slide,
15 in terms of the rationale, the second bullet there -- is
16 the primary reason that the guidance is out of date now is
17 that there are a lot more evidence-based practices and a
18 lot more proven models of care? I wanted to better
19 understand this, and, you know, you can touch on it
20 briefly, but in the chapter itself, to the extent that we
21 might be moving in the direction of a recommendation on
22 Option 1, I want to make sure that we're really pretty

1 clear on what we mean by that bullet. I recognize that
2 some of the materials got deeper than this particular deck.
3 For the sake of the public and for the sake of
4 building out the case for this recommendation, could you
5 just elaborate on why this is out of date?
6 MS. ROACH: Sure, and that's something certainly
7 we can flesh out in the draft chapter.
8 You're right. Part of it is including these
9 evidence-based practices that experts have recommended
10 should be highlighted in federal guidance. I think
11 therapeutic mentoring is one that comes to mind that states
12 are increasingly offering to this population.
13 I think there are a plethora of newer state
14 examples that other states would benefit from having access
15 to. The 2013 guidance highlights a variety of states, but
16 even the links that are offered in that guidance are no
17 longer live, so it's just less of a useful tool for states
18 now that are trying to learn about how to move forward in
19 this area. And I think there may be some updates that CMS
20 may want to make in terms of discussion of available
21 Medicaid authorities, so that something that we can detail
22 further in the draft chapter for April.

1 VICE CHAIR MILLIGAN: Yeah, thank you, because,
2 as I said when we were doing the section that Erin walked
3 us through, I think recommendations about collaboration
4 have been around for a while, and I think the more we can
5 make the case for why we're weighing here, I think the
6 better.
7 My second question relates to the second option,
8 about TA, and you did, in the next on the slide and in the
9 recommendation, you touched on existing federal funding.
10 So the second-to-last line on this is to use existing
11 federal funding. I had a question around your thoughts
12 about CMMI as an element here, and to the extent to which
13 maybe they've underfunded or underscoped pilots and
14 demonstrations using CMMI authority around the behavioral
15 health gaps needs. And this might come back to the
16 technology piece that Toby touched on, is I think CMMI
17 could have a role here in how they consider using their
18 authority and some of their funding sources to help pilot
19 improvements in care and outcomes and access. And I was
20 curious about whether we know much about CMMI involvement
21 to date, and whether that, in your view, Melinda, is ripe
22 for what we mean by using existing Federal funding here as

1 well.

2 MS. ROACH: I think that's something that we can
3 explore further. One CMMI model that comes to mind, and
4 I'm blanking on the full name, but the InCK kids model that
5 launched recently I think is relevant in this space. I'm
6 not sure of other investments being made on the part of
7 CMMI, but there may be opportunity there. I would hesitate
8 to sort of speak to that now without looking into it a
9 little bit further.

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

18 My, I think, last question and comment is we
19 heard a couple of things in this discussion from the
20 Commissioners around areas where we might want to include
21 language in a recommendation, one having to do with
22 workforce, one having to do with race and ethnicity data

1 collection, and maybe a recommendation around using our
2 bully pulpit here in a recommendation to urge collection
3 and dissemination of information along those lines.
4 I'm curious about whether you think those can be
5 incorporated in the existing recommendations that we've
6 talked about in this meeting, whether they might be
7 separate recommendations, whether you think they are
8 appropriate for consideration. And we can come back to
9 this in April, but I did want to call out that the
10 workforce and the race and ethnicity piece I think merit
11 some form of explicit call-out, when we get to it. That's
12 my own personal opinion. And I just wanted to get your
13 sense of if we might want to approach that when we come
14 back in April.
15 MS. ROACH: I think certainly there is a good
16 amount of descriptive information that we can provide in
17 terms of background and context to help set up the
18 recommendations. You know, one idea is to think about how
19 we could sort of incorporate those issues into the existing
20 policy options in terms of things that CMS and SAMHSA and
21 ACF should be working to address in helping states address.
22 So that could be one avenue in terms of building it into

1 the work.

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

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

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

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

1 Thank you for the work.

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

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

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

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

16 **### PUBLIC COMMENT**

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

19 VICE CHAIR MILLIGAN: Yes.

20 Mr. WOODLOCK: Great. Great. Thank you. Good
21 morning, everybody, and thank you for an impressive
22 conversation. So I'm David Woodlock. I live in New York

1 State and currently run a large not-for-profit here that
2 serves overwhelmingly a Medicaid population, so by quick
3 background.
4 A couple of things, if I can say. I just saw
5 this morning an impressive study on the commercial side of
6 things, that having reviewed 92 billion claims on the
7 commercial side that there has been a 90 percent increase
8 in self-harm claims for young people 13 to 18, and a 94
9 percent in overdose claims, year-to-year, March-to-March,
10 from 2019 to 2020.
11 So I think as we were just discussing, the
12 urgency of better attending to young people, I think the
13 data is absolutely overwhelming in that, and I think if we
14 don't do something fairly soon we are going to have a
15 wounded generation on our hands that is not ready to be
16 successful in school or be healthy in the broadest way.
17 Forgive the familiarity here, but Fred mentioned
18 the importance of a continuum of care on the adult side,
19 and I think a little bit later in the kids conversation
20 Peter mentioned the importance of pediatrics. So I would
21 really underscore, as we think about both the workforce
22 issue and the access to care issue that primary care across

1 the age continuum is a critical issue. So I think payment
2 incentives and collaborative guidance from CMS on ways to
3 encourage and promote care and attention from the primary
4 care community is critically important. So that is one
5 point, if I may.
6 The second, really, we talked a little bit about
7 workforce development, and I think it's important also in
8 the access issue that we think broadly about how we define
9 the workforce. And somebody mentioned the inclusion of the
10 Department of Labor in these discussions, which I would
11 strongly support myself. But all the way from peer
12 supports, family supports, and the professional community,
13 so whether those are community health type workers that can
14 address behavioral health needs and the like, I think is
15 critically important, as is school-based mental health
16 initiatives.
17 And then, lastly, if I may, I think when thinking
18 about young people, in particular, and the issues of race
19 and ethnicity and the confluence of poverty, the young
20 people, particularly, I think, are very comfortable with
21 and amenable to the use of digital technologies for
22 communication. We here rolled all of our services -- we

1 take care of about 10,000 people a year with pretty serious
2 mental health problems -- we rolled to tele-mental health
3 intervention pretty quickly, and it became painfully
4 apparent that the more the distressed folks were, the less
5 access they had to digital technologies.
6 So whether that's smartphones or computer-based,
7 or it's the fees associated with being online, I think as
8 we think about all of the wonderful benefits of telehealth
9 and tele-mental health and substance use issues, the
10 digital divide is very real and painfully apparent the more
11 you use the digital technologies. There are an awful lot
12 of people who are some of the most needy, who simply don't
13 have access to that. So an expansion of telehealth could
14 inadvertently be another example of escalating health
15 disparities.
16 So that's my two cents. Thank you for listening.
17 VICE CHAIR MILLIGAN: Appreciate the comments,
18 David.
19 Operator?
20 MS. HUGHES: Kirsten Beronio? I'm sorry if I'm
21 pronouncing that incorrectly. You're unmuted.
22 MS. BERONIO: Thank you. Hi. I'm Kirsten

1 Beronio. I am the director of Policy and Regulatory
2 Affairs for the National Association for Behavioral
3 Healthcare.
4 I just wanted to make a few suggestions regarding
5 the guidance that you are thinking about recommending CMCS
6 forward on crisis services. One recommendation I wanted to
7 make was that you specifically encouraged CMCS to address
8 how states can access federal Medicaid match for
9 administrative costs. As has been discussed, some of these
10 services can be tricky to directly cover via Medicaid, but
11 a lot of the activity that needs to take place at the state
12 level, to really stand up the infrastructure that's needed
13 to address these crisis calls, to crisis call centers and
14 mobile crisis units, et cetera, are activities that could
15 potentially be reimbursable as administrative costs, as
16 long as that was properly allocated to take into account
17 the degree to which Medicaid beneficiaries are taking
18 advantage of those services. So that would obviously be an
19 important part of that.
20 Some states have already been doing this. So
21 there are examples that CMCS could look to, to how to
22 properly do the cost allocation, et cetera.

1 I would also encourage you to call out
2 specifically, to make sure that it's addressed, the
3 availability of enhanced administrative match for some of
4 the technology that needs to be put in place. Again, some
5 of the challenges in this area is that sometimes you don't
6 know if someone is on Medicaid. Obviously, we want to make
7 these services available to all people, regardless of
8 payer. So how do you properly cost allocate? How do you
9 make sure all payers are participating?
10 I would encourage that this guidance not just
11 address commercial, how to incorporate commercial payers in
12 supporting this, but also Medicare and so making sure that
13 CMCS is working with the Center for Medicare Services, and
14 what more Medicare can do in this space, I think would be
15 important as well as CCIIO to think about how the
16 marketplace systems can help support access to crisis
17 services.
18 Finally, I wanted to just point out I think it's
19 really important that we call out and offer more support
20 for the three areas that SAMHSA's guidelines focus on,
21 namely the call centers and the mobile crisis units and the
22 crisis receiving centers and stabilization centers. Those

1 are severely under-resourced right now, and so we do need
2 to pay attention to those.
3 But I think we also need to keep in mind that a
4 lot of the people accessing these services may need access
5 to inpatient care. So if you're suicidal, a 23-hour
6 program is really not going to be sufficient, and you may
7 need inpatient care. For the Medicaid beneficiaries
8 accessing these services, they do face a big barrier, which
9 is the IMD exclusion for accessing that inpatient care. So
10 I think it is relevant to these discussions and should be
11 called out in the guidance.
12 At CMCS, there is an 1115 opportunity. There has
13 been legislation introduced over the years to try to
14 address this one recent bill. It's either introduced or
15 will be introduced soon that creates a state option that's
16 similar to the 1115 opportunity.
17 So there are potentially opportunities there, but
18 it continues to be a big challenge for accessing that level
19 of care. So thank you very much.
20 MS. HUGHES: Hilary Daniel, you may unmute to
21 make your comment.
22 MS. DANIEL: Hi. Can you hear me okay?

1 VICE CHAIR MILLIGAN: Yes.
2 MS. DANIEL: Great. Good morning, and thank you
3 for a great discussion thus far. My name is Hilary Daniel.
4 I'm with the Children's Hospital Association. CHA works to
5 advance child health through innovation in equality, cost,
6 and delivery of care to Children's Hospitals across the
7 nation.
8 We are grateful the Commission has taken up the
9 vital issue of access to children's behavioral health care
10 services and appreciate the opportunity to share our
11 perspective.
12 While mental and behavioral health conditions can
13 occur at any age, children are especially vulnerable.
14 Approximately 15 percent of adult mental illnesses occur by
15 the age 14 and 75 percent by age 24.
16 As mentioned before, the pandemic has exacerbated
17 an already worrisome trend in the mental health of children
18 and youth, as social isolation has limited kids' access to
19 school, friends, and other support systems. For Children's
20 Hospitals, this means seeing children who are in crisis.
21 In communities across the country, Children's
22 Hospitals have seen increases in suicide attempts, self-

1 harm, and violent outbursts. From April to October 2020,
2 hospitals saw a 24 percent increase in the proportion of
3 mental health emergency visits in kids ages 5 to 11 and a
4 31 percent increase for kids and teens ages 12 to 17. This
5 crisis is further exacerbated by racial inequity and those
6 in underserved or under-resourced communities.
7 In addition to the increase in crisis care,
8 preliminary data from CMS shows a marked decline in
9 outpatient mental health for children during the pandemic,
10 with 44 percent fewer outpatient mental health services
11 between March and May of 2020 compared to the same period
12 in 2019.
13 The rapid expansion and adoption of telehealth
14 has helped to offset some of these services and connect
15 children with the care they need. Audio-only telehealth
16 has been particularly beneficial in reaching children who
17 may face unique barriers to accessing video visits, like
18 children in lower-income homes who may not be able to
19 access their own devices, or children living in group home
20 settings who may not feel comfortable being on video due to
21 privacy concerns or feeling stigma. Although telehealth
22 has helped to offset, some of those challenges remain.

1 The Commission should examine ways Medicaid can
2 address the acute inpatient crisis by better supporting
3 alternatives to inpatient care. This includes options such
4 as partial hospitalization programs, day programs, or step
5 down programs to offer a bridge between inpatient and
6 traditional outpatient settings.
7 It is also important to advance policies and
8 legislation that support and strengthen the pediatric
9 health care system. This includes broader support for
10 sustainable Medicaid payments for the behavioral health
11 workforce, including primary care, through enhanced
12 provider rates and through enhanced Medicaid matching
13 funds, as well as investments in training pediatric mental
14 health and behavioral health care providers.
15 There are immediate and long-term needs to create
16 sustainability across the spectrum of children's behavioral
17 and mental health care. We recommend the Commission
18 examine ways to better support care in the community and
19 invest in upstream interventions such as prevention
20 surveillance to enable timely diagnosis and treatment,
21 potentially avoiding more intensive care and costs down the
22 road. Further strategies should include increased federal

1 funding for children's health care research, ongoing
2 awareness in research in deliveries reform, support for
3 community-based resources to address key social
4 determinants of health, identification and ways to evolve
5 and enforce existing provisions of the EPSDT benefit to
6 ensure children are receiving comprehensive pediatric care,
7 and additional guidance to state Medicaid programs on the
8 ability to provide necessary Medicaid coverage for
9 behavioral health services to children in school settings.
10 We further recommend MACPAC detailed support for
11 children's mental, emotional, and behavioral health needs
12 across the federal government and explore how these
13 resources could be better coordinated and leveraged
14 together to improve care and services across Medicaid and
15 other federal programs such as those under HRSA and SAMHSA.
16 Children's Hospitals and their affiliated
17 providers stand ready to partner with you as you continue
18 your work focusing on the behavioral health needs of
19 children. We will provide follow-up with more detailed
20 comments and welcome the opportunity to work with
21 Commissioners and Commission staff to support access to the
22 pediatric behavioral health services.

1 Once again, we thank you for the opportunity to
2 provide comments on this critical issue and for your
3 attention to children's mental, emotional, and behavioral
4 health care needs.
5 VICE CHAIR MILLIGAN: Thank you.
6 Just as a quick check, I see three more folks
7 lined up to speak, and after we get through the three,
8 Anne, if you could just help remind everybody on how to
9 submit comments in writing. I don't happen to remember
10 offhand, but that is another opportunity that we will take
11 into consideration.
12 So let's have these three individuals offer their
13 comments, and then we'll wrap up this session.
14 MS. HUGHES: Andrew Sperling, you may unmute your
15 line.
16 MR. SPERLING: Good morning. My name is Andrew
17 Sperling. I'm the director of Legislative Advocacy for the
18 National Alliance on Mental Illness. I want to thank the
19 Commission for a very rich discussion this morning,
20 particularly around crisis management and crisis
21 intervention.
22 It was briefly mentioned that there is a

1 provision in the American Rescue Package to Medicaid and
2 the health crisis intervention. It's something called the
3 CAHOOTS Act, which actually stands for the Crisis
4 Assistance Helping Out on the Streets Act. It was actually
5 introduced in the last Congress by Senator Ron Wyden and
6 Senator Catherine Cortez Masto from Nevada. It is in the
7 American Rescue Package that passed the House early
8 Saturday and is in the Senate bill. They're still making
9 some adjustments to it. This bill provides 80 percent FMAP
10 for states to fight crisis intervention for mental health
11 crisis. It's a bill that NAMI is vigorously supporting.
12 This is a model that was originally developed in
13 Eugene, Oregon, which accounts for Senator Wyden's strong
14 interest in this, and we're hopeful that the way this is
15 structured, it's really going to incentivize states to
16 engage in using Medicaid to finance evidence-based crisis
17 intervention services for mental health.
18 I’d also draw the Commission's attention to a
19 provision that was in the American Rescue Package but was
20 removed last week because of a ruling of the Senate
21 Parliamentarian under the very byzantine and complicated
22 budget rules that govern the budget reconciliation process

1 that this bill is being written under. This is the
2 Medicaid Reentry Act, which would create an eligibility
3 category under Medicaid for inmates 30 days prior to
4 release. We believe this is also a part of crisis
5 intervention. We know that when people leave prison or
6 jail and don't have a valid access to Medicaid, falling
7 into crisis, not getting the treatment they need, and
8 ending up in recidivism is quite high. This bill
9 unfortunately because of the budget rules was stripped. We
10 think there's enormous attention being paid to this in
11 Congress because of the challenges at the level that all
12 Members of Congress and policymakers hear about with
13 respect to mental health crisis, so a lot of attention here
14 in addition to 988, but we appreciate the Commission's
15 support on this and look forward to helping you further
16 down the road with your deliberations. Thank you.
17 VICE CHAIR MILLIGAN: Thank you.
18 I think one or two folks jumped on the line after
19 I mentioned it before. So if the remaining folks could
20 please try to be brief with your comments.
21 Operator?
22 MS. HUGHES: Dorothy Dupree, you've been unmuted.

1 You can unmute your own line.

2 MS. DUPREE: Can you hear me okay?

3 MS. HUGHES: Yes, we can.

4 MS. DUPREE: This is Dorothy. Okay. Thank you.

5 This is my first time. So please bear with me.

6 I think this is a wonderful discussion. I've really

7 enjoyed the first two presentations.

8 I can't agree more. Well, first of all, my name

9 is Dorothy Dupree. I am from Montana. I have worked in

10 health policy for many years, 10 years in Centers for

11 Medicare and Medicaid Services, and I'm not back working

12 for tribes in Montana. I work primarily for the Rocky

13 Mountain Tribal Leaders Council.

14 We represent a number of tribes in Montana and

15 Wyoming. It's the Assiniboine, the Sioux, the Gros Ventre,

16 Blackfeet, Confederated Salish and Kootenai Tribes, Crow,

17 Little Shell Band of Chippewa, Rocky Boy Tribe of Chippewa

18 Creek, Northern Cheyenne, Northern Arapaho, and Eastern

19 Shoshone, very important tribes, all considered to be

20 Plains tribes. We're very rural, and we suffer a high

21 level of health care disparities.

22 Racial disparities, I can't agree more with what

1 you are discussing. I think it's really important for us
2 to understand the racial disparities, and one comment was
3 made about data, that it's difficult to get data for
4 minority populations. And I know it's nearly impossible to
5 get data for the Native American population.
6 We have an EpiCenter in Billings, Montana that's
7 part of the Rocky Mountain Tribal Leaders Council that I
8 work for, and it's difficult for the EpiCenter, even though
9 legislation states to provide data, provide the access to
10 data, that it's been difficult for our EpiCenter to gain
11 access to data. And that makes it then almost impossible
12 to develop reasonable policy for how we reach out, how we
13 treat, how we recognize what our disparities are and what
14 our individuals are suffering from. So without data, then
15 you begin to rely on basically horror stories.
16 We have an epidemic of suicides amongst our
17 youth, and we see that somewhat like a rollercoaster. It
18 will go away for a while, and then it comes back with a
19 vengeance. So we're in an epidemic situation right now
20 with suicide, but I think part of that can be related to
21 the pandemic. But I think a lot of it, we've seen even
22 before the pandemic set in.

1 I agree. We have looked at the social
2 determinants of health. We're developing our policies
3 within the framework of the social determinants of health,
4 and I cannot agree more that agencies absolutely need to
5 work together. It's more than just what I say -- it's more
6 than just a lack of access to health care services. It's
7 more than that. It's transportation. It's housing. It's
8 access to data, as I said. It's working relationships.
9 So I encourage you to keep on the path that
10 you're working on. I will continue to participate and
11 observe in these meetings. I think it's very good to see,
12 and it gives me hope that you are intending to go down the
13 right path.
14 Some of you may think that we have the Indian
15 Health Service and the Indian Health Service is going to
16 step up and assist us, but the Indian Health Service is
17 woefully underfunded.
18 Plus, I think equality -- the difference between
19 equality and equity is one size does not fit all. We're
20 very different in our traditions and our practices. Our
21 cultures in Montana are very different, and we also have to
22 accommodate the differences between tribe to tribe, among

1 tribe to tribe. So it's challenging to say the least to
2 ensure that there's equity that we have without data,
3 without analysis, and without a lot of working
4 partnerships. It's difficult to get to that equity
5 position where what we're designing will fit this tribe and
6 what we design will fit another tribe and so forth. So we
7 realize very clearly that one size does not fit all.
8 So thank you for this time. I appreciate it, and
9 I'll end my comments there.
10 VICE CHAIR MILLIGAN: Thank you, Dorothy.
11 MS. HUGHES: Patricia Johnston, you may unmute
12 your line.
13 MS. JOHNSTON: Hi. This is Pat Johnston. I am
14 the director of Public Policy for the National Association
15 for Children's Behavioral Health. Our members provide
16 home- and community-based and institutional services for
17 kids and families, and I will be brief.
18 I want to make a pitch for the Commission to take
19 a look at how the Medicaid IMD exclusion affects kids,
20 which it does significantly, and it hasn't seemed to fit
21 into any prior reports or this report that the Commission
22 has done.

1 Just to mention several connections with the
2 presentation and earlier comments, EPSDT does not trump the
3 IMD exclusion. So kids may be identified as needing a
4 level of care that the IMD exclusion prevents Medicaid for
5 paying for.
6 Out-of-home placements that are made to the child
7 welfare system or the juvenile justice system are to a
8 unmeasured degree, in some cases, a result of the appropriate
9 level of care not being available. So there's a couple of
10 things that were in the presentation that connect directly
11 with the IMD exclusion.
12 Then as far as some of the Commissioners'
13 comments, obviously, it also connects with parity. The IMD
14 exclusion is the greatest parity violation, at least the
15 spirit of parity that we have in this country, and as far
16 as making the case for collaboration between ACF and CMS, I
17 think the biggest barrier there is a reluctance to deal
18 head on with the IMD exclusion. As Melinda noted, with the
19 Family First Prevention Services Act, this is really coming
20 to a head as a barrier for states to fully implementing
21 that child welfare reform law.
22 So that's it. Thank you very much for your

1 attention, and I'll follow up with specific comments to
2 staff.
3 VICE CHAIR MILLIGAN: Thank you.
4 I think that leaves Marisa.
5 MS. HUGHES: Yes. Marisa Aguilar, you've been
6 unmuted. You can unmute your own line.
7 MS. AGUILAR: Thank you, Operator. If you can
8 also unmute Laura Wilson-Slocum and Shery Blyth. They are
9 with me and will be also making brief comments as well.
10 VICE CHAIR MILLIGAN: Yes, please do be brief if
11 there are three of you about to comment. Thank you.
12 MS. AGUILAR: Yes. Thank you, everybody, for
13 having us. My name is Marisa Aguilar. I am the practice
14 manager over at the Expanded Mobile Crisis Outreach Team in
15 Austin, Texas. I work for the local Mental Health
16 Authority, Integral Care. We provide a strong foundation
17 for well-being. We support adults and children living with
18 mental illness, substance use disorder, and intellectual
19 and developmental disabilities.
20 We are proud to share our experience as a CCBHD,
21 as it's really led the framework for the work that we've
22 been doing. Our program launched in 2013, and we partner

1 with first responders who have the ability to request us
2 for co-response when they've identified someone that's
3 experiencing a mental health crisis.
4 Our goal is to connect people to treatment in the
5 most appropriately least restrictive option, diverting them
6 from emergency rooms, case officers, emergency detentions,
7 and jails.
8 What we did in FY20 is we integrated clinicians
9 into our 911 call center, wherein when the call takers have
10 recognized and identified that someone is experiencing a
11 mental health crisis, they can immediately transfer the
12 call to our clinicians on the floor in the absence of a
13 public safety or a medical emergency so that we take over
14 and provide support and figure out the most appropriate
15 resource for that individual, diverting police response
16 where it's not necessary.
17 We've had a lot of successes that have come with
18 this integration at the 911 call center, wherein prior to
19 this, if someone called 911 and was experiencing a mental
20 health issue, a first responder would go to the scene to
21 begin with and then call out an expert clinician to do that
22 assessment that is needed. This provided us with an

1 opportunity to divert more upstream, diverting police when
2 it was not necessary to get the most appropriate care at
3 the right time for that individual.
4 On February 1st of this year, our community added
5 a fourth option when somebody calls 911. So the script now
6 reads, "Are you calling for police, fire, EMS, or mental
7 health services?" This provides earlier identification of
8 signs and symptoms of mental health, wherein we've been
9 able to divert 86 percent of the calls transferred to our
10 clinicians from police response when it was not necessary,
11 connecting people to timely intervention and the right care
12 at the right time.
13 I will now pass it over to my colleague Laura
14 Wilson-Slocum so she can provide additional information.
15 MS. HUGHES: Laura, you've been unmuted, and if
16 you could also tell me the name of the other person so I
17 can find her while you're making your comment.
18 MS. WILSON-SLOCUM: Yes. Thank you, Operator.
19 Our colleague is Sherry Blyth. She's the director of
20 Crisis Services. Thank you so much.
21 I will keep my comments brief at the request of
22 the committee. My name is Laura Wilson-Slocum, and I'm the

1 administrator for Crisis Services and Justice Initiatives
2 at Integral Care.
3 I mainly wanted to share with you all that about
4 six months after the EMCOT team began their work with
5 Austin Police Department, one of their assistant chiefs
6 administered a survey to their patrol officers, of which
7 there's over 800 patrol officers. They had a fantastic
8 response for patrol officers. I think about 60 percent of
9 the officers took the time to fill out a survey about how
10 they felt the EMCOT team was serving the community and
11 assisting the department.
12 What we found in particular that one officer said
13 that struck us is he said that EMCOT is a force multiplier.
14 It keeps more police on the street.
15 As all of us reimagine what public safety
16 actually means and reimagine how we want to monetarily
17 invest in public safety, this is a sentiment that we can
18 all keep in mind. Of the many years that we've worked with
19 Austin Police Department and the Travis County Sheriff's
20 Deputies Office, we've never encountered a deputy or a
21 patrol officer who has said, "No. We want to handle all
22 mental health crisis calls ourselves. We don't want mental

1 health clinicians to assist." They all want to work with
2 mental health clinicians because a mental health crisis
3 deserves a health care response, and police officers are
4 trained in public safety. And they're public safety
5 experts.
6 We've been thrilled with the collaboration we've
7 had with Austin Police Department, and we're thrilled to be
8 the first city in the country, according to Texas Meadows
9 Mental Health Police Institute to add the fourth option on
10 a 911 script.
11 Thank you, and I pass this over to our director
12 of Crisis Services, Sherry Blyth.
13 MS. BLYTH: Hi, everybody. I'm Sherry Blyth.
14 I'm the director for Crisis Services. I will be very
15 brief.
16 I think you've already heard what we're doing in
17 Austin. I think a good example that people can relate to
18 is one of the first calls we received was from a mother who
19 was calling from out of state about her adult son living in
20 Austin who does have a serious mental illness. She called
21 911 for a welfare check. She hadn't heard from him, and
22 she was very, very concerned about him. That was the first

1 call that our -- that call was moved to our clinician at
2 the 911 call center. We were able to dispatch the mobile
3 team directly and not involve police, and that person was
4 linked to care. And we were able to let his -- and we were
5 able to connect him with his mother so that she knew he was
6 safe.
7 That is a great example of the kind of situation
8 that does occur on a daily basis, and I'm sure many of you
9 are familiar with these kind of scenarios.
10 I work at the 911 call center. I think that is
11 the furthest upstream you could get in terms of linking
12 people to care and when there's not an unnecessary law
13 enforcement involvement.
14 Thank you so much for your time. We appreciate
15 it.
16 VICE CHAIR MILLIGAN: Thank you all, and just for
17 your awareness, we did receive the letter that David Evans
18 from your organization sent. And we've had an opportunity
19 to read it ahead of this meeting as well.
20 Anne, if you could maybe just let folks know how
21 to submit comments by writing, and then, Melanie, turning
22 it back over to you for whatever concluding remarks you

1 want to make before the morning session ends.
2 EXECUTIVE DIRECTOR SCHWARTZ: Sure. The email
3 address is comments@macpac.gov, and every comment that we
4 receive through that, we share with all the Commissioners,
5 so rest assured that all comments are shared.
6 CHAIR BELLA: I don't have anything to say except
7 thank you for this morning's sessions. We're going to
8 break now. We'll be back at one o'clock to start the
9 session on specialty drugs. Thank you, everyone. Thank
10 you, Chuck.
11 VICE CHAIR MILLIGAN: Thanks.
12 * [Whereupon, at 12:16 p.m., the Commission was
13 recessed, to reconvene at 1:00 p.m. this same day.]
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22 AFTERNOON SESSION

1 [1:00 p.m.]

2 CHAIR BELLA: Welcome back, everyone. I'm going

3 to it like 30 seconds, and then, Chris, we'll hand it over

4 to you to get started.

5 [Pause.]

6 CHAIR BELLA: Okay. Let's get going. Thanks,

7 everyone, for rejoining. We're going to start off with

8 high-cost specialty drugs, and Chris, take it away.

9 **### HIGH-COST SPECIALTY DRUGS: MOVING TOWARDS**

10 **RECOMMENDATIONS**

11 * MR. PARK: Thanks, Melanie. As you recall, over

12 the past year, MACPAC contracted with NORC at the

13 University of Chicago to conduct an analysis of the drug

14 pipeline and convene a technical advisory panel, or TAP, to

15 look at issues with high-cost specialty drugs more closely.

16 The TAP met three times over the fall to examine drugs in

17 the pipeline that are particularly challenging for states

18 to manage and to identify design coverage, payment, and

19 rebate models to address the challenges these drugs present

20 and to assess the potential effect of these models on

21 various stakeholders.

22 At the January meeting, staff presented findings

1 from the TAP's work, and in particular two possible models
2 to address challenges for cell and gene therapies and with
3 drugs approved through the accelerated approval pathway.
4 Commissioners expressed interest in moving toward a
5 recommendation for the differential rebate model for
6 accelerated approval drugs, but they were not ready for a
7 recommendation on cell and gene therapies but wanted to
8 continue work on this issue.
9 So today I will review the U.S. Food and Drug
10 Administration, or FDA's accelerated approval pathway for
11 prescription drugs and the issues these drugs present to
12 state Medicaid programs. I will then describe the proposed
13 differential rebate model and the rationale for increasing
14 the rebate on accelerated approval drugs, as well as the
15 implications for different stakeholder groups. Finally, I
16 will present two potential recommendations to implement the
17 differential rebate model on accelerated approval drugs.
18 The first recommendation that increases the
19 minimum rebate is the primary recommendation. If the
20 Commission decides to proceed with that one it can then
21 decide whether or not to include a second recommendation as
22 well.

1 In order for any recommendation to be included in
2 the June report, the Commission must reach a decision on
3 which options it prefers at this meeting, so that staff can
4 draft the chapter and specific recommendation language to
5 be voted on at the April meeting. The chapter will also
6 provide context for MACPAC's work on high-cost specialty
7 drugs, including the work of the TAP on the pipeline
8 analysis and cell and gene therapies. We will not move
9 forward with a recommendation on cell and gene therapies
10 but we can include a discussion of the design framework
11 that the TAP discussed, and that will serve as a marker for
12 our continuing work on this topic.
13 The FDA allows for expedited approval pathways
14 for products that demonstrated substantial improvement over
15 other available therapies or that fulfill an unmet medical
16 need. One pathway, the accelerated approval pathway,
17 allows the FDA to approve a drug based on whether the drug
18 has an effect on a surrogate endpoint that is reasonably
19 likely to predict a clinical benefit. The use of surrogate
20 endpoints means an accelerated approval drug enters the
21 market before the clinical benefit has been definitely
22 demonstrated. In some cases, accelerated approval has been

1 controversial when the relationship between surrogate
2 endpoints and the clinical benefit have not been well
3 established.

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

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

20 Although there are some practical reasons for the
21 delays, drug manufacturers do not have the same financial
22 incentives to complete the confirmatory trials that they do

1 with Phase III clinical trials under the traditional
2 pathway. These products are already generating revenue and
3 negative findings could result in the drug being pulled
4 from the market.
5 The Medicaid Drug Rebate Program, or MDRP,
6 requires drug manufacturers to pay a statutorily defined
7 rebate. In exchange, states are generally required to
8 cover all of the participating manufacturers' products as
9 soon as they have been approved by the FDA and enter the
10 market. This means that states must cover accelerated
11 approval drugs, unlike other payers who have the ability to
12 exclude coverage.
13 Many states have expressed concern in being
14 required to cover and pay for these drugs, while additional
15 studies are still needed to verify the clinical benefit,
16 and that the high price for many of these products is not
17 supported by the existing evidence. In some cases, states
18 may end up paying for a product that ultimately does not
19 demonstrate a clinical benefit. For example, Makena, a
20 drug used to reduce the risk of preterm birth, received
21 accelerated approval in 2011. In October of 2020, the FDA
22 proposed that the drug be pulled for the market because the

1 post-market study failed to show a clinical benefit.

2 As we discussed in January, the TAP proposed a
3 differential rebate model for accelerated approval drugs
4 that would increase the rebate on these products. This
5 increased rebate would be added as a statutory change to
6 the MDRP and increase the minimum rebate above the current
7 23.1 percent of average manufacturer price. Participants
8 felt that increasing the rebate struck a balance between
9 maintaining coverage of these products in Medicaid while
10 addressing concern that manufacturers are charging prices
11 that are not supported by the existing clinical evidence.

12 Increasing the rebate would provide a lower net
13 price to help account for the uncertainty that the product
14 will produce the anticipate clinical benefit. Medicaid
15 will pay less while there is a limited amount of evidence.
16 Additionally, the higher rebate would create a financial
17 incentive for manufacturers to complete confirmatory trials
18 in a timely fashion.

19 Another option is to add an additional
20 inflationary penalty should the manufacturer not complete
21 the trial after a set period of time, for example, five
22 years. This additional inflationary penalty would help

1 mitigate any increase in the list price while there is a
2 limited amount of clinical evidence, and provide even more
3 incentive for manufacturers to complete the confirmatory
4 trial in a timely manner. However, because this option is
5 tied to the inflationary rebate, it would not have any
6 effect if the manufacturer does not increase the product's
7 price faster than inflation.
8 The increased rebate would apply until the
9 manufacturer completes the confirmatory trial and verifies
10 the clinical benefits. The FDA has an existing process to
11 convert accelerated approval to traditional approval. Once
12 the FDA grants traditional approval, the rebate would
13 revert back to the standard amount under the MDRP. This
14 would effectively be increasing the net price for the
15 manufacturer.
16 Manufacturers are likely to oppose this policy,
17 and they argue that additional Medicaid rebates may
18 discourage research and development on drugs and delay
19 market availability for these drugs. Manufacturers would
20 need to decide whether to bring their product to the market
21 early under the accelerated approval pathway and incur the
22 additional cost of the increased rebate. Manufacturers

1 already take into account several factors, including
2 Medicaid rebates, when making decisions on a product's
3 launch. Medicaid is not the sole payer for these drugs,
4 and an increased rebate would not necessarily have a
5 significant influence on a manufacturer's decision to
6 pursue the pathway. They may also try to build the new
7 rebate into the price.

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

12 Because this rebate would be implemented under
13 the MDRP, states would still be required to cover
14 accelerated approval drugs. The beneficiary would still
15 maintain similar access to accelerated approval drugs that
16 they currently have. If a manufacturer decides to forego
17 the accelerated approval pathway then beneficiaries may
18 have to wait longer for the drug to come to market. The
19 increase rebate will reduce net spending for both the
20 Federal Government and states. We have requested a score
21 from the Congressional Budget Office and will provide this
22 at the April meeting.

1 But to get a sense of potential scale, prior
2 MACPAC analysis found that Medicaid spend about $686
3 million before rebate in fiscal year 2017 for 27 drugs
4 approved under accelerated pathways since 2014. If the
5 rebates were increased 10 percent, for example, then this
6 could potentially be savings close to $1 billion over ten
7 years, depending on the cost of the accelerated approval
8 drugs in that time frame.
9 We are presenting two potential recommendations
10 today. Recommendation 1 is the primary recommendation,
11 which would be included if the Commission wishes to
12 proceed. Recommendation 1 would increase the minimum
13 rebate, and it reads:
14 "Congress should amend Section 1927(c)(1) to
15 increase the minimum rebate percentage on drugs that
16 receive approval from the U.S. Food and Drug Administration
17 through the accelerated approval pathway under Section
18 506(C) of the Federal Food, Drug, and Cosmetic Act. This
19 increased rebate percentage would apply until the
20 manufacturer has completed the confirmatory trial and been
21 granted traditional FDA approval. Once the FDA grants
22 traditional approval, the minimum rebate percentage would

1 revert back to the amount listed under Section
2 1927(c)(1)(B)(i)."
3 Recommendation 2 would increase the inflationary
4 rebate, and it reads:
5 "Congress should amend Section 1927(c)(2) to
6 increase the additional inflationary rebate on drugs that
7 receive approval from the U.S. Food and Drug Administration
8 through the accelerated approval pathway under Section
9 506(c) of the Federal Food, Drug, and Cosmetic Act. This
10 increased inflationary rebate would go into effect if the
11 manufacturer has not yet completed the confirmatory trial
12 and been granted traditional FDA approval after a certain
13 number of years. Once the FDA grants traditional approval,
14 the inflationary rebate would revert back to the amount
15 typically calculated under Section 1927(c)(2)."
16 So the next steps, the Commission should decide
17 today whether to proceed with recommendations that would be
18 included in the June report. If you wish to proceed you
19 have two options to choose from. You could choose
20 Recommendation 1 only or you could choose both
21 Recommendations 1 and 2. Staff will bring back the
22 recommendation for a vote at the April meeting, along with

1 a draft chapter for the June report.

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

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

15 [Show of hands.]

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

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

22 CHAIR BELLA: Okay. Sorry, Tom. I thought I

1 saw your hand. Okay. Why don't you then -- can you say a
2 little bit more about your concerns?
3 COMMISSIONER BARKER: Yeah, but can I ask Chris a
4 question first, before I do?
5 CHAIR BELLA: Sure.
6 COMMISSIONER BARKER: Chris, on Recommendation 2,
7 that recommendation, as I understand it, would only kick in
8 of a manufacturer increased the price of the drug more than
9 CPI, right? In other words, there would be an enhanced
10 inflationary rebate but it would only be enhanced if they
11 increased the price beyond CPI. But if they didn't
12 increase the price beyond CPI, only Recommendation 1 would
13 apply.
14 MR. PARK: That's correct.
15 COMMISSIONER BARKER: Okay. Thanks.
16 So I guess, Melanie, I would just say I'm just a
17 little bit concerned -- Chris, can you go back maybe three
18 slides? I guess my concern is that Congress has created
19 this pathway for accelerated --
20 MR. PARK: Is this the slide?
21 COMMISSIONER BARKER: Let me finish my point
22 first.

1 MR. PARK: Okay.

2 COMMISSIONER BARKER: Then I'll find the slide.
3 Congress has created this pathway for accelerated approval
4 for a set of drugs for which there is an unmet medical
5 need, and I guess my concern is that an enhanced rebate
6 might create a disincentive for manufacturers to go through
7 that pathway, and it would therefore delay access to drugs
8 for which there is a clear medical need.

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

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

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

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

22 COMMISSIONER GORTON: I just want to respond to

1 Tom with a clarification. So its access to unproven drugs
2 with demonstrated need. And, you know, for me that's a
3 whole big difference, right? So you're exposing people --
4 yes, they have a need, I get it, but let's get it proven as
5 quickly as we possibly can. I'm sensitive to that. I've
6 lived with a child in a wheelchair. I've buried a child
7 who used a wheelchair. So I get the implications of this.
8 But to expose people to unproven drugs is simply
9 not what we are supposed to do in the Medicaid program.
10 There's a role for experimentation. It's one thing if
11 there is evidence behind the drug, but Exondys is a great
12 example of a place where the experts said, "We don't think
13 so," and the agency went in another direction. And not
14 only did that expose young adults and families to an
15 unproven treatment, it also generates enormous costs for
16 taxpayers.
17 And so that's why I'm in a different place from
18 you. I think if we had proven therapies, yeah, we ought to
19 get them out there as quickly as possible. But access to
20 unproven therapies, I mean, what is that access to,
21 exactly? And I just think we need to raise that question
22 because the manufacturers always push the need, and I don't

1 think people who are suggesting that there be some level of
2 circumspection in putting these potential therapies out
3 there -- you know, nobody is saying there isn't a need.
4 The issue is, is this stuff any good, or is it even
5 potential harmful, as we found with autologous bone marrow
6 transplantation for breast cancer, where folks were pushed
7 to authorize the therapy for women, which, in fact, turned
8 out to be harmful to them.
9 So I just think that, you know, I get it, but if
10 we're going to talk about this we need to talk about the
11 fact that we're talking about unproven therapies. Thanks.
12 CHAIR BELLA: Thank you, Kit. Anne, you had a
13 clarification?
14 EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I just
15 wanted to quickly make sure that we're careful about our
16 language here, and also make clear that we are staying out
17 of FDA's business. The point is simply about Medicaid
18 payment policy.
19 So I'm not going to argue your point with you,
20 Kit, but I think there are people who will argue about the
21 word "unproven." And so I just want to caution folks to be
22 careful about the language that we're using to make it

1 clear what we're doing here. I hear what you're saying,
2 Kit, but I think the FDA watchers would push back on your
3 choice of words.
4 CHAIR BELLA: Stacey, then Chuck, then Martha,
5 then Sheldon.
6 COMMISSIONER LAMPKIN: Yeah. Thank you. I have
7 a comment or two, and then maybe a question for Chris. So
8 I'm very supportive, conceptually, of Recommendation 1,
9 because it feels like a nice compromise between preserving
10 some access but also providing some incentive and some
11 relief. But it feels a little bit like an article of fate
12 that there is a rebate increase percentage that is
13 significant enough to be meaningful to states, significant
14 enough to provide the incentive to encourage the clinical
15 trials, and yet not so high that it discourages
16 manufacturers from doing the research or making the product
17 available through this avenue.
18 And so, you know, the TAP thought, I guess,
19 Chris, that there could be an increase that would kind of
20 meet all those goals, help address all those goals, that
21 they didn't have a particular recommendation of an
22 increased amount. Am I recalling that correctly? Did they

1 have any sense of order of magnitude that they were able to
2 suggest or anything that they used to have some confidence
3 that there was a sweet spot here?
4 MR. PARK: They didn't identify a particular
5 amount, but as like kind of a starting point, the moderator
6 had put out the 8 percent increase that was included in the
7 ACA, that took the minimum rebate of 15.1 to 23.1, and most
8 of the TAP members felt like it needed to be higher than
9 that 8 percent, but they didn't say it should be, like, 15
10 or 20 or anything like that.
11 So I think the feeling is it should probably be
12 above 8 percent, so maybe like 10 percent or above, but
13 they didn't kind of narrow in on a specific amount.
14 COMMISSIONER LAMPKIN: And so how would we
15 address that point, you know, in the rationale for our
16 recommendation, do you think, Chris?
17 MR. PARK: Sure. I think we can certainly point
18 out, you know, with the caveat that it should probably be
19 at least around 10 percent, but I don't think we have the
20 ability to zero in on like a specific amount. And I think
21 that will be up to legislators to try to figure out what
22 that should be. I'm not exactly sure how they decided the

1 15.1 to 23.1. And so I can try to do a little bit more
2 research on that to see how they came up with that
3 estimate, but I'm not sure that we would be able to
4 recommend a specific amount.
5 COMMISSIONER LAMPKIN: Okay. Thank you for that,
6 and then, while I have the mic, Melanie, because you asked
7 for feedback on the second recommendation, I would just
8 say, from my perspective, I feel more strongly about the
9 first recommendation and I feel a little ambivalent about
10 the second one. But if others thought that that was the
11 way to go, I think I would be fine with that.
12 CHAIR BELLA: Thank you, Stacey.
13 Chuck and then Martha.
14 VICE CHAIR MILLIGAN: Thank you.
15 Chris, I had just a few questions. The first
16 question is, is every drug that is approved under the
17 accelerated approval process required to -- is there any
18 drug for which that's the end of the FDA process and there
19 is not a confirmatory trial aspect? In other words, are
20 there ever instances in which if we were to adopt this
21 recommendation and it became law, there's no pathway for
22 certain medications to complete the process because the

1 accelerator approval itself is the completion of the
2 process, and there is not a confirmatory trial?
3 MR. PARK: My understanding is that manufacturers
4 do need to complete that confirmatory trial, but I can
5 double-check that to make sure that that is the case.
6 VICE CHAIR MILLIGAN: Yeah. To me, if there are
7 instances in which the confirmatory trial isn't necessary -
8 - or I guess if the accelerated approval is the endpoint in
9 any instances, it seems like we would be setting up that
10 particular medication for a permanent higher rebate if they
11 had no pathway or no element of confirmatory trial. So I
12 just want to make sure to understand that aspect.
13 The second thing I wanted to ask is, in the TAP,
14 did it ever come up around non-Medicaid payers and whether
15 they also have tools they use to try to get manufacturers
16 to go through a confirmatory trial? In other words, are
17 commercial payers or other payers -- do they use tools like
18 PDL or tiering or cost-sharing provisions or any other
19 tools to try to incent manufacturers to complete the
20 confirmatory trial using the levers available to those
21 particular payers? Do we have any awareness of that?
22 MR. PARK: Sure. Certainly, other payers that

1 you mention have tools with formularies, tiering, cost
2 sharing, where they can either not cover the drug if they
3 don't believe it's effective or they could kind of strictly
4 limit the use of the drug if they have very high prior
5 authorization policies in place.

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

18 VICE CHAIR MILLIGAN: So my suggestion is when we
19 get around to the chapter on this, Chris, whatever context
20 you're able to incorporate around other payers -- you know,
21 Medicaid doesn't have some of those tools. It doesn't have
22 the ability to use a lot of differential cost sharing. It

1 doesn't have the ability to use some of the exclusion
2 mechanisms because of the Drug Rebate provisions. I think
3 contextualizing this around the fact that potentially other
4 payers also have tools and use tools around accelerated
5 approval, I think that context would be helpful that
6 Medicaid wouldn't be an outlier in trying to use its levers
7 to incent completion of the confirmatory trial.
8 One comment and then one final question. The
9 comment is in the materials, one of the examples that I
10 found most persuasive was the example that you referenced
11 around medications that would receive accelerated approval
12 because they showed evidence of shrinking tumors, but they
13 had not yet shown evidence of actually improving survival
14 rates for individuals with cancer. I think the more that
15 we can differentiate in the chapter around not just the
16 examples you referenced in the slide deck in your
17 presentation today, but examples where a surrogate endpoint
18 might demonstrate a meaningful impact, but that the
19 ultimate health outcome that the medication is seeking to
20 pursue, which in this case would be a higher survival rate
21 or better quality of life or something else, that we don't
22 yet have that evidence, and that the importance of the

1 confirmatory trial is aimed at getting to those deeper
2 clinical -- evidence of clinical effectiveness.
3 My final question is, are we simply speculating
4 about the increase in launch price? And it's actually on
5 the slide that's on the screen right now. You mentioned
6 that a potential effect might be manufacturers would bake
7 in the higher rebate into the launch price. I assume you
8 don't have any evidence of that, although I assume that if
9 they were to do so, Medicaid wouldn't have a lot of tools
10 to address that because, as we've seen, Medicaid doesn't
11 have a lot of tools to address and negotiate launch price
12 issues. I just wanted to ask whether it's pure speculation
13 or whether we have any evidence of that launch price issue.
14 MR. PARK: Sure. I think a long time ago, CBO
15 tried to do an analysis where they tried to see if launch
16 prices changed after -- I think when the Medicaid rebate
17 program came into existence. It seemed like they found a
18 little bit of evidence of that, but I think this is a
19 tricky topic, and that kind of depending on the particular
20 economist you talk to, some of them believe that
21 manufacturers already have every incentive to launch at the
22 highest price possible that the market will bear. So kind

1 of regardless of where the rebate is for Medicaid, they are
2 going to try to launch at the highest price possible.
3 So I think we can't definitively say that this
4 will or will not be an issue, but I think it's certainly
5 something that several economists argue about as to whether
6 or not there could be a change in their launch price
7 because of this.
8 VICE CHAIR MILLIGAN: Okay. Thank you.
9 Thank you, Melanie.
10 CHAIR BELLA: Thank you, Chuck.
11 Martha and then Sheldon.
12 COMMISSIONER CARTER: Anne, I appreciated your
13 comments about the FDA, and I just want to elaborate on
14 that a little bit. I wondered as I read the materials. I
15 think we need to be careful that we're not commenting on
16 the effectiveness of the FDA's expedited approval pathways.
17 That's not our role and acknowledging Kit's concerns that
18 there perhaps have been drugs that didn't pan out the way
19 they were intended. There are also a lot of drugs that
20 have.
21 So I think we just need to make sure we're
22 focusing on the effect on the Medicaid program and whether

1 Medicaid programs need some assistance, some financial
2 assistance as they evaluate and in most cases are required
3 to cover new drugs.
4 CHAIR BELLA: Thank you, Martha.
5 Sheldon?
6 COMMISSIONER RETCHIN: There. Am I on?
7 CHAIR BELLA: Yep.
8 COMMISSIONER RETCHIN: Okay. Yeah. I'm going to
9 circle back and just make a -- maybe ask two questions,
10 Chris, or embedded in a comment.
11 The first was that I interpreted Tom's comment
12 this way, which I thought was quite appropriate. It was a
13 question of whether if the rebate level is too high, then
14 the manufacturers will argue that they'll stay away from
15 investing in the development of drugs that particularly
16 disproportionately serve Medicaid beneficiaries. If it's
17 too low, then we'll have drugs that have this accelerated
18 approval, and there's no look back in terms of getting the
19 results of the clinical trials. This is sort of a
20 Goldilocks framework.
21 You know, but what concerns me -- and I'll ask
22 this of Chris -- on several occasions and like on

1 Recommendation 2, can this be determined generically? That
2 is, aren't some of these decisions in terms of rebate
3 level, in terms of the number of years as embedded in
4 Recommendation 2, the number of years that we would give a
5 manufacturer, isn't that somewhat drug-specific? And if it
6 is, is there something we should do in terms of a panel
7 review? I mean, there are not that many novel therapeutics
8 that would be following this.
9 I looked back, and it was startlingly low.
10 Actually, only 11 percent of novel therapeutics actually go
11 the accelerated approval pathway. So that was my first
12 question: Is this drug-specific, and should there be some
13 reference to that in Recommendation 2?
14 The second one was I'm just curious to circle
15 back. We asked -- we wondered if you've included a
16 bioethicist on the panel. Has the bioethicist made any
17 recommendations or contributed any thoughts on any of this?
18 [No response.]
19 CHAIR BELLA: Chris, did you --
20 MR. PARK: Sorry. Clicked the wrong button.
21 so I'll start with Question 2 first. The
22 bioethicist did not make any specific comments on the

1 accelerated approval recommendation. I think the main
2 concern is access, and by including it in the MDRP,
3 Medicaid still is required to provide coverage for these
4 products when they come to market. so I think they felt
5 like that was a good balanced way to address the issue for
6 this particular case would be to try to address the concern
7 on the price side, and by lowering the net price for
8 Medicaid, that could be a good balance to kind of address
9 any concerns but still provide beneficiaries to have access
10 to potentially very important medications.
11 Then to your first question about whether or not
12 this should be drug-specific, not necessarily in terms of
13 the rebate amount, but the TAP did have a discussion about
14 whether all accelerated approval products should be subject
15 to this increased rebate, only a handful of them, because
16 certain surrogate endpoints maybe have a much higher degree
17 of certainty in terms of predicting clinical benefit versus
18 others.
19 And they thought it would get kind of messy, and
20 that the decision process, which one applies and which one
21 doesn't, they thought that was a slippery slope and
22 potentially just complicates things. And it would be a

1 cleaner process to just apply this to all accelerated
2 approval drugs. So I think that context would apply to
3 having some kind of committee trying to fine-tune what the
4 rebate should be for each specific drug.
5 COMMISSIONER RETCHIN: Thanks.
6 CHAIR BELLA: Does anyone have any strong
7 feelings? I'm hearing general support for Recommendation
8 1. Does anyone have any strong feelings on Recommendation
9 2? We need to give Chris some guidance on what to bring
10 back to us. Are most folks in a position of ambivalence?
11 Tom and then Fred.
12 COMMISSIONER BARKER: Thanks, Melanie.
13 I'm not going to reiterate my comments from
14 before because you know what my position is.
15 I did want to just suggest maybe -- Anne, I'd be
16 interested in your input on this. Would it maybe be worth
17 mentioning if we did go forward with Recommendation 1 on
18 the 340B program? Because 340B-covered entities would then
19 get -- would get the benefit of a lower price. Is that
20 something we would normally do, mention the 340B program?
21 EXECUTIVE DIRECTOR SCHWARTZ: I mean, we wouldn't
22 mention it in the recommendation, but it could be something

1 in the implications section, because those are providers
2 that serve the Medicaid population.
3 COMMISSIONER BARKER: Yeah, that is what I was
4 thinking.
5 Then with regard to 340B, I think with respect to
6 the discussion that Chuck and Chris were having, I do think
7 if you were to look at the legislative history of the 340B
8 program, you would see that there is -- that the whole
9 reason 340B was enacted was because there was a concern
10 that manufacturers built the original Medicaid rebate into
11 a launch price. So I'd just point that out, Chris, when
12 you're doing the research that you are conducting.
13 CHAIR BELLA: Thank you, Tom.
14 Fred?
15 COMMISSIONER CERISE: Yeah. Just an observation
16 on one. We've had a lot of discussion about it, but in the
17 recommendation itself, there's not a real statement about
18 the amount of the rebate. I've heard that we don't want to
19 say an amount, but do we want to give some direction there?
20 We could default to a pharmacoeconomist or people like
21 that, that can look at it, but to say it should be of the
22 magnitude that is going to encourage completion of their

1 trials or something to push, because I think what we're all
2 saying is right now the incentive may be to go slow and
3 just drag feet. But if we put an added rebate there, the
4 idea is to encourage to complete it. So I'd just throw out
5 the thought that you might want to put a substantial amount
6 or an amount to incentivize completion of trials and maybe
7 even reference getting the expert help, to help determine
8 what that would be.

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

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

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

19 MR. PARK: Okay.

20 CHAIR BELLA: Thank you, Fred.

21 Chuck?

22 VICE CHAIR MILLIGAN: I just wanted to talk about

1 the second recommendation for a second. I remember in the
2 past, we got presentations around the magnitude of the
3 inflationary rebate, and it tended to be very substantial
4 for a lot of drugs, that in fact, inflationary rebate was
5 worth more than the base rebate, if I'm recalling all of
6 that previous work correctly, and we made recommendations a
7 few years back along those lines.
8 I'm in support of Recommendation 2, although I
9 think, like Stacey, it's probably not as strong as No. 1,
10 but I am in support. If we go there when we take a vote in
11 April, I want to make sure that we pull through some of
12 that context in history of our previous work around
13 inflationary rebates, because those can be quite
14 substantial as time passes, and it's not a trivial
15 financial impact to states and the federal government. I
16 just want to make sure we pull through that previous work
17 we've done on that topic.
18 Thank you.
19 CHAIR BELLA: Thank you, Chuck.
20 Are those the comments on Recommendation 2 in
21 particular? Does anyone not want to see it come back in
22 April?

1 [No response.]

2 CHAIR BELLA: Did you all eat stuff at lunch that
3 made you sleepy? I'm not getting much activity here.

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

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

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

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

22 [No response.]

1 CHAIR BELLA: Okay. Chris, thank you. I think
2 you're staying, though, correct?
3 [No response.]
4 CHAIR BELLA: Yep? Okay. We'll get moving to
5 the next session, which is about the COVID vaccine. We've
6 had lost of discussion about this, and this is obviously
7 something that's top of mind, how we ensure access for
8 folks on Medicaid.
9 So, Chris and Michelle, I will turn it over to
10 you.
11 **### MEDICAID POLICY ISSUES RELATED TO THE COVID-19**
12 **VACCINE**
13 * MS. MILLERICK: Great. Thank you, Melanie.
14 Today Chris and I are going to provide an update
15 on Medicaid policy issues related to the COVID-19 vaccine.
16 This builds upon work presented by Chris Park and Amy
17 Zettle at the September Commission meeting, which focused
18 on Medicaid coverage of vaccines in general and explored a
19 range of possible strategies to improve vaccine access for
20 adult Medicaid beneficiaries.
21 In response to the urgency and public health
22 importance of the COVID-19 pandemic, we narrowed the

1 immediate next step in our work to identifying if there are
2 any particular issues in accessing the COVID-19 vaccine in
3 Medicaid and to examining whether any of our proposed
4 policy options are particularly well suited to address
5 these issues or whether, perhaps, any new policy options
6 are needed.
7 During the September and December Commission
8 meetings, Commissioners raised several questions and
9 concerns regarding the available supply of COVID-19
10 vaccines and policies for coverage and payment of the
11 vaccine in the Medicaid program, which were established in
12 the interim final rule published in November. A lot has
13 changed since then, and the Administration and Congress
14 have taken steps to address many of these concerns.
15 The purpose of today's presentation is to update
16 you on the details of these developments.
17 As you see on this overview slide, we'll first
18 take a look at Medicaid coverage of the COVID-19 vaccine,
19 both under the ongoing public health emergency, or PHE, and
20 going forward after the PHE ends.
21 Next, we will summarize key findings from
22 stakeholder interviews that we conducted as part of this

1 work, including interviews with state and federal
2 officials, academic and clinical experts on vaccination,
3 and national organizations representing a wide range of
4 stakeholders.
5 Then we will describe administrative and
6 legislative actions that affect Medicaid coverage of the
7 COVID-19 vaccine, including the COVID-19 relief
8 reconciliation bill that is currently before Congress. As
9 you know, the House passed its version last week, and the
10 bill is currently under consideration in the Senate.
11 Finally, we will highlight two additional policy
12 issues for consideration before summarizing next steps.
13 We welcome any questions Commissioners might have
14 in response to this update and look forward to the
15 discussion.
16 First, with respect to Medicaid coverage of the
17 COVID-19 vaccine, the Families First Coronavirus Response
18 Act, or FFCRA, provides a 6.2-percentage-point increase to
19 the FMAP for expenditures on or after January 1, 2020,
20 through the end of the quarter in which the PHE ends if
21 states meet certain conditions.
22 Coverage of COVID-19 vaccines without cost

1 sharing is required as part of the terms of the FMAP
2 increase included in FFCRA, and all states and territories
3 are currently claiming the increased FMAP. However, the
4 COVID-19 vaccine coverage requirement under FFCRA does not
5 apply to certain limited-benefit enrollees.
6 At this time, the supply of COVID-19 vaccines has
7 been purchased by the federal government, and states are
8 only responsible for paying for administration of the
9 vaccine.
10 At the end of the quarter in which the PHE
11 expires, the FMAP increase and other conditions of the
12 FFCRA will no longer be in effect, so vaccine coverage
13 requirements will revert to those in place prior to the
14 COVID-19 pandemic.
15 Many beneficiaries, such as children under 19,
16 adults receiving essential health benefits such as the new
17 adult group, and those in separate CHIP will continue to
18 have mandatory coverage of all ACIP-recommended vaccines.
19 However, coverage of vaccines, including the COVID-19
20 vaccine, will be optional for certain adult groups, such as
21 those eligible on the basis of disability, parent and
22 caretaker relatives, and pregnant women. For these adults,

1 states may also charge cost sharing for a vaccine or its
2 administration within the existing cost sharing
3 requirements after the PHE.
4 In addition, a Public Readiness and Emergency
5 Preparedness Act, or PREP Act declaration, authorized
6 qualified pharmacists to order and administer COVID-19
7 vaccinations. The PREP Act specifically provides immunity
8 from any liability arising from COVID-19 countermeasures
9 and preempts state and local laws that may otherwise
10 prohibit a qualified pharmacist or pharmacy intern from
11 ordering or administering COVID-19 vaccines.
12 CMS has expressed the expectation that consistent
13 with Medicaid's freedom of choice requirement, all state
14 Medicaid programs will make payment for a COVID-19 vaccine
15 and its administration to all pharmacies or pharmacists who
16 meet the qualifications under the PREP Act.
17 Next slide, please.
18 Over the last two months, MACPAC conducted 11
19 interviews with Medicaid medical directors, national
20 organizations representing Medicaid managed care plans,
21 pharmaceutical manufacturers, patient advocacy groups, and
22 pharmacists, as well as officials from CMS and the Centers

1 for Disease Control and Prevention. The goal of these
2 interviews was to learn whether these stakeholders had any
3 concerns about Medicaid coverage of the COVID-19 vaccine
4 both now during the PHE and in the future once the PHE ends
5 and if there are any particular policies that are better
6 suited to COVID-19 vaccines compared to other adult
7 vaccines.

8 First, stakeholders commented that most of the
9 current issues with access to the COVID-19 vaccine are
10 supply and logistical issues that affect all payers and
11 populations and are not specific to Medicaid. There was
12 also general consensus that the immediacy of the COVID-19
13 pandemic could warrant a different approach from coverage
14 of other adult vaccines, particularly in the near term.
15 Many states and stakeholders reported that they have not
16 yet begun to contemplate long-term Medicaid coverage and
17 policy decisions for the COVID-19 vaccine after the PHE
18 concludes. While many believe it's likely that COVID-19
19 vaccination will become an annual occurrence, similar to
20 flu and other vaccines, it's difficult to engage in
21 planning until there's more evidence on whether boosters
22 will be required and if so how often.

1 Payment adequacy was one of the most common
2 issues raised by stakeholders who expressed concern about
3 the level of provider payment for administration of the
4 COVID-19 vaccine, including the potential for low payment
5 to discourage provider participation and increase barriers
6 to vaccination for beneficiaries. Stakeholders generally
7 recommended that vaccine administration should at least
8 match the Medicare rate, which is $16.94 for the first dose
9 and $28.39 for the second dose in a two-shot series.
10 Stakeholders also expressed support for PREP Act
11 flexibilities that have authorized pharmacists as qualified
12 providers to administer COVID-19 vaccines and believe this
13 will help to increase vaccine access.
14 The importance of accurate and timely reporting
15 on vaccine uptake was also a theme in our interviews.
16 Reporting and functionality varies by state, but current
17 CDC rules require vaccine administrators to report COVID-19
18 vaccinations and certain data into their medical records
19 within 24 hours of a COVID-19 vaccination and into the
20 relevant IIS, or Immunization Information System, within 72
21 hours.
22 Some stakeholders expressed concern about the

1 limited sharing of immunization information with entities
2 involved in coordinating a member's care, such as Medicaid
3 managed care plans.
4 With respect to health equity issues, states and
5 stakeholders acknowledge the importance of addressing
6 racial disparities in vaccine uptake. Experts emphasize
7 the importance of addressing vaccine hesitancy and engaging
8 in targeted efforts to increase awareness of the vaccine
9 and its efficacy. It was also suggested that improved data
10 collection reporting on vaccine update by race and
11 ethnicity would be helpful to inform interventions that
12 address disparities.
13 All stakeholders emphasized the importance of
14 collaboration with community-based organizations and
15 provider partners, such as federally qualified health
16 centers, which typically serve populations who have been
17 disproportionately affected by the pandemic.
18 Finally, stakeholders generally supported the
19 policy options that MACPAC discussed last September but did
20 not necessarily favor one option over the other. To
21 address short-term issues, stakeholders expressed support
22 for policies that would increase funding for the purchase

1 and administration of the COVID-19 vaccine, including
2 enhanced FMAP for vaccine administration and continuation
3 of federal purchasing of the vaccine for a temporary period
4 of time.

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

8 * MR. PARK: Thank you, Michelle.

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

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

20 Additionally, the administration recently
21 announced that it would send vaccines directly to certain
22 federally qualified health centers that would increase

1 access to vaccines for underserved communities.

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

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

19 The bill also gives states the option to provide
20 coverage of COVID-19 vaccination and treatment for
21 uninsured individuals without cost sharing. It also
22 provides additional funding for the CDC, HHS, and FDA to

1 advance vaccine distribution, uptake, transparency, and
2 surveillance. This bill has passed in the House, and the
3 Senate is expected to vote on it shortly.
4 While the federal proposals address most of the
5 issues identified during our interviews, there were a
6 couple of things that are not addressed that may warrant
7 further consideration. First is the adequacy of provider
8 payment rates for vaccine administration. Most of the
9 stakeholders thought Medicaid should pay at least Medicare
10 rates.
11 We did some research and found payment rates from
12 49 states, and the majority are paying Medicare rates, but
13 10 states are paying less than Medicare for COVID-19
14 vaccine administration. Presumably, states that are
15 currently paying less than Medicare rates would be willing
16 to increase payment rates up to Medicare levels if
17 provisions for 100 percent matching for vaccine
18 administration becomes law. However, the legislation does
19 not require states to pay at Medicare rates nor does it set
20 a minimum payment amount.
21 Stakeholders also emphasized the importance of
22 timely and accurate reporting on COVID-19 vaccination data

1 to applicable state and federal entities as well as other
2 organizations and individuals involved in patient care or
3 member outreach. There may be opportunities to improve
4 data reporting and sharing, particularly on race and
5 ethnicity, and to target outreach for at-risk populations
6 in communities with low vaccine uptake.

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

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

18 Additionally, Medicare is not required to share
19 immunization information on dually eligible beneficiaries
20 when Medicaid providers and managed care plans also provide
21 care for those individuals, such as managed long-term
22 services and support plans.

1 At this time, the American Rescue Plan Act of
2 2021 appears to address many of the short-term issues that
3 were identified in our interviews. We will continue to
4 monitor the Medicaid payment and coverage of the COVID-19
5 vaccine, particularly as more information becomes available
6 on the need for boosters or annual vaccinations to address
7 variants and maintain immunity.
8 We will provide any updates to the Commission as
9 needed if further action may be warranted.
10 Going forward, staff will continue to examine the
11 issues of Medicaid coverage of adult vaccines more broadly,
12 continuing the work we presented in September. Many of the
13 stakeholders that we interviewed expressed general support
14 for the policy options we presented last fall, and we will
15 continue to explore those options.
16 And with that, I will turn it back over to the
17 Commission for any questions.
18 CHAIR BELLA: Thank you, Michelle. Thank you,
19 Chris.
20 Just to kind of highlight what was just said for
21 Commissioners, this is not for any action on our part.
22 This is trying to keep us as much real-time updated as

1 possible, as this thing is moving quickly, but several of
2 the concerns we had had do seem to be addressed, which is
3 reassuring.
4 So how about if folks have any comments or
5 questions or things that you want to make sure we're
6 keeping an eye on, that would be a good time to call them
7 out now.
8 Peter and then Chuck.
9 COMMISSIONER SZILAGYI: Good. Thanks, Michelle
10 and Chris. This was really an excellent presentation, very
11 clear, and actually really exciting because many of the
12 issues that we had talked about and that many other people
13 had been discussing have been addressed by what the
14 administration has done.
15 I mean, obviously, the pandemic has highlighted
16 the vital importance of the vaccines. If you think about
17 it, what the administration has done has been, in a way, a
18 big variant of the VFC program. They purchased the
19 vaccine. They have a good administration fee, tracking
20 with the IIS. So I'm just planting that seed in terms of
21 discussion for other adult vaccines.
22 And I do agree that the American Rescue Plan this

1 year addresses these short-term issues, and that the
2 barriers now are really supply, distribution, and
3 hesitancy.
4 I do think I am worried about the 10 states that
5 appear to be paying less or can pay less than Medicare
6 rates. With the pandemic, if there are surges in certain
7 states, they are likely to spread to other states. So it's
8 a national emergency, it's a national crisis, and I'm
9 worried about states -- if there is cost sharing, if
10 payment isn't Medicare rates, I am worried that there may
11 be lower vaccination rates in those states.
12 And I do agree with the -- I think you mentioned
13 sort of a second kind of concept of requiring both
14 reporting of race and ethnicity and data sharing, and I
15 think that's actually a good idea as well.
16 One last point about the equity issue. There
17 used to be enormous disparities in childhood vaccination
18 rates with people of color having -- children of color
19 having lower rates. That disparity has disappeared, and it
20 disappeared because major structural changes were done in
21 the immunization delivery system, including financing, and
22 it includes the VFC program and Medicaid. I think if we

1 can do something similar for adult vaccines, we might be
2 able to -- and there are big disparities in adult vaccines
3 -- we may be able to reduce those disparities.
4 For COVID vaccine, there is also a real concern
5 about higher hesitancy among people of color for the COVID
6 vaccine. So what that translates to in my mind is the need
7 to do more work for public health, more efforts to engage
8 individuals and including people of color for the COVID
9 vaccine.
10 But overall, I do think that most of these
11 concerns that we've talked about earlier have been
12 addressed. I'm worried about the Medicare payment rates in
13 those 10 states, and I would suggest reporting on race and
14 ethnicity from the IIS's or the data repositories.
15 Thank you.
16 CHAIR BELLA: Thank you, Peter.
17 Chuck and then Sheldon. Thank you, Chuck.
18 VICE CHAIR MILLIGAN: Thank you.
19 I want to align myself with Peter's comments.
20 Chris, do you mind just going briefly to Slide 7?
21 I'm just going to make a couple of very brief comments.
22 In that final bullet in terms of continuing to

1 examine strategies to improve access for adults, to me, one
2 of the eye-opening things about this whole body of work
3 that we've been doing over the last year has been to learn
4 about the coverage and benefit rules and the extent to
5 which vaccines were not really a required benefit for
6 adults. I do think articulating to whatever extent we know
7 or have confidence, articulating what we mean by continuing
8 to examine strategies when we get to the chapter and when
9 we get to next steps and to not have it entirely vague --
10 but I recognize there's going to be some uncertainty. But
11 I want to just call out that I think keeping an eye on this
12 over time is going to be important.
13 Whatever lessons we can draw from this particular
14 experience with the pandemic, again, around hesitancy and
15 some of the other things that Peter touched on, I would
16 encourage that we examine what the future work may or may
17 not look like and what we can commit to when we talk about
18 continuing to examine strategies.
19 The other thing I want to add is I share Peter's
20 concerns about the payment rate for administration and also
21 supply and also hesitancy. I would add another element,
22 which is to the extent that there are difficult-to-locate

1 and difficult-to-engage Medicaid beneficiaries, whether
2 it's homelessness or transience or other pieces, I think it
3 would be beneficial for MACPAC at some point in time to
4 catalog approaches and strategies around outreach and
5 engagement and location to capture best practices or
6 lessons learned or any of that kind of work in some
7 potential chapter or issue brief down the road.
8 So I will leave it there. Great work leading us
9 through this, during the course of this year, and,
10 Michelle, thank you as well as Chris.
11 CHAIR BELLA: Thank you, Chuck.
12 Sheldon and then Kisha.
13 COMMISSIONER RETCHIN: This is a great, great
14 report, Michelle and Chris. I really enjoyed reading it.
15 It's very comprehensive.
16 Let me bring up two issues and really circle back
17 and support what Peter said about communities of color with
18 higher vaccine hesitancy rates. This is historic,
19 historical, and we need to engage those communities more in
20 terms of determining some of the barriers. Some of the
21 barriers are well known, but also, let's not forget just in
22 terms of having providers, sufficient providers in some

1 communities of color means that there are unmet needs and
2 no relationships with or not active relationships
3 potentially with primary care physicians and other
4 providers that would be able to overcome that hesitancy.
5 So that's important.
6 The other group that I found puzzling, not
7 addressed by the administration -- and I don't know if this
8 is on your radar, Michelle or Chris -- that is that today
9 there are 12 million Americans who are homebound, who are
10 largely at home. They're not likely to get in lines to get
11 vaccinated in Dodger Stadium or whatever the name of the
12 stadium is now, and they have no access. Walgreens is
13 going to congregate living facilities and not to the home.
14 I don't know. Chris or Michelle, have you heard
15 that addressed at all -- and Peter?
16 MS. MILLERICK: It came up in our interviews of
17 both states and some provider organizations and managed
18 care entities having that issue sort of risen to their
19 level of awareness, who are actively working with their
20 states and partners to try to address that.
21 There weren't specific examples that folks gave
22 us of how the problem had been solved. It seemed like they

1 were really in the trenches of saying that we recognize the
2 need for this. Some of them talked about trying to partner
3 with more mobile types of providers like ambulance
4 providers who might be able to be mobilized to go to people
5 in the community where they are who are homebound, but it
6 was certainly something that was on people's radar. And
7 people were really still in the process of trying to solve
8 it.
9 MR. PARK: And just to add on, I think the recent
10 development of the Johnson & Johnson vaccine being approved
11 and having much less requirement in terms of cold storage
12 and things like that maybe will make it easier to kind of
13 get the vaccine to the homebound population.
14 COMMISSIONER RETCHIN: Peter?
15 CHAIR BELLA: Peter, on this?
16 COMMISSIONER SZILAGYI: I will make a quick
17 comment to that. There's a lot of discussion in the
18 vaccine world about using the Johnson & Johnson vaccine for
19 individuals who are homeless, homebound, for which a single
20 dose -- it's difficult to track them down for a second dose
21 or it's difficult even to get a first dose in, and as Chris
22 says, I think that's one of the strategies.

1 And I love Chuck's comment about documenting kind
2 of best practices. MACPAC has done that so well in so many
3 different areas, whether it's best practices across states
4 or within states, but documenting best practices for COVID
5 vaccination and with respect to lessons for other types of
6 either public health measures -- vaccines or other types of
7 public health measures.
8 Just as an example, we at UCLA have incorporated
9 the Social Vulnerability Index, the SVI, to actually help
10 prioritize patients for vaccinations; in other words,
11 patients who are in the highest Social Vulnerability Index
12 are going to be prioritized earlier for COVID vaccination
13 with special outreach. So there are, I think, interesting
14 practices that might be generalizable to other settings.
15 CHAIR BELLA: Thank you, Peter.
16 Kisha?
17 COMMISSIONER DAVIS: Thank you.
18 I'd like to cosign on many of the comments that
19 were already made, especially, Peter, your comments at the
20 very beginning.
21 Two points that I want to bring up just around
22 vaccination and using all available means to get

1 vaccinations in arms, shots in arms, some states are
2 focusing on mass vaccination sites, some are focusing on
3 pharmacies, some are focusing on community health centers.
4 But I also want to make sure to highlight that including
5 the primary care office and primary care doc and
6 physicians, physician offices in that distribution, some
7 states -- I know in Maryland, it's been very rare, if not
8 impossible, for primary care offices to be able to
9 administer vaccines. Even I know some offices who have
10 gone to the extent of purchasing a deep-freeze freezer to
11 be able to distribute and haven’t been able to do so
12 because they can't get supply from the state or from the
13 federal government.
14 Many of these docs have already created that
15 level of trust with their patients and the community, and
16 so it's a way to get at that vaccine hesitancy. If they're
17 not able to be part of the solution, then that's a barrier,
18 and so making sure docs who have been -- clinicians who
19 already have that established relationship with patients
20 are able to be a part of the solution. They are effective
21 every year in administering immunizations, so keeping them
22 as part of the loop.

1 The second is around the racial disparity, and I
2 echo many of the concerns that Commissioners have brought
3 up around vaccine hesitancy in minority communities. I
4 would actually really like the Commission to dig into that
5 a little bit more. I appreciate collecting best practices,
6 but also, I would love to see us specifically track the
7 immunization rates in minority Medicaid beneficiaries and
8 just to see where that is and then maybe using some of
9 those best practices and sharing that out.
10 It's a trend that concerns me. I think it
11 affects our ability to get there, and we've already seen
12 the disparities in Black and brown communities. I just
13 want to make sure that we are continuing to pay attention
14 to that.
15 Thanks.
16 CHAIR BELLA: Thank you, Kisha.
17 Have I missed anyone? Fred and then Martha.
18 COMMISSIONER CERISE: I'll be quick. I agree
19 with all the comments that have been made, great comments,
20 and it's really encouraging to see the federal proposals
21 because it really does address a lot of the critical
22 issues.

1 I just have a question for Michelle or for Chris.
2 Do you know why in the American Rescue Plan Act that allows
3 100 percent coverage, coverage at 100 percent FMAP, that
4 it's optional for states to apply that to the uninsured?
5 Why wouldn't that just be part of the -- I mean, first off,
6 maybe the option is meaningless because everybody is going
7 to do it, but why wouldn't they just include that in the
8 set of expectations? If you're going to do Medicaid and
9 you take that up, you'll make it available to the uninsured
10 too, since that's at 100 percent FMAP as well.
11 MR. PARK: Sure. I think it's primarily for the
12 states who have taken up that option. Originally, it was
13 to provide COVID testing for uninsured populations, and the
14 bill in Congress right now would extend it beyond testing
15 to include vaccines and treatment.
16 I think another reason it's optional is that
17 there is funding through HRSA, through the kind of
18 uninsured pool, to provide payment for those who are
19 uninsured to get the vaccine. So I think there is another
20 mechanism for vaccine administrators to get payment when
21 they do administer the vaccine to the uninsured population.
22 CHAIR BELLA: Anything else, Fred?

1 COMMISSIONER CERISE: No. It just seems like
2 you're leaving a gap there of an important population from
3 a public health perspective, but if the idea is there are
4 other vehicles and states are taking advantage of it, I
5 guess I understand.
6 CHAIR BELLA: Okay. Thank you.
7 Martha, then Darin.
8 COMMISSIONER CARTER: Thanks.
9 Since I think we're doing okay on our time, I
10 wanted to highlight the current program between HRSA and
11 the CDC to use the community health centers to distribute
12 vaccine because the health centers are really providing
13 care for the populations that we're really concerned about
14 in terms of disparities.
15 So the health centers that were invited to
16 participate are those that are already documented, because
17 the health centers have great data, already caring for a
18 large percentage of people experiencing homelessness,
19 public housing residents, migratory and seasonal
20 farmworkers, and patients with limited English proficiency.
21 I think there were 137 health centers invited and
22 113 currently participating. 137 doesn't sound like a lot,

1 but these are usually big health centers. This represents
2 millions of people that are potentially reachable through
3 the community health centers. Nationwide health centers
4 care for 29 million people. So these are the large health
5 centers in each state that have the organizational capacity
6 to field a major vaccine push.
7 So I think it's really promising, and I think we
8 need to track it. But also, we know there is going to be
9 good data coming out of this group.
10 Thanks.
11 CHAIR BELLA: Thank you, Martha.
12 DARIN?
13 COMMISSIONER GORDON: Chris and Michelle, thank
14 you for this.
15 I think your part on -- you know, you collecting
16 the feedback on data is really important. As I think about
17 not only on the race and ethnicity gaps in the data as
18 being an issue, I also think the point you raised about the
19 lack of visibility that health plans have into who's been
20 vaccinated and who hasn't been vaccinated is an area of
21 opportunity, because we basically have this resource in
22 many states. Managed care covers much of that population,

1 and their ability to do effective outreach to those who
2 have yet to be vaccinated has been limited because of the
3 lack of that data sharing. So I'm glad you raised that
4 point. I think it's something that doesn't seem like it's
5 been addressed by any of the actions to date, but I think
6 it's something that is causing us to be somewhat sub-
7 optimized in our effort in really attacking this issue head
8 on.
9 CHAIR BELLA: Thank you, Darin.
10 Other comments?
11 [No response.]
12 CHAIR BELLA: Well, Michelle and Chris, I think
13 you can tell that we're very appreciative of this and
14 really reassured to know that you're keeping an eye on all
15 of this and you're letting us know of developments
16 especially in the areas that we're interested in and look
17 forward to having this pave the way for some of our
18 discussion on adult coverage of vaccines writ large. So
19 thank you very much.
20 We are going to move into the next session.
21 Sheldon, I'm not sure if that was the excitement
22 about the adult coverage in vaccines or something else you

1 do or do not want to share, but if you'd like to share, we
2 have a second. If not, we'll just pass.
3 COMMISSIONER RETCHIN: I'm not sharing that, but
4 it involved my daughter. Thanks.
5 [Laughter.]
6 CHAIR BELLA: Good. All right. Well, that level
7 of excitement is always good to see.
8 All right. Just to kind of get level set on what
9 we have left to do, Rob is going to talk to us about the
10 Medicaid Innovation Accelerator Program. Then we are going
11 to take public comment on these last three sessions. We
12 are not going to run past three o'clock because at three
13 o'clock we are taking a break, and we must promptly begin
14 at 3:15 because we have guests from the territories joining
15 us, and we have a very robust panel at that time. So we
16 need to stick to our schedule.
17 So Rob is going to go through this. Then we'll
18 take public comment, and, Rob, it's all yours. Thank you.
19 ### **BUILDING STATE CAPACITY: WHAT WE LEARNED FROM THE**
20 **MEDICAID INNOVATION ACCELERATOR PROGRAM**
21 * MR. NELB: Great. Thanks so much, Melanie.
22 So this afternoon, I'm going to speak about the

1 findings from the evaluation of the Medicaid Innovation
2 Accelerator Program, known as IAP.
3 I'll first begin by providing some background
4 about IAP and about the CMS Center for Medicare and
5 Medicaid Innovation, known as CMMI, and then I'll discuss
6 some of the findings from the evaluation regarding state
7 interest and engagement in the program as well as some of
8 the barriers that states encountered when implementing
9 their IAP projects.
10 It's important to note that the Commission is not
11 required to write a formal comment letter on this
12 evaluation, and we're not planning to, since the Commission
13 has already previously expressed its support for IAP.
14 However, we're presenting these findings to you today
15 because we're hoping that they will help facilitate a
16 discussion about the Commission's future work on state
17 administrative capacity and the role of CMMI in supporting
18 state innovation.
19 So, as a result, I will conclude today's
20 presentation with a few policy questions in those areas,
21 and I'll look forward to your feedback on the future
22 direction you'd like to take this work.

1 So first some background about CMMI. CMMI was
2 created in 2010 as part of the Affordable Care Act in order
3 to test new innovations to improve quality and reduce
4 costs. Congress appropriated $15 billion for CMMI for the
5 first 10 years and $10 billion every 10 years thereafter.
6 So far, about 10 CMMI models have focused on
7 Medicaid beneficiaries or statewide innovation, totaling
8 about $2 billion, which it's important to note it's much
9 less than the number of models in the funding that has been
10 devoted towards models for Medicare enrollees.
11 So the IAP is one of the main CMMI initiatives
12 related to Medicaid, but it's a little bit different from
13 other types of CMMI models. So rather than testing a
14 specific policy change, IAP provided technical assistance
15 to states and helped them implement payment and delivery
16 system reforms using existing Medicaid authorities.
17 CMMI initially appropriated about $100 million
18 for the initiative over five years. This amount represents
19 a pretty large increase in federal administrative funding
20 for Medicaid, but it's a relatively small share of state
21 administrative funding and of course even smaller share
22 when you look at total amount of spending on Medicaid

1 benefits for the entire program.

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

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

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

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

22 Similar other CMMI projects, IAP was

1 independently evaluated to assess whether it achieved its
2 goals. The final evaluation was published last December
3 based on data collected as of September 2019.
4 Overall, the evaluation found a pretty widespread
5 interest in IAP program activities. Of all the different
6 program areas, the substance use disorder and LTSS tracks
7 were two of the most popular. One potential reason may
8 have been the fact that CMS introduced new opportunities
9 for substance use disorder waivers and housing supports in
10 LTSS at about the same time that IAP was first introduced.
11 Ultimately, many states that were participating in IAP took
12 advantage of the TA to help implement some of those new
13 program options in their states.
14 The evaluation found that states rated all the
15 different types of TA as useful, but they noted that the
16 coaching was particularly helpful for states that were
17 further along in their implementation process and could
18 benefit more from the individualized support.
19 States also appreciated the opportunity to learn
20 from other states participating in the same program area,
21 suggesting that there were some benefits in CMS's approach
22 to group similar states together throughout the TA process.

1 This figure shows the geographic reach of IAP
2 program in functional areas as of September 2019. As you
3 can see, most states participated in at least one program
4 or functional area. In addition, not shown in this figure
5 is the fact that virtually all states participated in the
6 many webinars that CMS put together through IAP.
7 There were three main barriers that the
8 evaluation identified. First, in some states, they faced
9 challenges with staffing that prevented them from fully
10 taking advantage of all the IAP opportunities. In some
11 cases, it was difficult for coaches to get full engagement
12 from state staff who are busy with many competing
13 priorities. In other cases, states just simply didn't have
14 staff with sufficient data analysis skills to really use
15 and take advantage of some of the more sophisticated data
16 models and value-based simulations that were created by the
17 IAP coaches that they worked with.
18 The evaluation also noted that some states faced
19 roadblocks because of changes in state priorities. So
20 although the state Medicaid director was required to sign
21 off on projects at the start, these efforts sometimes faced
22 challenges as they were being implemented as they needed to

1 get buy-in from state legislatures or other state agencies.
2 Finally, because of state budget constraints,
3 some states were not able to fully scale up the programs
4 that they developed through IAP. Here, it's important to
5 note that IAP only provided funding for federal TA, and it
6 didn't provide any funding directly to states. So it was
7 not directly intended to address state budget challenges.
8 So now that IAP funding has expired, the future
9 of IAP is unclear. At this time, it's a bit too early to
10 know where the Biden administration will focus its CMMI
11 efforts. Using existing authorities, CMMI could choose to
12 continue IAP with new funding or could create new IAP-like
13 models that use some of the lessons learned from the
14 program.
15 In addition, the administration will have an
16 opportunity to take a closer look at the full range of
17 models being tested by CMMI and consider whether there's a
18 need for more investment in Medicaid-specific models more
19 broadly.
20 The findings from IAP can also help inform future
21 efforts for CMS to provide TA to states using its existing
22 administrative funding as well as other efforts to support

1 state capacity. For example, as you'll recall, the
2 Commission made a recommendation last year about providing
3 funds for state capacity to implement integrated care
4 models, and you all talked this morning about potential
5 recommendations related to supporting state capacity around
6 behavioral health.
7 The Commission has not commented specifically
8 about how this type of support should best be provided or
9 finances, but the IAP evaluation provides some insight into
10 some of those questions.
11 So that concludes my presentation for today. As
12 I mentioned at the outset, we're really looking for your
13 input on how this evaluation can help inform our future
14 work on state capacity and on the role of CMMI.
15 There are some questions here to help guide your
16 discussion, and if you do want to pursue further work in
17 this area, it would be particularly helpful to know what
18 direction you want to take the work, what ideas we should
19 develop further, and of course, ultimately, what
20 information would be most helpful in your decision-making.
21 Thanks.
22 CHAIR BELLA: Thank you, Rob.

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

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

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

18 I will say I was, however, taken aback by the
19 fraction of CMMI funding that goes to Medicaid, and maybe
20 I'm just missing something. But given the variation among
21 the different Medicaid programs along with the thin
22 administrative structure of most state programs, that

1 shouldn't be a reason not to innovate. That should be a
2 reason to actually invest.
3 But I don't know. Maybe, Melanie, you could
4 address this. Why did Medicaid get such a small amount of
5 funding through CMMI? Or maybe, Rob, you can jump in too.
6 CHAIR BELLA: Well, Rob, you should elaborate.
7 Part of it is I think that CMMI authority to test
8 isn't as broad in Medicaid as it is in Medicare, and I
9 think that that's one of the reasons that would be given.
10 It's more limited. So it has to be paired with another
11 Medicaid authority, which perhaps the agency is much more
12 familiar with Medicare. So having to pair them together
13 maybe was a barrier internally, but that is definitely an
14 issue, Sheldon, in terms of the reach of the innovation
15 center on Medicaid and what it can waive. The wand is much
16 smaller for Medicaid than for Medicare, I guess, is how I
17 think of it.
18 And, Rob, I don't know what you would say to
19 that.
20 MR. NELB: I think that's fair, and perhaps the
21 converse of that is important to note too is that Medicaid
22 under its existing authority has a lot of waiver authority

1 through 1115 to test new --

2 COMMISSIONER RETCHIN: Right.

3 MR. NELB: But it's interesting it's still about

4 the CMMI sort of funding and this overall focus. I think

5 IAP was an example of how CMMI kind of recognizing that

6 there's a lot of flexibility in Medicaid, and so trying to

7 use CMMI funding to help support and complement that is a

8 bit different for approaches.

9 But we can take a closer look at that, thinking

10 about those authorities, and perhaps we could talk to CMMI

11 more about whether there are some barriers in their statute

12 or why they're not focusing on Medicaid.

13 COMMISSIONER RETCHIN: I'll just end up and just

14 say I know that there's -- Anne had mentioned having Liz

15 Fowler come to the Commission, and I think it's an

16 important area early on in our tenure to make that point.

17 I know the 1115. There are other areas for innovation, but

18 this CMMI was meant to be for both agency.

19 CHAIR BELLA: Yeah. I do think the point you

20 started out with, though, like even if we still have to

21 equip states with the ability to take advantage of these

22 opportunities, which is something that we can't lose sight

1 of.

2 COMMISSIONER RETCHIN: Right.

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

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

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

12 I would want to say three things. One is that I
13 think there are much increased opportunities -- and this is
14 partly a result of the pandemic -- to use via virtual
15 technology as a technical assistance tool. For example,
16 the technology that we use for this meeting here is
17 significantly more advanced than any technology that was
18 available during the contract. We did have some
19 videoconferencing. We did do webinars, but the speed of
20 development of these technologies just over the last two
21 years is amazing, and I think there's a lot more that CMS
22 could do with these technologies now that they couldn't do

1 before.

2 There wasn't a videoconference in which there
3 wasn't some kind of technical, logical glitch usually
4 during that contract, not only at the federal level or at
5 even IBM, but at the state level, people not being able to
6 get on, all kinds of things. So I would encourage much
7 greater investment. I mean, these things do cost money in
8 those as part of a TA effort.

9 Secondly, the IAP-TA model was to put together
10 cohorts of states to address certain policies of maybe
11 relevance to the states, but they were fairly long-term
12 engagements, usually a year or more. It often took an
13 amount of time to get the states organized and on board and
14 engaged and working on it, but I do think there's an
15 opportunity to also provide technical assistance over the
16 short term. I would support a pool of part of the
17 investment to do things with much greater immediacy and
18 quick turnaround to very short-term topics of immediate
19 interest to the states. I think with these types of
20 technologies, it would be a lot easier to form meetings,
21 get consultants, address issues over a very short period of
22 time.

1 Third was -- and Rob alluded to this in the
2 chapter was the inability of the contractors and their
3 consultants to provide technical assistance around the
4 direct operation of the program. So there was this fine
5 line that we cannot step over around advising states on how
6 to put together 1115 waivers, for example, because the IAP
7 organizational structure at CMS and other reasons was not
8 part of the overall operation of Medicaid, and they didn't
9 want people who didn't have that operational responsibility
10 giving advice around operational issues.
11 I think there's an opportunity to integrate those
12 two, the TA component organizationally with the direct
13 program operations, so that there could be technical
14 assistance that actually led to real policy and program
15 change, state plan amendments, waivers, whatever.
16 I'll stop there. I just think there's a better
17 opportunity to integrate those two functions.
18 CHAIR BELLA: Thank you, Sheldon.
19 Toby?
20 COMMISSIONER DOUGLAS: Yeah. I'll be brief.
21 First of all, I think that the TA is essential
22 for states, but what was clear from the findings -- and I'd

1 say this is where we need to focus -- is on these emerging
2 areas that are not where states have the expertise. We
3 talked about it this morning that when we get into some of
4 these new emerging areas around mental health, and we saw
5 that the same wouldn't be recommended around duals.
6 But it needs to come, and one area, when I think
7 back to the financial alignment demos, there was 100
8 percent federal funding for support for implementing those
9 demonstrations. So if we could complement it with efforts,
10 the TA with getting states some resources on their side
11 where they don't have to put out state match, I think that
12 could help with the infrastructure and building off some of
13 those.
14 Am I remembering it correctly, Melanie, how you
15 guys -- we did that?
16 CHAIR BELLA: Sort of, yeah. Every state got a
17 million dollars, and they could use it for like
18 implementation costs, including hiring staff to support the
19 program.
20 COMMISSIONER DOUGLAS: Yeah. Because it's very
21 hard, as we know, for states. Even with the TA, it's going
22 to come down to bandwidth on the state side. So what do we

1 do or recommend around the TA coupled with some
2 infrastructure building for these unique emerging issues?
3 CHAIR BELLA: Thank you, Toby.
4 Fred?
5 COMMISSIONER CERISE: Yeah. I think it's an
6 important program to have. I think the ability to spread
7 good ideas is important. So I certainly would look for how
8 to be able to continue to facilitate it.
9 Rob, I have a question about the state
10 constraints. You mentioned three things -- the staffing
11 challenges which I get, and changing priorities. The third
12 one around state budget constraints is a confusing one
13 because if the program is designed to propagate models that
14 have been proven to improve quality and lower costs or at
15 least not increase costs, then perhaps a heavier focus on
16 those programs that we have, harder evidence that they
17 really do lower costs could help state uptake.
18 Do you have any insight? That explanation of why
19 states couldn't participate because of the budget
20 constraints seems a little hard to understand, given the
21 program is going to put forward ideas that lower costs.
22 MR. NELB: Sure. So to be clear, these were

1 states that did participate initially, and maybe through
2 IAP, they developed sort of a small-scale model or they
3 developed the concept for a new value-based payment
4 arrangement or whatever. But then when they maybe went to
5 their legislature to try to scale that up statewide or
6 getting the funds to implement, they faced some challenges.
7 Obviously, the goal is to do things that reduce
8 costs and improve quality, but with some of these, there is
9 still an up-front investment required and the savings
10 aren't achieved until down the road. So in states with
11 tighter budget constraints, it's harder to make that
12 initial investment, even if you think it's going to lead to
13 savings down the road.
14 COMMISSIONER CERISE: I guess that's an important
15 point because everybody who spends money has people coming
16 at them with ideas that are going to lower costs, but not
17 this year. But it's going to come. You know it's going to
18 come. So to be able to really focus on the ones that if
19 you want update, there are some that really do have good
20 evidence that they are going to lower costs as well. So
21 maybe that would help.
22 CHAIR BELLA: Thank you, Fred.

1 So my comments will not come as a surprise, and
2 depending on how we think about TA, I mean, it feels to me
3 like we have to address the issue of state capacity and
4 bandwidth and actual hands in the state to do things.
5 Before, we're worrying about spreading best practices,
6 because the TA that passes on best practices means nothing
7 if they have nobody there to implement it. So I just don't
8 want to lose sight of that as we think about where CMS
9 should focus and how we get value.
10 Honestly, like Medicare, it's easier in Medicare.
11 So I think we do have to keep beating the drum, "Don't
12 forget about Medicaid," and let's make sure states are at
13 the table, particularly when decisions are made that impact
14 the Medicaid programs.
15 I think Liz Fowler will be very receptive to
16 those comments and to brainstorming with us, and I know
17 Anne has her on the list of folks that we'll talk with
18 sooner rather than later. So I feel like this is -- we're
19 all kind of aligned on the fact that we want to see more of
20 this in Medicaid, and I think maybe we'll have receptivity
21 from the folks that are going to be planning the next few
22 years of activities at the innovation center.

1 Any additional thoughts? Anything else, Rob,
2 that you want to add?
3 MR. NELB: No, that's all. Thanks. This is
4 really helpful and will give us some ideas going forward.
5 CHAIR BELLA: Well, this is wonderful because it
6 honestly is a theme in every single session, so thank you.
7 All right. We are going to move into public
8 comment. We're going to try this a little differently. I
9 would like to ask anyone who wants to make a public comment
10 to please raise your hand. Then we are going to tally up
11 the number of people that want to make a public comment and
12 try to make sure we have enough time allotted for everyone.
13 So far, I see one person, two people. We'll just
14 give it 10 more seconds. If you'd like to make a public
15 comment, please raise your hand now.
16 All right. Every time I think I can predict
17 where we're going to get public comment, I'm wrong. We
18 just have a couple folks that want to speak. If you could
19 start with Camille, that would be great.
20 MS. HUGHES: Camille, you're unmuted. Just
21 unmute your line.
22 **### PUBLIC COMMENT**

1 * MS. DOBSON: Great, thanks. Good afternoon.
2 Thank you again to the staff for great work on these two
3 topics. I wanted to briefly, on the COVID vaccine issue,
4 let you know that we are working really hard with our
5 states to gather best practices around getting vaccines to
6 homebound individuals, and so we should have some materials
7 to share, hopefully shortly.
8 There are not a lot of good practices. A couple
9 of states are using their health plans to identify folks
10 that are homebound and using care managers. The complexity
11 needing to have the ultra-cold storage and being able to
12 watch someone for 15 minutes after they have gotten the
13 vaccine has really caused a lot of challenges, staff,
14 manpower-wise.
15 One really interesting initiative is in Delaware,
16 they're using their paratransit system to go to all of
17 their known providers where the paratransit individual --
18 the buses actually will take four or five nurses and drop
19 two off at one site and then hop forward to another site
20 that can get those first two and forward to another two.
21 So they continue to do this hopping, and they're making
22 some really good progress.

1 I know Michelle mentioned EMS. That's happening
2 in Kentucky and a couple of other states.
3 But, anyway, we'll be happy -- I'll let Anne know
4 when we have that publication or that highlight document
5 available to share with you.
6 On IAP, I have a lot to say too, but I won't
7 spend a lot of time. I was a subcontractor through IBM
8 Watson for the IAP LTSS track, and we have a lot of
9 thoughts about the way it was structured.
10 I agree with -- I think it was Peter, maybe, who
11 said -- or Sheldon, I think -- that talked about the lack
12 of funding for Medicaid. It's horrific, actually, how
13 little money from CMMI went to Medicaid, and I think back
14 to Melanie's point, some of it is based on the waiver
15 authority. But fundamentally, the way they evaluate, that
16 was really the problem. They really wanted pre, post, or
17 having control groups to evaluate the impact, and that's
18 not how it works in Medicaid. So I think they were
19 hampered by coming up with models that worked for Medicaid.
20 So that's the structure of the CMMI evaluation criteria
21 that I think is in the control of the agency, at least from
22 my perspective, having been there when they started.

1 Then IAP, I think, in the health space, it was
2 very frustrating that CMS did not take advice from the
3 states on what they were most concerned about, and what
4 they really wanted help with was meeting the HCBS settings
5 rule. And they wanted help figuring out how to do
6 different day services, for example, or on quality, and
7 what we got was value-based payment. The reality is that
8 the states -- value-based payment is very minimal in the
9 HCBS space, except -- well, in the HCBS space, in nursing
10 facilities in a number of states, real quality improvement
11 and value-based payment, but it was a struggle to get
12 states to evaluate, to come up with an idea that would
13 work, because you need to have value-based payment. You
14 need to have a value proposition, and that's very
15 challenging in the HCBS space.
16 It was very valuable. State capacity was very
17 hard. I think in the four years that I was working with
18 Brian and IBM Watson, staff turned over every year. Every
19 single year, we had new staff that were coming on board.
20 So that's a challenge. But it would be great if the agency
21 would dedicate some funding to the problems that states
22 really have as opposed to the structure to sort of fit

1 everyone into one model, although the housing track, I
2 know, is very successful.
3 So that's it. I appreciate the opportunity to
4 comment today. Thank you.
5 CHAIR BELLA: Thank you, Camille, and thank you
6 for the information you'll be sharing on best practices.
7 MS. HUGHES: Scott, you may unmute your line now.
8 MR. WOODS: Great. Thank you so much. Good
9 afternoon, Madam Chair and members of the Commission. My
10 name is Scott Woods, vice president of Policy and Research
11 at PhRMA.
12 We submitted written comments to the Commission
13 in advance of this meeting urging members not to advance
14 the recommendations on the differential rebates for
15 accelerated approval drugs and cell and gene therapies, but
16 I do want to make two brief points about the differential
17 rebates.
18 First, as an initial matter, the FDA has
19 clarified in guidance that drugs granted accelerated
20 approval must meet the same statutory standards for safety
21 and efficacy as those granted traditional approval, and we
22 cited the guidance in our written comments for your

1 reference.

2 Second, we believe that by raising the statutory

3 rebate on drugs where only surrogate endpoints have been

4 leveraged for approval and where confirmatory trials have

5 not yet been completed, drug manufacturers could be

6 potentially deterred from pursuing this pathway, especially

7 as you consider the significant rebate level that has been

8 discussed this afternoon, 8-plus percent. That

9 differential rebate would come on top of the base statutory

10 rebate, supplemental rebates that states may negotiate, and

11 potentially other policy levers, including the removal of

12 the AMCP that's currently under consideration by the

13 Congress in the COVID reconciliation bill.

14 Given the vulnerable populations that Medicaid

15 serves and the broad access to medicines that they are

16 afforded, we believe that it's paramount that MACPAC not

17 advance its recommendation to the Congress at its next

18 meeting. We look forward to a further dialogue with the

19 Commission and staff, and we're happy to help in any way

20 that we can.

21 Thank you for your consideration.

22 CHAIR BELLA: Thank you, Scott, for submitting

1 comments and for being here today to make public comment.

2 MR. WOODS: Thank you, Madam Chair.

3 CHAIR BELLA: Anybody else like to make any

4 comment?

5 [No response.]

6 CHAIR BELLA: It does not appear so.

7 All right. Anyone else on the Commission have

8 any final words, questions, comments?

9 [No response.]

10 CHAIR BELLA: Okey doke. We are going to take a

11 break. I think we need to stick with the time frame

12 because we have the territories coming at 3:15. So we will

13 not start earlier than that, even though we have a little

14 bit more time. So you all have about a half an hour. We

15 will see you back here promptly at 3:15. Thank you.

16 * [Recess.]

17 CHAIR BELLA: Okay. We're ready.

18 MS. BUDERI: Hi. Good morning.

19 CHAIR BELLA: Good morning for us and good

20 afternoon to all of you.

21 **### PANEL DISCUSSION: CURRENT AND FUTURE ISSUES**

22 **FACING THE TERRITORIES**

1 * MS. BUDERI: Hi, Helen.
2 Well, everyone, thank you. Today at this
3 session, we are excited to welcome panelists from four of
4 the five U.S. territories -- American Samoa, although I
5 don't know if our panelist, Sandra, is on yet, but also the
6 Commonwealth of the Northern Mariana Islands, or CNMI,
7 Puerto Rico, and the U.S. Virgin Islands, or USVI. And our
8 panelists will discuss several issues facing their Medicaid
9 programs, including a major reduction in federal Medicaid
10 funds, often referred to as the Medicaid fiscal cliff, that
11 will occur this October without congressional intervention.
12 Let me see if I can advance these slides. There
13 we go.
14 Before I introduce our panelists, I'm going to go
15 briefly over some background information on Medicaid and
16 the territories and talk about the upcoming Medicaid fiscal
17 cliff. I'll provide a refresher on MACPAC's prior work and
18 statements on this issue, and then I'll turn it over to our
19 panelists.
20 Territories are generally considered states for
21 the purposes of Medicaid unless otherwise specified, but
22 their Medicaid programs differ from states in several

1 important ways. Guam, Puerto Rico, and USVI have similar
2 program structures as states. CNMI and American Samoa
3 operate their programs under section 1902(j) waivers, which
4 are uniquely available to them and allow the Secretary to
5 waive almost any Medicaid requirement. And I'll just note
6 that for anyone looking to learn more about Medicaid
7 programs in the territories, there's a link on this slide
8 to our fact sheets for each territory.
9 So territory Medicaid programs operate on a
10 capped allotment financing structure. This means that
11 unlike the states, which can access an unlimited amount of
12 federal dollars at the applicable matching rate,
13 territories may only do so up to an annual cap, which is
14 specified in Section 1108 of the Social Security Act. This
15 is called the Section 1108 cap or Section 1108 allotment.
16 Moreover, the federal medical assistance
17 percentage, or FMAP, is specified in statute at 55 percent,
18 which is much lower than what territories would receive if
19 their FMAPs were determined through the same formula used
20 for states, which is largely based on per capita income.
21 This arrangement has historically been
22 insufficient to fund territory Medicaid programs, and as a

1 result, territories have had to rely on time-limited
2 increases in federal Medicaid funds and FMAPs.
3 Congress provided temporary additional federal
4 Medicaid funds or enhanced FMAPs on several occasions in
5 the last decade, including through the Patient Protection
6 and Affordable Care Act.
7 Most recently, through the Further Consolidated
8 Appropriations Act of 2020, Congress substantially raised
9 each territory's Section 1108 cap for FY 2020 and 2021 and
10 raised the FMAPs for these fiscal years as well to 76
11 percent for Puerto Rico and 83 percent for other
12 territories. The Families First Coronavirus Response Act
13 further raised these allotments to help respond to COVID-19
14 and also provided a 6.2-percentage-point FMAP bump during
15 the public health emergency to all states and territories.
16 Along with the extra funding, Congress added
17 several new requirements for the territories related to
18 program administration, program integrity, and reporting.
19 For example, all territories must designate a program
20 integrity lead, and American Samoa, CNMI, and Guam must
21 make reasonable progress towards establishing methods of
22 reporting data to the transformed Medicaid statistical

1 information system and establishing Medicaid fraud control
2 units. And there were several additional requirements that
3 apply only to Puerto Rico.
4 So to help illustrate the Section 1108 allotments
5 with and without temporary increases, I've included this
6 table showing allotments from FY 2019 through 2022, with
7 and without the increases. I'll note that in FY 2019,
8 additional funds were available to territories, but they
9 are not shown here because they were structured separately,
10 in addition to the allotments rather than as part of the
11 allotments.
12 Congress has not provided any increases or
13 additional funds for FY 2022 or future years, and I'll draw
14 your attention to the last two columns here where we see
15 the amounts provided by current law for FY 2021 and the
16 amounts provided for FY 2022, when the allotments will
17 revert back to their statutorily specified levels. The
18 difference, as you can see here, is stark, dropping, for
19 example, from $85.6 million in 2021 to $13 million in 2022
20 for American Samoa.
21 This drop-off, as I mentioned, is referred to as
22 the fiscal cliff and will occur on October 1 without

1 congressional intervention. FMAPs will also revert from
2 their current levels of between 82.2 and 89.2 percent down
3 to 55 percent for all territories.
4 Territories have faced similar fiscal cliffs in
5 several previous years, most recently at the beginning of
6 FY 2020. In most cases, fiscal cliffs have been averted by
7 last-minute action by Congress, but CNMI did experience a
8 lapse in funds in March 2019.
9 MACPAC expressed concern about the territory
10 financing arrangement in our June 2019 report to Congress
11 on Medicaid in Puerto Rico, which we wrote in response to a
12 congressional request.
13 In anticipation of the fiscal cliff expected in
14 October 2019, MACPAC stated that an additional infusion of
15 temporary funds would keep the Medicaid program afloat, but
16 in the long term, reliable, sustainable access to care for
17 the Medicaid population will likely require changes to the
18 existing financing arrangement that provide a higher level
19 of federal investment and over a longer period of time than
20 past interventions. Although this work was specific to
21 Puerto Rico, the Commission also noted implications for
22 other territories.

1 Now I'm going to turn it over to the panel. We
2 have asked our panelists to discuss the issues shown on
3 this slide, including unique features of their Medicaid
4 programs and circumstances affecting the programs, current
5 and future priorities for program improvement, effects of
6 new federal requirements, effects of COVID-19 and efforts
7 to respond to those effects, the upcoming Medicaid fiscal
8 cliff and level of federal investment needed for FY 2022
9 and future years, and other issues facing the program.
10 So to introduce our panelists, I am not sure if
11 Sandra was able to join, but we have Sandra King Young from
12 American Samoa, Helen Sablan of the Commonwealth of the
13 Northern Mariana Islands, Jorge Galva Rodriguez of Puerto
14 Rico, and Gary Smith from U.S. Virgin Islands.
15 So, with that, I'm going to turn it over to our
16 panelists. I'm not sure if Sandra was able to join.
17 Sandra, are you here? If not, maybe we can start
18 with Helen. Would you be ready?
19 * MS. SABLAN: Yes, I am ready.
20 MS. BUDERI: Great.
21 MS. SABLAN: Okay. So the Commonwealth Medicaid
22 Agency on behalf of the U.S. citizens in the Commonwealth

1 of the Northern Mariana Islands appreciates the opportunity
2 to provide an overview to the Medicaid and CHIP Payment and
3 Access Commission. We really appreciate the work of MACPAC
4 and wish we had the capability to analyze our Medicaid
5 program like MACPAC has for the nation.

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

12 The Medicaid program for the CNMI and U.S.
13 territories arrived at the Medicaid fiscal cliff in March
14 2019. No more funding for providers. Medicaid members
15 advised to go to our only hospital Commonwealth Healthcare
16 Corporation safety net health system for care. Congress
17 provides disaster assistance in 2019. Congress passes
18 Consolidated Appropriations Act FY 2020 and provides
19 accurate Medicaid funding for two years. So Congress funded
20 for 2020 and '21, so a fiscal cliff again by September 30,
21 2021.

22 Transition for the '19 Medicaid ACA all spent.

1 Medicaid disaster assistance, CNMI expand Medicaid funding,
2 Consolidated Appropriation Act FY 2020, and the reports to
3 Congress, PIE, T-MSIS and others.
4 Super-Typhoon Yutu on October 2018, ACA increase
5 could have been un-expended, and in 2020 of December, got
6 approved for Medicaid. Disaster assistance helped greatly
7 -- following Typhoon Yutu and then 2020 COVID with the
8 additional funding and eligibility.
9 We are the smallest U.S. territory, farthest and
10 west, 8,900 miles from D.C., distance, travel, and time
11 zone and a day zone is the challenges. Smallest Medicaid
12 population, 16,000 Medicaid and 52,000 total population.
13 Medicaid accounts for 46 percent of the U.S. citizen
14 population. 2010 census, median income for a family of
15 four, CNMI is $19,000 versus the U.S. at $62,000. Medicaid
16 funding is critically important for health care system.
17 Commonwealth Heathcare Corporation does not have
18 all specialties and travel immediately invokes air travel.
19 Capacity in territory is limited. The Section 1108 ceiling
20 today will provide about $7.3 million for the medical
21 assistance program, and CHIP is about $11.3 million.
22 In 2018, the CNMI and Medicaid paid $54 million

1 in Medicaid and CHIP claims, MAP and IBNR but not recorded
2 of $18 million total Medicaid expense of $72 million, and
3 then CMS informs CNMI that FY 2020 would have received 7.2
4 for 2020 for MAP and $11.2 million for CHIP, leaving a
5 major shortfall.
6 In March 2019, the Section 1108 cap funds and the
7 final amounts left from the Affordable Care Act are
8 completely expended. CNMI closed access to private
9 providers and notified beneficiaries that care would only
10 be provided by the Commonwealth Heathcare Corporation, a
11 public corporation, and a safety net system.
12 1978 Medicaid program established in the
13 Commonwealth with Section 1108 caps and 50 percent FMAP.
14 2010, Affordable Care Act provides 101 million to Section
15 1108 caps to be expended by 9/30/2019, increases the FMAP
16 from 50 percent to 55 percent federal amount. 2011,
17 certified public expenditures with the only hospital on the
18 island, and there's no local match because of recession.
19 2018 October, hit by Typhoon Yutu.
20 2019 March, Medicaid exhaust Section 1108, ACA
21 increase of 101 million from 2012 to 2019 and local
22 funding. 2019 in March, Medicaid refers all beneficiaries

1 to CHCC. 2019, Congress provides disaster relief. 2019 in
2 December, Congress Consolidated Appropriation Act increases
3 cap to $60 million and FMAP to 83 percent.

4 2020, program works hard to meet congressional
5 and statutory and program requirements, and then September,
6 this coming September 2021, the fiscal cliff again.

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

20 The CME, APD and IPDs for the decision support
21 system, data warehouse, Medicaid management information
22 system, health information technology is in the planning

1 stage, and we already have a plan that we're working on.
2 Program integrity lead and joint operating
3 agreement with unified program integrity contractor and
4 submitted data from largest health care provider,
5 designation of the attorney general, the office of public
6 auditors, independent investigation unit and policy
7 deliberation.
8 T-MSIS data, CMS approve advance planning
9 document for EVV, MMIS, and T-MSIS project. CNMI to use
10 the reuse provisions and partnerships to lessen cost of
11 system.
12 CMS approved the decision support system so that
13 CNMI is able to analyze costs, services, outcomes, waste,
14 fraud, and abuse, among many others. CMS approve the HIE
15 implementation plan, and CNMI is revisiting the need for
16 the Health Information Exchange.
17 Reports to Congress and CMS, has submitted many
18 others, compliance activities, which is third-party
19 liability from private VA, DoD, private provider enrollment
20 and eligibility, electronic visit verification, and then
21 COVID-19 for some eligibility has increased Medicaid
22 beneficiaries from 16,000 to 27,000. This means that over

1 50 percent of CNMI residents are currently covered by
2 Medicaid.
3 CNMI has the uninsured rate highest in the
4 nation. So fee is excellent. The inclusion of the compact
5 of freely association, the co-financials in Medicaid is
6 also good. Although the Commonwealth does not have many
7 COFAs[citizens of freely associated states] as Guam and
8 other states.
9 Fiscal cliff is priority number one, number two,
10 number three, and number four; U.S. citizens of the CNMI
11 are treated the same as in states; and eliminate the 1108
12 caps; and apply the FMAP formula as states. Local match,
13 CNMI does not have the local match. COVID-19 has severely
14 affected our tourism-based economy. Making reasonable and
15 appropriate progress in compliance is a fundamental
16 priority. Our goal is to manage program as well as any
17 state.
18 Our many other issues are internal. Many bidding
19 capacity deal with civil service. CNMI never get a pricing
20 study. We openly acknowledge our own issues and then CNMI
21 local budget issues and options.
22 All plans and activities are dependent on Section

1 1108 caps and FMAP. The health of the health system is
2 dependent on Medicaid. The CNMI is unable to plan with any
3 anticipation because of the inability to predict amounts
4 over Section 1108 Medicaid, the grant. Purpose is to
5 define state to include all states, the District of
6 Columbia, and U.S. territories and eliminate the cap or
7 increase the cap by CMS or MACPAC estimate, and maintain
8 the FMAP at same level. The cap should increase based on
9 any increase in percentage based on the latest CMS National
10 Health Expenditures, the NHE, grow for the latest year
11 published. The inability to predict the Medicaid grant in
12 future years means that CNMI cannot plan any waiver
13 program.
14 And this concludes my presentation. Thank you.
15 MS. BUDERI: Thank you so much, Helen.
16 Jorge, would you like to go next?
17 * MR. GALVA RODRIGUEZ: Sure. Thank you very much,
18 Helen.
19 I'd like to thank the panel for the opportunity
20 of letting you know the particularities and the challenges
21 that we face at the Medicaid program in Puerto Rico.
22 Puerto Rico has a population insured by Medicaid,

1 which amounts to approximately 1.5 million insured. Of
2 these 1.5 million, approximately 275,000 are dual
3 eligibles. Representing Medicaid insurance represents 42
4 percent of all insured population in Puerto Rico, and it
5 represents a lifeline for our medically indigent
6 population.
7 The net effect of Medicaid for the island's
8 economy cannot be dismissed because of the huge impact it
9 has not only on the well-being of our population but also
10 on the viability of our health care system and the economy
11 as a whole.
12 In terms of particularities of our system, we are
13 one of the few territories or states in the United States
14 that has a 100 percent managed care system for the delivery
15 of medical and hospital services to our insured population,
16 and we also have a particularity of having the single state
17 agency separate from the agency that runs the managed care
18 operation that provides payment to our providers, both on
19 the hospital and medical side.
20 Under Public Law 116-94, Puerto Rico was able to
21 achieve the provision of funds for fiscal years '20 and '21
22 in the approximate amount of $2.6 billion for fiscal year

1 '20 and $2.7 billion for fiscal year '21.

2 This amount was instrumental not only in

3 operating the system as it existed at that time, but also

4 providing enough wherewithal to fund what we called at the

5 time "sustainability initiatives," and these sustainability

6 initiatives included the following. Raising the poverty

7 level in the Puerto Rico poverty level to 85 percent of the

8 federal poverty level, raising the reimbursement to our

9 medical providers under Medicare Part B at 70 percent of

10 the Medicare fee schedule, providing supplementary

11 reimbursement to hospitals -- and I will go into the

12 hospitals in a minute when talking about COVID -- provide

13 increases to physicians, primary physicians with sub-

14 capitated arrangements, and of course, providing coverage

15 for our hep C patients.

16 The total amount of money that was involved in

17 the funding of these initiatives was approximately $700

18 million, which were added on top of the existing budget

19 that we had developed under Obamacare, of Obamacare

20 funding, and the VBA funding in the preceding years, and

21 with the state matching funds, the total amount of our

22 budget for fiscal '20 raised to approximately $3.4 billion

1 and approximately $3.5 billion for fiscal '21, which is the
2 year that we are handling now.
3 In terms of the sustainability initiatives, they
4 were instrumental in strengthening both the ability of
5 bringing new population into the Medicaid, into the
6 Medicaid program. As you probably know, our population,
7 around 50 percent of our population is currently under the
8 poverty line. So the Medicaid program becomes the lifeline
9 and the only means of providing medical and hospital
10 services to this population.
11 But in addition to having a vulnerable and
12 fragile population in terms of income and socioeconomic
13 status, we also have a particularly weak position in terms
14 of the reimbursement scheme for our providers of both
15 hospital and physician providers.
16 In terms of our physician providers, the
17 situation, as probably some of you know, has been quite
18 dire in the past few years. Physicians have been
19 emigrating from Puerto Rico at a very rapid rate. So
20 having additional reimbursement for our physicians was
21 instrumental in keeping them on the island and not de-
22 populating our professional base for the treatment of our

1 Medicaid population and our population at large.

2 In terms of hospitals, our first estimation when
3 PL 116-94 was discussed revealed that hospitals were
4 experiencing an operational loss in the management of our
5 Medicaid population. It was originally estimated at
6 approximately $46 million. We revisited that amount of
7 money and estimated that the direct operational loss
8 accruing on our hospital operations was closer to $106
9 million a year. Still, there are some of our hospitals
10 that are experiencing an extreme weakness in their
11 financial statements, which was only partially redressed
12 with this additional reimbursement that was secured by PL
13 116-94.

14 The act also imposed on Puerto Rico, 13
15 individual requirements that speak to oversight and
16 accountability for the federal funds received by the
17 program, and these requirements basically have to do with
18 oversight and accountability measures to make sure that the
19 expenditures of federal money in Puerto Rico are
20 appropriately safeguarded and that we also have appropriate
21 contracting practices to ensure the best deal possible for
22 the program and robust systems to detect improper payments

1 and allow for recovery and recoup of these improper
2 payments.
3 I'm happy to say that at this point in time and
4 ahead of schedule, Puerto Rico has either complied with
5 some of the requirements in PL 116-94 or is ahead of the
6 curve in complying with these requirements. So we feel
7 pretty confident that in going before Congress this year
8 asking for reauthorization of funds for the program, we are
9 in a very strong position to show that substantive programs
10 have been developed to account for the money that is sent
11 over here and to account for the spending of this money
12 properly.
13 We have engaged in substantial contracting
14 reform. At this point, we have already performed an
15 evaluation of some of the contracts that we were not
16 letting out through RFPs or RFIs. We have corrected that
17 issue, and we are ready to let out big contracts,
18 especially for our PBM and our PPA. These RFPs are going
19 out before this month is over, and in this sense, we're
20 going to be addressing one of the biggest issues that was
21 brought forth by the GAO when they audited our operations
22 on the basis of a mandate, legal mandate in 116-94.

1 Of course, we also have to take care of PERM and
2 the MEQC issues, and we are working closely with external
3 consultants to make sure that our PERM and MEQC programs
4 are up to par and that our reporting on both of those
5 indicators are in accordance with the provisions of PL 116-
6 94.
7 In terms of the effect that we received from the
8 COVID pandemic for the program, we are affected basically
9 because of a drop, a very severe and marked drop in
10 utilization that affected two segments of a provider
11 network. The first one was hospitals, and the second one
12 that was very severely impacted by the COVID emergency was
13 dentists. Our dentists basically were facing empty offices
14 because of patients not arriving due to their fears of
15 contagion from COVID-19, and the same effect was seen at
16 hospitals.
17 As a matter of fact, our hospitals have not
18 recovered their prior occupancy, their pre-pandemic
19 occupancy levels, and at the present date, hospitals are
20 still experiencing historically low occupancy rates,
21 hovering around the mid-50s, which, of course, we know is
22 not sustainable in the long run because of the preexisting

1 weakness of their financial statements and the effect that
2 this has had on their operations.
3 An independent study commissioned by the Puerto
4 Rico Hospital Association was instrumental in showing us
5 that hospitals could have experienced a loss of between
6 $700 million and $1 billion arising from the lockdown that
7 Puerto Rico experienced in the first part of 2020 and the
8 decrease, the sustained decrease on average occupancy.
9 So, in this respect and hospitals being -- almost
10 all hospitals being private in the territory because of the
11 health reform that was effected more than almost 30 years
12 ago, it is imperative that we continue providing increased
13 reimbursement under the program for the Medicaid patients.
14 As I said prior, almost 42 percent of all insured
15 population in Puerto Rico belongs to Medicaid, which means
16 that at the hospital level, that same percentage holds in
17 most of our hospitals. The book of business depends on a
18 strong Medicaid showing, and of course, it also depends on
19 strong Medicaid or stronger Medicaid reimbursement, which
20 we don't have yet.
21 So this is an issue that we are going to be
22 bringing before Congress, have them understand that given

1 the fact that most of our hospitals are private
2 organizations, we cannot allow for the sustained weakness
3 in their financials and the potential problems down the
4 road that could even signify the closing of some our
5 hospital institutions.
6 In other elements of the effect of COVID on our
7 operations, we were pretty fast in providing our normative
8 letters that allowed for the coding of initially testing.
9 We also provided for coding and the possibility of
10 reimbursement for monoclonal antibodies from remdesivir,
11 and when the vaccines came along, we provided for the
12 expansion of our vaccination network, allowing the proper
13 codes for pharmacies and other providers to be able to
14 vaccinate and also providing for a fee schedule for the
15 provision of the vaccines that equals the fee schedule
16 that's used in Medicare.
17 We made an estimation of our actuarial situation,
18 and we were satisfied that we could pay the Medicare fee
19 schedule for the vaccination program. Why? Because we
20 wanted to incentivize providers through a Medicare funding
21 scheme for vaccinations instead of going for a lower fee,
22 as is usual when we're dealing with Medicaid versus

1 Medicare.

2 The fiscal cliff is something we're looking at
3 with a lot of trepidation. Of course, we are very
4 confident that because of Puerto Rico's strong position in
5 terms of complying with the oversight and accountability
6 provisions in PL 116-94, we are going to receive a positive
7 reception at Congress when we go over there to fight for
8 reauthorization of the funds.

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

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

21 So what would be the effect of that gap on the
22 operations of Medicaid? Basically, we would have to roll

1 back all the increases we provided to our medical and
2 hospital providers. We would have to roll those back. We
3 would have to disenroll the additional population that was
4 brought in with the increase of the Puerto Rico poverty
5 level, and that would take care of only part of the gap.
6 In addition to rolling back all the
7 sustainability initiatives and the effect that that would
8 have on our providers and the insured population, we would
9 also have to disenroll anything between 350- and 400,000
10 beneficiaries from our Medicaid rolls. That would, of
11 course, be a very severe blow to our health care system.
12 That would reverberate through the entire system, with a
13 drop in utilization, and mainly would affect the hospitals
14 which are still trying to recover from historically low
15 occupancy rates.
16 So we've made it a purpose of ours to go to
17 Congress, and basically, we would like to receive a
18 treatment similar to the states. We would like for us to
19 receive an FMAP at 83 percent and, of course, do away with
20 the Section 1108 cap. The cap is currently -- as you saw
21 in the prior numbers that were shown to the panel, the cap
22 is fixed at around $400 million a year. That is completely

1 insufficient to deal with the expenses associated with the
2 program. At this point, we need at least $3.5 billion a
3 year to run the program, provide adequate coverage for our
4 beneficiaries, and maintain the increases that we did in
5 our insured population and the increases provided to our
6 medical and hospital providers.
7 In addition to this, in our search for parity, we
8 have a few programs that are not being paid at this point,
9 are not being covered at this point by Medicaid, and we are
10 interested in starting to look at the possibility of
11 bringing those into the Commonwealth, beginning with the
12 Part B Medicare coverage for dual eligibles. We do not
13 have a payment of the Medicare Part B for dual eligibles.
14 That is a huge gap in care that affects one of the most
15 vulnerable segments of our population, and we would very
16 much like to be able to achieve enough funding to perform
17 this purchase of Part B Medicare coverage for the dual
18 eligibles.
19 In addition to that, another huge gap that Puerto
20 Rico suffers at this time because of lack of adequate
21 funding is the lack of long-term care coverage under the
22 program. We do not fund long-term care, and as you might

1 understand, that causes a significant gap in the ability of
2 providing a full complement of care to our beneficiaries
3 and even increases the overall expenses to the system since
4 we have people staying in hospitals that don't have to stay
5 in hospitals. They would be in a much better venue, in a
6 much more economically feasible venue of care, with long-
7 term care instead of hospitals, but because of lack of
8 funds, we are unable to fund this.
9 So, basically, in a nutshell, that gives you a
10 high-level idea of the situation of the program in Puerto
11 Rico. I'll be more than happy to entertain your questions
12 or any other comments as the panel proceeds further. Thank
13 you for your attention.
14 MS. BUDERI: Thank you so much.
15 Gary, would you like to go?
16 [No response.]
17 MS. BUDERI: Oh, I think you are on mute, Gary.
18 MR. GALVA RODRIGUEZ: He's on mute.
19 MS. BUDERI: There you go. Oh.
20 MR. SMITH: Yes, I am.
21 MS. BUDERI: There you go.
22 * MR. SMITH: My apology. Again, good afternoon.

1 I'd like to thank MACPAC for providing this opportunity for
2 the Virgin Islands to provide you with an overview of our
3 program, and, Kacey, you did an excellent job in outlining
4 the variances and differences between the programs in the
5 territories and the programs in the states.

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

11 Our program is unique from the states, as we're
12 located -- we're stationed on four different islands,
13 separated by water, covering 133.73 square miles. Our
14 total staff is 33, which is, I have 15 staff at my St.
15 Croix location and 19 staff in my St. Thomas location which
16 also covers the Island of St. John, which is approximately
17 10 miles east of us. St. Croix is approximately 20 miles
18 south of us. So we connect by traveling via ferryboat to
19 St. John, and we can catch the airplane sea shuttle to St.
20 Croix on a small 7-seater or 15-seater airplane from
21 airport to airport to St. Croix.

22 That 33 staff provides services to, as of today,

1 32,401 members. The territory of the Virgin Islands
2 population is approximately is 105,000, which our
3 membership is about 28 percent of our population.
4 Based on research and studies from the University
5 of the Virgin Islands, which is our local university, there
6 is approximately an additional 20,000 persons here in the
7 territory eligible for the program. So if those members
8 were in the program, it would be insuring approximately 50
9 percent of our population just as in Puerto Rico and also
10 CNMI and my sister territories.
11 Our program is 100 percent fee-for-service.
12 There is no managed care. We reimburse our private
13 providers by utilizing the approved Virgin Islands Medicare
14 rates.
15 Our two public hospitals receive per diem
16 payments, which we establish based on cost reports that we
17 collect on an annual basis as well as our two FQHCs,
18 federally qualified health centers. They are on a fee-for-
19 service basis. Then also we have the Department of Health
20 who they have clinics as well that provide direct services.
21 In all of those facilities, presumptive
22 eligibility is available, and that has assisted our

1 membership enrollment but only on average about 6 percent
2 annually.
3 Goals and priorities currently for the Virgin
4 Islands program is -- number one on the list is the Health
5 Information Exchange implementation. We just completed the
6 RFP process this Monday, and we received a total of 10
7 proposals for the Health Information Exchange, and I think
8 about a week from now, which is next week, Thursday, we
9 will begin the review process of those proposals.
10 Also what we're working on is expanding our
11 benefits to the membership as we're moving towards a more
12 community-based-type program, we're implementing a state
13 plan amendment to include personal care attendant services,
14 so we can reach those elderly persons, the blind and also
15 the disabled, and then also those who because of COVID may
16 be having to stay home.
17 We also are going to move to extending the home,
18 community-based services by delving in more to long-term
19 and support services, which will also help us address long-
20 term services, which is very much needed by our elderly
21 population, and then also behavioral health is a big
22 challenge for us, which we're going to be utilizing those

1 services to address that challenge as well.

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

11 With respect to COVID-19, as of today, we have
12 2,704 positive cases, and of the total that has been
13 provided, we provided a total of 48,711 tests so far since
14 the pandemic began. We have 46,007 negative tests. We
15 currently have 113 pending cases. Of the confirmed
16 positive cases, a total of 2,547 persons have recovered.
17 We have 132 active cases and 25 total deaths.

18 Okay. Relative to the vaccinations, our
19 Department of Health in conjunction with our Emergency
20 Management Agency has rolled out a plan. All vaccinations
21 through the Department of Health are free of charge.
22 Physicians are being directed to utilize the program

1 through HRSA, the Health Resources and Services
2 Administration, which is reimbursing our providers for the
3 administration of the medications. So there's no charge
4 for our citizens to obtain the vaccination.

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

18 We received approval from CMS under a disaster
19 state plan amendment to provide telemedicine and telehealth
20 services, and implementing telehealth is another goal and
21 priority that we are working on in conjunction with the
22 governor's office.

1 Safer at home, which is the phase that we're
2 currently under right now, that's the third phase. So
3 right now, nonessential businesses are open. Bars are
4 still closed. If you have a bar only, that's still closed.
5 Hotel reservation systems are closed as well. Restaurants
6 are still at takeout only. Indoor/outdoor recreation
7 facilities are open. No food or drinks. Facial coverings
8 are required. No gatherings greater than 50. Facial
9 coverings are also required and social distancing. All
10 commercial entities require facial coverings. Our schools
11 and daycares are still closed during this phase. Our
12 school children are still attending school virtually, and
13 that has had a tremendous effect on a lot of our children.
14 And I can attest to that personally. I have a
15 grandson who he is not doing well at all. He said,
16 "Grandpa, I want to be able to go to school and see my
17 friends, and this is difficult." His attention span is
18 short. So we're struggling with him, but we're trying to
19 get him back on track and pray to God that will be opening
20 soon so the kids can begin to interact with their friends,
21 families. And I miss it as well. I would have preferred
22 doing this presentation face-to-face with you guys rather

1 than virtually.

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

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

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

17 So issues facing the program including the
18 additional federal financial support needed for the years
19 ahead. Congress had enacted a Consolidated Appropriations
20 Act of 2020 to temporarily avert the fiscal crisis that we
21 faced back in September of 2019, which increased our cap to
22 $126 million for fiscal years 2020 and 2021. So we're

1 going to be facing another fiscal cliff come September 30th
2 of this year. So these amounts were premised on our
3 request for additional 100 percent federal funding for our
4 program for FY 2020 and 2021. That was subsequent to the
5 Bipartisan Budget Act funds expiring in September 30th of
6 2019.
7 So we would like to see a permanent solution to
8 the issue for us and also our brethren and sistren in the
9 other territories where we no longer have to rely on an
10 arbitrary piecemeal fix to our health care system, which
11 promotes uncertainty and also inequities for our citizens,
12 which we are U.S. citizens, and how we are treated.
13 Also, it prevents us, as both Jorge and Helen
14 have mentioned. It's just not available to us. We were
15 not able to plan properly and appropriately as to how we
16 move our programs forward, because from one year to the
17 next, we don't know what's going to happen.
18 So this is the second time in the past couple of
19 years we're going through this, having to decide, well,
20 what services are we going to roll back, how many members
21 are we going to have to take off our rolls because we're
22 not going to be properly funded. So we would like to see a

1 permanent fix and not having to go through this on an
2 every-year or every-two-year basis.
3 So it's even more critical now with the ongoing
4 impacts of the physical and mental health of my citizens,
5 brothers and sisters here on the Virgin Islands as well as
6 the other territories.
7 The results from the impacts of the two
8 hurricanes, which we're still recovering from, now has been
9 exacerbated by the impacts of COVID-19.
10 So, as I had mentioned before, we have attempted
11 to reduce the uncompensated care at our public facilities
12 by implementing presumptive eligibility, which is available
13 at both of our hospitals, the two federally qualified
14 health centers, and also our Department of Health clinics.
15 This helps reduce uncompensated care, but we
16 still need to have the ability to receive disproportionate
17 share hospital payments to help with the truly
18 uncompensated care costs, because undocumented immigrants
19 or non-qualified immigrants do not qualify for presumptive
20 eligibility, thereby that is still a large portion of the
21 uncompensated care to our facilities.
22 As we have opened borders and everyone wants a

1 piece of the American way and life, we have a lot of folks
2 coming in illegally, but we also want to be able to help
3 them when they require health care and medical services.
4 So we believe that a permanent fix needs to be
5 enacted which addresses, at minimum, the following areas
6 for the Virgin Islands and the other territories and
7 citizens to be treated like those in the states and the
8 District of Columbia. One, remove the annual dollar cap on
9 Medicaid funding and allow the funding to be open-ended
10 based upon the needs of our program. Two, eliminate the
11 artificially low Federal Medical Assistance Percentage, the
12 FMAP, for Medicaid and allow our FMAP to be determined per
13 the formula the states have. Three, provide for Medicaid
14 disproportionate share hospital payments; and four, allow
15 the Section 1902(j) waiver which currently applies only to
16 American Samoa and the Northern Mariana Islands to apply to
17 all U.S. territories.
18 And that's the conclusion of my presentation, and
19 I welcome any questions that the Commission has.
20 CHAIR BELLA: Kacey, do you have anything else or
21 should we launch right in?
22 MS. BUDERI: No, I think you can launch right in.

1 CHAIR BELLA: Okay. First, let me say thank you
2 to our panelists. While we would prefer to be sitting
3 across the table from you, that's not always convenient, so
4 I feel fortunate that we have all three of you here with us
5 today, so thank you for taking the time.
6 I want to be respectful of your time. We have a
7 little over 20 minutes with our panelists, and so let's
8 jump right in. Who would like to start with a question or
9 a comment? Kit.
10 COMMISSIONER GORTON: Okay. Wow. Part of me is
11 speechless, and it's not because we don't care but because
12 you guys have laid out this incredible knot that I think
13 most of us would like to help you untie, from a policy
14 perspective. But it's pretty incredible. Special thanks
15 to Helen for getting up in the middle of the night. By my
16 check, it's like four o'clock in the morning there, or
17 maybe not even? So thanks.
18 MS. SABLAN: It's actually seven o'clock in the
19 morning.
20 COMMISSIONER GORTON: Oh, gosh. It's still
21 early.
22 MS. SABLAN: Yeah.

1 COMMISSIONER GORTON: But I guess, so you've laid
2 out all of these pieces, and I think we've heard common
3 themes in terms of eliminate the caps, common themes in
4 terms of you need a planning horizon that's more than a
5 year out, common themes in terms of relatively small
6 populations -- Puerto Rico is bigger in that regard, but
7 the other territories are really quite small, in terms of
8 the populations that they serve and the resources that are
9 available.
10 You didn't talk about limited technical
11 resources, and I can only imagine what an agency with 33
12 people is doing to try and figure out T-MSIS and PERM and
13 COVID and DSH payments, although, be careful what you wish
14 for with DSH payments.
15 So I guess my question is, how do we thoughtfully
16 unpack that? I mean, what is your advice to us in terms of
17 where to dig in first, understanding that it's a complex
18 set of problems that is not going to go away fast. And we
19 did weigh in with the last fiscal cliff, and certainly one
20 option is for us to refresh those arguments and weigh in
21 again.
22 But, you know, from your perspective on the

1 ground there, what are the most pressing things, and how do
2 we triage? How do we organize our thoughts around what's
3 happening there, in a sensible way? I'll stop there.
4 MR. SMITH: So, if I may, Jorge and Helen, I'll
5 go and then you guys can add anything you may. So for us,
6 the top priorities would be not to have these piecemeal
7 fixes, and, you know, provide state-like treatment for us,
8 and not give us two years at this increased amount, giving
9 us two years at the increased FMAP, and have it be a
10 permanent fix. If not a permanent fix, at least give us
11 10- to 15-year span period. I would say that, let's say if
12 the territories were to be funded at the current numbers
13 that were provided to us in PL 116-94, the total for a 10-
14 year period for all territories -- and that would include
15 Puerto Rico -- would not be the budget of, let's say, you
16 know, Massachusetts or -- where is another small
17 jurisdiction? -- possibly North Dakota. These states'
18 Medicaid budgets are $16, you know, $17 billion. And I
19 don't think that if you combine all of the funding for the
20 five territories for a period of 10 years, I don't think,
21 mathematically -- that budget or that cost would be less
22 than 85 or 90 percent of the states across the nation.

1 It provides us with such difficulty to decide and
2 determine how we plan, how we budget. You know, I finished
3 budget proposals for coming up in our territories,
4 switching from annual to biennial budgeting, and I had to
5 provide budgets based on 55/45 match, because I'm not sure
6 what's going to happen for the coming fiscal year and
7 beyond.

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

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

21 In addition to that, of course, we would like to
22 be placed on a formula for FMAP that would take us away

1 from the 55/45 percentage division that is coming down the
2 pike, once 116-94 expires at the end of this Federal fiscal
3 year.

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

18 Second, the instability is having a profoundly
19 deleterious effect on our provider network, and I want to
20 stress this very strongly. We have suffered an exodus of
21 physicians to the Mainland that is probably unprecedented
22 in the other territories. We have lost literally hundreds,

1 if not thousands, of physicians, both specialists and
2 general practitioners. And I already mentioned the
3 situation of our hospitals, which are very weak at this
4 point and cannot tolerate another financial shock like the
5 one we suffered under the pandemic.
6 So in terms of the instability of our health care
7 system, having a longer time horizon, doing away with
8 artificially low caps, and giving our providers the
9 certainty that they are going to be paid at least a
10 reasonable fee for their services -- nobody is going to get
11 rich serving the Medicaid program; we know that -- but we
12 cannot tolerate that the Medicaid program implies an
13 operational loss for our providers, because under those
14 circumstances we won't be able to sustain either our
15 physicians, who are going to leave Puerto Rico for the
16 Mainland, or the hospitals, which will eventually go under.
17 So the longer planning horizon, doing away with
18 the caps, getting a formula for FMAP, and having at least
19 something similar to the access to the funds we need as
20 opposed to an artificial cap, those are themes that
21 resonate in the Virgin Islands, in Puerto Rico, and
22 anywhere else across the territories.

1 CHAIR BELLA: Thank you. Helen, did you want to
2 add anything?
3 MS. SABLAN: Yes. Actually, I agree with Gary
4 and also with Jorge. We actually, in the ancillary area,
5 there is a parity act, H.R. 6495, and this bill would
6 eliminate Medicaid funding limitations for the territories.
7 However, we still need to address the FMAP, because it is
8 not included in there.
9 So no matter how many deals, or no matter how
10 costly or prolonged their treatment, that cap will always
11 limit care in the territories, and this is coming from
12 Congressman Sablan. We have to send our patients off-
13 island because we have limited resources available here on-
14 island. So some of our patients are actually in L.A.,
15 being treated, from cancer to cardiac, and then our
16 children, also in San Diego, they are still there, and it's
17 really costing us a lot of money. But we really need to
18 address our cap and increase our FMAP, from the 55 percent,
19 because we can't afford it. That's all I have.
20 CHAIR BELLA: Thank you very much.
21 MR. SMITH: I'm sorry. If I may, I just wanted
22 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 CHAIR BELLA: Thank you. Kit and Darin, is it on
11 this point or something else? If it's something else I'm
12 going to put you later in line. If it's this point, go
13 ahead.
14 COMMISSIONER GORDON: It's on --
15 COMMISSIONER GORTON: I just want to follow up on
16 what Gary said, real quick. Gary, what rates do you get?
17 Do you get the in-state Medicaid rates or do you have to
18 negotiate case-by-case rates?
19 MR. SMITH: I have to negotiate case-by-case.
20 Most of the facilities will not accept their state Medicaid
21 rates. I have been working with the Florida program to try
22 and work something out. Beth Kidder, who is the Medicaid

1 director there, she and I have plans to have continued
2 conversations and see if we can work something out through
3 their hospital association. But usually they'll accept the
4 Medicare rate there. It's just one hospital, though.
5 They're just egregious and they will not accept the
6 Medicare rate, so they really hit us hard, and I won't call
7 any names but, yeah, so we have to negotiate case-by-case.
8 MS. SABLAN: It's the same situation for CNMI, so
9 we have to negotiate with them in order for them to take
10 our patients.
11 CHAIR BELLA: Okay. Darin, is it on this?
12 COMMISSIONER GORDON: Yeah, that was what I was
13 trying to understand how that compared to the rates they
14 had at home. And so he explained it's significantly
15 higher. Thank you.
16 CHAIR BELLA: Okay. Thank you. Chuck, and then
17 Toby, and then Sheldon, and then Kisha, and we've got a
18 little less than 10 minutes.
19 VICE CHAIR MILLIGAN: So, thank you all very much
20 for joining us and sharing information, and Kacey, thank
21 you for teeing it up so well. I do want to commend to
22 everybody in the public, and others who read the

1 transcript, to track down those fact sheets that Kacey
2 linked in the deck, because they are very helpful.
3 I have a question, just one question, but I was
4 hoping the three of you would be comfortable answering, and
5 it's a little bit of a hard question. In the past, when
6 the issue has come up about eliminating the cap or using a
7 more traditional FMAP that the States have, part of the
8 tradeoff that people discuss is then whether the
9 territories would also then feel willing to accept the
10 other requirements that the States have. And so, for
11 example -- and this is in the fact sheet Kacey linked to --
12 Puerto Rico and the U.S. Virgin Islands are not obliged to
13 use eligibility standards that the states you. You all
14 can set your local standards, and you're not tied to FPL
15 and those sorts of things.
16 On the benefit side, for CNMI, the 1902(j) waiver
17 means you're not required to offer mandatory benefits that
18 the states are required to offer -- and I'm just
19 referencing a couple of things on the fact that, that even
20 though the U.S. Virgin Islands and Puerto Rico don't have
21 that waiver and are theoretically required to offer the
22 mandatory benefits, Puerto Rico apparently doesn't offer

1 transportation benefits, and Puerto Rico apparently also
2 doesn't offer coverage for nursing facilities. And, Jorge,
3 correct me if those are wrong, but I'm referencing what was
4 in the fact sheet. And for the Virgin Islands, there isn't
5 coverage for free-standing birth centers or rural health
6 care clinics.
7 So the broader question, not to get into the
8 specifics of those benefits, the broader question is, would
9 you be willing to adhere to the other mandates that states
10 have about eligibility and benefits in exchange for being
11 subject to the FMAP provisions and the lack of a ceiling on
12 overall allotments, because I think it's going to be
13 difficult to advocate for one without the other. So that's
14 the question.
15 MR. GALVA RODRIGUEZ: I'll go first. We have
16 been discussing this issue, and the answer, from the
17 Commonwealth of Puerto Rico, is yes, we want to provide
18 those mandated services. We know we are not providing
19 those at this point. So it would be a very acceptable
20 tradeoff to get those caps eliminated or substantially
21 revised, get the FMAP either placed on a formula similar to
22 the States or have it raised permanently. And we think it

1 would be a reasonable tradeoff in terms of the provision of
2 these services for our population in exchange for those
3 additional funds. I would gladly go down that road.
4 MR. SMITH: So for us, in the Virgin Islands, we
5 would, as well, but, you know, I would say we are well on
6 our way, because back in 2015, we implemented a new
7 eligibility and enrollment system, and the rules are MAGI-
8 related. That's the rules and policies, how the system was
9 set up. It's also we hope to integrate the system. That's
10 what the system, the Medicaid program, uses now. We hope
11 to integrate our SNAP TANF, child care programs for that
12 eligibility enrollment citizen, where it can be one-stop
13 shopping for our members. You know, the only have to see
14 one eligibility and enrollment case worker.
15 And then regarding the rural health clinics, I
16 mean, we are a rural jurisdiction, and, you know, as far as
17 I know there aren't many services that we don't cover at
18 our Department of Health clinics or the FQHCs, and we do
19 not have any freestanding birthing centers. But, you know,
20 we would be willing to do that. St. Thomas is only 32
21 square miles. St. Croix is 84, and St. John is, I believe
22 26 or 28. So, you know, it's very small jurisdictions that

1 we have, and it doesn't take much time to get from one end
2 of the island to the next. But, you know, we're open to
3 that discussion and would do anything that the Federal
4 Government will require us to do.
5 So we have our T-MSIS stood up. We have a
6 certified MMIS system. We have an established MFCU
7 operating out of the Department of Justice. We just
8 received approval to hire program integrity staff, with a
9 program integrity director, quality control, and also fraud
10 investigators will be hired. So I think we're on a good
11 path, but, you know, whatever it takes for us to be able to
12 have those stipulations removed, we're in.
13 CHAIR BELLA: Helen, did you want to --
14 MS. SABLAN: Yeah. With CNMI we are also willing
15 to do that, you know, as a tradeoff, but the only problem
16 that we have here is the limited resources, the provider
17 resources, on the island. But then when they are referred
18 off-island, we will definitely cover it then.
19 We also are in the process of complying with the
20 requirements, the Federal requirements under the
21 Consolidated Appropriations Act. We are in the process of
22 having the eligibility and enrollment as well.

1 CHAIR BELLA: Okay. Thank you. Do the three of
2 you have a few more minutes? We have two questions left.
3 MR. SMITH: Sure.
4 CHAIR BELLA: We will try to be quick. So Toby
5 withdrew his question because of time, so that leaves
6 Sheldon and Kisha. Sheldon?
7 COMMISSIONER RETCHIN: Yeah, thanks. I will
8 address this actually to Director Galva, and I jumped off
9 so I may have missed some of your presentation regarding
10 the brain drain, the physician brain drain that the island
11 is experiencing, which I am well aware of, dramatic, and in
12 part because there's no stability in payment and the
13 variables.
14 But maybe this is also for Kacey. You know, when
15 I look on the website, the AAMC published state workforce
16 data, and particularly around physicians. But if I look at
17 Puerto Rico it says even after the brain drain, recently as
18 the data of 2018, it says there are 250 physicians per
19 100,000 population. And then when I compare it to
20 Virginia, in Virginia there are only 230 physicians per
21 100,000 population.
22 So there must be a mistake. I don't really

1 understand how Puerto Rico could have that kind of brain
2 drain and still have a higher density of physicians than
3 Virginia. Maybe that should be corrected, because I know a
4 lot of policymakers look at that website for state
5 workforce data. Do you have an explanation, or can you
6 figure out why that is?
7 MR. GALVA RODRIGUEZ: Yes. The intensity of care
8 in Puerto Rico is higher than the one that we typically
9 find in the States, because we have a much sicker
10 population. The incidence and prevalence of chronic
11 diseases in Puerto Rico is quite higher than in most
12 jurisdictions in the United States. For example, diabetes
13 tops basically any other jurisdiction in the States. We
14 also have a prevalence of chronic pulmonary disease and
15 also chronic heart conditions.
16 So this demands an amount of care that is unlike
17 what you find in jurisdictions where the population is
18 healthier and they don't have such a dire need of medical
19 and hospital attention. So that explains why, even though
20 the numbers seem, on the surface, to suggest that we don't
21 have a problem with our physician brain drain, the fact of
22 the matter is we are experiencing shortages of physicians,

1 especially on the specialist side.

2 COMMISSIONER RETCHIN: Thanks.

3 CHAIR BELLA: Kisha?

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

16 I think now I'll just end with a comment. As Kit
17 mentioned, you've really kind of presented us with this
18 knot, and what strikes me and stands out to me is that you
19 are all American citizens, and it bothers me the disparity
20 that we see in the health care of our fellow American
21 citizens, and recognizing that while you are not states,
22 you are representing American citizens, and we want them to

1 have access to high-level health care. And so we just
2 appreciate Kacey and the Commission for the opportunity and
3 for you all meeting with us to continue to just dig in a
4 little bit further into this, and hope that we continue to
5 follow it.
6 CHAIR BELLA: Kisha, those were excellent closing
7 remarks. Kacey, though, any last words to wrap up this
8 panel, before we thank them?
9 MS. BUDERI: No. I just want to say thank you to
10 all of our panelists for coming.
11 CHAIR BELLA: Yeah, I want to echo that. I can't
12 tell you what is the value of hearing from you directly.
13 And so this is an area of interest to us that we will
14 continue to work on, and don't be strangers to us and to
15 Kacey, as I'm sure you won't be. But thank you again for
16 taking time out of your day to spend with us.
17 MR. GALVA RODRIGUEZ: Thank you very much for the
18 opportunity.
19 CHAIR BELLA: Thank you.
20 MS. SABLAN: Thank you. thank you, too.
21 MR. SMITH: Good evening, everyone.
22 **### FURTHER DISCUSSION BY COMMISSION**

1 * CHAIR BELLA: Kacey, thank you for putting that
2 panel together. We have the remainder of our time for
3 additional conversations and discussion form the Commission
4 about what we heard.
5 Toby, would you like to start?
6 COMMISSIONER DOUGLAS: Yeah. First I just want
7 to echo --
8 CHAIR BELLA: You are very fuzzy.
9 COMMISSIONER DOUGLAS: Can you hear me better
10 now?
11 CHAIR BELLA: Does everybody else think it's
12 fuzzy?
13 COMMISSIONER DOUGLAS: Is it any better?
14 CHAIR BELLA: Okay. While Toby figures that out,
15 other comments? Darin?
16 COMMISSIONER GORDON: Yeah. I appreciate Kisha's
17 closing remarks. I really appreciate this. Obviously, the
18 size of this cliff is not inconsequential. I do think some
19 of the points that Chuck brought up about some of the
20 requirements that aren't currently imposed upon the islands
21 would likely be part of a conversation if you look at
22 changing how you reimburse islands.

1 But one of the things that I think was a constant
2 theme that kept coming up was also how expensive it was to
3 receive services on the Mainland, and how rates were
4 incredibly more expensive than what they were paying back
5 in their respective islands. And I think it would be worth
6 having a conversation about getting more information and
7 data on that. I know we did hear kind of the general scale
8 of how much services are provided, like for the Virgin
9 Islands, back in the States, but it would be good to get a
10 better sense of that, because I think that would be one
11 area -- again, this is such a big, broader issues, but it
12 is one area that I do think is worth exploring more and
13 getting more data on, because that rate disparity is only
14 taking those limited funds and extinguishing them at a much
15 more rapid pace. So this is something that just stood out
16 to me.
17 CHAIR BELLA: Thank you, Darin. Chuck?
18 VICE CHAIR MILLIGAN: I want to echo Darin's
19 comment, and I was struck by that as well.
20 I'm not proposing that we get to this kind of
21 recommendation any time soon, but there is a step Congress
22 could take, which is requiring any provider that

1 participates in Medicaid, in its own state, to accept that
2 state's Medicaid rates in providing services to the
3 territories as a way of putting a ceiling on potential
4 extortionary behavior.
5 And, you know, we've seen examples of this in the
6 past around managed care services that cross jurisdictions,
7 and I just do think that separate from the allotment,
8 separate from the FMAP issue, separate from the cliff, some
9 of these other pieces, there is another step that Congress
10 could take, which is linking the rates charges to the
11 territories to the rates the providers are willing to
12 accept from their local Medicaid jurisdictions.
13 CHAIR BELLA: Thank you, Chuck. Fred?
14 COMMISSIONER CERISE: Yeah. It feels like I'm
15 missing something, and I know there's got to be a bigger
16 story here, because the problem is just -- it seems like
17 it's just too obvious. And so I'm asking myself, what else
18 was going on here, because, you know, you're getting these
19 year-to-year fixes, so there's some acknowledgement that
20 there's a real issue. There's no way you can plan a
21 program with these year-to-year fixes. We're like a half a
22 safety net program, because you've got Medicaid, but you've

1 only got it up to this level.

2 And it just feels like we're missing something,
3 and maybe there's a bigger issue around statehood and why
4 we're withholding this program, because, you know, you
5 can't run half a safety net program, and that's what we're
6 doing here. If you're going to do Medicaid you can't have
7 a cap, you've got to have reasonable match rates, and they
8 have got to have the ability to play year to year.

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

18 CHAIR BELLA: Martha?

19 COMMISSIONER CARTER: At the risk of opening a
20 can of worms, I believe I heard one of the speakers say
21 that they don't get DSH payments. And I don't know. None
22 of them, get DSH payments, or some of them get DSH

1 payments? But that's got to also -- go ahead, Kacey.
2 MS. BUDERI: That's correct that none of them get
3 DSH allotments.
4 COMMISSIONER CARTER: So that feeds into the
5 instability of their safety net program. I mean, I don't
6 know. I guess we might need to explore that more, but it
7 seems like that's part of the picture that we would need to
8 understand.
9 CHAIR BELLA: Kacey or Anne, do you have any
10 comment -- thank you, Martha -- on what Fred was saying,
11 which is how we got where we are? I know we've gone over
12 it before, but anything else you want to say to the
13 overarching comment about --
14 EXECUTIVE DIRECTOR SCHWARTZ: So the one thing I
15 would say is that the 1108 amounts for each territory are
16 not based on some notion of what it takes to run a program,
17 that is, they're not necessarily scaled to what those
18 territories are doing from a functional perspective. So I
19 think trying to find a rationale for these amounts is
20 probably not going to be a fruitful endeavor. The issue is
21 more how do you get from the statutory amounts to whatever
22 you think is a path to the future -- whether they need to

1 look exactly like states or something else-- would be more
2 helpful. And we tried to do that a little bit with the
3 work that Kacey did for our Puerto Rico chapter, in which
4 we scaled the Puerto Rico program against the states, even
5 taking out the LTSS.
6 From a budget perspective, Congress has to think
7 about where we are now in terms of those caps. But I think
8 from a policy perspective, and thinking about what those
9 programs should be, those amounts doesn't represent some
10 objective level of what it takes to run a Medicaid program.
11 CHAIR BELLA: Kacey, I'm sorry. Did you want to
12 make a comment? And then I have just an overarching
13 comment.
14 MS. BUDERI: No. I was just going to say what
15 Anne said about how we don't know why the caps were set
16 where they were set back in the '70s or the '60s, when the
17 territories joined the program.
18 CHAIR BELLA: You don't know congressional intent
19 back then?
20 [Laughter.]
21 CHAIR BELLA: No, just so my head is straight on
22 what we think would be coming, we expect that Congress may

1 ask us to weigh in on what happens as the cliff is
2 approaching. Is that correct? And so we will have this
3 discussion again. So is there anything else? I think,
4 Kacey, you've heard sort of the sentiment and the concerns
5 and some of the questions. Is there anything else
6 Commissioners want to ask Kacey to keep in mind in
7 preparation for a discussion as we get closer to the cliff?
8 Kit, then Chuck. Kit, you're on mute.
9 COMMISSIONER GORTON: So sorry about that. I
10 think we should have as much granularity as we can
11 reasonably get along the lines of what the administrative
12 resources the territories have to deal with. I mean, I
13 think we have some level of insight into Puerto Rico and
14 the FOMB and what goes on there, but the other four, they
15 are running tiny programs. They have huge numbers of
16 administrative demands that they are trying to live up to
17 all of the other requirements of the program. They have
18 limited staff. I mean, our theme for the year is that
19 states lack resources, dot, dot, dot, right? If the states
20 lack the administrative resources to run their programs,
21 what on earth, you know, do these people have?
22 And I'm not suggesting that we make a normative

1 statement there, but will we be able to say this is an
2 agency of 33 people, and here's where they get their extra
3 teeth from, Zoom calls to the Mainland, and be able to talk
4 about -- and do they have constraints, right? Do they have
5 local constraints? Do they have to use their cap money to
6 pay for their staff? I'm still a little hazy on that. Can
7 they even get staff? Are they seeing the same kind of
8 brain drain in Puerto Rico for technical staff as they are
9 seeing for other kind of staff?

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

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

22 VICE CHAIR MILLIGAN: I will withdraw it,

1 Melanie. It's covered.

2 CHAIR BELLA: No, no, no.

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

4 fine.

5 CHAIR BELLA: Look, I was joking. Make your

6 comment, please.

7 VICE CHAIR MILLIGAN: The question that I posed,

8 I think it would be helpful to have awareness of where Guam

9 and American Samoa around that question, because to me, if

10 MACPAC is asked to make some recommendations, it would be

11 helpful to know whether there was a similar willingness to

12 accept kind of a broader set of state-like treatment in

13 exchange for state-like financing.

14 CHAIR BELLA: That's a good comment. Anybody

15 else? Kacey, do you have what you need?

16 MS. BUDERI: Yeah. This has been really helpful.

17 I think I'm all set.

18 CHAIR BELLA: Well, thank you for getting ahead

19 of the game and getting this panel together and having it

20 present today so that we might be prepared if and when we

21 get asked.

22 Okay. We have wrapped up the day. Does anybody

1 have any final comments or questions? Or, Anne, do you
2 have any final words?
3 [No response.]
4 CHAIR BELLA: I'm taking that as a no. Okay. As
5 always, thanks, everybody, for staying engaged over, what
6 are we using, not Zoom, GoToWebinar.
7 Our next meeting is April 8th and 9th, and at
8 that meeting we will be going through recommendations and
9 taking votes for the June report. And so for the public,
10 thank you for attending. Look for our March report to come
11 out, what, the 15th, Anne? March 15th?
12 And I want to say thank you to Anne and the
13 MACPAC staff and to Jim and all the folks that keep us up
14 and running with the technology.
15 CHAIR BELLA: And then I actually would be remiss
16 -- sorry, false ending -- just to see if there's anyone in
17 the public who wants to make any comments on this last
18 session.
19 **### PUBLIC COMMENT**
20 * MS. HUGHES: No hands.
21 CHAIR BELLA: No hands. Then, for real this
22 time, thank you, everybody, for staying engaged. I really

1 appreciate your participation, and our meeting is
2 adjourned.
3 * [Whereupon, at 4:48 p.m., the Commission was
4 adjourned.]
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