PUBLIC MEETING

Reserve Officers Association
Top of the Hill Banquet and Conference Center
One Constitution Avenue NE
Washington, DC 20002

and

Via Zoom

Thursday, September 15, 2022
10:00 a.m.

COMMISSIONERS PRESENT:

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FREDERICK CERISE, MD, MPH
ROBERT DUNCAN, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
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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 [10:00 a.m.]

3 CHAIR BELLA: Good morning. Welcome to the
4 September session of MACPAC. Is everything good for us to
5 get going? Okay. Perfect.

6 We have most of the Commissioners in the room.
7 Welcome to the new Commissioners as we kick off this cycle.
8 And we have a couple of Commissioners joining remotely, and
9 of course our public is joining remotely. So we will do
10 our best to accommodate comment from everyone. And I'm
11 going to turn the first session over to Kisha.

12 VICE CHAIR DAVIS: Hi. Good morning, everybody.
13 We are excited to have this session, talking about
14 ethnicity data, and we will turn it over to Linn and Jerry
15 to get us started.

16 **### BACKGROUND ON MEDICAID RACE AND ETHNICITY DATA**
17 **COLLECTION AND REPORTING**

18 * MX. JENNINGS: Thank you, and I think if we could
19 go back to the slide show right before this one.

20 CHAIR BELLA: We're one session ahead of you,
21 trying to keep you on your toes.

22 Do you guys want to get started and then the

1 slides can catch up, and we can go back to the first
2 session slides, please.
3 MX. JENNINGS: Great. All right. I'll get
4 started then. Good morning, Commissioners.
5 The Commission is committed to prioritizing
6 health equity across all of its work, and in MACPAC's June
7 of 2022 report to Congress the Commission described state
8 Medicaid approaches for promoting equity and addressing
9 racial disparities, including improvements to federal and
10 state Medicaid administrative race and ethnicity data.
11 During this cycle we will examine opportunities
12 to improve the completeness and quality of T-MSIS race and
13 ethnicity data so that they can be used to measure racial
14 and ethnic health disparities. And today Jerry and I will
15 present background on Medicaid race and ethnicity data
16 collection and reporting, to set the stage for future
17 presentation.
18 Should I wait for the slides?
19 CHAIR BELLA: Let's just keep going.
20 MX. JENNINGS: Okay. So I'll start today by
21 explaining the importance of high quality in standardized
22 race and ethnicity, and then I'll describe the existing

1 federal standards and guidance for collecting race and
2 ethnicity data and then how these standards have been
3 implemented by state Medicaid programs. And then Jerry
4 will present the reporting requirements for administrative
5 data and results from MACPAC's earlier assessment of the
6 quality of T-MSIS data, and he'll also summarize some of
7 the challenges with reporting and collecting these data.
8 So advancing racial health equity is also an
9 administration-wide priority, and this is highlighted both
10 in the 2021 Executive order, Advancing Racial Health Equity
11 and Support for Underserved Communities Through the Federal
12 Government, and CMS's Framework for Health Equity. Both
13 recognize the importance of prioritizing standardized,
14 complete, high-quality data to measure and assess racial
15 and ethnic health disparities.
16 And there are some concerns with the data quality
17 including inconsistent collection of race and ethnicity
18 data across federal and state-level data sources, high
19 rates of missing data, and small sample sizes for some
20 racial and ethnic groups. So these issues can lead to
21 biased and inaccurate data and an incomplete understanding
22 of racial and ethnic health disparities.

1 OMB established the federal minimum standards for
2 collecting race and ethnicity data in federally sponsored
3 activities. They first established these standards in 1977
4 to promote uniformity and comparability across race and
5 ethnicity data across data sources. So these standards
6 included four race categories and two ethnicity categories.
7 And then in response to criticism that these categories
8 didn't reflect the racial and ethnic diversity in the U.S.,
9 OMB and the OMB-established interagency committee completed
10 a comprehensive review of these standards, and then in
11 1997, OMB published a new rule updating the minimum federal
12 standards to include five categories and two ethnicity
13 categories, which are listed on this slide.
14 And these standards apply to federally sponsored
15 data collection where race and ethnicity information is
16 collected. It does not require the collection or reporting
17 of this information. It also applies to CMS as a federal
18 agency but doesn't directly apply to state Medicaid
19 programs. And although revisions have been considered
20 since 1997, these standards haven't been revised.
21 HHS has also established requirements and
22 guidelines for collecting and reporting these data in HHS-

1 sponsored data collection. First, following the 1997 OMB
2 revisions to these standards, HHS also issued a policy
3 statement reiterating these OMB standards and outlined
4 which HHS-sponsored data collection efforts are required to
5 collect and report these data.
6 And although this policy applies to HHS-sponsored
7 data collection and administrative records, it doesn't
8 specifically specify whether they would apply to state
9 Medicaid programs, and CMS did not enforce these data
10 collection or reporting requirements on states.
11 And then later, Section 4302 of the ACA charged
12 the Secretary of HHS to establish uniform data collection
13 standards for race and ethnicity, sex, primary language,
14 and disability status, and it also extended these data
15 collection standards to state Medicaid and CHIP programs.
16 In 2011, published their guidance for collecting
17 race and ethnicity data, which included more granular
18 categories that can be aggregated up to the OMB standards.
19 If you refer to your materials in the appendix you can see
20 which of those categories align with the OMB and aggregate
21 up to it.
22 Moreover, this implementation guidance only

1 applies to HHS-sponsored and conducted national population
2 health surveys so it doesn't address other forms of
3 federally conducted data collection, including it doesn't
4 specify whether these standards or other standards would
5 apply to state Medicaid programs.
6 So although there are standards and guidance for
7 collecting these data, we have heard in our interviews with
8 HHS, CMS, states, and other experts that there are
9 inconsistent interpretations of how these standards apply
10 to state Medicaid programs.
11 However, we've also heard from our interviews in
12 states, that despite this inconsistent interpretation, it
13 may not actually be a barrier to collecting or reporting
14 the data. So in the next slides we'll discuss how states
15 have implemented these standards across the collection and
16 reporting of race and ethnicity data.
17 State Medicaid programs have the flexibility to
18 determine if and how they collect race and ethnicity
19 information, and if they include it on their applications
20 these questions have to be included as optional questions
21 as they aren't a requirement of Medicaid eligibility. And
22 although states aren't required to collect this

1 information, in a 2021 review by the State Health Access
2 Data Assistance Center, or SHADAC, they found that all
3 states are actually collecting race and ethnicity data that
4 aligned with the OMB standards, at minimum, and some states
5 have opted to include additional categories that align with
6 the HHS guidance, and some have included additional
7 categories such as the Middle Eastern and North African or
8 MENA categories.
9 And I'm going to hand it over to Jerry.
10 * MR. MI: Thanks Linn. As a federal agency, CMS
11 is required to report race and ethnicity data that, at
12 minimum, align with the 1997 OMB standards. States are
13 required to report enrollee demographic characteristics,
14 including race and ethnicity, the Transformed Medicaid
15 Statistical Information System, or T-MSIS, whenever
16 possible. To enable its own reporting, CMS requires states
17 to report race and ethnicity data in a way that can be
18 aggregated to the OMB standards.
19 We conducted data quality assessments for each
20 state's race and ethnicity data using CMS's methodology, as
21 outlined in their Data Quality Atlas. There were two
22 primary criteria for this assessment. The percentage of

1 records with missing race and ethnicity values and the
2 number of combined race and ethnicity categories, where the
3 2019 T-MSIS data differed from the 2019 American Community
4 Survey values by more than 10 percent.
5 We combined these two criteria to determine the
6 usability of each state's race and ethnicity data,
7 characterizing the data as low concern, medium concern,
8 high concern, or unusable. Our assessment determined that
9 in fiscal year 2019, 30 states met the minimum data quality
10 standards of low or medium concern for conducting analyses
11 with race and ethnicity data.
12 Because states have the flexibility to determine
13 how to collect race and ethnicity data, each state has
14 their own approach designed to meet their own objectives.
15 As a result, in SHADAC's 2021 review of state applications,
16 they documented 62 variations, both in race and ethnicity
17 categories included on state online and paper applications
18 and in how these questions are asked. The variation can
19 make it difficult to compare the racial and ethnic
20 categories across states.
21 Self-reporting of race and ethnicity data is the
22 preferred method of collecting such information.

1 Therefore, beneficiary reluctance to provide this
2 information for racial and ethnic categories that do not
3 sufficiently capture an individual's identity can lead to
4 missing data.
5 States may experience challenges in reporting and
6 submitting race and ethnicity data when translating the
7 data from their enrollment systems into the required CMS
8 format for T-MSIS. For example, states may find it
9 difficult to map the race and ethnicity categories captured
10 on their applications to the required fields in T-MSIS.
11 In October, we will present findings from
12 interviews with relevant stakeholders such as HHS, CMS,
13 states, managed care plans, application assistors, and
14 research experts. We will also discuss federal and state
15 data collection and reporting priorities, state processes,
16 and approaches to addressing the challenges associated with
17 collecting and reporting high-quality data. Future
18 meetings will also focus on possible policy options.
19 Thank you.
20 VICE CHAIR DAVIS: Thank you, Linn and Jerry.
21 Definitely very important information, and just kind of for
22 the Commissioners this is informational for us, confirming

1 that we want to continue on this path in terms of bettering
2 the collection of race and ethnicity data. I think we have
3 said before, as a Commission, how important is open source
4 to have some more consistency across the board in that
5 collection to make it easier to compare across state lines
6 and across different programs.
7 There are other questions or comments from
8 Commissioners to help guide the work? Yes, Darin.
9 COMMISSIONER GORDON: As part of our additional
10 work in this area, to the extent we could identify those
11 states that do appear to have better data collection
12 efforts, it would be great to tease out, you know, what
13 they're doing differently, so those lessons learned that
14 can be extrapolated and carried over to other states. That
15 would be helpful.
16 VICE CHAIR DAVIS: We'll go to Heidi and then
17 Sonja.
18 COMMISSIONER ALLEN: Thank you, Linn and Jerry.
19 This is really useful. I'm trying to get a sense of
20 chicken or egg, whether it's missing-ness, people not
21 filling it out, or whether it's this other issue that you
22 brought up, which is the aggregation to the 2011 required

1 OMB standards, and each one would require such different
2 interventions. Do you have a sense of what the
3 proportionality is between these two places where we are
4 losing good data?
5 And second of all, I hear that there is a
6 requirement that it be able to be aggregated into these
7 2011 categories, but were states provided a standardized
8 crosswalk for doing so?
9 MX. JENNINGS: I can respond to the first part
10 and then Jerry can speak to the T-MSIS side. Regarding
11 missing this versus the categories, I think we'll be
12 talking more about this in October. But preliminarily,
13 really hearing that there are issues on both sides, and
14 those are two challenges that we'll be looking to different
15 approaches that we can be addressing this. But on the
16 missing side that's certainly an issue for many states.
17 And then states are having issues with processing those
18 data and moving them from their eligibility systems to CMS,
19 there might be additional challenges there, and various
20 approaches have come up in our interviews about how to
21 address that. So we'll be bringing more results in October
22 on that.

1 MR. MI: I want to echo that statement. We are
2 still collecting data through the interview process, but to
3 sort of give you a glimpse into the HHS guidance and
4 whether there is a standardized mapping for the race and
5 ethnicity categories, we've heard from some states that if
6 they do communicate with CMS that there is a mapping that
7 they do use. But as we are still collecting this
8 information we don't know if all the states are using it.
9 COMMISSIONER ALLEN: May I ask a follow-up
10 question? So is the issue -- because missing data is
11 empirical. You could observe it. But is the issue that we
12 can't observe it because we don't have access to state-
13 specific data, all we can see is what they have already
14 given us for T-MSIS and therefore we can't tease out what
15 really is missing-ness versus the crosswalk issue?
16 MR. MI: States are required to submit their data
17 from the enrollment systems to T-MSIS whenever they can. I
18 think when it comes to missing-ness, not all states
19 actually submit data that's granular to the 2011 HHS
20 guidance. And so whatever states receive in their
21 enrollment system is put onto the T-MSIS raw data, which is
22 what we use, if that answers your question.

1 COMMISSIONER ALLEN: So you can see when there's
2 missing-ness then?
3 MR. MI: Right.
4 COMMISSIONER ALLEN: Okay. Thank you. I think
5 it would just be helpful to have a sense of the variation
6 of missing-ness across states because I think that would
7 speak to really focusing on guidance for helping states
8 communicate to the beneficiaries why we collect race and
9 ethnicity data and what it's used for versus that it's some
10 kind of system error when we are trying to take different
11 racial categories and put them into this federal standard,
12 which seems like having a formalized, standardized
13 crosswalk that every single state uses could be very
14 helpful to states.
15 MR. MI: Gotcha.
16 COMMISSIONER ALLEN: So thank you.
17 MR. MI: Yes. I also do want to add that we did
18 put out an issue brief on the availability of race and
19 ethnicity data that includes a state-by-state glimpse of
20 the T-MSIS data and the degree of missing-ness and unknown
21 for each state.
22 COMMISSIONER ALLEN: Great. Thank you.

1 MR. MI: And that is with the fiscal year 2019 T-
2 MSIS data. We are currently working on updating that
3 brief, which will come out within the next year, with
4 fiscal year 2020 T-MSIS data.
5 VICE CHAIR DAVIS: Thank you. Sonja and then Bob
6 and then Dennis.
7 COMMISSIONER BJORK: Thank you. I'm curious
8 about the other sources of the race and ethnicity data.
9 For example, a beneficiary may feel comfortable letting
10 their primary care provider know the information, or their
11 health plan might collect it when they did an immunization
12 campaign, and how that can be captured, but also the issues
13 of the hierarchy of data, the governance, who has the final
14 determination if that's the real data and how that can be
15 handled.
16 MX. JENNINGS: This is something we've been
17 asking in our interviews and trying to learn a little bit
18 more about the data sources. In general, what we've been
19 hearing is that the data that go into T-MSIS are only
20 coming from the application, so the enrollment file. But
21 there are states that are looking into other possibilities
22 and kind of thinking about this hierarchy or true source of

1 the data. But at this point it seems like all the states
2 are really just using the data that they collected on the
3 application.
4 COMMISSIONER BJORK: I was wondering, are there
5 any best practices in that regard, that we could maybe make
6 a recommendation on if there's a known way that that is
7 actually usable or helpful without getting in the way or
8 ruining the information that goes in through the
9 eligibility worker. There are ways that other demographic
10 data gets uploaded and updated that's not through the
11 eligibility worker. Health plans can update counties, and
12 then they, in turn, update the eligibility file. So
13 perhaps a similar process could be in place for race and
14 ethnicity data.
15 VICE CHAIR DAVIS: Thank you, Sonja. Bob?
16 COMMISSIONER DUNCAN: Thank you, Jerry and Linn,
17 for the presentation information. A couple of questions
18 here. One, is MACPAC able to break down the existing data
19 by age, so we can look at from an age category? And the
20 other is with the recent release from CMS on the health
21 equity RFI, do we have the opportunity to weigh in on
22 comments about the data needs that will enable us to make

1 better decisions?

2 MR. MI: I can answer the first question. I

3 believe we are able to break it down by age, but no

4 promises here. But I'll get back to you on that, for sure.

5 MX. JENNINGS: And regarding the RFI, we can get

6 back to you on that and take a look at that.

7 VICE CHAIR DAVIS: Thank you. Dennis?

8 COMMISSIONER HEAPHY: Thanks. Would it be

9 possible for you to use eligibility data to understand the

10 intersection of race and disability status, because that

11 would be really helpful, at a minimum, when any states use

12 the HHS questions, which is really what states should be

13 doing. But having that crosswalk would be very helpful to

14 see what's happening with folks with disabilities, by race.

15 MX. JENNINGS: Yeah. This isn't something that

16 we are specifically working on with this project but it is

17 something that staff are looking into, in other work right

18 now.

19 COMMISSIONER HEAPHY: I just raise it because we

20 know there are such disparities, in general, but then for

21 folks with disabilities -- African American, Latino,

22 depending on what the category is -- when the issue is high

1 disparities, by only looking at folks who are well and
2 looking from a prevention perspective and folks who don't
3 have disabilities, then we are really leaving out, in the
4 cold, folks who are living with disability now. That is
5 why I think it's really an important issue, and if there is
6 a way to do that within this, that would be great. But if
7 it's going to come, then it would also be helpful to know
8 when and how.
9 VICE CHAIR DAVIS: Thank you, Dennis, for
10 bringing that up. I think it is something that we want to
11 make sure that we are keeping in mind, especially when we
12 are thinking about disabilities and how certain groups
13 might be hidden and more severely impacted. So as much as
14 we are bringing that through in the research.
15 Jennifer.
16 COMMISSIONER GERSTORFF: Just a question, if I
17 could. Is there a single race field on the T-MSIS data or
18 are there multiple fields?
19 MR. MI: To answer that question, so basically
20 there is a race field, there is an ethnicity field, which
21 are then combined to create condensed and expanded race and
22 ethnicity fields. So technically, if you are talking about

1 race alone there is only one field.

2 COMMISSIONER GERSTORFF: And have we done any
3 research into beneficiary interviews and understanding
4 reluctance for responding to questions versus
5 understanding?

6 MX. JENNINGS: So in our interviews, both in
7 talking to states and then to application assister
8 organizations, have been learning a lot about the types of,
9 I guess, questions that beneficiaries have and their
10 understanding a little bit more about that reluctance. So
11 we will definitely be bringing that back in October. Thank
12 you.

13 VICE CHAIR DAVIS: Thank you, Jennifer. I just
14 wanted to add, you know, race and ethnicity state data is a
15 hard thing but it doesn't have to be a hard thing. So my
16 race and ethnicity doesn't change when I cross state lines,
17 but somehow the difficulty and ease in being able to
18 collect that data or track and report it does. And I
19 really appreciate the work that we are doing here to try
20 and streamline some of that information and make it easier.

21 Going back to Sonja's points a little bit about
22 the hierarchy, I think it has been well established that

1 self-reported data is the gold standard. But in our work
2 also looking at what is the governance and how do we take
3 into account data from other sources while we are waiting
4 for the best practice. There are lots of organizations out
5 there that have imputed race data, and it's not the gold
6 standard but there is certainly good information that we
7 can find from there, and how do we use that, incorporate
8 that into some of the research findings while we are
9 working towards the best.
10 COMMISSIONER HEAPHY: I was thinking that even in
11 Massachusetts where the Department of Public Health has a
12 lot of rich data, but it doesn't crosswalk with the
13 Medicaid data. So that's where, I think, there are best
14 practices taking place in states that we don't even know
15 about. They are just not communicating with each other.
16 CHAIR BELLA: Can you just remind us one more
17 time what to expect in October, how many folks you are
18 talking to and what we might expect to hear?
19 MX. JENNINGS: So in October we have talked to
20 about seven states and then CMS and HHS, and four
21 application assister organizations, and we will be talking
22 to managed care plans as well. So we will be bringing back

1 findings from that and then also kind of highlighting which
2 challenges were brought up in those interviews and then
3 approaches that they have brought up as potential solutions
4 to some of these challenges, and moving towards narrowing a
5 little bit what those approaches might be and what the
6 interest is.

7 COMMISSIONER BJORK: Is it important to talk to
8 county eligibility workers, and also since we are having
9 the big Medicaid redetermination effort is that a chance
10 for us to get some improved practices in place while we go
11 through this?

12 MX. JENNINGS: We definitely can take a look at
13 that. We have heard a little bit from our state interviews
14 about the experience of county eligibility workers or
15 other, I guess, workers on the state level versus
16 application assisters and navigators. So we can continue
17 to look into that.

18 VICE CHAIR DAVIS: Thank you. So I think that
19 you are hearing continued interest from the Commission to
20 continue down this path, and we are excited to hear what
21 you bring back to us in October. Is there anything else
22 that you all need to hear from the Commission?

1 MX. JENNINGS: No. This is great. Thank you.
2 VICE CHAIR DAVIS: I think we are running a
3 little bit ahead. Do you want to see if there is any
4 public comment?
5 I see there is Erin Guay with her hand raised.
6 ### **PUBLIC COMMENT**
7 * [No response.]
8 VICE CHAIR DAVIS: Maybe that was an accident.
9 If folks would like to make public comment you can raise
10 your hand on Zoom, and we will ask you to state who you are
11 and where what organization you are with. And we ask folks
12 to limit their comments to two minutes.
13 [No response.]
14 VICE CHAIR DAVIS: All right. We will not play
15 the Jeopardy theme song, but I am not seeing any hands.
16 All right. Thank you, Linn. Thank you, Jerry.
17 CHAIR BELLA: Thank you, Jerry and Linn. We have
18 a little bit of transition time built in, to transition to
19 our next panel, which is virtual. And so for those of you
20 listening at home this panel will begin at 11 a.m. Eastern,
21 so you have a little bit of time. And come back and we
22 will be having the panel on the PHE, hearing from three

1 different state organizations or states. Thank you.

2 * [Recess.]

3 CHAIR BELLA: Welcome. We're super excited to

4 have this panel, and I think we could go on and on, so

5 we'll try to keep it contained. Martha, you'll kick us off

6 and set the stage, and thank you very much to the panelists

7 for being here today.

8 **### STATE PROCESSES AND STAKEHOLDER ENGAGEMENT FOR**

9 **UNWINDING CONTINUOUS COVERAGE REQUIREMENT**

10 * MS. HEBERLEIN: Thank you, Melanie.

11 So as you are all well aware by now, the Families

12 First Coronavirus Response Act provided states with a

13 temporary 6.2 percentage point increase in the FMAP if they

14 meet certain conditions, including a continuous enrollment

15 requirement for most Medicaid beneficiaries who were

16 enrolled in the program as of or after March 18, 2020. The

17 PHE remains in effect until at least early next year, but

18 once it ends, states will resume the process of routine

19 redeterminations.

20 Federal and state Medicaid officials have been

21 planning for the resumption of redeterminations for some

22 time. However, they, as well as Commissioners,

1 policymakers, and beneficiary advocates, have all raised
2 concerns regarding the return to routine operations given
3 the magnitude of the administrative tasks ahead, overloaded
4 eligibility systems, state workforce and budgetary
5 constraints, and the potential risk of eligible individuals
6 inappropriately losing coverage.
7 The Commission has long been focused on the
8 unwinding, holding two prior panel discussions focused on
9 these areas of concern, as well as strategies to mitigate
10 coverage loss. In July of this year, we held a special
11 meeting to provide an update on where states were in their
12 planning efforts and whether additional certainty around
13 the timing or federal financial support would assist state
14 efforts.
15 In our conversations over the summer with states,
16 they noted that they felt prepared for the eventual
17 unwinding, emphasizing that the tools and technical
18 assistance provided by the Centers for Medicare & Medicaid
19 Services had been helpful.
20 So given this and that the date for unwinding may
21 -- I'm going to say "may" -- may be close at hand, the
22 Commission is shifting its focus this fall to look toward a

1 post-PHE world. So we'll begin this cycle's work with a
2 panel discussion on how states will operationalize their
3 unwinding plans. And then in October, we will return for
4 an additional discussion on monitoring the unwinding
5 progress. And in December, we will discuss approaches to
6 easing transitions between coverage sources at the end of
7 the PHE.

8 So on to our panel. Our two state
9 representatives have been asked to discuss their process
10 for conducting redeterminations and challenges they faced,
11 how stakeholders have been engaged in the planning process
12 and their role going forward, as well as their states'
13 approach to monitoring progress during the unwinding. A
14 beneficiary advocate will then share her insights on the
15 challenges and the role the assister community can play in
16 mitigating these concerns.

17 The panelists will each have about 10 minutes to
18 share their thoughts before we open it up for discussion
19 with the Commission, and then after public comment and a
20 break for lunch, we will return for further discussion
21 among Commissioners with issues raised during the panel.

22 So to introduce our speakers today, Jami Snyder

1 has served as the Director of AHCCCS, overseeing Arizona's
2 Medicaid and CHIP program since January 2019 after having
3 served as the agency's deputy director since December 2017.
4 Prior to joining AHCCCS, Ms. Snyder served as Medicaid
5 director for the state of Texas. She is also the immediate
6 past president of the National Association of Medicaid
7 Directors.
8 Carl Feldman is Executive Policy Specialist in
9 the Office of Policy Development for the Pennsylvania
10 Department of Human Services, the state's Medicaid agency.
11 Mr. Feldman works primarily with the office responsible for
12 determining eligibility for the commonwealth's means-tested
13 programs, including Medicaid, as well as the office
14 responsible for administering long-term care for older
15 individuals and individuals with physical disabilities.
16 Jodi Ray is the Director and Principal
17 Investigator for Florida Covering Kids & Families at the
18 University of South Florida. Ms. Ray has more than 20
19 years' experience in designing, implementing, and
20 evaluating outreach and enrollment efforts in Florida.
21 Over the course of her career, she has overseen statewide
22 efforts to connect consumers to public health coverage

1 programs and currently leads the largest navigator
2 organization in the country.
3 With that, I will turn it over to Jami to begin
4 the discussion. Jami?
5 * MS. SNYDER: Thanks so much, Martha, and thank
6 you to the Commission and to the MACPAC staff for inviting
7 me to be a part of today's conversation.
8 I'll just start with the questions that you
9 posed, Martha, in anticipation of this discussion. You
10 asked a little bit about the state's process for conducting
11 redeterminations at the end of the PHE, so just to give you
12 an overview, we've continued to, like many states, process
13 redeterminations behind the scenes during the public health
14 emergency. So we do have a pretty good idea of those
15 individuals that fall into one of two categories:
16 individuals that during the PHE, when we processed their
17 redetermination, were found to be factually ineligible as
18 well as individuals who failed to submit documentation in
19 order for us to make an eligibility determination. And the
20 number of individuals in that group -- we call it the
21 "COVID override group" -- is just over 600,000 individuals.
22 And our enrollment, I should mention, sits at about 2.4

1 million, and it has grown by over 555,000 over the course
2 of the pandemic period.
3 So over the course of the last several months --
4 almost a year, actually -- we've been partnering -- we're a
5 managed care state, as many of you know. We've been
6 partnering with our contracted health plans and providing
7 them with files to assist them in proactively reaching out
8 to individuals that sit in that COVID override group. So
9 we've been providing them with files that detail out for
10 their enrolled membership those individuals that were found
11 to be factually ineligible as well as those individuals
12 that failed to submit documentation in order to establish
13 eligibility.
14 More recently, we've asked that our contracted
15 health plans start pushing that information down to
16 providers, and most notably, federally qualified health
17 centers, as well as Indian Health Service and tribally
18 owned 638 facilities. We have a smaller fee-for-service
19 program, and they're working directly with those IHS and
20 638 facilities for their enrolled members, providing files
21 of those individuals that are either potentially ineligible
22 or failed to submit documentation.

1 We also at the agency level have conducted a
2 robocall campaign to those individuals, a text message
3 campaign, and a letter campaign, so really trying to cover
4 all the bases in terms of reaching out to those
5 individuals. And the expectation of the plans, our
6 contracted health plans and providers, is that they'll have
7 those conversations within individuals in terms of updating
8 their contact information, ensuring that they're responding
9 to our requests for information so that we can make that
10 eligibility determination.
11 We do believe that it will take us 12 months to
12 process all the redeterminations once the PHE ends.
13 Originally, when we thought the PHE was going to end a
14 little sooner, we thought it would take us six months, then
15 we were at nine months, and now we do feel it's going to
16 take us a full year to process those redeterminations.
17 A couple of steps that we're taking to create
18 some efficiency in the process. We're aligning renewals at
19 the household level to minimize the number of renewal
20 actions needed during the unwinding period, so we'll
21 redetermine the entire household at once. We're also
22 aligning Medicaid renewals with SNAP recertifications to

1 reduce the burden for members. We are trying to distribute
2 the renewals or redeterminations across that 12-month
3 period to prevent a renewal bulge, which I know a lot of
4 states have talked about.
5 In terms of prioritization, we're prioritizing
6 those members who actually screened as factually ineligible
7 during the PHE first in order of oldest determination date
8 to newest determination date. We understand that
9 individual circumstances may have changed, so we
10 absolutely, as CMS has dictated, are committed to
11 conducting a new redetermination following the end of the
12 PHE, but we will prioritize that group first. And then our
13 second priority will be those individuals who failed to
14 submit documentation in order to establish eligibility or
15 to make an eligibility determination.
16 In terms of our work with the stakeholder
17 community, I mentioned we've been doing a lot of work with
18 our contracted health plans, with providers, with FQHCs,
19 IHS and 638 facilities. You probably know that Arizona is
20 home to 22 tribes, so it's really important that we're
21 connecting with those IHS and 638 facilities.
22 We also are working with advocacy groups like the

1 Children's Action Alliance in Arizona and the University of
2 Arizona Center for Rural Health. They helped us actually
3 overlay some information around individuals in rural areas
4 that fall into that COVID override group and where those
5 individuals are in proximity to eligibility offices. So
6 I'm specifically focused on rural areas because we know
7 that a lot of individuals in rural areas of the state have
8 challenges with connectivity, Internet connectivity, and
9 are more likely to travel to eligibility offices, so we
10 want to make sure that they're able to get into those
11 eligibility offices to supply documentation and the like.
12 So working with advocacy groups as well.
13 In terms of monitoring our progress during the
14 unwinding process, we're already monitoring fluctuations in
15 that COVID override group, and we have seen a drop from
16 about 635,000 to 625,000, and we believe that that really
17 demonstrates that the outreach that the plans and providers
18 are doing with members is helping, in fact, to ensure that
19 they update their contact information, that they provide
20 that documentation in order for us to make an eligibility
21 determination. But we'll continue to monitor that COVID
22 override group in anticipation of the end of the PHE.

1 In addition, of course, we'll maintain reporting
2 consistent with what CMS has asked for in terms of the
3 number of redeterminations initiated, those pending, and
4 those completed, including outcomes. In addition to that,
5 we plan to post a dashboard on our agency website once the
6 end of the PHE begins, and we're going to provide a picture
7 of our total population to give a sense of what we're
8 talking about in terms of those who may be at risk of
9 losing coverage. We'll provide that number in terms of the
10 COVID override population. We'll provide information on
11 renewals completed as well as those whose eligibility
12 continued and those whose eligibility was discontinued as a
13 result of our redetermination process.
14 We also are going to provide numbers in terms of
15 those that failed to submit documentation in order to
16 establish eligibility. We'll talk -- in our dashboard,
17 we'll detail out the total population referred to the
18 marketplace, the total number of appeals.
19 One of the really, I think, key indicators of
20 performance for us is going to be really watching our call
21 center data to ensure that we are monitoring any spikes in
22 calls, that we're appropriately staffing and making

1 adjustments. But I think that will be really telling as
2 well in terms of how we're performing throughout the PHE.
3 So I think, Martha, that kind of summarizes the
4 questions that you asked at the outset. I know there may
5 be some interest in talking a little bit about our ex parte
6 rates. I'm happy to provide additional information on that
7 front as well if it's helpful.
8 MS. HEBERLEIN: Thank you, Jami.
9 I'm going to turn it over to Carl to go next.
10 Thank you.
11 * MR. FELDMAN: Okay. Thank you to the Commission
12 for inviting me today to discuss the experience of the
13 commonwealth of Pennsylvania's state Medicaid agency, the
14 Department of Human Services. I'm Carl Feldman, Executive
15 Policy Specialist in the Office of Policy Development. Our
16 office reports to the Secretary of the Department of Human
17 Services and the Governor's Secretary of Policy and
18 Planning in Pennsylvania. And the public health
19 emergency's unwinding is of great importance to us and the
20 people we serve, so we're working daily to prepare for
21 that.
22 Pennsylvania's Medicaid program, known in the

1 commonwealth as Medical Assistant, or MA, like all states,
2 elected to provide continuous coverage to receive enhanced
3 federal match funds through the end of the quarter in which
4 the PHE ends. This has enabled us to allow individuals to
5 remain enrolled in Medicaid even if they became ineligible
6 based on regular eligibility criteria, except for in rare
7 circumstances. And as a result, over the last two years,
8 from March of 2020 to July of 2022, the number of
9 individuals covered by MA has grown in the commonwealth
10 approximately 24.8 percent, which I understand fairly
11 closely mirrors the national statistics on that.
12 Although we're not disenrolling recipients beyond
13 limited circumstances, DHS's Office of Income Maintenance
14 has continued to send paperwork, update recipient
15 information, and perform renewals throughout the public
16 health energy.
17 As of July 13, 2022, DHS has identified about
18 525,000 individuals which have been maintained eligibility
19 despite not meeting eligibility criteria. And,
20 additionally, there are 314,000 cases that have not
21 completed the renewal process since the public health
22 energy was put into place.

1 Once the public health emergency ends and during
2 the unwinding period, these individuals will be sent a
3 renewal, and if they do not return the renewal or if they
4 no longer meet eligibility criteria, these cases will close
5 after proper noticing.
6 So our approach in handling this workload,
7 Pennsylvania's public health emergency unwinding process
8 will be completed between six and 12 months. A final
9 decision will likely be made during the state fiscal year
10 2023-24 budget process, which occurs in June of 2023. DHS
11 supports and continues to advocate to align with federal
12 recommendations and complete the renewal process across the
13 full year, but lacking additional federal financial support
14 beyond the quarter in which the PHE ends, DHS is planning
15 to complete its unwinding within six months.
16 Planning the six-month unwinding period has
17 special challenges and considerations which may not be
18 relevant to states presently committed to employing a
19 longer unwinding period. And a key question DHS has to
20 consider is how to structure the MA caseload renewal dates
21 for the individuals which are already known to DHS for
22 having failed an element of eligibility or not returned a

1 renewal.

2 Thus far, our approach to this planning is with
3 the state-developed methodology which has as a core
4 assumption that with the limited time available to conduct
5 the unwinding, success will require a workload for our
6 eligibility workers that is as evenly distributed as
7 possible in order to avoid overtaxing our workforce and
8 resulting in errors.

9 We aim to achieve this not by moving individuals
10 with renewal dates within the unwinding period if possible.
11 For those with renewal dates outside the unwinding period,
12 we aim to distribute their renewals within the unwinding
13 period's available months to create an even distribution.

14 In addition to not moving renewal dates when
15 possible and evenly distributing the caseload, DHS plans to
16 align MA renewals to SNAP for combined cases in our
17 combined eligibility system to minimize duplicative work in
18 the unwinding period.

19 There are some more limited populations which we
20 are moving to specified time frames. These are fairly
21 marginal in the scope of the total population which must
22 receive a renewal during the unwinding period.

1 We were asked about our advocacy and
2 communications efforts, so I'll expound on that.
3 Pennsylvania recognizes what a significant shift the
4 unwinding will be and in response is taking extraordinary
5 efforts to enhance communications about the unwinding with
6 clients, stakeholders, and advocates. The traditional
7 renewal process for a client in Pennsylvania included a
8 mailer that went out 90 days prior to the renewal about
9 reporting changes, and then a renewal packet which was
10 mailed for the month in which the renewal date occurs if
11 that renewal could not be processed ex parte. Clients have
12 30 days to return that renewal packet.
13 To support urgency around ensuring renewals being
14 completed and returned when a client's renewal is due, DHS
15 is adding a multi-touch outreach effort for all clients.
16 DHS' 90-day change reporting flyer has been updated to
17 emphasize the many ways clients can report changes
18 electronically or over the phone, and this flyer will be
19 accompanied by text messages, emails, and helper calls,
20 which are automated phone calls with the same message.
21 A new letter will be mailed 60 days prior to the
22 renewal, which will emphasize that unless the client

1 completes and returns their renewal, their MA will be
2 closed. This letter will include all of the information
3 necessary for the client to do their renewal online through
4 the Commonwealth of Pennsylvania Access to Social Services
5 web portal. We call that "COMPASS."
6 When the renewal packet is mailed, it will be
7 accompanied by text messages, emails, and helper calls to
8 emphasize the need to complete and return it.
9 Finally, if a client's MA is closed for failure
10 to return the renewal or failure to provide a verification
11 letter, a letter will be issued to that client telling them
12 about the 90-day reconsideration period and the ability for
13 them to do their renewal at that time through our web
14 portal.
15 The adoption of these many new tactics and
16 language used in the outreaches have been informed through
17 DHS' work with members of a subcommittee of our statutorily
18 established Income Maintenance Advisory Committee that's
19 focused on the unwinding, and we meet with this body of
20 client advocates every three weeks to discuss the
21 unwinding.
22 DHS has also developed tools and channels to

1 engage with the Medicaid program stakeholders to prepare
2 for the unwinding. We held our first PHE unwinding webinar
3 for health plans. We are a managed care state. That
4 happened in May of 2022 and was open to all MA managed care
5 organizations, CHIP plans, and QHPs. We've scheduled a
6 follow-up webinar for September 28th to provide new
7 information on our unwinding plans, and we may hold
8 additional calls in the future. To reach as broad a swath
9 of the health plan personnel, provider community, and
10 advocate population as possible, we've launched an
11 unwinding web page that includes FAQs for clients and
12 health plans, communications content such as scripts,
13 flyers, graphics, and other items that can be copied and
14 used to speak about the unwinding, and we have our helper
15 portal which DHS will use to disseminate unwinding specific
16 information to anyone signed up to receive it. We are
17 hosting a number of renewal assistance and training events
18 for our COMPASS Community Partners which assist us with
19 enrollment issues so that they are ready and prepared to do
20 this work.
21 We were asked about monitoring, and we feel as
22 though Pennsylvania is well prepared to monitor and

1 evaluate progress of eligibility determinations during the
2 unwinding. DHS will comply with all CMS requirements to
3 report on Medicaid eligibility processing activities.
4 Unlike some state Medicaid agencies, DHS never experienced
5 any dramatic reduction in workload capacity as a result of
6 the pandemic, and we remain staffed to 93 percent of our
7 eligibility worker complement, and we are prepared for
8 specialized overtime shifts to complete unwinding work
9 should it become necessary.
10 Our process of eligibility work involves workload
11 distribution in any of our 93 local county assistance
12 offices or regional processing centers. Because of this
13 broadly distributed state workforce, DHS has insight at all
14 times into the processing capacity and efficiency of our
15 workforce. Problems can be quickly escalated, and we have
16 the ability to shift work statewide should the need arise.
17 DHS similarly monitors call center outcomes
18 daily. Metrics such as outstanding pending verification
19 items, unprocessed renewals, and call center wait times
20 will all provide insight into how the unwinding work is
21 proceeding in the field.
22 I hope that this gives you some useful insight

1 into Pennsylvania's plan for unwinding. Thank you.

2 MS. HEBERLEIN: Thank you, Carl.

3 Jodi, can I turn it over to you?

4 * MS. RAY: Thank you. So, obviously, I do not
5 represent the state. I'm actually with University of South
6 Florida. We have an initiative that oversees over 200
7 assisters across the state that do the enrollment for
8 Medicaid and CHIP and for the marketplace.

9 So from the perspective of what this might look
10 like on the ground and what our concerns are, we actually
11 hosted a virtual convening with our Department of Children
12 and Families, our CHIP program, and we were also fortunate
13 enough to have Tricia Brooks from the Georgetown Center of
14 Children and Families present on what states are doing,
15 what states can be doing, what are some of the best
16 practices.

17 I will say from a stakeholder perspective, it's
18 disappointing for Florida. We have a state that currently
19 hasn't really shared our plan, so we're not entirely sure
20 what the state is planning on doing and what information
21 they're going to be willing to share.

22 We did have some questions that we posed to the

1 panel on some of the opportunities that states have to
2 ensure that we mitigate the numbers of people that fall
3 into the coverage gap. Currently we have over five million
4 people in Medicaid, so this is absolutely concerning.
5 We're really concerned with the seamlessness of being able
6 to move enrollees from CHIP and Medicaid and the
7 marketplace. It is not currently a seamless process in
8 Florida, unfortunately, and so we have requested maybe some
9 updates on how the state could improve those transfers. We
10 do see people who don't make it through the transfers.
11 Obviously, right now, most people who are applying for
12 Medicaid are primarily getting Medicaid, but at some point,
13 when work is as usual, we see folks kind of get stuck in
14 that process because we have a big manual component to it.
15 So if they're not coded right, we see a lot of
16 people that could end up in medically needy or share of
17 cost and don't really move through the process to where
18 they need to be. Hence, the value of having in-person
19 assistance for folks on the ground that know how to
20 navigate these systems, to help them sort of unstuck in the
21 system.
22 We also have a very low ex parte redetermination

1 rate. We have one of the lowest rates in the country, and
2 this contributes to unnecessary churning and really is a
3 drain on administrative resources. So one of the questions
4 we have for the state is how can we increase the ex parte
5 redeterminations. Certainly the more that we minimize
6 people submitting documentation, the more likely they are
7 to retain coverage.
8 Unfortunately, our CHIP program and our Medicaid
9 program don't share all the information they collect, so
10 oftentimes individuals have to resubmit this documentation
11 more than once.
12 The state did say they will be using AI for text
13 messages and emails for applicants and redeterminations,
14 and they are updating the website to include more
15 information, but they are going to increase their reliance
16 on technology such as chatbox in the AI to read returned
17 mail and assign them to a case. How they're going to
18 reprioritize redeterminations, they did not share that in
19 answer to the question, so we don't really know yet for
20 Florida. We did have some key recommendations. One
21 essential recommendation we have for folks in our state is
22 to improve the written communication. We have found that

1 the written communication is still really not in line with
2 the varying literacy levels and language barriers that we
3 have in the state, and they really need to be written in
4 plain language. Right now we're seeing redetermination
5 letters that are very confusing; consumers are getting
6 letters that are telling them that they're going to be
7 coming up for redetermination, they should go out to their
8 accounts, but then there's really no follow-up in terms of
9 what they should do next, such as making sure their contact
10 information was up-to-date.
11 So our team across the state has really been
12 investing in -- really focusing on encouraging people to
13 get out there and update their information. We know that's
14 going to be the first essential piece. Also encouraging
15 the state to take advantage of some of the CMS waivers that
16 are available, increased staff support. Our state told us
17 that they thought this would be business as usual at the
18 convening. We're concerned on the ground that that won't
19 be effective. You know, we've seen too many people get
20 incorrect denials and administrative denials, so we know
21 there's a real need to have clear communication, clear
22 access to information on our CHIP program websites, on the

1 Medicaid websites. We need better -- we need to increase
2 the outreach efforts and leverage the relationships they
3 have with the MCOs. I think there's a real untapped
4 opportunity there for the state of Florida.
5 The other thing is I think that there should be a
6 stronger engagement with stakeholders. We hear a lot of
7 communication around communicating with stakeholders, which
8 are other agencies or maybe some of the health plans. But
9 the folks on the ground are actually going to be the ones
10 engaging with consumers and especially consumers who are
11 struggling to get through these processes and these systems
12 or helping them to retain that coverage. So I think
13 including them in the conversation is really important,
14 particularly when you're looking at community health
15 centers and you're looking at free and charitable clinics
16 and you're looking at some of these programs like the
17 Connecting Kids to Coverage or navigator folks that have
18 assisters on the ground. I think there's a real strong
19 resource there to try to mitigate the loss of coverage.
20 Obviously, things like creating an assister
21 portal and using enhanced CHIP funds that haven't been used
22 to help outreach, utilizing social media, especially for

1 Latino and Hispanic communities, are a big recommendation
2 that we have, and engaging the philanthropic community I
3 think would be another advantage. So that we have to get
4 this information out, and we have people on the ground that
5 are on the front lines that understand this as well as the
6 folks that are doing the actual processing.
7 So some of these things are key, and some of them
8 we've heard from other members of the panel that states are
9 doing. Florida currently is not one of the states that is
10 checking any of the boxes on the options that states could
11 do, so this happens to be why we have such a strong
12 concern. And we have such a large number of folks in the
13 program with over five million people that are going to be
14 up for redetermination. It's concerning if we're just
15 going to approach this as business as usual.
16 So that's where we are in Florida.
17 MS. HEBERLEIN: Thank you, Jodi. Thank you to
18 all the panelists, and I will turn it over to Melanie to
19 open it up for Commission discussion.
20 CHAIR BELLA: Thank you very much to all the
21 panelists.
22 I'll start out asking Jami just for a little more

1 detail on ex parte since you sort of teed that up for us.
2 MS. SNYDER: Sure, sure. Happy to talk about our
3 process. I mean, we're fortunate relative to other states,
4 I think, in that our ex parte renewal rates sit between 85
5 and 89 percent. Currently I know there are some larger
6 states like Florida and Texas who have much lower rates.
7 Our process is pretty straightforward. We start by hitting
8 up against federal hubs for information, including Social
9 Security Administration, Equifax which verifies income, the
10 SAVE online database which verifies immigration status.
11 Then we move to state hubs. We look at the Arizona state
12 retirement system to get a sense of pension income, long-
13 term and short-term disability benefits, third-party
14 liability, the Arizona base wage guide which produces
15 quarterly wage reports, unemployment insurance income. And
16 then we also hit up against our motor vehicle department
17 for the purpose of establishing Arizona residency and vital
18 statistics, again, for verifying U.S. citizenship.
19 So we've had a lot of success. Our rates have
20 actually increased over the course of the last year. I
21 think we were 75 percent or so a year ago. Again, we're
22 between 85 and 89 percent regularly on a month-to-month

1 basis at this point. So that certainly does, you know,
2 assist us as we move forward with the unwinding process,
3 because we have such a high rate of auto renewals based on
4 our ability to kind of gather that information from those
5 federal and state hubs that exist.
6 CHAIR BELLA: Thank you. Carl, you mentioned it.
7 Did you want to give any more detail on Pennsylvania?
8 MR. FELDMAN: Yeah, I understand the Commission
9 is interested in ex parte, so I can share a little bit
10 about Pennsylvania's experience. We have a fairly low rate
11 relative to other states with an ex parte rate typically
12 below 25 percent. We use many of the same income source
13 identifications that were described by Arizona, and we
14 believe the kind of core of the challenge for ex parte in
15 the state of Pennsylvania relates to the fact that we have
16 a truly integrated eligibility system. It's not just an
17 integrated application. For the state of Pennsylvania,
18 there is a single source of income for all benefits that we
19 administer -- SNAP, cash, LIHEAP, Medicaid -- and that
20 typically creates challenges where we are not able to use
21 sources for one program versus another program, and having
22 that single source is beneficial because we think it

1 accurately reflects the reality of program beneficiaries.
2 But it does have a drawback when it comes to our ability to
3 automate the processing of the renewals.
4 CHAIR BELLA: Thank you. Jodi, I don't know if
5 you would like to comment as well?
6 MS. RAY: I can only say that we also have a very
7 low rate of under 25 percent for ex parte redeterminations.
8 So, you know, we're not utilizing it probably to the extent
9 that we can. That's pretty much all I can say about that.
10 CHAIR BELLA: Okay, thank you.
11 Kisha, then Verlon.
12 VICE CHAIR DAVIS: Thank you. This has been a
13 great panel so far. You know, particularly for Jami and
14 Carl, I'm curious what monitoring you've put in place to
15 know if things are going well or when there are problems,
16 what kind of red flags are in place to be able to flag that
17 and alert where problems might arise.
18 Along those lines, we've been hearing from health
19 departments that, you know, places are just gutted. And so
20 I'm curious around staffing needs that you're going to --
21 if you have adequate staff or challenges there in being
22 able to address redeterminations.

1 MS. SNYDER: Well, that's a great question, and I
2 think we're feeling pretty good about where we're at from a
3 staffing perspective. But as I mentioned in my initial
4 comments, we're really going to watch that call center.
5 That's where we're most concerned, is really around having
6 appropriate staffing for the call center once the PHE comes
7 to a close, and so we'll really going to watch that call
8 center data closely -- and report it out, too, on our web
9 page so that we're, you know, creating a level of
10 transparency for the public. But we've been very hands-on
11 with our call center vendor, letting them know that they
12 need to be able to flex and scale up if we do start to see
13 those metrics -- some decline in the metrics relative to
14 our expectations. But as I mentioned, a couple of other
15 areas that we're monitoring, even before the PHE, really,
16 you know, keeping our eye on that COVID override group, and
17 we want to see declines. And that's what we should see
18 given our expectations of our contracted health plans and
19 providers on the ground as they're meeting with members and
20 letting them know they need to update their contact
21 information; they need to respond to those requests for
22 information. We want to see that number continue to come

1 down over the course of the next couple of months as a
2 result of that kind of proactive outreach that our plans
3 and providers are doing.
4 Then I talked a little bit, I know, about the
5 dashboard we plan to post, but it will not only provide
6 information to the public, it will be a good guidepost for
7 us in terms of how things are playing out in completing
8 renewals, in monitoring those that remain eligible versus
9 those that are no longer eligible, and making sure that
10 we're making those appropriate referrals to other sources
11 of coverage, whether that's the marketplace or other
12 commercial coverage. And that's one of our expectations of
13 the health plans as well as we start to process through our
14 redeterminations, that they're proactively reaching out to
15 those individuals that are no longer eligible and
16 connecting them to other coverage sources.
17 I think we really appreciate the flexibility --
18 CMS' flexibility in that regard, allowing the plans, if
19 they have a corresponding marketplace product anyway, to
20 proactively market that to their members.
21 MR. FELDMAN: For the state of Pennsylvania, I
22 would agree that staffing is something of a bright spot so

1 far. As I mentioned, we believe we're at 93 percent of our
2 complement for eligibility workers, which is good. We're
3 set up in such a way that workload can be shifted, if
4 necessary, around the state, which is important, and we
5 think we'll have some flexibility on overtime availability
6 to continue working on this project.

7 I would say in terms of monitoring, we have items
8 that I think we will be trying to track for the purposes of
9 determining what would be useful for the public in
10 understanding what's taking place. We haven't made any
11 firm commitments on that at this point, but we are
12 interested in that. But from the perspective of the state
13 in trying to understand how this process is going, pending
14 work verification items is going to be a major one. Our
15 call center volumes are going to be very important. It's
16 truthfully very typical monitors of our work getting done,
17 and then we would have to dig a little bit deeper to see
18 what is driving that.

19 We have some changes in the works that we're
20 excited about. We have a state-based exchange pending that
21 we work closely with, and we will continue to send them
22 referrals for eligible individuals. We're even adding a

1 step to send referrals for people who didn't complete
2 verification requirements, which traditionally wasn't done
3 in the state of Pennsylvania. Our CHIP system is changing
4 in such a way that we think that eligibility determinations
5 may be smoother during the end of the public health
6 emergency because of the move for CHIP eligibility from our
7 CHIP managed care organizations into the eligibility
8 cascade that the eligibility workers have access to. So
9 that's what I'd say at this time.
10 CHAIR BELLA: Thank you.
11 Just to clarify for Commissioners, this is an
12 opportunity to ask questions of the panelists, and then
13 after lunch we'll come back and having a Commission
14 discussion for about 30 minutes.
15 Okay. Next up is Verlon and then Heidi, please.
16 COMMISSIONER JOHNSON: Thank you. So this may
17 actually be a lead-in from the last question, but, you
18 know, Jodi brought up the importance of engaging
19 stakeholders at all levels of the process, getting that
20 people-on-the-ground approach. So I'm really wondering if
21 Carl and Jami may be able to talk a little bit more in
22 detail about your strategy that you use from an engaging

1 perspective, and even more specifically from a community
2 perspective, and then also how that will play into your
3 monitoring efforts as well.
4 MR. FELDMAN: Well, I can speak about
5 Pennsylvania, and our initial approach to this has been
6 using our statutorily established advisory committee,
7 having more -- we typically meet with them on a quarterly
8 basis. We've established a separate sub-group for this.
9 We're meeting with them every three weeks for an extended
10 period to discuss these issues. We're sharing documents
11 with them and receiving their feedback and incorporating it
12 where we can.
13 We also are likely to have a paid media strategy
14 which will assist us in connecting with people. We think
15 that that will pay dividends. We intend to set it up in
16 such a way that we'll be reaching people through new modes;
17 social media advertising is of great interest to us. And
18 we are also scheduling webinars to enable the provider
19 community, the advocacy community, to better understand how
20 the renewal process works, how they can be COMPASS
21 Community Partners to assist us with this work. That's
22 where our focus has been thus far. I think it's going to

1 evolve as we close in on the true end of the PHE.

2 MS. SNYDER: Yeah. And just to echo some of the

3 work that is being done in Pennsylvania, we're working

4 really closely with community advocacy work. I mentioned

5 Children's Action Alliance, but also organizations like the

6 Vilas Foundation, which is a pretty prominent health care-

7 related foundation. They're going to conduct a social

8 media campaign on our behalf, which they've been successful

9 in, in other instances that are similar to this.

10 We also are partnering really closely with our

11 provider associations, our hospital association, our

12 behavioral health provider association, primary care

13 association. We found them to be really great partners in

14 this effort, and we don't have a separate advisory council,

15 but our approach has really been to kind of meet providers

16 where they're at and attend their existing meetings so that

17 we can get the word out. And they're eager to help us, of

18 course. It's to their benefit, right? So we've had a fair

19 amount of success in that regard.

20 I mentioned federally qualified health centers.

21 They're a critical partner as well in this process, and

22 they're doing a lot of work at the point of care in terms

1 of talking with members that are on that COVID override
2 list.
3 And I failed to mention, but I should, that we're
4 encouraging all of our contracted health plans to become
5 community assister organizations so that they can actually
6 assist individuals, you know, get into the system and
7 assist them in obtaining that documentation, uploading it
8 into the system, so that we can successfully complete that
9 redetermination.
10 But I think Carl is right on the money. I think,
11 you know, clearly, we have more work to do, especially as
12 we head into what we believe is kind of the last 90 days of
13 the public health emergency and just really ensuring that
14 we're on the ground in particular with advocate
15 organizations and that they're getting the word out as
16 well.
17 CHAIR BELLA: Thank you.
18 Heidi, then Tricia, then Dennis.
19 COMMISSIONER ALLEN: Thank you so much, Jodi,
20 Carl, and Jami.
21 My question is about indications of beneficiary
22 movement, as you've been sending out these communications.

1 Are you getting -- do you have a sense of what percentage
2 of your mailings are being bounced back or emails bounced
3 back, and is there any effort to try to use national
4 databases to get correct information about beneficiaries,
5 or will you just continue to send it to those bad addresses
6 when the time comes?
7 MS. SNYDER: That's a great question, Heidi, and
8 I failed to mention some of our work in that area. We
9 haven't historically done anything with return mail, but we
10 -- as a result of the work that we normally need to do, in
11 anticipation of the end of the PHE -- we actually have
12 begun to process that return mail and send the new address
13 information to our MCOs. And we've asked that the MCOs
14 actually confirm with us that they're updating the address
15 information in their files so that when they do outreach on
16 their end, they have the most current information.
17 MR. FELDMAN: In Pennsylvania, I mean, we are
18 spending a lot of time on this question, trying to figure
19 out how to make sure that we are reaching people in the
20 right way. We are intending to take advantage of CMS
21 flexibilities to use managed care organization addresses,
22 and we are talking about -- though we have made no

1 commitments at this time, about using national change of
2 address database information as verified and not, say, a
3 lead.
4 I think what makes things challenging for
5 Pennsylvania, same with the ex parte information, is that
6 with a truly integrated eligibility system, changes for one
7 program impact other programs as well. So we have to be
8 careful in designing out policy and think about the impacts
9 that those changes have to the other programs.
10 I understand FNS recently released some
11 flexibilities to deal with that, and we're kind of working
12 through what we've received to try and see how we can best
13 use the information that's coming to us and not cause
14 negative impacts for households.
15 MS. SNYDER: I should mention that -- and I think
16 I mentioned it earlier -- we have conducted at the agency
17 level a call campaign, a text campaign, and a letter
18 campaign. It's our understanding that agencies can, in
19 fact, text members, and they don't have to opt in to
20 receiving texts. Whereas, MCOs, the member actually has to
21 opt in. I know a lot of our contracted health plans have
22 expressed concern around that and really, you know, desire

1 more flexibility in terms of being able to text members
2 without that opt-in.
3 CHAIR BELLA: Thank you.
4 Jodi, did you want to add anything from your
5 perspective in terms of bad addresses?
6 MS. RAY: Well, I mean, we ask questions around
7 what they were going to do with the addresses, but I don't
8 really have anything I can add at this point.
9 I think that, like I said, to the extent that we
10 have some ability to move the needle, we are pushing out a
11 lot of messaging around letting people know that they
12 should make sure that their address or contact information
13 is good and current.
14 CHAIR BELLA: Thank you.
15 Tricia and then Dennis and then Fred.
16 COMMISSIONER BROOKS: Thank you all for being
17 here and for your comments.
18 Pennsylvania and Arizona, I want to particularly
19 thank you for your transparency. The Center for Children
20 and Families launched an unwinding tracker last week
21 showing the kinds of documents that we can readily find on
22 state websites, and your states came up as being among some

1 of the most transparent. And that's really important as we
2 go forward, although I didn't hear Carl indicate whether
3 they plan to post the unwinding data, so that's one
4 question I have.
5 But I wanted to dig a little bit deeper with
6 Jami. You pegged it when you said that you're going to be
7 monitoring those call center statistics very, very closely.
8 I've written about this as being the canary in the coal
9 mine. We still don't know how many states are going to be
10 willing to provide those data, even though those are part
11 of the Medicaid performance indicator data that states have
12 been required to report since 2014.
13 So, you know, the call center data is going to
14 give us some early information, but the listening, the
15 intel from the field, the qualitative stories from the
16 field, from community health centers, from navigators, from
17 pharmacists -- pharmacists are front line here. People
18 show up at their pharmacy to fill their prescription every
19 month, and in many cases, they are the first to tell people
20 that, sorry, your Medicaid has ended.
21 So I'm just curious, Jami and Carl. Are you
22 planning to have some frequent huddles, if you will, with

1 frontline organizations in the very early weeks to start to
2 get to supplement what you have on a data front, to start
3 to hear? We're hearing from a lot of people who said they
4 never got the mailing, or we're hearing from a lot of
5 people who don't, you know, understand their notice. So
6 I'm just curious about that early intel from the field.
7 MS. SNYDER: Quite candidly, Tricia, I don't know
8 that we've had those conversations, but I think that's a
9 fantastic idea, actually. Very similar, right, to the work
10 that we did at the beginning of the PHE when we had to make
11 all of these decisions really quickly without data. We
12 really relied upon community input. So I think this is
13 another opportunity for us. I think the idea of a huddle
14 on like a weekly basis at the end of the PHE is fantastic
15 with providers, with stakeholders, with -- you know, get
16 some member input as well. Yeah, no, great idea.
17 MR. FELDMAN: I think we are, too, interested in
18 the provider experience of this. I think we haven't
19 established any particular means by which to get at it just
20 yet.
21 As I said, our current thinking on getting to
22 this population is through what we're calling our "health

1 portal." It's essentially a listserv focused exclusively
2 on PHE and end of PHE content, and it includes means by
3 which people can contact us with their questions. So will
4 that evolve in the future? It probably will. Will it kind
5 of take that shape? I'm just not sure yet.
6 COMMISSIONER BROOKS: And, Carl, are you planning
7 to post your unwinding data?
8 MR. FELDMAN: We haven't made any decisions about
9 what particular metrics will be made publicly available
10 yet. We do intend to release a public unwinding plan. We
11 just have not yet completed that.
12 COMMISSIONER BROOKS: Thank you.
13 CHAIR BELLA: All right. Just a time check. We
14 have about 10 minutes left, three Commissioners lined up,
15 so Dennis, then Fred, then Martha.
16 COMMISSIONER HEAPHY: Thank you.
17 I actually have two questions, one for Carl and
18 Jami, and that is, can you tell us what kind of assistance
19 you're providing beneficiaries who have had administrative
20 denials to address those in-house so they can actually get
21 back on the Medicaid rolls?
22 MR. FELDMAN: So, in Pennsylvania, one of the

1 changes we're anticipating making in that space is an
2 additional mailing and outreach beyond what we would
3 typically do, to state clearly to the person that if they
4 were denied as a result of an administrative issue,
5 something was not returned, they can still come in the door
6 with whatever is missing and have their eligibility
7 reviewed up to 90 days after their renewal date, and we
8 will resume their coverage once we determine eligibility on
9 what we were waiting for. So we are adding steps in the
10 process to make sure people understand that they -- if they
11 fall off, we can get them right back on.
12 COMMISSIONER HEAPHY: Thank you.
13 MS. SNYDER: Yeah. We're taking a very similar
14 approach in Arizona.
15 COMMISSIONER HEAPHY: Thank you both.
16 And then a question for Jodi is, if there was one
17 takeaway you had for the Commission that you think would be
18 beneficial to beneficiaries right now, what would it be,
19 that one takeaway? We think they should do X, Y, or Z.
20 MS. RAY: I would definitely say engaging
21 community-level stakeholders because they're going to be --
22 they are going to be your folks that are going to provide

1 the feedback loop that you're going to need to know.

2 It's one thing to create the policy. It's
3 another thing to implement the policy and the practice on
4 that ground, and those folks on the ground, the folks that
5 are working with individuals who have to access care,
6 they're the ones that are going to see where the -- you
7 know, where the holes are and where the challenges are, and
8 they're going to be -- they're going to know the wrongful
9 denials, you know, the folks that are being deemed
10 ineligible incorrectly.

11 So I think engaging them throughout the process
12 is more important than, I think, maybe, you know, a lot of
13 states realize as they're trying to create this process at
14 the state level because it's a disconnect.

15 So, if you want to see what's working and what
16 you need to know, what is being effective and what's not
17 effective, I would say have them at the table from the
18 beginning.

19 COMMISSIONER HEAPHY: Thank you.

20 CHAIR BELLA: Thank you.

21 Fred, then Martha, and then we'll go to public
22 comment.

1 COMMISSIONER CERISE: Hi. I'm just wondering,
2 what are you guys estimating in terms of just in general
3 percentages you expect to fall off? And do you know
4 anything about them? Are these people that are currently
5 getting services, or do you have any way of kind of making
6 those projections or assumptions?
7 MR. FELDMAN: So, in the state of Pennsylvania, I
8 think what we've been saying is there's people we feel a
9 little more confident about, and then there's people we
10 don't really have a lot of confidence in saying what will
11 happen.
12 So 64 percent of the 550,000 or so individuals
13 which failed that eligibility criteria in their most recent
14 renewal that was sent to them, and we feel a little more
15 confident that those are the people who will likely remain
16 ineligible when they get their next renewal, though, of
17 course, we can't know for sure. That's, I think, around
18 330,000 or something like that.
19 But then when it gets to the overdue population,
20 we don't really feel comfortable making any particular
21 claims about who will and won't be ineligible because it's
22 just too hard for us to tell. Even with the 64 percent

1 figure, you know, again, we're only willing to say we're a
2 little -- we think it's a little more likely that those
3 people will remain ineligible.
4 MS. SNYDER: Yeah. And I would say we're being
5 cautious in terms of pointing to a number, you know, but we
6 do know, as I mentioned, that over 600,000 individuals fall
7 into that at-risk group. Either we've deemed them
8 ineligible during the PHE or they haven't supplied
9 documentation in order to establish their eligibility.
10 Of course, we incorporated some assumptions in
11 terms of the disenrollment rates into our budget submittal
12 to the governor's budget office on September 1st, and I
13 think that that sits right around 70 percent of the growth
14 that we've seen. But, again, we're being pretty cautious
15 around really, you know, pointing to a number.
16 CHAIR BELLA: Thank you.
17 Martha?
18 COMMISSIONER CARTER: Thank you. This is really
19 helpful, your points.
20 And Dennis asked one of my questions which is,
21 what are the takeaways that you would have for the
22 Commission, any words of wisdom or things that you'd like

1 to see happen.

2 I'm going to go back to something that you said
3 about Pennsylvania, and I'm maybe reading between the
4 lines. But I think this is something we've heard, which is
5 that you felt pushed to try to get your redeterminations
6 done within six months because of the ending of the federal
7 support. So is there anything more you want to say about
8 that? I'm curious about how many other states are in that
9 position. It seems like six months is a pretty heavy lift.
10 So, yeah, just talk about that a little bit more, if you
11 can, and if there's anything in particular for the
12 Commission to hear about that.

13 MR. FELDMAN: I mean, the only thing I feel as
14 though I could say is that we feel as though we only have
15 budgetary certainty for a six-month unwinding period,
16 though we would like to use the full year. As the state
17 Medicaid agency, we just can't make a plan for a 12-month
18 unwinding if we don't have budgetary certainty for that.
19 So that is the position that Pennsylvania is in.

20 I think there are probably other states that are
21 experiencing that, but I can't really speak to that.

22 We're happy, as we said, about our staffing

1 levels. We've gotten overtime approvals that will help us
2 with this, but there's no doubt about it, it will be a
3 challenge for DHS.
4 COMMISSIONER CARTER: Do any of the other
5 panelists have any other comments about takeaways for us?
6 MS. SNYDER: Yeah, really echoing again Carl's
7 sentiment. I think the challenge facing Medicaid programs
8 across the country is that that enhanced match only lasts
9 through the end of the quarter in which the PHE ends, but
10 clearly, we're not going to be able to process through all
11 those redeterminations within a two-and-a-half-month
12 period. And so I'm sympathetic to the situation in
13 Pennsylvania.
14 We certainly are having to have difficult
15 conversations with legislators about what that looks like
16 going forward into the next state fiscal year.
17 The only other kind of parting comment I would
18 make is I think it's really important to continue to have
19 conversations about unwinding relative to eligibility, but
20 I think it's also important to remember that states are
21 unwinding a whole series or a whole host of programmatic
22 flexibilities, which are going to be really challenging to

1 terminate, including flexibilities like allowing parents to
2 offer paid care to their minor children, provider
3 enrollment flexibilities, where we have waived the
4 enrollment fee and site visits. We've already reinstated
5 our standard provider enrollment practices, and it's been a
6 lift. And there are providers that entered the program
7 during the PHE and have no experience, you know, working
8 through our standard processes, so just encourage the
9 Commission to think about some of the challenges that are
10 going to be facing states on the programmatic end of things
11 as well.
12 CHAIR BELLA: Thank you.
13 Jodi, did you have any final words? You gave us
14 your if you were queen statement, which we always
15 appreciate.
16 MS. RAY: Oh. Yeah, if I was queen, first of
17 all, I'd say states should invest in an outreach effort. I
18 think a lot of consumers are going to get left behind
19 simply because, you know, if -- particularly if I look from
20 a perspective from Florida, trying to do business as usual
21 leaves a lot of folks that we're going to miss.
22 I think Jami mentioned the rural areas. We have

1 a lot of rural areas. We have a very diverse state
2 geographically and demographically, and I think it leaves
3 the potential to leave a lot of people behind.
4 So I think the more that we're investing in
5 connecting with those consumers, I think the likelihood
6 that we can keep them in coverage or help them navigate
7 their coverage options increase, and so I think that's real
8 important.
9 I'd like to see -- personally, I love the idea of
10 the data dashboard that Jami mentioned. I think that level
11 of transparency should be required across all states so we
12 know what's really happening to our consumers and our
13 citizens in the state.
14 CHAIR BELLA: Well, thank you. I want to be
15 respectful of your time. Thank you to Jami and Carl for
16 the links you sent us as well. They are really good
17 models, and we appreciate having those.
18 We'll be looking at this issue for quite a while
19 trying to figure out the best role for the Commission.
20 Oftentimes the role for the Commission is -- well, not
21 oftentimes. All the time, we want to be supportive of the
22 states and also supportive of consumers. If you see things

1 along the way where you think, boy, I really wish somebody
2 would say something or look into this, please don't be a
3 stranger to us with that input. It's incredibly valuable,
4 as is the time you've been with us today, so thank you very
5 much.
6 MS. SNYDER: Thanks so much.
7 CHAIR BELLA: Thank you.
8 MR. FELDMAN: Thank you.
9 CHAIR BELLA: All right. We are now going to open
10 it up for public comments. If any members of the public
11 would like to comment, please use your hand icon. I remind
12 folks to please introduce yourself, the organization you
13 represent, and to keep your comments to three minutes or
14 less.
15 It looks like Stan Dorn for the first comment.
16 **### PUBLIC COMMENT**
17 * [Pause.]
18 CHAIR BELLA: Okay. We'll give it just another
19 minute.
20 Just to remind Commissioners, we're going to take
21 a break, and after the break, we'll come back and have
22 Commissioner dialogue about what we heard, new questions,

1 new ideas we have, and any additional feedback from Martha.
2 And it does not look like we have anyone who
3 would wish to make public comment.
4 So, Martha, thank you. You know how much we love
5 panels. This was a great one, and we'll look forward to
6 speaking with you more about it after the break.
7 So we are on break until 12:45 Eastern time.
8 We'll see you all back then. Thank you.
9 * [Whereupon, at 12:02 p.m., the meeting was
10 recessed, to reconvene at 12:45 p.m. this same day.]
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1 AFTERNOON SESSION

2 [12:45 a.m.]

3 CHAIR BELLA: Welcome back from lunch.

4 Martha, thank you again for putting that panel

5 together, and I think right now, tell us what would be most

6 helpful for you at this point, please.

7 **### FURTHER DISCUSSION BY THE COMMISSION**

8 * MS. HEBERLEIN: Well, for new Commissioners, our

9 usual mode of operation for panels is to have the time with

10 the panel to ask questions, which you've already had, and

11 then to have some time now to talk amongst yourselves about

12 what you heard, how this influences our work going forward.

13 So I'll leave it to Melanie to facilitate that

14 conversation.

15 CHAIR BELLA: Can you level set, just since we've

16 had lunch and the panel, what the rest of the fall work is

17 leading into?

18 MS. HEBERLEIN: Sure. In October we will come

19 back with more information about monitoring, so including

20 some more discussion on what is in the CMS required

21 reporting as well as other potential data sources, what we

22 know from what we heard from states and what their plans

1 are. And then in December we will come back with more
2 discussions on transitions and coverage, which is also
3 something that the Commission has raised, specifically in
4 regards to the end of the PHE, so what are states and CMS
5 doing to facilitate transitions between Medicaid and CHIP
6 and QHPs on the marketplace.

7 And then in January -- oh okay.

8 CHAIR BELLA: All right. I see Martha to start
9 please.

10 COMMISSIONER CARTER: Great. So thank you for
11 that panel. I had a couple of takeaways to think about. I
12 think distributing redeterminations over 12 months isn't a
13 guarantee of a smooth process, and trying to do
14 redeterminations over shorter periods of time doesn't
15 necessarily mean it's not going to go well. But I think
16 that would be a place to really pay attention to the states
17 that, for budgetary and other reasons, have decided to try
18 to do all the redeterminations in a short period of time.

19 It wasn't reassuring to me that Pennsylvania said
20 they would get people back on quickly if they were deemed
21 ineligible inappropriately. For some situations, for
22 example, somebody in a drug treatment program, it could be

1 truly the difference between life and death that they have
2 coverage for their treatment ongoing. So, you know, it
3 concerns me.
4 The other sort of factor that I think we should
5 pay attention to are the states that are really actively
6 engaging stakeholders on the ground now, because, again,
7 that's not for sure a predictor of successful
8 redetermination period. But, you know, the fact that they
9 are engaging with FQHCs and hospitals and pharmacists and
10 clinician practices is going to help reach people that may
11 not be reached otherwise. And so states that aren't doing
12 that, are they going to have a tougher time and have maybe
13 more disenrollments that are later found out to be not
14 appropriate?
15 So I think those are two factors, how they're
16 spreading out their redeterminations and how they're
17 engaging with stakeholders now to get the word out.
18 Thanks. It was a great presentation.
19 CHAIR BELLA: Thank you, Martha. Tricia, your
20 comments are making me laugh. We can see your hand even if
21 we can't see your face, so you can go next.
22 COMMISSIONER BROOKS: Yeah. Just a couple of

1 things I want to share, and I'll try to be brief. I think,
2 you know, it's clear that we heard a tale of two states,
3 maybe something in between two, Florida and Arizona, huge
4 difference. I mentioned that we launched this tracking
5 program where we're tracking six elements to see if we can
6 find information on state websites. There is no
7 information on nine states, and there is one piece of the
8 six information on eight states. And we have about a third
9 of the states that aren't even talking about or posting
10 anything publicly. That doesn't mean they're not doing
11 anything but they certainly aren't being transparent about
12 that.
13 And I don't know if folks saw the report that
14 ASPE put out about three weeks ago. It was the first
15 estimates or projections of the share of people who may
16 lose coverage for procedural reasons, and it was really
17 shocking. ASPE is projecting that 45 percent, overall, of
18 people will lose coverage for procedural reasons. The
19 greatest risk was for kids, 72 percent, meaning 3 out of
20 every 4 children that loses coverage during the unwinding
21 will still remain eligible, like for CHIP.
22 The risk is also great for people of color,

1 Latinos 64 percent expected to lose coverage for procedural
2 reasons, 40 percent for Black non-Latinos, compared to 17
3 percent for white-non-Latinos. And that's looking at what
4 they use to base those numbers on, traditional or typical
5 churn, and indicated that overall 6.8 million people will
6 be disenrolled for procedural reasons, and that that
7 number, if it was a high-churn scenario, could be 10
8 million.

9 So I think that's really scary information, and
10 monitoring this very early and having the ability to hit
11 the pause button and reassess what the plan is and what
12 steps you can take to avoid those inappropriate
13 terminations is going to be really important.

14 When you hear states talk about the enhanced FMAP
15 ending and what pressure that puts on the state, a lot of
16 states are flush with money right now and they are imposing
17 tax cuts. And I don't think it's a money issue at all, and
18 I don't know that there's anything the Commission can do
19 about that, but I do think that we all need to be really
20 aware that it all depends on what happens at the state
21 level. It's going to depend on the state approach to the
22 timeline that they take, whether they're following up with

1 folks, whether they've done a good job of communicating
2 with people.
3 So we can feature the best practices. I think
4 Jami did an outstanding job. Yet we're still going to have
5 probably about a third of the states where this is going to
6 be pretty damaging.
7 CHAIR BELLA: Thank you, Tricia. Darin?
8 COMMISSIONER GORDON: Two things. One, I'd be
9 interested in when they talked about if someone was
10 disenrolled and that they would put them back on I'm just
11 curious, is that back to where there is no break in
12 coverage or is it just from that point going forward? I
13 don't know how they're handling that, and I think that
14 would be relevant to some of the prior points that were
15 made.
16 Secondly, we've seen somewhat unrelated, but it
17 is absolutely related, we went through the situation in
18 Tennessee where we had to pause reverification multiple
19 times. But what also happens when you go through this
20 process, and there's going to be a large swing in
21 enrollment -- whatever that number is it's going to be a
22 big change in the population -- being able to look real

1 time in providing actuaries information on what's going on
2 more real time instead of waiting to see what happened and
3 looking back in a rear-view mirror 18 months later because,
4 you know, what we had experienced, and see the risk pool
5 changes pretty dramatically in these situations.

6 And if you waited 18 months to look back to see
7 what happened you may have been going for some period of
8 time with inadequate rates, which is just another thing
9 that I think it would be good know. You know, are states
10 thinking about that aspect of it, particularly in a managed
11 care state? I think it's something that, from painful
12 experiences, that we saw is also important to keep in mind
13 as we're going through this. I know they're juggling a lot
14 of different things.

15 I guess one third comment, I think Jami is spot-
16 on with the waivers that states got that I don't think we
17 have spent as much time talking about the unwinding of some
18 of those and the consequences of those, the impact of those
19 being done suddenly, which, you know, I think that will
20 step into areas of access clearly, but I think it may have
21 other repercussions I don't know if we, as a Commission,
22 have fully discussed.

1 CHAIR BELLA: Tricia, can I ask you a clarifying
2 question? When you use your tracker, what counts for a
3 state to have something that counts as on your tracker as
4 being in the having something versus not having something
5 category?
6 COMMISSIONER BROOKS: So we indicate whether they
7 have posted a plan or a summary of the plan. Typically
8 those are PowerPoints. They're not full plans, often
9 coming through the MCACs, the advisory committees. Whether
10 they've just got any general information on the website,
11 whether it's on the webpage or not. Whether there is
12 encouragement to update your mailing addresses. Whether
13 the state has an FAQ. A lot of the FAQs are provider
14 focused and not necessarily consumer focused. Whether
15 they're providing unique communications toolkits or
16 materials for partners to use. And the last one is the one
17 that is a little harder to tease out right now. It's
18 whether they plan to do a data dashboard or have committed
19 to posting data on their website. So we only have four
20 states, and I'm going to add Arizona to that list. We
21 didn't have them on there yet. But those are the elements
22 we're tracking. And if you just google CCF tracker --

1 CHAIR BELLA: I made myself a note.
2 COMMISSIONER BROOKS: -- you'll find it with CCF
3 Unwinding Tracker.
4 CHAIR BELLA: Of course, none of us are googling
5 during the meeting so we can't look at it now.
6 COMMISSIONER BROOKS: And if I can just add,
7 there is a spot on the tracker where you can download, and
8 it has links to all the documents that we found, so you can
9 actually see what states are saying or posting.
10 CHAIR BELLA: That's wonderful. I think my
11 question or request, Martha, is just, you know, as we think
12 about particularly going into October, having some clarity
13 around -- there's lots of information that we could try to
14 collect or monitor or watch or observe, and understanding
15 how we think about timeliness and frequency and
16 availability and accuracy. And if there are several things
17 we could be look at, like what's realistic to think is
18 actually going to be real time such that a state might
19 think maybe I need to pause here?
20 And the more concrete I think you can be with us,
21 understanding that's a lot of emphasis on call center data,
22 understanding is that going to be the best source of

1 information, and if so, what is CMS saying to the states
2 about call center data and what are the states doing. Many
3 of them use the same vendor, right, or vendors.
4 So I think the more concrete you can help us get
5 about how we might narrow what we think some key indicators
6 are and maybe focus our attention on working with CMS and
7 the states on a key set of indicators. I'm not suggesting
8 we're going to come out with a core set of indicators. I
9 just think we can't boil the whole ocean, and so if we
10 could understand what your findings that you think is going
11 to be timely and most helpful, that would be helpful.
12 Tricia.
13 COMMISSIONER BROOKS: So I would just put my plug
14 in for two pieces of information, both of which should be
15 being reported to the states. The first is the call center
16 statistics, which also can be sort of secret-shoppered. If
17 the state doesn't release it somebody could just make
18 random calls to the call center and keep a track of the
19 call time. There are still some ways to get at that.
20 The second one is in the supplemental unwinding
21 data reporting that CMS is going to require of states,
22 which they do have to publish the share of procedural

1 disenrollments. So they have to show what share was ex
2 parte successful, and of those, where they processed off
3 the renewal form, what share of those were ineligible
4 versus procedurally denied or disenrolled.
5 So if I could only get two pieces of information,
6 those would be the two I would want.
7 CHAIR BELLA: Thank you. Other comments from
8 Commissioners, and also if we want to talk about ex parte
9 at all, that's been an area of interest that came up a
10 little bit today. I'm looking for any other hands.
11 Dennis, did you have a comment? Yeah?
12 COMMISSIONER HEAPHY: I think Jodi's points are
13 really important about the consumer engagement as being key
14 to this. I like Darin's points he raised as well as what's
15 going to happen programmatically in the states once the PHE
16 ends.
17 And then is there any way, based on what you were
18 saying too, Darin, of projecting what the actual costs of
19 churn might be, based on state experience in the past?
20 Because that could be, really, I don't know. I don't know
21 if that's helpful data or not but I think it's level-
22 setting or just clarifying what's happening.

1 And then also in terms of the process itself,
2 letters are not enough, and making sure they’re plain
3 language. But then Arizona is on Twitter and a couple of
4 other ways of doing outreach at well, and working with
5 community groups. But I don't think letters are going to
6 work. I don't know what recommendation we can make about
7 that but I think that's really important.
8 So those are just some quick things I had. Oh,
9 and then MCOs, because they're going to lose money from the
10 churn. So if there's a way to incentivize them to helping
11 them with the administrative pieces of the data so they
12 don't fall off Medicaid, just to get back on again.
13 CHAIR BELLA: Thank you, Dennis. Jennifer.
14 COMMISSIONER GERSTORFF: If there anything that
15 we can do to understand what areas beneficiaries are most
16 affected, I think that would be helpful. You know, is it
17 prescription drugs? Is it behavioral health? Is it kids?
18 Is it adults? That's something that I would be interested
19 in seeing.
20 CHAIR BELLA: Tricia.
21 COMMISSIONER BROOKS: I'm happy to monopolize the
22 conversation if folks want me to, but I just wanted to make

1 a point. One of the things that really bothers me is when
2 I constantly hear about enrollee failure to do this or
3 enrollee failure to do that. And there are a variety of
4 reasons why people lose coverage without being determined
5 ineligible. Sometimes the mail doesn't reach them, the
6 renewal notice is confusing or not in the preferred
7 language, they can't get through to the call center to get
8 questions answered. It's not uncommon for states to lose
9 paperwork that has been sent in. And then there always are
10 issues with people having difficulty getting paper
11 documentation, particularly those who work as gig or cash
12 employees.
13 So I hope that in anything the Commission does
14 that we will refrain from that failure frame on the part of
15 the beneficiary, because I think in reality it's a failure
16 within the system to streamline the process and make it as
17 fluid as possible.
18 COMMISSIONER HEAPHY: As a beneficiary it's
19 overwhelming. You get so many letters, and they can be
20 very confusing. I can't tell you the volume of mail I
21 receive, and other people receive even more mail. And
22 sometimes it just sits there and you stare at it, hope it

1 will go away. Because I don't know sometimes what's
2 important and what's not, and I have an education. And I
3 just can't even imagine what it's like for folks who look
4 at the mail and don't understand what it's saying.
5 So it's daunting to know what to do. It really
6 is. It's daunting. I can't overstate that, especially for
7 neighbors of mine who I help out with this stuff. When
8 they look at it they say, "Dennis, what does this mean?"
9 When something says "Urgent," urgent can also mean I'm in
10 trouble. What's going on? I think the language and the
11 different mail we get from folks, and knowing what's
12 important and what's not.
13 Yeah, I think I just wanted to say that. And the
14 other thing is just reinforcing stereotypes of folks on
15 Medicaid. Thank you.
16 CHAIR BELLA: Dennis, I'm curious. Did you
17 continue to get renewal notices during the PHE, and then
18 did you get a notice that said to disregard this, or how
19 did that work in your state?
20 COMMISSIONER HEAPHY: Yes, I did. Yep. Because
21 I hear it called a mess. I know people that say, "This is
22 a mess. What do I do with this? I got two of these and

1 now I get this one." And they say, "No, you're fine."

2 CHAIR BELLA: And if you needed to update your

3 address, would you know how to do that right now?

4 COMMISSIONER HEAPHY: No.

5 CHAIR BELLA: Okay. Martha, what else do you

6 need form us?

7 MS. HEBERLEIN: That's been really helpful. I

8 have a few more things to add to my October list, but just

9 a few so you can stop there.

10 CHAIR BELLA: Well, you better leave the table

11 because we never stop.

12 COMMISSIONER HEAPHY: My expectation would be

13 that the MCO would contact me and say, "Dennis, did you

14 receive this," or "Dennis, do you know what's going on?"

15 Because that was the expectation that we all had when the

16 plans were created was that they would do that outreach and

17 say, "Are you aware of?" so that churn wouldn't take place.

18 Because it would benefit the plans as well as the person.

19 So that would be my hope, is they would say,

20 "Dennis, we need to talk about that." Maybe it's a high

21 bar to set for the MCO, but that is my expectation.

22 CHAIR BELLA: Tricia. Martha said you can't add

1 to her list.

2 COMMISSIONER BROOKS: I know. I was going to
3 actually say to Martha, I don't know that we have the
4 bandwidth to do this now, but it should be on a future list
5 to look at notices. I mean, I don't think any of us know
6 now horrendous those notices can be. I remember the head
7 of the Ohio Health Policy Institute. She was a guardian
8 for a relative. And she said, "I have a PhD and I can't
9 understand what the state is asking me to do or asking for
10 us to take care of."

11 You know, I've been in this business for 30
12 years. We're still at the same place of people saying the
13 same thing about notices, and at some point it's really got
14 to be something that gets addressed.

15 CHAIR BELLA: I'm sure Dennis would share notices
16 any time we asked, and we will be coming back to you with a
17 question of when you hear from your MCO when this thing is
18 declared over.

19 COMMISSIONER HEAPHY: And I say, "Oh, my god,
20 Dennis. You said you don't know how to change your
21 address." But I truly -- I know how to do it at the post
22 office but I don't know how to do it bureaucratically, like

1 when I call. In general, though, there's so many folks
2 you've got to call and contact. So I think it's
3 overwhelming.

4 CHAIR BELLA: Yeah, I just think, and I'm not
5 trying to put you on the spot, it's pretty telling given
6 how involved you are in the process.

7 COMMISSIONER HEAPHY: -- the policy side of it.
8 Do what they say, not what they do. Because it's very
9 overwhelming. The stack just sits there. Or the stacks
10 sit there. Because most of them are junk. They're just
11 telling you what you were given. And I'm like, "Oh, my
12 god, I've got to take care of this." And that's the
13 difference. It's overwhelming.

14 And then to Tricia's comment, with the language,
15 some of it I have to read through several times.
16 Massachusetts is getting better with the plain language.
17 We're working together with them on the plain language.
18 But even then, it would be helpful if the letter said, if
19 you need help with this contact this organization or these
20 organizations that are working with us, to help you with
21 this. Because that can be less daunting than talking to
22 the state or calling the call center, because you can be

1 forever on a call center line. And if you get anybody on
2 the call center line, the level of knowledge can vary. And
3 so you call three times and you get two different answers
4 or three different answers.
5 CHAIR BELLA: We have the best source of
6 information right here, so thank you, Dennis, for sharing
7 that.
8 Thank you, Martha, for putting together the panel
9 and for continuing this work, and we will look forward to
10 having it come back in October. Thank you.
11 Okay, we are going to transition into our next
12 topic, which is about rate-setting and risk mitigation in
13 Medicaid managed care. Welcome, Sean.
14 **### IMPROVING RATE SETTING AND RISK MITIGATION IN**
15 **MEDICAID MANAGED CARE**
16 * MR. DUNBAR: Thank you, Melanie, and good
17 afternoon, Commissioners. For this session, I look forward
18 to discussing staff's research into managed care rate
19 setting, which is part of the Commission's broader work on
20 managed care oversight and accountability.
21 For today's discussion, I'll first provide an
22 overview of the Commission's prior work as well as some

1 background on recently announced rulemaking that is likely
2 to touch on some of the rate-setting issues we researched.
3 I'll also present a number of policy issues for
4 the Commission's consideration based on our findings.
5 These topics are organized into four groupings
6 based on where the Commission may choose to respond.
7 We'll then spend some time getting your feedback
8 on the policy areas and how you'd like to move forward with
9 our rate-setting work this cycle.
10 Can you pop to the next slide? This doesn't seem
11 to be working. There we go. Sorry.
12 During the last report cycle, MACPAC conducted
13 several studies that provided insight into the managed care
14 rate-setting process; first, an expert roundtable on risk
15 mitigation explored the challenges that states, actuaries,
16 and plans face in responding to unexpected shocks to the
17 system and whether they have the tools necessary to adjust
18 to those circumstances. Stakeholders believe that while
19 the set of tools available to mitigate risks are
20 sufficient, the timing of when those tools can be
21 implemented is limiting.
22 To learn more about the rate development process

1 and actuarial soundness, MACPAC conducted an extensive
2 review of the state and federal rate-setting requirements
3 and practices. We found that states have substantial
4 flexibility to promote efficiency, access, and other
5 program goals while meeting actuarial soundness
6 requirements. But CMS's oversight authority is limited,
7 focusing primarily on compliance with federal requirements
8 for actuarial soundness.
9 MACPAC's work on directed payments last cycle
10 also had implications for rate setting. In particular,
11 among other key findings, that work revealed directed
12 payment arrangements did not have a clear link between
13 quality and access, and the role of actuaries is limited.
14 From that work, the Commission identified several
15 areas of interest, including emerging rate-setting issues
16 such as in-lieu-of services, expedited rate reviews and
17 midyear rate changes, the use of multiyear risk corridors,
18 and partial deferral authority. Staff further researched
19 these areas through additional interviews with CMS, health
20 plans, and state actuaries.
21 Since staff presented those findings from that
22 research last spring, HHS has announced proposed rulemaking

1 expected to be released in late 2022 and early 2023. We
2 anticipate that one of the rules will focus on access and a
3 second rule will address other areas we researched such as
4 in-lieu-of services and state-directed payments.
5 ` Given that these rules provide the Commission
6 with a chance to comment on federal managed care rate-
7 setting policy, we've organized our follow-up work based on
8 how the Commission may choose to respond. These groupings
9 include policy areas that are likely to be raised in future
10 rulemaking, which could be addressed in a comment letter,
11 policy areas that have not been identified on the CMS
12 regulatory agenda but could be raised in a comment letter
13 by the Commission, one policy option that would require
14 changes to statute where the Commission could make future
15 recommendations, and a policy area where we found little
16 evidence to support a policy change and potentially could
17 be dropped from further Commission consideration.
18 We'll walk through the policy areas in each of
19 these buckets and circle back at the end of the
20 presentation for a discussion.
21 As we discuss the first two groupings, please
22 keep in mind the questions for consideration that we

1 included in your background materials for this session.

2 For this first grouping, our goal today is

3 identify what questions the Commission would like to know

4 more about in each of these areas, so staff knows what to

5 bring back for the Commission's consideration over the next

6 several meetings.

7 The first area is treatment of in-lieu-of

8 services and value-added benefits in rate setting. Under

9 current rate-setting rules, nontraditional services that

10 are not substitute services or settings for health care

11 services are considered value-added benefits which can only

12 be funded through the nonmedical portion of the capitation

13 rate. This is an increasing area of interest among states,

14 and CMS is getting an increasing number of questions

15 regarding what services can and cannot be included in the

16 capitation rate.

17 Interviewees believe that further clarity from

18 CMS in what distinguishes an in-lieu-of services and a

19 value-added benefit could help states better structure

20 their capitation rates. For example, state efforts on

21 health equity could be better supported by guidance on what

22 data could serve as a basis for rates and what utilization

1 and population adjustments are appropriate.
2 Additional guidance from CMS indicating which
3 types of in-lieu-of services could be quickly approved or
4 which services are considered appropriate substitutes was
5 also mentioned by stakeholders.
6 States have also asked CMS to provide additional
7 direction on how the MLR can be used as an additional rate-
8 setting tool to support social determinants efforts; in
9 particular, how to factor costs associated with SDOH-
10 related services into the MLR when developing capitation
11 rates and when reporting to CMS.
12 Our research also reiterated prior findings from
13 MACPAC's directed payment work. In particular, that
14 actuaries have very little involvement in the review of
15 directed payment preprints and that the link between these
16 payments and access and quality is unclear.
17 We did learn more about the ways in which the
18 inclusion of directed payment amounts and total capitation
19 complicates rate review and approval by CMS. For payment
20 amounts that are specified by state legislatures, for
21 example, the actuary will calculate a supplemental
22 capitation rate based on projected member months. Even

1 though it's added to the capitation rate overall, these
2 supplemental rates must be retroactively reconciled since
3 actual utilization may vary. In some cases, states may pay
4 the directed payment portion of the rate to MCOs in
5 periodic installments, separate from the monthly capitation
6 rates, and then reconcile based on actual utilization
7 during the rating period.

8 Furthermore, each reconciliation could be
9 considered a rate change, and the state would need to
10 submit a rate amendment for CMS approval.

11 Access was another area identified in our
12 research where gaps exist in the rate-setting process. In
13 particular, there's no federal or professional guidance
14 that identifies specific approaches or methods to address
15 access in rate setting. Typically, if a state is starting
16 a new managed care program and using the fee-for-service
17 fee schedule, actuaries may rely on the state's
18 determination that the rates are adequate to ensure
19 appropriate access to services.

20 And when approving rates for continuing managed
21 care programs, actuaries base their assessments on
22 historical program data. The ability of MCOs to influence

1 access in rate setting is also limited. We heard across
2 these projects that oftentimes plans have limited
3 opportunity or no opportunity to review rate assumptions in
4 advance. Also, MACPAC work on access last report cycle
5 noted that managed care access measures are more structural
6 in nature such as traditional time and distance
7 requirements.
8 As a reminder, we'll circle back to these three
9 areas for more detailed discussion and to determine what
10 staff need to bring back for subsequent meetings.
11 The second grouping we have here includes other
12 policy areas that are likely excluded from the rulemaking
13 on the horizon but where the Commission may be interested
14 in offering comments.
15 The first policy area relates to expedited rate
16 reviews and midyear rate changes. CMS has taken steps to
17 reduce administrative burden on states and streamline the
18 rate review process by introducing the accelerated rate
19 review option for rate submissions that meet certain
20 criteria. However, some stakeholders felt that
21 consideration of expedited rate reviews could be a useful
22 tool during times of emergency, like a future pandemic or

1 natural disaster, and they liken the expedited rate review
2 as something analogous to the Appendix K flexibility that
3 exists for 1915(c) waivers.
4 Other stakeholders had mixed thoughts on the need
5 for an expedited rate review process because during those
6 times, providing a close and careful review to rate changes
7 is important to understanding how states are trying to
8 change their Medicaid managed care programs. Also, midyear
9 changes tend to move faster in general because states,
10 actuaries, and CMS are already starting at a point of
11 having actuarially sound rates.
12 Stakeholders were more aligned in their comments
13 on documentation requirements for midyear rate changes; in
14 particular, clarity on what actuaries need to provide as
15 part of their rate submissions.
16 We heard several examples demonstrating where
17 additional clarity could help improve rate reviews; for
18 instance, when states are submitting an entire rate
19 certification when they're just changing one component or a
20 few components in the rates, as well as documentation
21 around de minimis rate changes.
22 Many states enacted retroactive risk corridors

1 during the COVID-19 pandemic to address the uncertainty of
2 how utilization would change, but this is a one-time
3 flexibility that CMS has no plans to replicate in the
4 future. Now, federal regulations require any risk
5 mitigation strategies to be specified in the contract at
6 the beginning of the rating period. However, states found
7 the flexibility to be a useful tool in responding to the
8 pandemic and see this tool, even if limited to certain
9 circumstances, as useful for any future shocks to the
10 system.

11 Plans find retroactive changes challenging since
12 they make a series of operational decisions over the course
13 of a rating period to course-correct and address any
14 program challenges. Additionally, interviewees noted that
15 states have other tools to make adjustments during the
16 rating period, such as midyear changes or implementing
17 minimum MLRs with remittance requirements.

18 Staff's follow-up work also highlighted issues
19 related to transparency in the rate-setting process. For
20 example, there are no requirements that plans have a chance
21 to review the state's underlying assumptions that rates are
22 actuarially sound before agreeing to accept risk for

1 beneficiaries, and states vary in what and how much they
2 typically share with plans.
3 MCOs stated that having insight into the
4 capitation rates in advance helps them more effectively
5 meet a state's program goals such as hiring additional
6 staff, contracting with different provider types, or
7 developing new screening tools. Actuaries indicated that
8 one of the most helpful tools for them would be CMS
9 publicly posting rate certifications and other relevant
10 materials. They could offer actuaries a relatively real-
11 time roadmap of what's permissible, especially as it
12 relates to emerging areas like in-lieu-of services.
13 There is one policy issue staff looked into that
14 would require a federal statutory change, which is focused
15 in partial deferral authority. MACPAC's research into the
16 rate review process found CMS's oversight is limited.
17 While the agency can ask questions and seek clarifications
18 of assumptions, the agency ultimately can only approve or
19 disapprove of the full rate certification.
20 The idea of partial deferral authority was raised
21 in the 2016 proposed managed care rule, but CMS ultimately
22 concluded that it didn't have the statutory authority to

1 pursue it. This remains a tool that CMS is interested in
2 and was most recently included in the President's 2022
3 budget.
4 Stakeholders that were interviewed had mixed
5 opinions regarding this authority. Some indicated this
6 might be more feasible for separate payment terms outside
7 of the capitation rates like directed payments or certain
8 administrative costs like profit margin assumptions.
9 Interviewees noted this could also be potentially useful in
10 circumstances where a small component of the rate
11 certification is holding up approval such as funding for
12 member incentive program. Once you get into the crux of
13 the per member per month rate, it can be harder to parse
14 out a particular piece without undermining the overall
15 actual soundness of the rate.
16 There was general consensus that if CMS was given
17 this level of discretion, the parameters would have to be
18 very precise, but some stakeholders did think that it could
19 be a helpful tool to the rate review process.
20 There was one other policy area we explored where
21 we found little or mixed evidence to support a policy
22 change. Participants in last year's expert roundtable

1 raised the idea of risk corridors extending beyond the 12-
2 month rating period as a way to spread out plan and program
3 performance. Staff found that there's nothing in current
4 rules prohibiting states from using this approach so long
5 as it's specified in the contract at the beginning of the
6 rating period, but very few, if any, states actually used
7 this approach.

8 Overall, interviewees were not sure if this was
9 more likely to smooth out plan losses or plan profits and
10 likely would prevent states from getting remittances. But,
11 in the past, states have indicated that fewer settlement
12 calculations can save time, especially if a state contracts
13 with a large number of MCOs.

14 Stakeholders noted that states also have other
15 options at their disposal, such as risk adjustment and
16 acuity factors or even carving out a new service or
17 population from managed care temporarily.

18 Stakeholders raised notable challenges to this
19 approach, including reducing the likelihood of payouts or
20 recoupments, which can affect cash flow, especially for
21 smaller plans.

22 The larger risk, that you may have losses or

1 gains from one period commingling with losses and gains
2 from another period as well as the complexities of tracking
3 and reporting a multiyear corridor.
4 Stakeholders ultimately felt that keeping risk
5 corridors aligned with a rating period was the most
6 effective approach.
7 So, as for next steps, there are a few areas
8 where we would like the Commission's feedback today.
9 First, I'd like to focus the discussion on the areas likely
10 to come up in rulemaking. That way, staff will know what
11 to bring back for the Commission's consideration during the
12 next several meetings. In particular, what questions would
13 you like to consider when we facilitate a deep dive on
14 those areas?
15 For the policy areas that may be excluded from
16 rulemaking, we'd like to get Commissioners' feedback on
17 which areas, if any, you think can help inform future
18 comments and that you'd like staff to keep on the table.
19 After that discussion, I'd like to get the Commission's
20 feedback on partial deferrals -- sorry -- and multiyear
21 risk mitigation. In particular, is the Commission
22 interested in pursuing potential recommendations on partial

1 deferral authority, and should multiyear risk corridors be
2 dropped from further consideration?
3 So, as you discuss today, this slide will give
4 you a quick summary of the areas we talked about and sort
5 of the policy areas within those categories. Although I'd
6 also like to note that although we framed the discussion to
7 prepare Commissioners for potential comments as the rules
8 are released, it doesn't preclude the Commission from
9 making any recommendations it would like to make regarding
10 managed care rate setting.
11 Melanie, I can pass it back to you and the
12 Commission for your input on next steps and any questions
13 that you might have on the work that we've done.
14 CHAIR BELLA: Thank you, Sean. There's a lot
15 that I think we need to unpack here.
16 Just for the new Commissioners, can you remind
17 us, them, of the recommendation we made in June? Because
18 one of the slides alludes to this was or was not covered.
19 It was mostly around transparency, wasn't it?
20 MR. DUNBAR: Yeah, that's right.
21 CHAIR BELLA: Directed payments, the cert
22 package.

1 MR. DUNBAR: Yeah. The directed payment
2 recommendations were really focused on transparency of the
3 process, and I think there's a recommendation in there that
4 had to do with clarifying the role of actuaries. You know,
5 we had found that there's three or four different divisions
6 within CMS that had a role and responsibility in reviewing
7 the preprints, and it was vague on what role the actuaries
8 had. So that's what that slide is referring to.
9 CHAIR BELLA: Okay. We have also recommended
10 that the rate certification packages are made public, which
11 is something you're bringing back for discussion today. Is
12 that right?
13 MR. DUNBAR: That was one of the pieces of
14 feedback we heard from stakeholders when doing interviews.
15 Yeah.
16 CHAIR BELLA: Okay, wonderful.
17 Alright. I'm going to go to either Jennifer or
18 Darin to open it up. Who wants it?
19 COMMISSIONER GERSTORFF: So the first thing that
20 I was thinking about with the in-lieu-of services is the
21 data. So a lot of the in-lieu-of services that are used
22 are not necessarily encounterable, and so it wouldn't show

1 up in the administrative claims database. So guidance from
2 CMS on how states would collect the data, how they would
3 validate it, and then how we would ultimately use it would
4 be helpful.
5 CHAIR BELLA: Darin?
6 COMMISSIONER GORDON: I like all of your topic
7 areas, which I'm sure you're surprised to hear.
8 I would say bringing in the directed payments,
9 beyond what we said at this point, feels like merging two
10 different topical areas. Clearly, there shouldn't be a
11 disconnect. So I get that. But I think going too deep
12 into directed payments when we're talking about this can
13 get -- I think we get ahead of ourselves a little bit as
14 we're doing more work on directed payments, but I get that
15 it not be a separate and isolated topic over to the side.
16 The prospective versus retrospective changes, I
17 think, needs to stay on there. Even though CMS has said in
18 managed care regs, you can't do that, they did allow for
19 states to do 1115 waivers, to allow them to go retroactive.
20 To me, that sounds like that door, that pathway, you know,
21 could be used again. I think it's degrees of
22 retroactivity, I think, that we have to keep in mind.

1 If you're talking about -- I would say that if I
2 were talking to plans about, hey, this is what we're going
3 to do, we're experiencing something we never had before,
4 blah-blah-blah-blah, and I'm going to make this request,
5 going back to that time when we're having that conversation
6 might make sense. If I'm going back to a period that's
7 closed, that's what I have a hard time wrapping my head
8 around.
9 So, if the legislature came to me and said,
10 "Darin, I need you to find $500 million," and it's like
11 June 15th and our fiscal year ends in 15 days, it's not
12 feasible. There's only so much I can do, and I think the
13 same would apply to health plans. If I'm asking the health
14 plan, we're going to go back retroactive to a period that's
15 closed, I don't know how the system can react to that.
16 So it's not that I'm opposed to the concept, but
17 I think details matter in this and that is it actionable if
18 you're going retroactive or is it merely pulling back
19 resources after the fact. I think that's a very different
20 issue.
21 The deferral authority, I'm just curious, because
22 the comment was CMS can only reject entire rate

1 certification. When I think of deferrals, it's like after
2 the fact, right? It's like something isn't working the way
3 it's supposed to, and then we get a deferral notice.
4 It seems like in this context, though, we're
5 talking about in the process of requesting CMS sign off on
6 the rates, and I don't know -- I mean, let me say this. It
7 says, you know, that they can only reject entire rate
8 certification. Has that ever happened?
9 MR. DUNBAR: Not that I can think of, but I could
10 look into it.
11 CHAIR BELLA: Wait, wait. Can I make sure?
12 You're asking have they ever --
13 COMMISSIONER GORDON: Have they ever rejected an
14 entire rate cert? Because that was one of the comments.
15 CHAIR BELLA: Aren't the states holding off on
16 putting it in because they think the whole thing could get
17 rejected?
18 COMMISSIONER GORDON: They end up waiting for --
19 more states than not, even though it said in your review
20 that some states may do state-only dollars or, you know,
21 take other ways to try to make sure the system is still
22 going. But it said CMS can only reject an entire rate

1 certification, and I'm just curious if that's ever actually
2 occurred, because it was referenced that that's the only
3 tool that they have.
4 CHAIR BELLA: I'm going to say maybe it hasn't
5 occurred because the -- because of the threat of that and
6 no other option for that, the states don't put them in, in
7 this. So I might --
8 COMMISSIONER GORDON: So I guess you're getting
9 to the same place where I'm getting. If I'm not putting it
10 in until you're going to certify the rates, then you do
11 have a lever. CMS would have a lever, and that I'm not
12 doing anything until you give me signoff. So, if there's
13 issues or areas of concern, I don't understand why they --
14 I don't understand when a deferral would come into being.
15 If I'm not implementing the request, and CMS has a concern,
16 that's the lever CMS has. I'm not approving your rate.
17 CHAIR BELLA: Yeah, but it's holding up. Say
18 there's five things in there, it's holding up four of them,
19 while the fifth one gets worked out, which could be a
20 problem.
21 COMMISSIONER GORDON: It could be, but then a
22 state can make that determination whether or not they want

1 to modify their --

2 CHAIR BELLA: I guess, what's the harm in letting

3 them do partial? Like, what are you worried about?

4 COMMISSIONER GORDON: A partial deferral? I

5 think I am more reacting to deferral. I mean, because

6 deferrals in the context of CMS historically have been I've

7 done something wrong. I've done something inappropriate,

8 and that you are pulling back. And it's -- you know, I

9 didn't meet some federal requirement or used funds

10 inappropriately, and I think maybe I'm getting hung up on

11 that concept is this a deferral versus, you know, something

12 similar to what you have in a state plan amendment request,

13 where it's additional -- you know, additional questions and

14 additional information request. That's a different concept

15 to me. Deferral is a penalty, and that's where I think I'm

16 -- and maybe it's just semantics here.

17 MR. DUNBAR: Yeah. Deferring approval of certain

18 rated components, I don't know if that makes it sound less

19 punitive, but I think one of the examples that I very

20 briefly mention in the slide that one of the states shared

21 with us is it could be something -- there's obviously like,

22 you know, more high-profile things that they could look at,

1 and you might worry about whether they would defer approval
2 on. But it was an example of the state's rate
3 certification was held up about six or seven months as they
4 were trying to iron out whether or not the member incentive
5 program could be included in the rates or if it was admin,
6 and it amounted to -- I don't know -- I want to say a few
7 million dollars or so, which is a lot of money, but, you
8 know, their thought was like, well, you know, if you had
9 the authority to do this, they could have deferred approval
10 of that component as we were ironing things out in just the
11 whole, the rest of the rate certification could go in.
12 That's obviously just one small example, but --
13 COMMISSIONER GORDON: Yeah. And I think that --
14 I mean, I was just thinking back if I was in that role.
15 The reality is that more times than not, I would go ahead
16 and pay the new rates, and if CMS had issues, I would just
17 make adjustments to rates and go back and reprice them.
18 But I know others are waiting, and if you're talking about
19 something that's holding it up, state decision -- a state
20 could decide on, you know, what they want to do if it's a
21 big enough issue for them.
22 MR. DUNBAR: And that came up in the interviews

1 too, which is when we were having some plans and actuaries
2 of, you know, we hear that rates can be delayed a long
3 period of time, anyway, you know. How do you proceed? Are
4 you just using the prior year rates, or are you just
5 funding the increases with state-only dollars? You know,
6 they oftentimes just seemed comfortable doing one or --
7 COMMISSIONER GORDON: Yeah.
8 MR. DUNBAR: -- those kind of approaches.
9 COMMISSIONER GORDON: That's different. Risk
10 tolerance levels.
11 MR. DUNBAR: Right. Right, right, right.
12 COMMISSIONER GORDON: I do think your
13 transparency in rate setting, I mean, it's hard, not only
14 seeing the CMS approvals, but it's hard just finding, you
15 know, documents in states on what rates plan -- some have
16 good information out there, but I do think it's hard to
17 make a case or an argument against having transparency
18 here, so I definitely think that's something we should
19 continue to focus on.
20 The one last comment I will make, which we didn't
21 touch on, and at some point, whether it's here or
22 elsewhere, I do think spending more time looking at risk

1 adjustment in Medicaid I think is a worthy topic. As we
2 think about SDOH, as we think about LTSS, whether or not,
3 you know, the risk adjustment approaches in Medicaid are
4 appropriate to account for these types of issues that
5 there's pretty good evidence they are good reflectors of
6 costs and risks for that population.
7 That's it.
8 CHAIR BELLA: Thank you, Darin.
9 I just have a couple clarifying questions, then
10 Jennifer. So, Sean, I'm trying to remind myself of our
11 work last year on directed payments, and, Laura, maybe this
12 is you, too. We had five recommendations. There were a
13 lot around transparency. Did we decide that we -- I mean a
14 lot of that was getting more information in front of us so
15 that we could understand if there is a problem or if there
16 is more work needed to be done. Is that sort of where that
17 sits? Because, Darin, you mentioned not mixing it in with
18 this. This would be where we would do directed payments if
19 we're going to do anything else on directed payments, I
20 think, until we would get more information that would cause
21 us -- is that right, Sean?
22 MR. DUNBAR: Yeah, I think that focused primarily

1 on transparency and trying to get a better sense of how the
2 payments link to quality and access. But I'm certainly
3 happy to phone a friend in Rob if I'm missing anything.
4 COMMISSIONER GORDON: That was a nod. I guess
5 what my concern is is that, again, I don't want us to fall
6 into directed payments are bad when we haven't done the
7 analysis to bring us back that information, and I'm just
8 saying I don't want to jump over what we had previously
9 requested until we do a little bit of a deeper dive there.
10 That was the point I was trying to make.
11 MR. DUNBAR: Yeah, and I think -- my
12 understanding is that directed payments is likely to be in
13 one of the rules that's upcoming, and it's possible that
14 what's in there tackles some of the issues here. I think
15 our goal was just to make sure everyone felt, you know,
16 prepared and that we've done some of the thinking up front
17 about what might be.
18 CHAIR BELLA: So we may be able to add to that.
19 We can also reinforce our recommendations from last year.
20 Okay. Or this year. We're in the same 2022. Okay.
21 Jennifer?
22 COMMISSIONER GERSTORFF: Well, I thought Darin

1 had a lot of really great comments, and I agree with most
2 everything that he said. I wanted to come back to the
3 partial deferrals and just express that I would -- as an
4 actuary, I would have actuarial soundness concerns with
5 partial deferral, and I'm just opening that up, doesn't fit
6 with the actuarial side of the rates, I think.
7 I also wanted to reiterate what Darin said on
8 transparency and the rate certification. I think that's
9 definitely somewhere to continue pushing.
10 One other point on risk mitigation is getting
11 better clarity on the definition of risk mitigation from
12 CMS, because, again, as an actuary, risk mitigation means,
13 I think, a lot more than what CMS intends it to mean. And
14 so understanding better what can and what cannot change
15 after the rating period has started would be helpful.
16 CHAIR BELLA: Dennis.
17 COMMISSIONER HEAPHY: I have a few comments, but
18 one is I love this part. Some bright actuaries at MACPAC’s
19 risk mitigation tables suggested thinking about how
20 utilization is spent and tend to smooth that over time.
21 And you go into risk corridors. Are you making a
22 recommendation there? Because these were bright actuaries.

1 Or you're just an actuary and think they're bright?

2 MR. DUNBAR: Where?

3 COMMISSIONER HEAPHY: It's on page 4, at the

4 bottom.

5 MR. DUNBAR: I'm not trying to make any

6 recommendations.

7 COMMISSIONER HEAPHY: Just when I read that, I

8 didn't --

9 MR. DUNBAR: I'll also take a look, but I don't

10 think we were trying to --

11 COMMISSIONER HEAPHY: It says allowing risk

12 corridor can wind up -- it was in the slides as well. But

13 financial streamed forward across several years. It wasn't

14 too hard to read that.

15 MR. DUNBAR: Yeah, I wasn't trying to sneak in a

16 recommendation on you.

17 COMMISSIONER HEAPHY: But what are your thoughts

18 on it, I guess? Or others, Darin and other folks?

19 MR. DUNBAR: What slide was it, Dennis?

20 COMMISSIONER HEAPHY: I'm sorry. It's actually

21 in the memo on page 4.

22 MR. DUNBAR: Oh, in the memo, page 4.

1 COMMISSIONER HEAPHY: I do read this stuff.

2 MR. DUNBAR: I appreciate that.

3 CHAIR BELLA: On page 4? Where are you on page

4 4?

5 COMMISSIONER HEAPHY: The bottom, last paragraph,

6 the last four lines, five lines. It says some actuaries at

7 MACPAC's risk mitigation roundtable suggested thinking

8 about how -- or am I reading another document?

9 CHAIR BELLA: No, maybe our paging is just off.

10 MR. DUNBAR: I'm sorry. I'm having a hard time

11 tracking it, but I'll look into it, and I can certainly get

12 back to you.

13 CHAIR BELLA: Do you have any other questions,

14 Dennis?

15 COMMISSIONER HEAPHY: I'll get to it in a second.

16 CHAIR BELLA: Okay. Sonja?

17 COMMISSIONER BJORK: I just want to add my

18 support for Darin's and Jennifer's comments about

19 transparency and the assumptions. I'm not sure that

20 there's a reason to not promote transparency. It just

21 seems like it's the situation where everybody benefits for

22 planning and just understanding where we're going, the

1 different directions. And so I don't know, what's the next
2 step if we're all so interested and supportive of
3 transparency? What would happen next?
4 MR. DUNBAR: I think that's one of the topics we
5 can do a deeper dive on over the next few meetings as we
6 get some more detailed thoughts and ideas of where you'd
7 want to go with that. So I think our goal right now is to
8 just identify the topics and the questions that you'd like
9 to unpack in more detail when we come back on these topics.
10 COMMISSIONER BJORK: I wanted to comment on in-
11 lieu-of services because it's such an exciting area of
12 Medicaid as more and more states and plans are able to use
13 these excellent tools that just make sense for everyone.
14 But it is a challenge, and as Jennifer pointed out, how to
15 report how they're being used, and also in setting up this
16 framework, how to account for the time it often takes for
17 the value to be obvious. I know we're trying our best to
18 tie them into social determinants of health. You can tie
19 certain benefits very closely to an obvious added value,
20 and some are a little more remote. For example, excellent
21 drinking water quality, that's a social determinant of
22 health. And if a state or a health plan focused on that,

1 it certainly would take a long time to be able to tie it
2 specifically to any kind of difference or value in
3 somebody's direct -- in an individual's direct health care.
4 So in setting up the framework, I'm just
5 wondering if we can look at different options for how will
6 we evaluate their effectiveness. And then also in the
7 reporting, everyone needs help in submitting encounter data
8 about these. Everyone's looking for guidance about it, and
9 it's tricky, but I think we can come up with some good
10 recommendations with the help of our staff looking into how
11 these - and, actually, the help of Jennifer as well, what
12 makes sense from an actuary perspective in how we report
13 these things. I'm really interested in that area.
14 CHAIR BELLA: We're going to go -- we've found
15 what Dennis is asking about. It's on the bottom of page 3.
16 Dennis, is it the sentence, "Roundtable participants
17 largely agreed that existing risk mitigation tools are
18 sufficient to deal with shocks"? Is that the one?
19 COMMISSIONER HEAPHY: No.
20 CHAIR BELLA: Oh, shoot. Wrong roundtables.
21 COMMISSIONER HEAPHY: I know it's in there. I
22 didn't make it up.

1 CHAIR BELLA: Okay. Laura?

2 COMMISSIONER HERRERA SCOTT: Just piggybacking on
3 what Sonja said, are there any lessons learned from CMMI?
4 They have certainly funded several initiatives around in-
5 lieu-of services that states are using today, and so are
6 there any lessons learned from CMMI and outcomes related to
7 the things that they have funded?

8 MR. DUNBAR: Alright. Thank you.

9 CHAIR BELLA: Heidi?

10 COMMISSIONER ALLEN: I also very much agree with
11 Sonja and Jennifer in that this is a really exciting way
12 that managed care organizations can innovate and not being
13 able to learn from one another I think is a lost
14 opportunity, too, and also for accountability and
15 transparency, as everybody says. I just want to fully say
16 that I agree with all of those comments.

17 But going to kind of a different area, which is
18 account for access and race, I really would love to be able
19 to think about this with some nuance about, you know, how
20 many providers are participating and where they live in
21 relation to where Medicaid enrollees live, so that
22 enrollees aren't expected to travel super long distances to

1 have access. And so thinking about, you know, provider
2 participation and choice and how these are -- these rates
3 are set across different types of service, particularly
4 like behavioral health care as an example.
5 That's it for my comment.
6 CHAIR BELLA: Thank you, Heidi.
7 VICE CHAIR DAVIS: Thank you.
8 CHAIR BELLA: Dennis.
9 COMMISSIONER HEAPHY: I was actually looking at
10 that same area and thinking that -- one is what's the
11 difference between effective and efficient use of Medicaid
12 dollars. I just wondered about that, but also time and
13 distance is not enough of an adequacy standard. There are
14 other things that need to be taken into consideration,
15 including: Are the providers actually taking new patients?
16 Are they wheelchair-accessible or not accessible? I don't
17 know how much granularity you want to get into that, but it
18 seems that time and distance is not enough, and it needs to
19 be looked at more deeply than just very high level access.
20 CHAIR BELLA: Thank you. Other comments?
21 [No response.]
22 CHAIR BELLA: All right. So let's run the list

1 here. Clearly, we're going to want to comment probably on
2 everything that is in here, lots of comment letters to do
3 this fall. I think we've heard a lot on the in-lieu-of
4 services and value-add. I guess there is certainly a
5 theme, and it looks like you heard it from the stakeholders
6 as well about clarity in guidance. Will that be -- do you
7 envision that we will be reinforcing the need for guidance
8 and clarity, or are we actually going to try to determine
9 what some of that guidance might be?
10 MR. DUNBAR: That's a good --
11 CHAIR BELLA: You don't have to answer now.
12 That's --
13 MR. DUNBAR: Yeah, that's a good question. I
14 think I'll do some more thinking about that as we head into
15 the subsequent meetings to see if there's a way to -- you
16 know, how we might want to approach that.
17 CHAIR BELLA: For what it's worth, to the extent
18 that we can give some ideas, I think that's going to be
19 more helpful than just sort of jumping on the bandwagon
20 that more guidance would be helpful.
21 MR. DUNBAR: Right.
22 CHAIR BELLA: Jennifer, you may be co-opted into

1 some of those things. It sounds like there is interest in
2 continuing to reinforce the work we've done around directed
3 payments and transparency and kind of seeing exactly what
4 CMS is asking for.
5 By the way, as I'm running through this list, if
6 anyone disagrees with this summary, you need to jump in.
7 We heard the least, except for a little bit just
8 now -- thank you, Heidi, for bringing that up, and Dennis -
9 - on access. Is there anything else anyone wants to say on
10 access? Sonja.
11 COMMISSIONER BJORK: I request that we do a look
12 about rural when we're thinking about access. Many people
13 live way out in rural areas because they don't want to be
14 in a city where things are close by, and I think there's
15 other ways to look at the access for rural residents
16 besides time and distance. How else can they get their
17 care, whether it be through telemedicine, is there
18 transportation available, has the state of managed care
19 plan made very serious efforts to contract with the closest
20 providers, and can there be allowances for people getting
21 care across state lines? Sometimes it's very difficult for
22 people to go to the closest provider just simply because

1 they're over a state line, even though that's many miles
2 closer for them. So some of the rules that states have
3 about allowing beneficiaries to get their care in another
4 state, even if that provider is enrolled with the other
5 state's Medicaid program. So just a pitch for making sure
6 that rural gets considered.

7 CHAIR BELLA: Thank you, Sonja. Bob?

8 COMMISSIONER DUNCAN: I would agree with Sonja.
9 I was going to bring that up about being able to cross
10 state lines. Living in Tennessee on the Mississippi-
11 Arkansas border, we saw a lot of that flip-flop back and
12 forth. I'd also call out pediatrics and specialists.
13 Similar to rural, pediatrics are limited, and having access
14 to specialists, sometimes you have to cross state lines and
15 sometimes cross many states.

16 CHAIR BELLA: Thank you, Bob.

17 Okay, so that's kind of in the rulemaking bucket.
18 Other areas that we might want to comment on? Anything
19 else people want to say on expedited rate reviews or
20 midyear changes?

21 COMMISSIONER ALLEN: I'm sorry. I had my hand
22 up. I have one more thing on access.

1 CHAIR BELLA: Sure. Go ahead.

2 COMMISSIONER ALLEN: So I'm wondering if it's
3 possible for states to report their payments by different
4 types of providers as a percentage of, like, what
5 commercial insurance pays on average in their area or
6 Medicare rates, just to get some kind of barometer of how
7 they are performing in the markets that they're providing
8 care in relation to other payers. I don't even know if
9 that's like completely off the table or if that would be
10 something that could help us have a better sense of why
11 people are not getting access in different areas.

12 CHAIR BELLA: Thanks, Heidi. I think, Sean, can
13 you take that back and --

14 MR. DUNBAR: Yeah.

15 CHAIR BELLA: Yeah, okay. Thank you, Heidi.
16 Fred?

17 COMMISSIONER CERISE: I think it's a good point,
18 if you go there, you have to figure in all the other
19 supplemental payments and things like that that go along
20 with it, because it gets really distorted without that.

21 MR. DUNBAR: Melanie, just one point to add to
22 it. I think all of these comments are really helpful,

1 especially about rural and provider types. The backdrop
2 for this particular piece is -- you know, thinking about
3 access, in terms of how it's incorporated into the rate
4 setting, just so -- not necessarily, you know, new sort of
5 access standards for MCOs, but just kind of thinking about
6 it in the rate-setting process. I think these are all
7 helpful topics to think about, and we'll think about how to
8 frame some discussion around those when we come back.
9 CHAIR BELLA: Martha.
10 COMMISSIONER CARTER: I'm sorry to be slow. I'm
11 trying to wrap my brain around my question. I know there
12 are problems in some parts of the country with FQHCs being
13 able to contract with MCOs, and I get the under -- I have
14 the minimal understanding that somehow the rate-setting
15 process can be a problem because of the PPS rate that
16 health centers, the FQHCs, get and how that difference
17 between the regular rate and the FQHC rate gets paid and
18 how that gets factored into the rate-setting process, who
19 pays that.
20 So I'd like to understand that more, and I'd like
21 to understand more where there are problems, because I
22 understand there are problems, but that's about as much as

1 I understand.

2 MR. DUNBAR: Thank you. That's helpful. We'll
3 think about that.

4 CHAIR BELLA: Martha, I'm sure we can figure out
5 some offline resources or people to help walk through that,
6 and probably more than just you would like some clarity
7 there.

8 COMMISSIONER CARTER: Yeah, and I want to also
9 figure out what the barriers are so that MCOs will contract
10 with the FQHCs, which are often one of the main providers
11 in that community.

12 CHAIR BELLA: Thank you.

13 Okay. Anything -- I'm still looking for anything
14 on expedited rate reviews and midyear changes. Verlon.

15 COMMISSIONER JOHNSON: Just because you seem like
16 you really want someone to say something on it --

17 [Laughter.]

18 COMMISSIONER JOHNSON: -- I'll step up. I'm a
19 big proponent of always streamlining, so I guess I just
20 want to understand a little bit more about what the major
21 pain points are related to the process and, you know, the
22 need for us to do this. And then I do take issue, though,

1 with one of the downsides, which was careful review of
2 program changes is important. I just want to remind people
3 that we are streamlining operations. That means that we
4 are trying to make things better, and so there's never a
5 goal to miss a point like that. So I'm just curious about
6 any other information that might be helpful to us, if you
7 want to do that or not.

8 MR. DUNBAR: Yeah, just to your question about
9 pain point, I think the idea was more around just being
10 able to respond quicker if there's a natural disaster or
11 another pandemic, like that, since there were certain
12 aspects that -- you know, like the retroactive piece that
13 we -- you know, it's precluded based on the current --
14 based on current statute, so people were interested in at
15 least having the toolbox for the future, and I think the
16 same applies to the prospective expedited rate reviews,
17 it's just a tool to have should the need arise.

18 COMMISSIONER JOHNSON: I support that.

19 CHAIR BELLA: Thank you, Verlon.

20 So on the retro side, did it generally fall plans
21 and actuaries were not interested and states were
22 interested, or is that overgeneralizing?

1 MR. DUNBAR: I think that's a fair
2 generalization. I think states see it as an interesting
3 tool, yeah.
4 CHAIR BELLA: You spoke with your non-state hat
5 on, I think.
6 COMMISSIONER GORDON: I actually pointed out
7 trying -- well, it's reasonableness, because I've had both
8 experiences where I ignore practical things and then there
9 are systems implications, and then, you know, didn't learn
10 from that. And so my point was being, I think, having it
11 as a tool makes sense. However, there is a point when
12 retroactivity does not. So if I'm going back, you know,
13 two years, that's a different issue.
14 So I like having it as a tool within sensible
15 parameters to where, you know, an action can be taken to
16 effectuate the change that's occurring.
17 CHAIR BELLA: I think that one stays on the list.
18 We'll come back and keep talking about it. Obviously,
19 transparency is something we support in every area. I
20 think we've talked about partial deferral enough. Do any
21 of you -- some guidance there?
22 MR. DUNBAR: Yep.

1 CHAIR BELLA: Partial approval. And then is
2 there anything else? How are folks feeling about the
3 multiyear risk mitigation mechanisms? Bring it back? Let
4 it go? There's a lot of other stuff on this list.
5 Jennifer?
6 COMMISSIONER GERSTORFF: I would propose to let
7 it go.
8 CHAIR BELLA: Thank you, Jennifer. Verlon,
9 what's your vote?
10 [Off microphone.]
11 CHAIR BELLA: Okay. Anybody want to see some
12 more work done in this area to keep it on the list or can
13 we let that one go? It doesn't mean it's gone forever, but
14 there are a lot of other things on here that we're looking
15 at. That sound good to everyone?
16 All right. Sean, do you need anything else from
17 us?
18 MR. DUNBAR: No. This is really helpful. I know
19 this is a lot to go through, so I appreciate your time and
20 attention to it.
21 CHAIR BELLA: Well, we appreciate the way you
22 bucketed it. Why don't you stay there? We have a few more

1 minutes. I'm going to go ahead and go to public comment on
2 this now while we have the time. We haven't had a lot of
3 public comment today, but we'll see.
4 If anyone in the public would like to comment,
5 please use your "hand" icon.
6 [Pause.]
7 CHAIR BELLA: All right. It looks like you're
8 off the hook -- no, no, no. Sorry. We do have a
9 commenter. Monica, if you could please introduce yourself
10 and your organization, and then we ask that you keep your
11 comments to three minutes or less, please.
12 **### PUBLIC COMMENT**
13 * MS. TREVINO: Sure. Good afternoon, everyone.
14 My name is Monica Trevino. I'm the Director of the Center
15 for Social Enterprise at MPHI, the Michigan Public Health
16 Institute.
17 I really just had a comment on the network
18 adequacy and provider access piece. I just wanted to call
19 attention -- and you may have discussed it here at the
20 Commission meetings before -- to a study done by some
21 folks, I think just earlier this year and published in
22 Health Affairs in May: In Medicaid managed care networks,

1 care is highly concentrated among a small percentage of
2 physicians. So the authors actually did a study of several
3 states, I think including Michigan, looking at provider --
4 who is enrolled in a managed care network, and of those
5 providers, who actually sees managed care patients, and it
6 is a shockingly small number. So the number of providers
7 in a network actually bears, I think, very little impact on
8 how access is received by folks in that network.
9 So I just wanted to raise it to the Commission's
10 attention as another possible way of gauging adequacy and
11 access. Thank you.
12 CHAIR BELLA: Thank you, Monica, for raising that
13 and for joining today.
14 All right. Anything else from the Commissioners?
15 [No response.]
16 CHAIR BELLA: Okay. Sean, thank you very much.
17 We'll look forward to having this come back.
18 MR. DUNBAR: Thank you.
19 CHAIR BELLA: Okay. We are moving into our next
20 session, which is about nursing facility payment, and we
21 will welcome Drew and Rob.
22 [Pause.]

1 **### PRINCIPLES FOR ASSESSING MEDICAID NURSING**
2 **FACILITY PAYMENTS RELATIVE TO COSTS**
3 * MR. GERBER: Good afternoon, Commissioners. Rob
4 and I will be bringing for discussion today Principles for
5 Assessing Medicaid Nursing Facility Payments Relative to
6 Costs.
7 To start I'll walk through some background on our
8 nursing facility work plan in the past and how it has led
9 to the work that we are presenting today, and then I will
10 provide a bit of background on nursing facility payment
11 policies and some of what we heard from a technical expert
12 panel that we convened earlier this year. Then I will hand
13 it off to Rob to discuss some of the analyses we ran and
14 preliminary findings and how they can support some
15 potential payment principles.
16 Today's presentation on Medicaid payments
17 relative to costs marks the latest step in our work on
18 nursing facility payment, which the Commission began
19 examining in 2019. Previously we released a compendium of
20 state fee-for-service payment methods, conducted interviews
21 with state officials and other stakeholders, and reviewed
22 payment methods to promote adequate staffing.

1 For this report cycle we plan to synthesize our
2 findings into a report chapter that outlines policy
3 principles for states to consider. Our findings suggest
4 promising practices rather than promote any particular
5 payment methods or amounts. Additionally, the chapter
6 could recommend more support to states on rate-setting
7 activities and greater transparency about payments.
8 To begin, I will review a bit about how nursing
9 facilities are paid. Medicaid primarily covers long-stay
10 nursing facility residents, meaning those residents with
11 stays longer than 100 days. Most Medicaid-covered
12 residents are dually eligible for Medicare. Medicare Part
13 A covers those first 100 days of skilled nursing facility
14 care, and Part B covers many therapy services for long-stay
15 residents.
16 In general, the cost of care for Medicaid-covered
17 residents is much lower than that of Medicare-covered
18 residents because of their lower acuity as well as the
19 different services the payers cover.
20 States make a variety of different payments to
21 nursing facilities, including base payments and
22 supplemental payments, which are up to an upper payment

1 limit in the aggregate for that class of provider.
2 Medicaid-covered residents also contribute a substantial
3 portion toward the cost of their own care.
4 Historically, Medicaid nursing facility payments
5 were required to be reasonable and adequate to meet the
6 costs incurred by an efficiently and economically operated
7 facility, under the Boren amendment. That has since gone
8 but there is still the requirement under 1902(a)(30)(A) to
9 make payments along the principles of economy and
10 efficiency.
11 In determining payment adequacy, costs are an
12 imperfect measure. For example, a facility's costs may be
13 too low to meet resident care needs due to something like
14 understaffing, whereas costs may otherwise be too high for
15 a facility that's run inefficiently or due to costs that
16 are inflated by related party transactions.
17 Most states set nursing facility payments based
18 on costs, with ceilings and limits on which costs are
19 allowable, although there are other methods used by states.
20 In states that do use costs, it is expected that payments
21 will be less than those costs because not all costs are
22 allowable.

1 Now I'll speak a little bit about what we heard
2 in February. We convened a technical expert panel to
3 discuss the federal data sources available for measuring
4 Medicaid payments relative to costs. The panel comprised
5 state and federal officials, nursing facility
6 representatives, accounting firms, and researchers.
7 Their feedback about benefits and concerns
8 related to data quality point us toward three main sources
9 for our analyses -- Medicare cost reports for measuring
10 facility-level costs, the Transformed Medicaid Statistical
11 Information System, or T-MSIS, for base payments, and the
12 upper payment limit, or UPL, demonstrations for
13 supplemental payments.
14 For our analyses we examined 2019 data from these
15 sources, preceding the pandemic, which as we know has
16 impacted and disrupted facility finances.
17 Using that 2019 Medicare cost reports data we
18 established components of nursing facility costs. As you
19 can see in this pie chart, 80 percent of costs, in a SNF or
20 NF cost center, represent costs that are mostly for
21 services covered by Medicaid, whereas 14 percent are
22 ancillary costs, which mostly represent services such as

1 therapy that are covered under Medicare.

2 Additionally, in that 80 percent we see that

3 about half of those costs stem from wages for direct care

4 staff, whereas the others are attributable to other patient

5 care expenses and capital expenses.

6 When we are considering payments relative to

7 costs this sort of shows that not all Medicaid payments are

8 meant to cover the total costs a nursing facility might

9 incur. As we see here, looking at average nursing facility

10 costs per day, we can see they differ depending on the

11 method used to calculate them. In this left column here

12 the total facility costs per day are higher, $293 on

13 average, compared to when you take only Medicaid-allowed

14 costs and adjust according to acuity, which are then lower.

15 These average per diem costs also vary by the share of

16 residents whose primary support is Medicaid, as you can see

17 along the bottom row here. Those facilities that have the

18 highest share of Medicaid-covered residents, in the right

19 column here, have, on average, lower costs than the

20 facilities that have the lowest share of Medicaid-covered

21 residents.

22 For measuring nursing facility payment rates, T-

1 MSIS is the only federal data source with managed care
2 payment data. There are 24 states that currently have
3 managed long-term services and supports, or MLTSS,
4 programs. However, we did find that for many states, fee-
5 for-service and managed care payment rates were similar.
6 Base payment rates include the allowed amount
7 that Medicaid will pay for covered services, which is
8 higher than the net payment that providers receive, often
9 due to the post-eligibility treatment of income which
10 governs how much beneficiaries contribute toward the cost
11 of their care. Our analysis of 2019 data found that
12 resident contributions to their share of costs accounted
13 for about 10 percent of total payments. Therefore, allowed
14 payment amounts tend to be most appropriate when looking at
15 payment to costs in our analyses.
16 Unfortunately, the UPL demonstrations have
17 incomplete information on supplemental payments. Total
18 spending reported on the UPL does not always match that on
19 the CMS-64 state expenditure reports, and we found
20 discrepancies throughout between the data sources, which
21 states were making supplemental payments.
22 Additionally, we do not have information on

1 provider contributions to the non-federal share of nursing
2 facility payments, such as from provider taxes.
3 I will hand it over to Rob now to walk through
4 the analyses we conducted and to present some of our
5 preliminary findings.
6 * MR. NELB: Great. Thanks, Drew.
7 Ultimately, we were able to identify base payment
8 and cost information for about 13,000 facilities in 47
9 states and D.C., which represents about 91 percent of all
10 freestanding facilities that are dually certified by
11 Medicare and Medicaid. As Drew mentioned, we didn't have
12 quite as much information about supplemental payments, but
13 we did look at it where it was available.
14 Overall, as you'll see on the following slides,
15 we found that base payment rates varied widely across
16 states and within states, even after adjusting for wages
17 and resident acuity. We also found supplemental payments
18 have a substantial effect on payment rates in some states.
19 And our preliminary analyses about payment rates and
20 staffing didn't yield any clear results, but we are open to
21 doing more work in this area.
22 First, this slide looks at base payment rates.

1 It shows base payment rates per day relative to the
2 national average. So just to help orient you, an index
3 value of 1 represents payments that are equal to the
4 national average, and an index value of 2 are payments that
5 are twice the national average.
6 This is a box graph, so the boxes represent the
7 interquartile range, and then the dots are kind of outlier
8 values that are more than 1 ½ times the interquartile
9 range. Taking you back to math class there.
10 These values are adjusted for differences in the
11 Medicaid wage index as well as differences in patient
12 acuity. So it's notable that even after making these
13 adjustments we see such wide variation between states and
14 also within facilities in a particular state.
15 This next figure looks at base payment rates
16 relative to costs, and here we also see wide variation.
17 Nationally, the median base payment rate was 86 percent of
18 costs in 2019, but as you can see about 20 percent of
19 facilities appeared to receive payments in excess of 100
20 percent of costs, and about 15 percent of facilities
21 received payments less than 70 percent of costs.
22 However, the information we have on base payments

1 only tells part of the story. This figure illustrates the
2 potential effects of supplemental payments in two states
3 where we did have some provider-level data. As you can
4 see, on State A, in the left, if you just looked at base
5 payment rates alone it looks like more than half the
6 facilities are paid less than 60 percent of costs. But
7 after including supplemental payments we find that almost
8 half of facilities are actually paid more than 100 percent
9 of costs.

10 In State B, payment rates are close to the
11 national average, with many facilities receiving between 80
12 and 100 percent of costs. But after accounting for
13 supplemental payments most facilities in this state appear
14 to be paid more than 110 percent of costs.

15 Here it's important to note that most
16 supplemental payments are financed by providers, typically
17 in the form of provider taxes or intergovernmental
18 transfers. We don't have data on these provider
19 contributions but they end up sort of reducing the net
20 payments that provider receive.

21 Finally, when we look at staffing, we found some
22 sort of conflicting signals. First, on one hand,

1 facilities with higher staffing rates did pay workers
2 higher wages. However, we didn't find a clear relationship
3 between Medicaid payment rates and staffing. Specially, it
4 was interesting to note that facilities with lower staffing
5 ratings actually had higher Medicaid payment margins, and
6 one of the reasons for this is because their costs were
7 lower since they weren't paying as much of their revenue on
8 staff.
9 To try and adjust for the effect of staffing
10 rates on Medicaid margins we did look at payment rates
11 relative to costs, looking at what the costs would be
12 assuming that facilities staffed up to a higher level.
13 However, even after making this adjustment it was difficult
14 to find a clear relationship between payment rates and
15 staffing levels.
16 And some of this may be due to the differences in
17 payment methods, which we talked about last December. For
18 example, in many states with higher minimum staffing
19 standards they had higher staffing rates, regardless of the
20 payment rates.
21 I know we've presented a lot of data to you
22 today, and it's late in the afternoon, but we're hoping we

1 can kind of step back and get your thoughts on what types
2 of conclusions we might be able to draw from our work so
3 far about payment principles for states to consider.
4 Despite our data limitations, we are hoping the
5 idea is that we might be able to draw some payment
6 principles that could help guide future analyses and also
7 help support states if they are trying to make their own
8 payment reforms.
9 We are not trying to prescribe exactly how states
10 should pay nursing facilities, but if the Commission is
11 interested these principles could lead to potential
12 recommendations about improving data availability and
13 supporting states.
14 To facilitate your discussion today we have
15 organized some potential principles according to MACPAC's
16 provider payment framework, which is based on the statutory
17 goals of efficiency, economy, quality, and access. So just
18 to define the terms here, economy is a measure of what is
19 spent on provider payments, quality and access are sort of
20 measures of what is obtained as a result of payment, and
21 efficiency is the ultimate goal that we're aiming for,
22 really a measure of whether we're getting what we're paying

1 for.

2 First, with economy, the Commission may want to
3 reiterate a policy principle that has guided our prior work
4 on hospital payments, which is that it's important to
5 collect data on all Medicaid payments that providers
6 receive as well as sources of non-federal share that are
7 necessary to calculate net payments to providers. We could
8 also make a recommendation that CMS collect these data.
9 CMS is currently in the process of collecting more
10 provider-level supplemental payment data in response to our
11 prior MACPAC recommendations. However, we still don't have
12 data on sources of non-federal share.

13 In addition, as Drew mentioned, for nursing
14 facilities, in particular, it is very important to get
15 information on allowed payment amounts rather than the
16 actual paid amount for facilities because residents
17 contribute so much to the cost of their care. So we may
18 want to highlight that data element, in particular.

19 The Commission could also comment on the
20 importance of developing better measures of costs of care
21 for Medicaid-covered residents. Our analyses has
22 illustrated the importance of adjusting for acuity, but

1 it's important to note that the adjustments that we made
2 came from a CMS staffing study that's quite old, so some of
3 our members have suggested that it might be valuable for
4 CMS to update these studies to help enable more accurate
5 payment analyses in the future.
6 Next, regarding quality and access, our work so
7 far has highlighted the importance of staffing and
8 Medicaid's role in helping to reduce disparities in
9 staffing for facilities that serve a high share of
10 Medicaid-covered residents, which also serve a high share
11 of racial and ethnic minorities.
12 So far it seems like we don't have quite enough
13 evidence to recommend a particular payment model, although
14 we can point to a number of promising models, including
15 opportunities for states to improve their payment methods
16 without necessarily changing their payment rates.
17 Over the summer, CMS signaled its intent to
18 revise federal minimum staffing standards, and so we are
19 monitoring this and may want to comment about the potential
20 effect of this change on state Medicaid programs in the
21 future.
22 Also, as we're developing a report chapter, it is

1 an opportunity for the Commission to comment on other
2 quality and access challenges besides staffing. Some areas
3 we might want to comment include reducing hospital
4 readmissions, increasing the availability of private rooms,
5 and managing nursing facility closures. We haven't done
6 quite as much work in these areas but we can review
7 information that's available and signal areas for future
8 work.
9 Finally, in order to measure whether Medicaid
10 payments are efficient, more detailed, state-level analyses
11 are likely needed. During our prior interviews with states
12 we learned that the states we spoke with had a relatively
13 limited capacity to conduct their own rate studies, and we
14 learned that CMS doesn't currently require them in its
15 review of nursing facility payment rates. And so as a
16 result, many nursing facility payment methods have largely
17 remained unchanged over the past several years leading up
18 to the pandemic.
19 One option for the Commission to consider is
20 whether to require states to regularly assess payment rates
21 and outcomes in a way that's publicly available and
22 supported by CMS, so that the public can have a better

1 understanding of payment rates within and across states.
2 CMS used to require states to conduct such studies, but the
3 requirement went away when the Boren amendment was repealed
4 in 1996.

5 In order to promote efficiency the Commission may
6 also want to comment on other ways to encourage states to
7 test new payment models. We have been monitoring the
8 recent efforts at CMMI to integrate payments for patients
9 dually eligible for Medicare and Medicaid, and we could
10 talk about opportunities for more work in this area.

11 All right. So that concludes our presentation
12 for today. We are happy to answer any questions about our
13 analysis, but we are also hoping to get your feedback on
14 some of these draft payment principles and any
15 recommendations that we should further develop and
16 potentially include in our forthcoming chapter. Thanks.

17 CHAIR BELLA: Thank you, Drew and Rob. Good
18 thing you volunteered, Bill, because you were about to get
19 co-opted to go first anyway.

20 COMMISSIONER SCANLON: Yes. Thank you, Drew and
21 Rob. I mean, it's really heartening that we are continuing
22 this dialogue because this is such an important area. The

1 pandemic was not the first time the spotlight was on
2 nursing homes but it certainly was a very bright spotlight
3 in terms of how much we should be concerned that we're
4 doing the right thing for this very vulnerable population.
5 So thank you again.
6 Now, this dialogue, though, as you have
7 discovered, is incredibly complicated, and I think that
8 part of, as you said, as one of the goals is to try and
9 give some states some guidance in terms of practical
10 measures to take in thinking about how to approach policy.
11 And the standards that are in Section 1902(a)(30)(A), I
12 think they are key, and the problem with those standards or
13 those words is they have not been well defined. And that
14 was a very big handicap with respect to the Boren
15 amendment. The Boren amendment talked about efficiently
16 and economically operated facilities, but no one knew what
17 an efficiently and economically operated facility was. So
18 there was all this contention, which turned up in court,
19 and cost an incredible amount of resources as there were
20 arguments over what constituted that kind of facility.
21 So I think we are going to have to come to grips,
22 and I wouldn't propose that we think we can do it in an

1 afternoon or even after several meetings. We need to think
2 about how best to define those terms that will be guidance
3 that is going to be practical for the states to use.
4 And I'm going to differ with you a little bit
5 sort of on the economy, and this is kind of -- I'll
6 confess, I've worked on nursing homes before, and I feel
7 like they are a misunderstood sector, that they are very,
8 very different than the rest of health care. In one part,
9 Medicaid has been, forever, the dominant payer. It's the
10 only program or only service for which Medicaid is the
11 dominant payer.
12 The other thing which is very important is there
13 is also what I'll call a private market for nursing home
14 care. It used to be much bigger before Medicare grew in
15 size, but there still is like 20 to 30 percent of residents
16 are paying out of their pocket. They are doing so because
17 they recognize their need for care, or their families
18 recognize their need for care. They are able to sort of
19 evaluate in terms of how good that care is for them, and it
20 can be very distinctive than the care that's given to
21 others. So we need to be thinking about that.
22 Because I think a lot of people don't think of

1 nursing homes as being sort of heterogeneous, I try to use
2 other examples, and let me use my car example. Toyota
3 makes Camrys, Corollas, and Lexuses. I wouldn't call a
4 Lexus economical. So that's the kind of thing I think we
5 need to be thinking about in terms of what is the true
6 definition of economy. And it goes back to the one chart
7 you showed where you showed that there are 15 percent of
8 facilities which are being paid less than their costs. How
9 concerned should we be about that? And I think it depends
10 upon which facilities those are? What were their
11 circumstances?

12 And you said that facilities with higher staffing
13 and were paying higher wages. That could be consumer
14 choice. People with resources have gone to places where
15 there was more money being spent. But then the question
16 becomes, what is Medicaid's role in a facility like that?
17 So I think that we need to be talking about that sort of
18 for the future.

19 The other thing I would emphasize is that payment
20 policy is only sort of one of the tools that we have to
21 ensure that we accomplished the goals for Medicaid, sort of
22 in Medicaid eligibles in nursing homes.

1 Payment policy, it's constantly talked about in
2 policy circles about how we need to structure payment
3 policy to encourage efficiency. The reality is that
4 payment policy encourages lower cost, but lower cost can
5 come two ways -- by being efficient, which is to produce
6 sort of the same product at a lower cost, or by cutting
7 your quality of product so that your costs go down. We do
8 not want to have the incentive to be to cut the quality of
9 your product, and I'm afraid that what we have now in a lot
10 of payment policies is that simple -- if you can cut your
11 costs, you get to keep the difference, and that becomes too
12 strong of an incentive to reduce quality. So we have to be
13 thinking sort of about that.
14 Recognizing the limitations of payment policy, we
15 need to be thinking about what else should we be doing, and
16 there, it becomes critical that we look at our standards
17 for the quality of care and we assure that there is
18 compliance with those standards for the quality of care,
19 and that -- I mean, as long as -- there's been this long
20 history discussion of nursing home payment, there's also
21 been this long history discussion of our failure to
22 adequately assure compliance with the standards for nursing

1 facility care. And that is as critical as improving sort
2 of and assuring adequate reimbursement. It's critical that
3 we assure that we have compliance with the standards that
4 we set for quality of care.
5 So this is going to be a long sort of dialogue,
6 but it's so important and feel very good about the fact
7 that we're now engaging in it in this cycle. Thank you.
8 CHAIR BELLA: Can I ask you a question, Bill?
9 Because my head is spinning a little bit on this. When
10 you're talking about when you're looking at payment and
11 payment level, are you always talking about base plus
12 supplemental?
13 COMMISSIONER SCANLON: Unfortunately, yes, okay,
14 because we have -- you have -- we have to be asking --
15 CHAIR BELLA: Why is that unfortunate? Like,
16 that's supposed to be reality, right?
17 COMMISSIONER SCANLON: Well, it's the reality
18 because -- in the old world where I used to work, we only
19 had base, and we had a much simpler job, much easier than
20 Drew and Rob had in terms of finding measures sort of what
21 we being paid.
22 But now we have -- you're right. The reality is

1 there are significant supplemental payments. The question
2 would be, why would we make these payments if we weren't
3 going to be expecting that they're going to be invested
4 sort of in the care that is being provided sort of to our
5 residents?
6 So, yes, we have to focus on both, and that's an
7 issue of -- I mean, the transparency one is
8 straightforward. There needs to be data on every dollar
9 going in and how those dollars are being spent.
10 CHAIR BELLA: I'm just trying to figure out --
11 you called attention to the people at the bottom. Are you
12 also worried about the people at the top in reallocating
13 some of those dollars, or are you only worried about the
14 facilities at the bottom?
15 COMMISSIONER SCANLON: I think we need to look at
16 both, the entire distribution, okay? And the issue in
17 following people that are just, in some respects, "breaking
18 even," we have to be asking, well, what is the product that
19 they can produce when they break even with those level of
20 the cost?
21 So, I mean, I think this is an issue where that
22 three-dimensional array doesn't tell you the whole story

1 because there's so many other dimensions that need to be
2 considered.
3 CHAIR BELLA: Comments? Laura.
4 COMMISSIONER SCOTT: Well, just to piggy back on
5 some, and I'm certainly not a subject-matter expert here,
6 but a couple things. You already talked about the staffing
7 model, right, and CMS looking at that, and so understanding
8 what that staffing model looks like.
9 And the outcomes or the quality of care that a
10 patient receives based on the staffing model, I think to
11 your point about the payment and the higher margins,
12 there's also been a change of ownership based on those
13 margins. And so what has been the implication? And I'm
14 not suggesting you take that on. That's a whole other
15 issue, but because it's become an attractive financial
16 opportunity, ownership has changed. And then those
17 staffing ratios have gotten smaller and smaller and smaller
18 to make the margins bigger and bigger and bigger, and
19 that's an editorial comment.
20 But even just to look at the staffing and the
21 outcomes for starters and is those higher-cost facilities
22 just for self-pay, or they're, you know, traditional, you

1 know, entities that are really still altruistic to the
2 clinical model of providing long-term care and support
3 services, and does that make a difference? If there's any
4 way to get at that, that would be certainly something I'd
5 be interested in.
6 CHAIR BELLA: Thank you, Laura.
7 Can we go a couple slides back? Can we just make
8 sure we've talked about -- can we go back to the -- I think
9 the first one was economy. Okay. Is there anything folks
10 would like to talk about specific to -- this is about
11 collecting payment rate information and data on non-federal
12 sources. I think we said yes; that's of interest.
13 Staffing studies, yes. You're hearing a lot of
14 interest on staffing and understanding staffing.
15 Do you have what you need from us on the economy
16 piece?
17 MR. NELB: Yeah. I think this is, yeah, helpful,
18 and we can -- we'll flesh out more what it is. I think the
19 point with the staffing study, it can be both useful on
20 helping to better, more accurately capture the cost, but
21 also the other piece, I think, that you talked about is
22 figuring out for residents with certain care needs, this is

1 the amount of staff time that you do need, which can inform
2 the minimum standards but also, you know, thinking about
3 what that baseline amount should be from a care
4 perspective. So it has quality and access benefits as well
5 as the economy slide where we put it on.
6 COMMISSIONER HEAPHY: Can I ask a question? I
7 read something about there's a movement away from owning
8 the facility to renting the facility, and that that
9 increases the cost. Is that something you can also factor
10 into the calculations? Would that be beneficial to see
11 what that -- what the cost looks like now?
12 MR. NELB: Sure. So a couple, just comments,
13 maybe related to the ownership piece. So we -- I mean, in
14 our various studies, we do see that, yeah, the for-profit
15 facilities are the ones that do tend to have lower staffing
16 because it's sort of an incentive to reduce staffing costs.
17 They are also -- interestingly, for-profit facilities are
18 more likely to serve Medicaid-covered residents. Like, the
19 facilities that serve the highest Medicaid-covered
20 residents and racial/ethnic minorities are also more likely
21 to be for-profit, which is just an interesting piece.
22 I think, Dennis, regarding your comments about

1 ownership -- so, initially, we have the normal ownership
2 categories, you know, for-profit, nonprofit, government,
3 but then there's been a trend as part of the supplemental
4 payments that even though the facility is administered by a
5 for-profit entity that it is like technically owned by the
6 government for the purpose of making supplemental payments.
7 So that's part of the supplemental payment transparency and
8 sort of better understanding these sources of non-federal
9 share for that first option there. So both angles, we want
10 to take a closer look at.
11 CHAIR BELLA: So the last study, you said was
12 done like 15 years ago?
13 MR. NELB: Yes.
14 CHAIR BELLA: Yeah? Okay. So these are not --
15 this is not happening on an annual or regular basis.
16 MR. NELB: Yeah.
17 CHAIR BELLA: Fred?
18 COMMISSIONER CERISE: Just a question about that.
19 I mean, how important is -- how much do you think that has
20 changed, when we know that higher staffing should correlate
21 with better quality of care in general? I think that's a
22 fair assumption, and so if we think that's important in

1 whatever payment approach we take, how critical is it to
2 take on the details of the staffing study versus the policy
3 implications of either base or supplemental payments
4 targeted towards better staffing?

5 MR. NELB: Yeah. So a good point. Yeah. We
6 have continued research showing that relationship between
7 staffing and quality outcomes. The prior study was based
8 on CMS used to use a method called "resource utilization
9 groups" to sort of classify residents in a nursing facility
10 based on their different care needs, and so part of that
11 study is sort of identifying if you have this level of
12 need, this is how much staff time you need to help with
13 your activities of daily living or other therapies and
14 things.

15 Medicare has now switched to a new method called
16 the "patient-driven payment model," and it kind of
17 correlates to RUGs, but it's slightly different. And so it
18 could be an opportunity. We've done prior work on those
19 different models, and the new model was designed for
20 Medicare but not really for Medicaid, and so there could be
21 opportunities to more closely look at the long-stay
22 Medicaid population and sort of be the care that they need.

1 Yeah, wide consensus that, you know, staffing is
2 important, you know, more staffing the better, but to the
3 point of trying to get at, you know, for these long-stay
4 residents who are very different from the short-stay folks
5 coming off of the hospital stay, you know, trying to more
6 closely tailor the services to what a patient needs.
7 CHAIR BELLA: Thank you. I'm going to go to
8 Heidi.
9 COMMISSIONER ALLEN: Hi. Thank you so much.
10 This is super interesting and important.
11 One question I have is -- I don't know if anybody
12 read The New Yorker article that came out three weeks ago
13 about when private equity purchases nursing homes and what
14 happens to quality, and I'd be really interested to
15 understand more about what's happening there, if that is
16 something that we should be concerned about on a broader
17 level than, you know, this one article.
18 Additionally, I'm also wondering about what is
19 charged to patients and how that relates to their fixed
20 incomes and what happens if what is being charged is more
21 than they actually have. Does that mean that they can't be
22 there? I just don't understand, and I apologize if I just

1 missed it somewhere, how those determinations are made.
2 Maybe somebody here knows and can explain it to me.
3 MR. NELB: I can explain a little bit. It's a
4 little bit different than, like, cost sharing and other
5 sectors where you pay that amount up front and then get the
6 care.
7 With nursing facilities, the payment is taken
8 sort of after the fact. So someone is eligible and
9 enrolled, receiving care in a facility, and then basically,
10 the difference between their income and what's called a
11 personal needs allowance, sort of all of that income goes
12 to the facility to pay for their care. And so the average
13 personal needs allowance is like $50. So if someone has
14 other --
15 COMMISSIONER ALLEN: So $50 a month, that is all
16 they have that's there?
17 MR. NELB: Yes. And they have limited assets.
18 Yeah. It varies by state, and so we could comment about --
19 I know with HCBS, we're looking at separate personal needs
20 allowances, but that's -- yeah, it ends up for pretty much
21 most of the person's income goes to the cost of their care.
22 COMMISSIONER ALLEN: Thank you.

1 CHAIR BELLA: Thank you, Heidi.
2 Other comments from Commissioners?
3 [No response.]
4 CHAIR BELLA: Okay. Let's go to the next slide,
5 please, on quality and access. Anything that folks want to
6 additionally comment on here?
7 Fred.
8 COMMISSIONER CERISE: Are you asking for
9 comments, if we want to comment on minimal staffing
10 standards? I think we covered that a bit.
11 You know, other quality and access issues to
12 comment on, I know there are a lot of those that exist, you
13 know, falls and antipsychotic use and UTIs and pressure
14 ulcers and things like that, so not to add to that list.
15 I did have a conversation with Kathy about oral
16 care and the importance of that. I don't typically see
17 that in these quality metrics, but it's an important one.
18 And maybe Kathy can comment on that.
19 And then one that you mentioned, it really gets
20 at a point of, you know, what's -- what accrues to the
21 benefit of Medicaid or Medicare is hospital readmissions,
22 which would take an investment on the nursing facility

1 side, that the benefits would accrue to the Medicare side.
2 We put a lot into the issue of how do you coordinate care
3 for the dual-eligible people. You know, I just wonder if
4 whether it's through base payments or through supplemental
5 payments that you -- but you just have to get out in front
6 there and say we'll make this a Medicaid investment,
7 recognizing that the benefits are going to accrue to the
8 Medicare side, right? So do you put people, you know,
9 physicians, nurse practitioners, in the nursing home to
10 take care of stuff that would ordinarily result in an
11 ambulance ride or through telehealth or whatever. Those
12 take investments on the side of the nursing home, but
13 they're going to accrue to the Medicare side of the ledger,
14 right? And so I think it's a question worth us thinking
15 about.
16 MR. NELB: That's been the theory behind some of
17 the recent CMMI demos is to use the savings from the
18 Medicare side to help provide additional staff extenders in
19 the nursing facility. The initial demo found, you know, by
20 providing some more care, you could help reduce some of the
21 readmissions, but the second phase of the demo, trying to
22 put the financial incentives in place didn't have as much

1 of an effect. So there's more work to be done in that
2 area, but the theory behind it seems to make sense.
3 CHAIR BELLA: Any other comments on quality and
4 access? If not, we'll go to efficiency.
5 Dennis?
6 COMMISSIONER HEAPHY: Yeah. I think the value-
7 based purchasing, something needs to be done, regardless of
8 who is going to benefit Medicare and Medicaid, to ensure
9 that we don't have high mortality rates and morbidity rates
10 in nursing homes because it's just not acceptable.
11 I mean, those of us who live in the community
12 would rather die than go into a nursing home because the
13 conditions are so bad in nursing homes. With the rate of
14 hospitalizations and quality of care, it's just so poor.
15 Matter of fact, a provider that I work with said
16 there are only two nursing homes I'd ever use because the
17 rest of the ones in the state are just not -- don't provide
18 the quality.
19 And so I think we have an obligation to
20 prioritize quality of care and higher staff, whatever it
21 may be, and look and see where are costs being -- where are
22 dollars being siphoned off to admin or other areas. It

1 really should be put towards the care of the folks living
2 there in the facilities.
3 CHAIR BELLA: Thank you, Dennis.
4 All right. Last area, efficiency. Any
5 additional comments here? The first one, it's hard to
6 argue with periodic and regular assessments in the
7 transparency theme. Bob?
8 COMMISSIONER DUNCAN: Yeah. That's exactly what
9 I was going to say. I mean, it's shameful to see that that
10 has not happened, so yep.
11 CHAIR BELLA: And I think what you were just
12 referencing, Rob, on the nursing facility, two-phase demo
13 might be what you're talking about, the bottom here. Yeah.
14 I think if there are lessons learned from that,
15 that we can perhaps support or suggest building on that,
16 that would be additive to the discussion.
17 Martha?
18 COMMISSIONER CARTER: Thank you.
19 As with all of our work, cross-cutting is on the
20 issue of equity, and I think that fits best under quality
21 and access. But to the extent that data are available,
22 what are the equity issues around race, ethnicity,

1 morality, language, ability, disabilities? So I think we
2 just need to try to keep that in the forefront as well.
3 CHAIR BELLA: Thank you, Martha.
4 Other comments from Commissioners before we move
5 to public comment?
6 Kathy.
7 COMMISSIONER WENO: I was just thinking about
8 this too in terms of urban versus rural. You know, coming
9 from a rural state where there's a lot of older citizens, I
10 think, you know, you've also got intense workforce problems
11 there. So I was just wondering about the payment schedules
12 in rural versus urban areas.
13 And then also just to tag on to Fred who gave me
14 an opening for oral health, it's been a number of years
15 since I worked in nursing homes, but -- and I know it
16 varies from state to state, but just for your information,
17 in general, if you're in a state that doesn't have a
18 Medicaid coverage for an adult, you're pretty much
19 competing for payment for your oral services on that
20 personal needs allowance. So we would always say we didn't
21 want to follow the lady who did the haircuts because they
22 already spent all their money, and we weren't going to get

1 paid that month. So it's kind of like that's your
2 competition, oral care or haircuts or the guy who cut the
3 toenails.
4 CHAIR BELLA: On that note, any other comments
5 from Commissioners? It's a reality, though, I know.
6 Fred?
7 COMMISSIONER CERISE: Just one final one. As we
8 go further and look at the work, I notice on the panel,
9 there were two industries. One looked like a trade person,
10 which you generally know what you're going to get there,
11 but I do wonder if engaging some of the higher performance,
12 the ones that have higher staffing ratios, that tend to
13 look like they're doing a better job, with this engaging
14 some of them to get some of the real insights from the
15 industry on what some of the real barriers are, because
16 like Bill was saying, it's a mixed bag of what you got
17 there. It could be good providers, and you have the people
18 that are in it for the business and that are going to try
19 to make the margin, no matter what, and probably engaging
20 some of those good providers would be helpful in bringing
21 some insights into what some of the challenges are,
22 because, you know, Medicaid -- you want to pay so that

1 people are getting good care in the facilities, and I think
2 getting some more insight from the industry could be
3 helpful.
4 CHAIR BELLA: Thanks, Fred.
5 Darin?
6 COMMISSIONER GORDON: This made me think when we
7 were talking earlier about how much costs go into
8 administrative. I'm always -- words matter. So, like,
9 where does compliance usually show up? Is it going to show
10 up in administrative or training capacity? Is that going
11 to show up in administrative versus something? I just
12 think understanding when we use those terms, what's in it,
13 because, quite frankly, if compliance is there, I would
14 want to see a decent amount of resources going towards
15 that. So, when we're thinking about these things, make
16 sure that we're understanding a little bit what's caught in
17 that so we don't overgeneralize, that would be helpful.
18 MR. NELB: Yeah. And this is one of the -- I
19 think the limitations of the Medicare cost reports that
20 we're using. They provide standard data across the
21 country, but then some of the more granular information
22 isn't there. Typically, some of the general admin costs

1 sort of just get allocated across the cost centers, but
2 when states do their more detailed looks, they can better
3 understand if it's a cost that may be specific to Medicaid
4 or not.
5 COMMISSIONER HEAPHY: This is Dennis.
6 I agree with Darin. I do think we need to break
7 down the admin costs and know which ones are appropriate
8 ones and which ones may not be.
9 CHAIR BELLA: Okay. We are going to move to
10 public comment. We have one person so far.
11 I would remind commenters to please introduce
12 yourself and the organization you represent and keep your
13 comments to three minutes or less, please.
14 Sam?
15 **### PUBLIC COMMENT**
16 * MR. BROOKS: Thank you, and thanks to all of you.
17 My name is Sam Brooks. I'm the director of Public Policy
18 for the National Consumer Voice for Quality Long-Term Care.
19 I appreciate this presentation, and I think a lot
20 of people here have indicated -- and just particularly on
21 these last comments about how it's really hard to determine
22 cost for nursing homes in part because of the practices

1 nursing homes themselves use to somewhat hide what their
2 costs are -- and Drew, I think, brought it up initially
3 through the related party transactions. Seventy-two
4 percent of nursing homes, it's estimated, use related
5 parties, and these are parties that charge a facility a
6 certain cost for providing services. But, at the same
7 time, they have an ownership interest in that service.
8 So Dennis indicated it's very common now for a
9 nursing home to be sold to a company, and that company, the
10 owners, the corporate owners or whoever, operators, own
11 that company and then charge the nursing home exorbitant
12 fees for rent. And although these show up under general
13 statements such as administrative cost, it's clear that
14 it's almost impossible to determine just what the costs are
15 for nursing homes as -- you do not see beyond -- you do not
16 see the costs incurred by the related parties, and that's a
17 limit of the Medicare cost reports. And, certainly, they
18 may be captured in some state cost reports, but overall,
19 you can't really determine what those costs are.
20 And we as an advocacy organization for residents
21 focus on this consistently and think that until that bale
22 is pierced -- and I imagine Drew and Rob will admit this --

1 it's difficult to see just what those costs are unless we
2 do see the cost to the related parties. And remember those
3 are taxpayer dollars going to related parties which are who
4 the nursing home owed, and so we echo some of these
5 concerns that Dennis, I think, indicated and really
6 encourage, hopefully, the committee to speak out about the
7 increased need for transparency in these transactions, both
8 in the Medicare and Medicaid levels. But it really plays
9 out, because the source of this is Medicare cost reports,
10 and until they're required to show just the actual cost to
11 these related parties, we're not going to know really where
12 these dollars are going and really what the correct costs
13 are.
14 So I appreciate that conversation. Thank you.
15 CHAIR BELLA: Thank you, Sam, for joining and
16 making a comment.
17 Okay. It does not appear that we have any
18 additional comments. Drew and Rob, do you have what you
19 need from us?
20 Oh, okay. Yep. Roy.
21 MR. JEFFUS: Thank you, Melanie. Hey, long time.
22 I'm just representing myself, Roy Jeffus. I do work for

1 General Dynamics, but I'm monitoring this just for my
2 benefit.
3 So I was just going to throw out an idea because
4 since I was faced with being told by the political
5 leadership that I had to fire the long-term director and/or
6 her survey and certification administration, that we sat
7 down with the health care association here and started
8 looking at what we're finding in the survey and cert area.
9 Actually, I think Darin was faced with a similar situation
10 over in Tennessee. So we passed some of their work. That
11 was a third party with a QIO, but what they actually did
12 was just look at the findings and for the quality and what
13 my idea until I separated from the state was to start using
14 some of that as far as some of the reimbursement, because
15 what we actually looked at was false, to begin with, and
16 concentrated on what we could do to reduce that and
17 actually had a fairly good reduction in that.
18 So I don't know if that would work for you, but
19 I'm not hearing where the data is necessarily coming from
20 on the quality, so anyway, thank you. And enjoyed the
21 discussion from you all too.
22 CHAIR BELLA: Roy, you didn't really give

1 yourself street cred. I mean, this is a former Arkansas
2 Medicaid Director. So I'm sure that if we wanted to follow
3 up with him and pick his brain for a little more detail,
4 he'd be willing.
5 MR. JEFFUS: And, like I said, one that had the
6 pain of not only having Medicaid but having survey and
7 cert. So I had lots of enjoyment at the same time, so
8 thank you. Good to hear from you all.
9 CHAIR BELLA: Thank you, Roy, for commenting and
10 joining.
11 Okay. Kate, do you see anyone else?
12 [No response.]
13 CHAIR BELLA: Okay. We're going to wrap up this
14 session. Thank you both. Obviously, lots of interest
15 here, so we're excited for you to bring this back.
16 We are going to take a 15-minute break, and we're
17 going to come back with our session on countercyclical DSH.
18 So thank you all. Please be back at three
19 o'clock.
20 * [Recess.]
21 [Audio not present. Begins 2:03 into session.]
22 CHAIR BELLA: Heidi, can you hear us now?

1 COMMISSIONER ALLEN: Yes, thank you.

2 MR. PERVIN: Do you want me to back up?

3 CHAIR BELLA: Just go ahead.

4 **### COUNTERCYCLICAL DISPROPORTIONATE SHARE HOSPITAL**

5 **POLICIES**

6 * MR. PERVIN: DSH payments can also be affected by
7 economic recessions in a few ways. During an economic
8 downturn Medicaid enrollment and the number of uninsured
9 tends to increase which can result in increased Medicaid
10 spending and increased levels of uncompensated care. This
11 can have the effect of increasing the amount of DSH
12 payments that a hospital is eligible to receive. On the
13 other hand, economic recessions can also lower a state's
14 tax base, making it more challenging to finance the non-
15 federal share of Medicaid and also DSH payments.

16 In 2021, MACPAC recommended that Congress should
17 implement a countercyclical financing mechanism.
18 Implementing this recommendation would automatically
19 increase the federal match during a period of high
20 unemployment. This would be able to be done without
21 further congressional action, and the mechanism would
22 therefore provide additional federal funding to states as a

1 stimulus.

2 One component of this recommendation is that it
3 excluded DSH because a higher federal match means that
4 states would draw down their allotment quicker. This has
5 the effect of lowering total DSH funding in a state, and
6 we're going to explain this concept in a little bit more
7 detail in the next slide.

8 Here is a visual representation of what we're
9 talking about with regards to allotments and the federal
10 match. This graphic shows a hypothetical state with a $1
11 billion allotment. On the left you'll see the state has 50
12 percent federal match. So with a 50 percent federal match
13 the state would need to generation $1 billion as a state
14 share, and this results in $2 billion in total DSH funds.

15 On the other hand, on the right, this shows what
16 would happen if the state's federal match increased to 66
17 percent. The federal allotment is still $1 billion but the
18 state's contribution is much lower because the federal
19 allotment is now 66 percent of total DSH funding. This
20 means that the higher federal match results in a decrease
21 in total DSH by about half a billion.

22 So to help start the conversation on structuring

1 DSH during an economic recession we're going to look back
2 at past countercyclical DSH policies that Congress enacted
3 to help inform our approach.
4 In 2009, the American Recovery and Reinvestment
5 Act, or ARRA, temporarily increased the federal match to
6 states but treated DSH payments differently. For DSH,
7 states continued to have the traditional FMAP but DSH
8 allotments were increased by a fixed amount.
9 In March 2020, FFCRA increased the federal match
10 for all Medicaid spending, including DSH payments, but
11 there was no change in federal allotments. A year later,
12 ARPA kept the federal match for DSH payments but then
13 federal allotments were increased such that total DSH
14 funding would have been the same as if there was no
15 countercyclical policy.
16 So we're now going to walk you through what this
17 ended up looking like, using fiscal year 2021's federal
18 allotments. In 2021, allotments would have been $13
19 billion with no countercyclical policy while total DSH
20 funding would have been about $22.8 billion.
21 FFCRA kept the same federal allotment but
22 provided a higher federal match which had the effect of

1 lowering total DSH to about $20.8 billion. A year later,
2 Congress made an additional change. It maintained the
3 higher federal match and also increased allotments. This
4 allowed DSH funding to remain the same as if there had been
5 no countercyclical policy, but with the federal government
6 now providing a larger share.
7 Another approach that Congress could've taken was
8 going with the ARRA approach. Under an ARRA approach, ARRA
9 results in more total DSH funding, but you will notice that
10 in an ARRA state, under an ARRA-like policy, states would
11 need to kick significantly more money.
12 So we are still awaiting data on the potential
13 effects of these countercyclical policies on DSH spending,
14 so the changes to this are still a little bit unclear.
15 However, we know that the effects are likely to vary based
16 on two different components.
17 The first is the state's ability to spend down
18 its allotment. Some states have large amounts of unspent
19 allotments from year to year. For example, in 2019, $1.4
20 billion, or 13 percent of allotments, went unspent. To
21 make this a little bit more tangible, based on our data
22 half of the states had unspent DSH funding in 2018, that

1 was greater than their reduction in DSH under a FFCRA-like
2 policy.
3 The second potential effect is that DSH is
4 predominantly provider financed. A higher federal match
5 could lead to higher DSH payments once you net out the
6 provider contribution. However, this depends on how states
7 respond to an enhanced federal match during an economic
8 recession. I am going to explain this a little bit more on
9 the next slide.
10 Here is an example of how a net DSH payment
11 concept would work in a state that completely finances DSH
12 through a provider contribution. First the hospital sends
13 a $50 contribution through either a tax or
14 intergovernmental transfer. The state then passes that
15 contribution to the feds in the form of the non-federal
16 share. The feds then send back $100 gross payment, but
17 since the hospital put up $50, that $100 gross payment
18 turns into a $50 net payment.
19 Scenario A shows the state lowering its
20 contribution policy as a result of the higher federal
21 match. $44 is now going up with the increased federal
22 match, and because of the higher federal match the provider

1 is putting up a lower amount of the state's share and
2 getting a $56 net payment, or in other words, getting $6
3 additional to offset uncompensated care when compared to no
4 countercyclical policy.

5 Meanwhile, Scenario B shows the state receiving
6 the benefit of the enhanced federal match. The state
7 requires the same contribution from the provider as no
8 countercyclical policy, even though the state is providing
9 less funds to the federal government. And in this
10 scenario, the enhanced federal match is providing a $6
11 federal stimulus to the state and there is no net change in
12 the payment to the provider.

13 So with that I'm going to kick it over to my
14 colleague, Rob.

15 * MR. NELB: Thanks. So to understand a little
16 more about how some of these policies worked in practice we
17 talked with state officials and hospital associations in
18 five states, and a couple of key themes emerged from our
19 interviews.

20 First, although stakeholders did note that
21 uncompensated care typically increases during economic
22 recessions, they also noted that the COVID pandemic has

1 been a bit different because of the influx of other federal
2 support for hospitals as well as the effects of other
3 policies to help people keep coverage rather than become
4 uninsured. These policies have helped reduce hospital
5 uncompensated care, but the full effects of the COVID
6 pandemic on hospitals is still unknown.
7 Second, pretty much all of the stakeholders we
8 spoke with were concerned about the fact that the FFCRA
9 policy lowered total state and federal funding, and they
10 supported the ARPA effects that Congress enacted to help
11 restore DSH funding to pre-pandemic levels. Although the
12 federal government measures DSH allotments in terms of
13 federal funds, states and hospitals thought it was
14 important to look at both the total state and federal funds
15 available.
16 Third, we found that the benefits the increased
17 FMAP often accrued to states rather than providers,
18 particularly in states that financed DSH with a provider
19 tax, since the states we spoke with who use this, they
20 didn't end up changing their provider tax in response to
21 the increased FMAP. However, in one state we spoke with
22 that financed DSH with intergovernmental transfers, we did

1 find that the increased FMAP resulted in lower provider
2 contributions and thus higher net payment on to those
3 public hospitals that were providing the IGTs.
4 Finally, across the board we heard from
5 stakeholders about the importance of about providing
6 clarity of DSH allotments in a timely manner so that states
7 and providers could plan appropriately. The ARPA fix that
8 Aaron talked about was implemented a year after FFCRA, and
9 although it was retroactively effective this delay limited
10 states' ability to use DSH funds to help address some of
11 the cash flow issues for hospitals at the start of the
12 pandemic.
13 Stakeholders also noted that CMS's delay in
14 finalizing DSH allotments in the Federal Register also
15 delayed their spending, and it may be one reason why we see
16 so much unspent DSH allotments in some states. For
17 example, CMS didn't finalize the fiscal year 2018 DSH
18 allotment until 2022, about four years later.
19 This table summarizes how some of the different
20 countercyclical DSH policies that we looked at compared to
21 some of the policy issues that we heard during our
22 interviews.

1 First, in terms of total DSH funding available to
2 help support hospital uncompensated care, the FFCRA policy
3 was least preferable because it reduces total DSH funding,
4 whereas an AARA-like policy would result in the largest
5 amount of total funding available. The ARPA policy is
6 between those two options and would largely preserve
7 funding for most hospitals and possibly result in larger
8 net payments, particularly for public hospitals.
9 In terms of support for states, both the FFCRA
10 and ARPA policies provide an enhanced FMAP, where the AARA-
11 like policy would not, and would require states to put up
12 more non-federal share in order to drop down the higher DSH
13 allotment, which might be challenging in an economic
14 recession.
15 Finally, in terms of administrative simplicity,
16 both the FFCRA or ARPA-like policies could be implemented
17 automatically using the same principles that were
18 determined in a countercyclical FMAP. Going with ARRA-like
19 policy would probably require other considerations about
20 how much a DSH allotment should increase, which also may
21 take time for CMS to calculate and make it more difficult
22 to administer.

1 So for today's discussion we are looking forward
2 to getting your feedback on this issue and whether the
3 Commission is interested in making a countercyclical DSH
4 recommendation this cycle, and if so, whether there are any
5 other policy options we should consider or any that we
6 should remove from consideration. We would also appreciate
7 your feedback on whether there are any other policy issues
8 we should consider and any other information you need to
9 help inform your decision-making.
10 Based on your feedback, we will plan to return at
11 a future meeting with more details on a potential
12 recommendation, including design considerations. As I
13 noted before, implementing the FFCRA or ARPA approach would
14 be a bit easier because we could build off the Commission's
15 prior recommendation. However, implementing an ARRA-like
16 approach would require some more analyses, and so we would
17 welcome any feedback you have about any factors that we
18 should look at there.
19 Also, I don't want to forget our statutorily
20 required DSH report. At the December meeting we'll be
21 presenting those analyses, and it will be included in the
22 2023 report in March. Thanks.

1 CHAIR BELLA: Are you sure you don't want to
2 forget about that?
3 [Laughter.]
4 CHAIR BELLA: How can you forget about that? All
5 right, thank you very much, Aaron and Rob, and Kudos on
6 the graphics.
7 MR. NELB: Carolyn Kaneko really helped there so
8 we are very thankful for her help illustrating complex
9 Medicaid financing topics.
10 CHAIR BELLA: Nice. Be careful. That might be
11 raising the bar across the board.
12 Okay. You've made this very clear, very clear on
13 what you want feedback on, and so I'm going to open it up
14 to the Commissioners. Fred.
15 COMMISSIONER CERISE: Yeah. It's really clear.
16 Thanks to you guys. You know, in terms of whether we want
17 to say something about this, it's a pretty narrow area but
18 it's also pretty straightforward too, and it goes along
19 with our other countercyclical work. So I think it's worth
20 making a comment on, and like I said, it's pretty
21 straightforward. I like the way you laid out the options.
22 I do think the two simpler options, I would

1 probably lean in that way, and if you look at the one
2 that's going to really, I think, get the benefit of the
3 FMAP increase without reducing payments, the ARPA one,
4 that's the one that seems to make the most sense, certainly
5 from a provider and a state level. Whether the state has
6 the benefit or they pass that on, it does kind of put that
7 in the state's control, so that one seems to make the most
8 sense.
9 But if you want to take one off the table I would
10 take that ARRA off the table, but I think you've laid it
11 out nicely.
12 CHAIR BELLA: Bill.
13 COMMISSIONER SCANLON: I think I'm missing
14 something, and it goes to our sort of prior recommendation
15 about countercyclical funding. If we increase the FMAP
16 where we are matching what the state chooses to spend, what
17 are the barriers that prevent the state when there is a
18 recession and hospitals need more support, giving them more
19 support under, I'll call it, the general fund, so to speak.
20 Because on other occasions at these meetings we've been
21 discussing how should the DSH allotments be reduced. And
22 so they have a history, okay.

1 But I guess I'm thinking why isn't simplicity,
2 you know, an open-ended sort of FMAP, the simplest
3 solution, and why isn't it the right solution?
4 MR. PERVIN: Sure. So I think I can take that
5 question. We did hear in our interviews with states that a
6 few states did end up, when the FFCRA policy was enacted, a
7 few states did use unmatched funds to kind of increase DSH
8 payments to DSH hospitals without using any of the federal
9 share. And so I guess that is a possibility.
10 However, states did note that there are some
11 challenges with that, namely, you know, DSH is kind of
12 unique, right, so it can pay for both Medicaid shortfall
13 but it can also pay for unpaid costs of the uninsured. So
14 because of the uniqueness of the DSH program, because of
15 that dual mandate, they did see that once that particular
16 policy was enacted that a lot of hospitals did start seeing
17 a DSH cut. And so while some states did try to use kind of
18 unmatched funds to increase payments to hospitals, we
19 didn't see that for all states.
20 COMMISSIONER SCANLON: So there is real concern
21 about the money that goes for care for the uninsured that
22 someone is going to come and say this is not allowable? If

1 I were to do it out of my general fund, not out of DSH
2 funds. That seems to me the issue. When you say that
3 there's flexibility in using your DSH dollars, that implies
4 that there's not the same flexibility in using your other
5 dollars. And the issue then is, is there really going to
6 be an effective restriction on my other dollars. And so
7 that would be a legitimate concern.
8 MR. NELB: Right. It sounded like one of the
9 issues you're raising is sort of the issues you're raising
10 is the relationship between DSH and other sorts of payments
11 to hospitals, and that's been a principle we've had as
12 we've been looking at prior DSH allotments and sort of
13 recognizing that states can support hospitals in different
14 ways.
15 I guess just something to point out is that if
16 you just provide the enhanced FMAP for other Medicaid
17 services but not for DSH then you sort of have an inequity
18 there that some services get matched at a higher rate than
19 DSH. And so the ARPA-like policy here is one that would
20 sort of preserve whether you support the hospital through
21 DSH or through other sorts of the Medicaid payments, sort
22 of both getting matched at that higher rate in terms that

1 equity. So that's one of the other benefits of that
2 policy.
3 CHAIR BELLA: Anything else, Bill?
4 COMMISSIONER SCANLON: No. I'm still kind of
5 simple-minded on this.
6 CHAIR BELLA: Darin?
7 COMMISSIONER GORDON: I do think we're talking
8 about recessionary impacts, in which case that's when
9 general tax revenues go down, so therein lies somewhat of a
10 complicating factor. But also if you were to, say, use
11 some of other like enhanced match for other sources, non-
12 DSH, then we get into the directed payments again, so it
13 all comes full circle.
14 I think, again, depending on what those triggers
15 are that would trigger these kinds of countercyclical
16 measures, particularly if those triggers are high, then I
17 would think you wouldn't want to exclude DSH out of that
18 equation, particularly if the trigger is at a very high
19 point. That means the economy could be in really rough
20 shape, and from a variety of perspectives. Hospitals could
21 be seeing in on the uncompensated care side, very
22 significant issues there.

1 The only thing -- and in the back of my head when
2 I think about it on the uncompensated care side -- is also
3 when we see these countercyclical issues and higher FMAPs
4 is we see, since we've gone through COVID, is you also see
5 MOE requirements also, and you tend to see, I guess,
6 somewhat of a reduction in some of the uncompensated care,
7 or the uninsured, I should say.
8 I don't know how that plays out, and I think what
9 I have, after going through a variety of different
10 recessions and running one of these programs, is I found
11 that none of them are exactly the same, and how it plays
12 out, when it plays out, when you see the impact, in your
13 state versus another state.
14 So I am for having the tool available, just
15 understanding that if we would've had this conversation
16 pre-COVID I might have thought differently, but clearly
17 there are challenges that we haven't always anticipated,
18 and having the tool in the tool belt to ensure that the
19 health care system is operating is best at hand during a
20 difficult circumstance, I think we would want to have
21 something there.
22 CHAIR BELLA: So which one of these three are you

1 most interested in?

2 COMMISSIONER GORDON: Actually, I think the ARPA

3 policy makes the most.

4 CHAIR BELLA: ARPA is the one that Fred just

5 threw out, or Fred threw out ARRA?

6 COMMISSIONER CERISE: I said ARPA was --

7 CHAIR BELLA: You like ARPA. You like ARPA.

8 This is ridiculous. I feel like a seal -- ARPA, ARPA.

9 Tricia.

10 COMMISSIONER BROOKS: All right. This is going

11 to tell you that I wasn't paying attention in DSH 101. Can

12 you explain how the allotments work and the fact that we

13 have still got money left over from 2019 in 2022? What's

14 the process for that?

15 MR. PERVIN: Sure. So an allotment is for a

16 specific fiscal year, but after the close of the fiscal

17 year states actually have an additional two to three years

18 to spend that remaining amount, and a lot of that kind of

19 gets shuffled through as each state goes through their DSH

20 audit process. And so once those audits occur there can be

21 some clawbacks from the state or there can also be

22 additional DSH payments as hospitals adjust kind of what

1 that total level of uncompensated care that the hospital
2 might have seen within that specific fiscal year.
3 MR. NELB: But I think to your specific question
4 about why it takes CMS so long to finalize the federal
5 allotments, it really comes down to -- the allotment each
6 year is adjusted for inflation, which CMS knows in advances
7 and that's easy to calculate. But there is a provision in
8 the statute which limits DSH allotments based on 12 percent
9 of a state's Medicaid spending. When DSH allotments were
10 first enacted, some states were close to that. Now with
11 the provision it doesn't really have any practical effect
12 because most state spending is a lot higher than it was in
13 the '90s.
14 But as a result, CMS has to wait until states
15 finalize their expenditures for 2019, which can take
16 several years, and finalized on the 64, and then that
17 delays the process in which they put it in the Federal
18 Register.
19 So we could also do like a technical fix to this
20 part of the statute that does sort of delay just the
21 regular finalization of the DSH allotments, sort of a
22 procedural thing.

1 COMMISSIONER BROOKS: And just to confirm, the
2 FMAP for the DSH allotment is a separate FMAP than the
3 regular Medicaid match.
4 MR. PERVIN: So no. The FMAP for the DSH
5 allotments are the same federal match as other Medicaid
6 spending, but generally, in previous economic recessions
7 Congress has implemented a different federal match for DSH.
8 Specifically that's what occurred in 2009.
9 CHAIR BELLA: Bob?
10 COMMISSIONER DUNCAN: Thank you. I appreciate
11 Darin's comments and Fred's as well, showing support of
12 ARPA. The thing I think about, from a policy, is, to
13 Darin's comments, I do think having a tool, because each
14 cycle is different, and so states being able to do that.
15 But I think from a policy standpoint making sure that those
16 dollars are flowing, and the caveat conflict of interest,
17 that they work for a provider is a large portion of the
18 Medicaid population. But making sure it is the dollar
19 flowing to those hospital systems and providers that are
20 seeing a large number of Medicaid population as well as the
21 uninsured.
22 MR. PERVIN: Yeah, and then we can flesh that out

1 in a little more detail later.

2 I did want to point out one thing. Darin did
3 note about the countercyclical financing mechanism that the
4 Commission has previously recommended. So it's based on
5 the GAO prototype model. The GAO actually did an analysis
6 where they looked at prior recessions, and that
7 countercyclical financing mechanism would trigger during
8 all of our three previous recessions. So it's not so
9 hypersensitive where it would be triggered fairly
10 frequently or more frequently than we've actually had, like
11 a true recession.

12 CHAIR BELLA: Other comments?

13 COMMISSIONER HEAPHY: I have a question.

14 CHAIR BELLA: Dennis?

15 COMMISSIONER HEAPHY: When it says the FMAP can
16 go back to the state's fiscal deficit, is that general
17 funds or is that Medicaid funds? What does that mean?

18 MR. PERVIN: So that's talking, I think, about --
19 if I understand your question correctly it's talking
20 specifically about how the states are financing the non-
21 federal share of Medicaid. And generally for DSH and other
22 supplemental payments those types of payments tend to be

1 financed through provider taxes or other kinds of provider
2 contributions. But, you know, for other base payments
3 those tend to be financed through the general fund. So the
4 state share can be both general fund and it can also be
5 provider contributions.

6 COMMISSIONER HEAPHY: So they can use the
7 enhanced FMAP to address general funds?

8 MR. PERVIN: Sorry. I think I misunderstood your
9 question. Yeah, that's correct. So in some scenarios, a
10 state that is financing DSH through general funds, that
11 enhanced federal match could flow to the state's coffers as
12 a way to address the state's fiscal crisis.

13 COMMISSIONER HEAPHY: I don't know what folks
14 think about that. I'm wondering if it should go back to
15 Medicaid in the state or should it go the general fund?
16 It's just a question. I don't know, financially, if these
17 are Medicaid dollars or whether they should just go to
18 general deficit or if they should go to supporting deficits
19 in a recession that impact Medicaid. Does that make sense?

20 COMMISSIONER GORDON: This discussion comes up
21 frequently, but it is one of the mechanisms the federal
22 government has to get money to states, broadly. So I think

1 that's why it has been used historically, that it can free
2 up some state dollars to other critical services within a
3 state. It's one of the vehicles that they have on those
4 periods of time for the federal government to help states
5 broadly, beyond just Medicaid.
6 CHAIR BELLA: This is also why I think MOEs and
7 things are important to have other guardrails, to make
8 sure. You may not be plowing it all back in but you're not
9 running the program lower than where it was either.
10 COMMISSIONER HEAPHY: Okay.
11 CHAIR BELLA: Our other countercyclical has the
12 maintenance of effort in there.
13 COMMISSIONER BJORK: This option seems beneficial
14 to everyone. Is there an argument for using the other two
15 that I missed?
16 MR. PERVIN: Sure. So there are kind of some
17 arguments for using the other two policies, so it seems
18 like there is a general consensus on ARPA. A FFCRA-like
19 approach actually does provide a lot of support to states
20 because it means that the state does need to spend less of
21 its own resources on DSH. And then at the same time, an
22 ARRA-like approach would actually increase total DSH

1 funding during an economic recession.
2 There are some arguments for a FFCRA- or an ARRA-
3 like policy, but an ARPA kind of might hit that Goldilocks
4 zone.
5 COMMISSIONER BJORK: Thanks. I agree. I like
6 that [unclear].
7 MR. NELB: We all agree. That's okay too.
8 CHAIR BELLA: I think it's nice if we're able to
9 pick one that fits within our existing countercyclical,
10 which knocks ARRA out, right?
11 [No response.]
12 CHAIR BELLA: By the way, we don't have [audio
13 interruption] sound like there's interest. Were you guys
14 envisioning this would be part of the March report, you'd
15 do the statutorily required chapter and then there would be
16 this piece with a recommendation?
17 MR. PERVIN: Yes. We were thinking of having the
18 standard DSH report that you all see, likely in December,
19 and then this recommendation would kind of be an add-on to
20 that. We still haven't determined if it's going to be part
21 of the DSH chapter or kind of next to the DSH chapter, but
22 it would be part of the same report.

1 CHAIR BELLA: So would you need to bring this
2 back for additional discussion?
3 MR. PERVIN: It sounds like we're all kind of
4 going with an ARPA-like approach, and so I think we could
5 bring that back. I think we have a couple of questions
6 around maybe how to base those DSH allotments, but staff
7 could come back and think about kind of the right path
8 forward. But it sounds like we're kind of a consensus on
9 ARPA and we could do more deliberation later.
10 CHAIR BELLA: I think there is consensus. I
11 don't want to say that everybody's decided like we must
12 make this recommendation, but I think for you to bring back
13 to us, it sounds like it should be ARPA.
14 Bill, do you have any other comments?
15 COMMISSIONER SCANLON: No.
16 CHAIR BELLA: Tricia, your hand is still up. Do
17 you have a comment?
18 COMMISSIONER BROOKS: Oh, sorry.
19 CHAIR BELLA: That's okay. Heidi or Martha, are
20 you good? Head nod. Okay. Other comments, questions?
21 Other features you'll want to make sure that they are
22 thinking about when they bring it back to us, or have we

1 surfaced several of those?

2 Okay. Why don't we just give the public an

3 opportunity to comment on this one, since we have a little

4 bit of time. So if there is anyone in the audience that

5 would like to comment on this discussion for

6 countercyclical DSH, please use your hand indicator or

7 icon.

8 And just a reminder to folks, please introduce

9 yourself, the organization you're representing, and you

10 have about three minutes to make comments, please.

11 **### PUBLIC COMMENT**

12 * [Pause.]

13 CHAIR BELLA: Okay. It does not look like we

14 have anyone who wants to talk. If there is someone who

15 wants to talk and we missed you, please send us a note in

16 the chat.

17 Okay. That's a wrap on this session. Thank you

18 very much. I appreciate the work and the information.

19 All right. We will take on our last session of

20 the day, which I am going to hand over to Kisha to

21 moderate.

22 VICE CHAIR DAVIS: All right. Last session of

1 the day, we are going to be talking about monoclonal
2 antibodies and -- let me say it right -- Aduhelm. I'll
3 turn it to you, Chris.

4 **### MEDICAID COVERAGE OF MONOCLONAL ANTIBODIES**
5 **DIRECTED AGAINST AMYLOID FOR THE TREATMENT OF**
6 **ALZHEIMER'S DISEASE**

7 * MR. PARK: Thank you.
8 Today I'll be going through the potential
9 implications of the new Alzheimer's disease treatments on
10 Medicaid.
11 Just a quick note before I start, "monoclonal
12 antibodies directed against amyloid for the treatment of
13 Alzheimer's disease" is quite a mouthful. So I'm going to
14 shorten that to "anti-amyloid monoclonal antibodies"
15 throughout this presentation.
16 The first half of the presentation, if I can get
17 the clicker to work -- the first half of the presentation
18 will provide a lot of background information on the
19 Medicaid Drug Rebate Program, Medicare Part B drug
20 coverage, and the accelerated approval pathway for drug
21 approval.
22 Next, I'll provide some context for Aduhelm, the

1 only anti-amyloid monoclonal antibody currently approved,
2 and I'll also discuss the Medicare coverage decision.
3 I'll go through some of the implications that
4 anti-amyloid monoclonal antibodies may have on Medicaid,
5 including some analyses on the number of Medicaid
6 beneficiaries with Alzheimer's or mild cognitive impairment
7 and potential spending estimates based on the prevalence of
8 these conditions.
9 Finally, I'll go through a potential policy
10 option and next steps.
11 So the Medicaid Drug Rebate Program governs
12 coverage of drugs in the Medicaid program. Outpatient
13 prescription drugs are an optional benefit that all states
14 have chosen to provide. Under the Medicaid Drug Rebate
15 Program, or MDRP, drug manufacturers must provide rebates
16 in order for their products to be recognized for federal
17 Medicaid match. In exchange, states must cover all of the
18 participating manufacturer's products. States may limit
19 the use of particular drugs through utilization management
20 tools such as prior authorization or preferred drug lists,
21 but at the end of the day states cannot outright exclude
22 coverage of a drug.

1 Drugs subject to the coverage and rebate
2 requirements are also known as "covered outpatient drugs."
3 These are a subset of all drugs and generally include drugs
4 that have been approved by the FDA, the manufacturer has
5 signed a drug rebate agreement, and it's generally a drug
6 that can only be dispensed by prescription.
7 Under the MDRP, a state is generally required to
8 cover all of a participating manufacturer's products as
9 soon as they have been approved by the FDA and entered the
10 market. This requirement makes Medicaid program unique
11 among payers. In general, plans sold on health insurance
12 exchanges and Medicare Part D plans have minimum
13 requirements for drug coverage, but they are allowed to
14 exclude coverage of some drugs. Additionally, exchange and
15 Medicare Part D plans are also allowed a period of 90 to
16 180 days following a new drug's release onto the market to
17 evaluate it before making a coverage decision.
18 Rebates under the MDRP are established in statute
19 and based on average manufacturer price, or AMP. AMP is
20 defined as the average price paid to the manufacturer for
21 drugs in the United States by wholesalers for drugs
22 distributed to retail community pharmacies.

1 There are different rebate formulas for brand and
2 generic drugs. For brand drugs, there is a basic rebate
3 that is calculated at the greater of 23.1 percent of AMP or
4 AMP minus best price, and best price is defined as the
5 lowest price available to any wholesaler, retailer,
6 provider, or paying entity, excluding certain governmental
7 payers.
8 Additionally, there is an inflationary rebate
9 that kicks in if the increase in a drug's AMP exceeds the
10 rate of inflation over time. There's also a unique
11 provision for an alternative rebate for certain drugs that
12 qualify as line extensions, and those are drugs that are,
13 for example, like extended-release versions of a drug.
14 For generic drugs, the basic rebate is 13 percent
15 of AMP, and there is no best price provision. There's also
16 the inflationary rebate on generic drugs, and until January
17 1st, 2024, the total rebate a state receives on a drug
18 cannot exceed 100 percent of AMP. After that date, the cap
19 no longer applies, and the total rebate can exceed this
20 threshold.
21 Besides the statutory rebates, a state can
22 negotiate supplemental rebates with manufacturers.

1 Manufacturers can provide these rebates to ensure that
2 their products are placed on a state's preferred drug list
3 or have fewer restrictions on use.
4 I just want to quickly touch on physician-
5 administered drugs because the Alzheimer's drugs fall into
6 this category. Physician-administered drugs are typically
7 administered by a health care provider in a physician's
8 office or other clinical setting. These drugs are unique
9 in that their inclusion in the MDRP can depend on how a
10 state pays for the drug. So, if a state bills for the drug
11 as part of a bundled service within certain settings such
12 as a hospital stay -- and if they pay for it as part of
13 that service, such as a DRG payment -- then it cannot claim
14 the statutory rebate. If a state makes a direct payment
15 for the drug separately from the service, it can claim the
16 statutory rebate.
17 Under Medicare, prescription drugs can be covered
18 either under Part B or Part D, but I'll just focus on Part
19 B today. Part B covers drugs that are not usually self-
20 administered by the patient and are furnished as part of
21 physicians' services in an outpatient setting. So these
22 are generally the same as the physician-administered drugs

1 in the Medicaid program.

2 For Part B drugs, they're paid at 106 percent of
3 average sales price, and beneficiaries generally have a 20
4 percent co-insurance.

5 Medicare Part B must cover services that are
6 reasonable and necessary. For drugs, this means that Part
7 B generally covers FDA-approved drugs for on-label
8 indications and other approved uses.

9 Medicare administrative contractors are
10 responsible for making local coverage determinations of
11 items and services that apply only in the contractor's
12 regional area. CMS can develop coverage determinations for
13 items and services that apply nationally through a national
14 coverage determination. CMS can initiate that
15 determination internally, or one can be initiated at a
16 stakeholder's request.

17 Under certain circumstances, CMS can link
18 coverage of an item or service in Medicare to participation
19 in an approved clinical study or collection of additional
20 clinical data. This policy is referred to as "coverage
21 with evidence development," or CED.

22 Under CED, CED is used when there are outstanding

1 questions about the service's health benefit in a Medicare
2 population and allows CMS to gather additional data that
3 would further clarify the effect of these services on the
4 health of the Medicare beneficiaries.
5 Just a note, CMS has rarely used this policy for
6 prescription drugs. From what I have seen from MedPAC,
7 it's only been used three times on prescription drugs.
8 So the FDA has a couple of different pathways
9 they can approve drugs. The traditional FDA approval
10 pathway requires that a manufacturer demonstrate that the
11 drug provides clinical benefit. The accelerated approval
12 pathway allows the FDA to grant approval based on whether
13 the drug has an effect on a surrogate endpoint that is
14 reasonably likely to predict a clinical benefit. A
15 surrogate endpoint is a marker that is thought to predict a
16 clinical benefit, but it's not itself a measure of the
17 clinical benefit. This means that an accelerated approval
18 drug can enter the market before the clinical benefit has
19 been demonstrated definitively.
20 When the FDA approves a drug through accelerated
21 approval, it requires manufacturers to conduct additional
22 post-marketing studies to verify that the drug does indeed

1 achieve a clinical benefit. However, these confirmatory
2 trials are often delayed, and many have taken over five
3 years to complete.
4 States are concerned about being required to
5 cover accelerated approval drugs when the clinical benefit
6 has yet been verified, and just as a reminder to the
7 Commissioners, we did make some recommendations on
8 accelerated approval drugs in our June 2021 report.
9 In June of 2021, the FDA granted accelerated
10 approval to Aduhelm for the treatment of Alzheimer's
11 disease. This accelerated approval was granted against the
12 recommendation of the FDA's advisory committee. The
13 committee found that there is insufficient evidence of a
14 clinical benefit due to the conflicting results of the two
15 trials that were presented and voted almost unanimously
16 against approval.
17 The accelerated approval of Aduhelm raised
18 several concerns among stakeholders, including the lack of
19 clinical benefit due to the conflicting results of the
20 trials, the potential for adverse events such as brain
21 swelling, particularly given the lack of evidence, the
22 overly broad indication for all individuals with

1 Alzheimer's disease, which was broader than what was in the
2 population in clinical trial. The label indication was
3 subsequently narrowed by the manufacturer to those with
4 mild cognitive impairment or mild dementia due to
5 Alzheimer's, which is close to what was in the clinical
6 trial. And then there is also the lengthy timeline for the
7 confirmatory trials. The manufacturer was given nine years
8 to complete the trial.

9 Beyond the approval, there was concern over the
10 price. The launch price of Aduhelm equated to about
11 $56,000 per year to treat the average patient. The
12 manufacturer reduced the price to about $28,000 in
13 December.

14 The potential patient population for treatment
15 for drugs such as Aduhelm is large. Over six million
16 people in the U.S. are estimated to have Alzheimer's
17 disease. The vast majority of those with Alzheimer's are
18 age 65 and older. So they're most likely to be covered by
19 Medicare. Because Aduhelm is an intravenous medication
20 administered by physicians, it would be covered under
21 Medicare Part B, and to provide context for the potential
22 cost at the current price of $28,000 for a year of therapy,

1 Part B spending and beneficiary cost sharing could be about
2 $1.5 billion per year for every 50,000 beneficiaries who
3 receive the treatment.
4 Due to the concerns about the treatment's
5 effectiveness and potential cost, many stakeholders
6 requested that CMS initiate an NCD. So, in July of 2021,
7 CMS announced that it would begin the NCD process for
8 Medicare. After reviewing public comments on the proposed
9 NCD that was issued in January 2022, CMS finalized the NCD
10 in April of 2022. The final NCD was to cover Aduhelm under
11 a CED policy to allow for collection of additional data.
12 The CED applies to the entire class of anti-amyloid
13 monoclonal antibodies. Aduhelm is currently the only
14 approved drug, but there are at least 3 other candidates
15 undergoing phase 3 clinical trials.
16 The NCD specified that to qualify for coverage, a
17 Medicare beneficiary must have a clinical diagnosis of mild
18 cognitive impairment due to Alzheimer's or mild Alzheimer's
19 disease dementia. The coverage is limited to participation
20 in a clinical trial or other approved comparative study,
21 and it depends on which pathway the drug was approved
22 under.

1 For accelerated approval, it must be covered in a
2 randomized controlled trial. The trial can be the same one
3 as used for an FDA trial. If the drug was traditionally
4 approved, then coverage can be in a CMS-approved
5 prospective comparative study, and data may be collected in
6 a registry. This should allow for coverage to a broader
7 range of patients than in a randomized controlled trial.
8 Coverage is also allowed in a trial supported by the
9 National Institutes of Health.
10 Note that CMS did make some adjustments from the
11 proposed NCD in January in response to public comments.
12 For example, it is no longer restricting the places in the
13 final NCD. The treatment may be provided outside of a
14 hospital-based outpatient facility, and it also removed any
15 of the patient exclusion criteria so that those with
16 conditions such as Down syndrome may get coverage of the
17 drug.
18 Because Aduhelm is approved by the FDA, states
19 are required to cover Aduhelm and would be required to
20 cover any future drugs in that class once they're approved.
21 Medicaid has different coverage responsibilities, depending
22 on the patient population.

1 For non-dually eligible Medicaid beneficiaries, a
2 state must cover all medically accepted indications but may
3 implement prior authorization to manage utilization. For
4 beneficiaries dually eligible for Medicare and Medicaid,
5 coverage is limited to the terms of the Medicare NCD.
6 There initially was a concern that states could
7 be responsible for the full cost of the drugs for dually
8 eligible beneficiaries if Medicare doesn't cover it, but
9 CMS clarified in the final NCD that states do not have this
10 responsibility. Based on statutory definitions, a drug not
11 covered under Part B is covered under Part D. Medicaid
12 does not pay for Part D drugs or any associated cost
13 sharing for dually eligible individuals. So Medicaid is
14 not a payer of last resort when Aduhelm or any subsequent
15 drugs in that class are not covered under the NCD.
16 These coverage responsibilities translate to
17 different levels of cost. For non-dually eligible Medicaid
18 beneficiaries, a state would pay the full drug cost but
19 would be eligible to receive the statutory rebate. For
20 most dually eligible beneficiaries, the state pays for Part
21 B premiums, and for full-benefit dually eligible
22 beneficiaries and partial-benefit dual beneficiaries under

1 the Qualified Medicare Beneficiary, or QMB program, states
2 would also pay the beneficiary's cost sharing, so the 20
3 percent co-insurance.

4 We did an analysis of 2019 Medicare and Medicaid
5 data to estimate the potential number of beneficiaries with
6 mild cognitive impairment or Alzheimer's disease who may
7 qualify for treatment with Aduhelm or subsequent drugs in
8 the class. We developed low- and high-population
9 estimates. For the low estimate, we selected those that
10 have both a diagnosis of Alzheimer's and mild cognitive
11 impairment, which is similar to the current label
12 indication for Aduhelm. For the high estimate, we looked
13 at those either with a diagnosis of Alzheimer's or mild
14 cognitive impairment, because future drugs may have a
15 broader indication than Aduhelm.

16 We estimated that anywhere between 1,000 to
17 almost 60,000 non-dually eligible Medicaid beneficiaries
18 could be eligible for treatment.

19 As we mentioned earlier, states could have to pay
20 the 20 percent co-insurance for full-benefit dually
21 eligible beneficiaries and QMB partial duals. So, based on
22 this analysis, Medicaid could have co-insurance

1 responsibility for about 22,000 to 626,000 dually eligible
2 beneficiaries.
3 Based on the number of non-dually eligible
4 Medicaid beneficiaries with Alzheimer's disease or mild
5 cognitive impairment from the prior slide, states could
6 potentially spend between $29 million and $3.3 billion in
7 gross drug spending, that is, prior to drug rebates.
8 Using the current price of $28,000 per year for
9 Aduhelm as a proxy for low price, states could spend
10 between $29 million to $1.7 billion, depending on the
11 breadth of the label indication and take-up.
12 Using the initial launch price of $56,000 per
13 year as a high estimate, states could spend between $57
14 million and $3.3 billion.
15 For context, the high end of these estimates, the
16 $1.6 billion to $3.3 billion would be similar to Medicaid
17 spending on the hepatitis C drugs.
18 For dually eligible beneficiaries, there are two
19 potential Medicaid costs. Based on the number of dually
20 eligible Medicaid beneficiaries, states could potentially
21 spend between $127.8 million and $7 billion in gross drug
22 spending for Part B co-insurance, assuming states paid the

1 entire 20 percent of co-insurance.

2 For the low-price scenarios, states could spend
3 between $127 million and $3.5 billion, and under the high-
4 price scenario, states could spend between $253 million and
5 $7 billion.

6 It is important to note that net Medicaid
7 spending after the application of rebates would likely be
8 significantly less. If a state pays any amount for a
9 prescription drug, it is eligible for the full amount of
10 the rebate authorized under the MDRP. Because the minimum
11 rebate for the brand drug is 23.1 percent of AMP, a state
12 may not have significant increase in spending for Part B
13 co-insurance because the rebate amount may offset most or
14 all of the co-insurance paid. However, states may still
15 face a cash flow issue because the co-insurance would be
16 paid at the time of the service, and the rebates would
17 typically not be collected until two or three fiscal
18 quarters later.

19 In addition, states would still be responsible
20 for any increase in Medicare part B premiums that is
21 attributable to these drugs. Based on the CMS Office of
22 the Actuary reexamination of the 2022 Part B premiums, a

1 low-price utilization scenario similar to the current
2 status of Aduhelm could result in about a 10-cent increase
3 in monthly premiums or about $13 million year. Under a
4 high-cost utilization like the assumption used for the
5 initial development of the 2022 Part B premiums, the
6 monthly premium could increase by approximately $9.80. So
7 that would result in an additional cost of about $1.3
8 billion for state coverage of Part B premiums.

9 States may implement prior authorization to limit
10 use of these anti-amyloid monoclonal antibodies. However,
11 it is not clear to what extent states will be able to use
12 these tools to limit its use.

13 In a letter, the National Association of Medicaid
14 Directors asked for CMS to allow states for flexibility to
15 apply the same coverage requirements as Medicare; that is,
16 limit use to participation in a clinical trial or
17 comparative study. Because the MDRP coverage requirements
18 are in statute, CMS does not explicitly have the authority
19 to allow states to restrict coverage similar to a Medicare
20 NCD.

21 A beneficiary or drug manufacturer may challenge
22 the state's coverage criteria, and the extent to which

1 states can restrict coverage of a particular drug may
2 ultimately be decided by the courts. A statutory change
3 would be necessary to ensure states could implement
4 coverage criteria based on a Medicare NCD.
5 The Commission can consider a recommendation to
6 amend the Medicare Drug Rebate Program to allow states to
7 exclude or otherwise restrict coverage of a covered patient
8 drug based on a Medicare NCD, including any CED
9 requirements. Note that this potential recommendation is
10 not a national coverage decision for Medicaid. It would
11 provide states the option to follow a Medicare coverage
12 decision but is not required. This allowance is
13 potentially unlikely to affect many drugs. CMS has
14 indicated it does not expect to use CED frequently for
15 drugs, but it would ensure a state could follow CMS's
16 determination that are reasonable and necessary for a drug
17 in the future.
18 So we would appreciate any feedback on this
19 policy option and whether the Commission would like to move
20 toward making a potential recommendation. If so, staff
21 would appreciate Commissioner feedback on what additional
22 information would be needed to move forward, and I'll turn

1 it back over to the Commission for any questions or
2 comments.
3 VICE CHAIR DAVIS: Thank you, Chris. That was
4 really detailed background on where we are on drug pricing
5 and also on Aduhelm.
6 I just want to make sure that we're framing up
7 the conversation in the right way, that we're not the FDA,
8 and we're not here to really debate the merits of Aduhelm.
9 And that is really the example that we are using because
10 that's the drug that is at hand, but really the
11 conversation is about giving states flexibility to be able
12 to follow the Medicare guidelines and its recommendation on
13 this drug. And so it's not necessarily about the drug;
14 it's about that recommendation.
15 Actually, if you can go back to the prior slide
16 where you got the potential policy options there. So I
17 want to open it up now also to comments, questions from the
18 Commissioners on do we want to continue to go down this
19 path, and if so, what additional information you might
20 want.
21 Angelo.
22 COMMISSIONER GIARDINO: Thank you. That was

1 really an elegant presentation.

2 Again, I'm trying to set this policy level, but
3 the idea that a drug that's approved in an accelerated
4 pathway that we all who are paying for it would want to
5 make sure that over time, everybody is in a study, to me,
6 makes a world of sense. So, you know, I'm very interested
7 in participating at a policy level on making that a
8 requirement to cover a medication, regardless of it being
9 expensive or not.

10 Hydroxychloroquine was cheap as dirt, but we
11 needed to know if it worked. And the problem with allowing
12 people to use things that may not work and not studying it
13 is that you never know if it is going to work or not. So I
14 feel like that's a really important policy initiative that
15 we should be behind.

16 VICE CHAIR DAVIS: Heidi and then Bill.

17 COMMISSIONER ALLEN: Thanks.

18 I actually -- this is a new area for me, so I'm
19 learning more than I feel like I probably can contribute,
20 but I wonder about the narrowness of who can participate in
21 clinical trials and what that would mean for people who
22 have any other comorbidities whatsoever but would be

1 otherwise that the medication be indicated.

2 So, basically, if we're saying that it's only
3 paid for if you're in this RCT, doesn't that exclude
4 anybody who is outside of the population that -- I guess
5 just from my -- I'm not articulating so well. From my
6 understanding of these clinical trials, it's that they
7 often exclude. Minorities are often excluded because they
8 have comorbidities. Low-income people who have
9 comorbidities are often excluded, and that this could end
10 up making it so that dual-eligible patients are less likely
11 than Medicare patients who aren't dual eligible to be able
12 to have access to these drugs even through a clinical
13 trial.

14 Does that question make sense?

15 MR. PARK: Sure. So, first of all, the CED
16 policy that we're discussing in this Aduhelm case is a
17 Medicare policy, so it would apply equally to Medicare-only
18 beneficiaries and dually eligible beneficiaries, and there
19 were --

20 CHAIR BELLA: Wait. Time out there. Regardless
21 if we were to make this recommendation:

22 MR. PARK: Yes. Yeah.

1 CHAIR BELLA: Yeah.

2 MR. PARK: This is what's in place currently.

3 I just backed up to this slide just to address
4 the concern about the randomized control trial, and that
5 was a concern with the initial proposed NCD when it was
6 released in January. CMS has subsequently made some
7 changes so that the randomized control trial is only
8 required when it's under accelerated approval. If a drug
9 has received traditional approval where they've
10 demonstrated that clinical benefit, then coverage is
11 available in a CMS-approved perspective comparative study,
12 and so those could be broader populations that can include
13 some of those populations that may have co-morbid
14 conditions that might have been excluded in an RCT.
15 Because this can be prospective and doesn't necessarily
16 need that control element to it, the population that can
17 receive the drug in a prospective trial, a study, can be
18 broader.

19 VICE CHAIR DAVIS: Thank you, Chris, for
20 clarifying.

21 Bill and then Melanie.

22 COMMISSIONER SCANLON: My perspective is very

1 similar to Angelo's. I mean, it's the issue that we have a
2 drug for which we really want more evidence, and the
3 question is, should Medicaid be allowed to or actually
4 encourage to participate in helping us gather that
5 evidence?
6 There's a process here. I mean, the way you've
7 laid this out, Medicare has gone through the effort to
8 define the national coverage decision and set up the
9 condition. And national is key there. When I was GAO, we
10 were very critical of the Medicare administrative
11 contractors having individual coverage decisions because we
12 didn't think the physiology changed when you crossed the
13 state border. So this idea that we had a body that has
14 looked at this carefully, hopefully -- very carefully,
15 hopefully -- and establish a national coverage decision, we
16 should be thinking about how do we best approach generating
17 the evidence that we want to know about these drugs, and
18 we're talking again about an accelerated approval of drugs
19 where within the definition it's the idea that there needs
20 to be more evidence. So I'm very supportive of the idea.
21 And I think all the discussions about sort of
22 spending, they're secondary, in my mind at least, to the

1 issue of the evidence.

2 VICE CHAIR DAVIS: Thank you, Bill.

3 Melanie?

4 CHAIR BELLA: I was going to hop on the evidence,

5 but I'll just say ditto what Bill said.

6 I guess if I think about kind of themes in our

7 work, we're looking for state tools to manage their

8 programs better. We're looking for consistency across

9 programs. It strikes me as odd that here's an opportunity

10 to give states a little more control over not having to

11 cover everything the minute it comes out until we have some

12 evidence on that, and I don't understand why it would be

13 okay in one of the publicly financed programs and not the

14 other.

15 So I don't know, Chris. I don't think you're

16 looking -- I think there's still some talking. We could

17 talk to some folks to make sure that we understand some of

18 the implications here, but I'm hard-pressed to see why we

19 wouldn’t want to give states this exact same tool while --

20 and keep an incentive and kind of keep some fire to the

21 feet of folks to actually gather the evidence.

22 I'm mindful that if there's a bit piece of, like,

1 beneficiary viewpoint or consumer viewpoint that we're not
2 hearing, we need to hear that, but other than that, this
3 seems very consistent with our prior work. And it seems
4 like an important way to put some boundaries around MDRP
5 that's gotten sort of very broad.
6 VICE CHAIR DAVIS: Thank you, Melanie.
7 Yeah, Darin and then Fred.
8 COMMISSIONER GORDON: I agree with the prior
9 comments that are made. I think, one, this has been a very
10 unique situation, but in the event that, you know, we have
11 another situation that's similar, then I think it just
12 makes sense. Again, it's consistent with some of the prior
13 discussions we had in trying to align Medicaid with
14 Medicare in some of these situations and giving states
15 tools to manage, particularly, you know, states are looking
16 at what is the evidence so that they can set up the
17 coverage criteria appropriately. And without that
18 evidence, that makes it very hard to do and so, in some
19 cases, may actually be harmful.
20 So, again, I think it's unique situations. I
21 think, from being consistent with our prior discussions on
22 similar topics, I think giving states this option makes

1 sense.

2 VICE CHAIR DAVIS: Yeah, Fred.

3 COMMISSIONER CERISE: Yeah. I'm just agreeing
4 with the group. I think Angelo laid to out nicely.

5 There is a quality in evidence-based concern here
6 that if you use these programs that you should take that
7 responsibility seriously as an opportunity to do that.

8 There also is a cost issue, and you are going to
9 expect to be required to provide a very expensive drug that
10 does not have proven benefit yet. And from a common-sense
11 perspective, that doesn't -- that seems like something we
12 ought to weigh in on and address.

13 VICE CHAIR DAVIS: I mean, I think, Chris, you're
14 really hearing the consensus here of -- I mean, this is
15 really -- as Melanie mentioned, a really great opportunity
16 to give states flexibility and also to double-down on
17 really wanting the evidence.

18 Martha. Sorry.

19 COMMISSIONER CARTER: That's okay.

20 I'm in agreement here, to the extent that drugs
21 are those that would be used by the Medicare population and
22 the Medicaid population, and to I think we should proceed

1 along the line that we're going.

2 I want to make sure that we continue to look at

3 this issue related to drugs that are more likely to be

4 Medicaid predominantly used and just continue that

5 conversation about how to support the states in some of

6 these decisions.

7 VICE CHAIR DAVIS: Thank you, Martha.

8 Other comments?

9 [No response.]

10 VICE CHAIR DAVIS: I wasn't expecting to get to a

11 consensus this quickly, but I think we are following the

12 evidence, which is also pretty strong.

13 Chris, other things that you need from the

14 Commissioners? What I'm hearing is bringing this back and

15 support for going down the path of creating a

16 recommendation to allow this level of flexibility for the

17 states.

18 MR. PARK: Sure. Thank you.

19 I think, as you said, there's pretty clear

20 consensus to keep moving forward. So I think that's good

21 for today.

22 VICE CHAIR DAVIS: Thank you.

1 CHAIR BELLA: You might stay there just for a
2 second, Chris. We need to give the opportunity for public
3 comment, just so that if, for some reason, we need you to
4 respond, you're at the ready.
5 All right. We'll open this up to public comment.
6 A reminder to folks, if you'd like to make a comment,
7 please use your hand icon, introduce yourself, the
8 organization you represent, and we ask you to keep your
9 comments to three minutes or less, please.
10 Allison Taylor, welcome.
11 **### PUBLIC COMMENT**
12 * MS. TAYLOR: Hi. Good afternoon. Thank you for
13 having me. I appreciate the opportunity to provide
14 testimony on behalf of the National Association of Medicaid
15 Directors. I'm currently serving as the president of the
16 association.
17 And it sounds like you all are definitely on your
18 way, so I will try to be quick but just appreciate the
19 opportunity to provide some perspective on the process
20 presented, and some of the comments on state flexibility,
21 absolutely we appreciate.
22 We'd like to start when we look at these issues

1 with the lens of the Medicaid programs, you know, we have
2 to manage tensions between stewarding federal and state
3 dollars and providing access in services, supports,
4 therapies that improve the health and well-being of our
5 members that we serve.
6 And we have the added challenge of operating with
7 a balanced budget in our respective budget cycles, and as
8 we discussed today, unanticipated Medicaid cost can present
9 challenges to managing the program.
10 Pharmaceutical, absolutely a perennial challenge,
11 both physician-administered drug and covered outpatient
12 drugs.
13 And Aduhelm is a perfect example of the type of
14 drug that can present major challenges to Medicaid. When
15 the FDA approved the drug under the circumstances that were
16 discussed from the prior presentation, there was a question
17 as to whether or how Medicare would cover it. Medicare's
18 decision would have major implications for Medicaid. If
19 declined, Medicaid would become the primary payer for dual
20 eligibles; in essence, forcing states to pick up federal
21 cost.
22 Our preliminary analysis from the National

1 Association of Medicaid Directors predicted that Medicare
2 declining coverage could increase Medicaid spending by $1.5
3 billion, with some states seeing their state share of
4 spending increasing from 300 to 500 percent.
5 Fortunately, as was indicated, Medicare chose to
6 use coverage with evidence development authority and
7 regulations under the Part D prescription drug benefit to
8 shield states from this cost shift. Utilization remains
9 low, but that being said, this is just one example of the
10 persistent challenges that states face; in particular, with
11 drugs that are approved by the FDA with limited real-world
12 evidence, which can force states into difficult situations
13 regarding cost and coverage. This is especially true if
14 the drugs are covered, outpatient drugs with mandatory
15 coverage under the Medicaid Drug Rebate Program.
16 So, in those circumstances, states have to cover
17 those drugs, even if the post-market trials indicate that
18 they are not or that they do not, in fact, work. No other
19 payer is required to do this, only Medicaid.
20 So I think the key policy takeaway for us is that
21 states really need to have new tools to manage these
22 situations. One logical approach, which I think has been

1 indicated a little bit here today, is to give states the
2 same coverage flexibility in Medicaid that Medicare has and
3 make coverage contingent on the development of additional
4 real-world evidence. This will ensure states and members
5 they serve have confidence in the coverage decisions being
6 made and provide security for the limited state and federal
7 resources.

8 This might feel a little unique now, but we know
9 more and more specialty drugs under accelerated approval
10 pathways are coming. Aduhelm is not unique in that regard,
11 and without more flexibility in coverage strategies, states
12 will face more and more challenges and more and more
13 unmanageable pharmaceutical costs.

14 So we really appreciate the conversation today,
15 and I'll hand it back over to you. Thank you so much for
16 having me.

17 CHAIR BELLA: Thank you for joining in for your
18 comment, Allison.

19 Anyone else who wishes to make public comment?
20 Do you see anyone, Kate?

21 [No response.]

22 CHAIR BELLA: Okay. Chris, you really can leave

1 now. Thank you. Thank you very much.

2 Any last questions, comments from the

3 Commissioners?

4 [No response.]

5 CHAIR BELLA: You forget what it's like to sit

6 here all day. You're all anxious to get outside.

7 Okay. We will start -- our first session

8 tomorrow is on a couple of opportunities for us to comment.

9 One is on the core set rule, and the other is on a

10 congressional request for information on long-term services

11 and supports. We'll start that session at 9:30.

12 In the meantime, I want to thank Kate. This is

13 her first official -- well, sort of. We did our July

14 meeting, but this is our first official regular meeting,

15 and also welcome our new Commissioners, and thank the

16 MACPAC team for all that they do behind the scenes to

17 getting us ready for today, all of you as well, everybody.

18 So thank you, everybody, for your engagement.

19 Come back tomorrow ready to talk, and we're done for the

20 day. Thank you.

21 * [Whereupon, at 4:10 p.m., the meeting recessed to

22 reconvene Friday, September 16, 2022, at 9:30 a.m.]

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PUBLIC MEETING

Reserve Officers Association
Top of the Hill Banquet and Conference Center
One Constitution Avenue NE
Washington, DC 20002
and
Via Zoom
Friday, September 16, 2022
9:30 a.m.

COMMISSIONERS PRESENT:
MELANIE BELLA, MBA, Chair
KISHA DAVIS, MD, MPH, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
MARTHA CARTER, DHSC, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
ROBERT DUNCAN, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
VERLON JOHNSON, MPA
RHONDA M. MEDOWS, MD
WILLIAM SCANLON, PHD
LAURA HERRERA SCOTT, MD, MPH
KATHY WENO, DDS, JD

KATHERINE MASSEY, MPA, Executive Director

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

2 [9:30 a.m.]

3 CHAIR BELLA: Good morning. Welcome to Day 2

4 [audio interruption] with a panel, actually, well, sort of

5 a panel. But we're going to be talking about the proposed

6 rule on the core set and a congressional request for

7 information. So we'll turn it over to the two of you to

8 run through that with us, and then we can provide comment.

9 Thank you.

10 **### REVIEW OF PROPOSED RULE ON CORE SET REPORTING AND**

11 **CONGRESSIONAL REQUESTS FOR INFORMATION ON LONG-**

12 **TERM SERVICES AND SUPPORTS**

13 * MS. JEE: Good morning. I will be reviewing the

14 proposed rule on the mandatory core set reporting. This

15 proposed rule was issued on August 22nd, and comments are

16 due in October, on the 21st.

17 I'm going to move pretty quickly today through

18 some background. I'm going to highlight key provisions of

19 the proposed rule and then note some areas that

20 Commissioners, you may wish to comment on.

21 The core set, as you know, are standardized

22 measures for assessing quality of care for individuals

1 enrolled in Medicaid and CHIP. Currently there are core
2 sets for children, adults, health homes --
3 CHAIR BELLA: Can you stop for just a minute? We
4 need to find an echo. I think it's difficult for folks
5 remotely. Can everyone just double-check that they're on
6 mute or they've turned their computer audio off?
7 [Pause.]
8 CHAIR BELLA: Okay. Do you want to try it again?
9 MS. JEE: As I was saying, currently there are
10 core sets for children, adults, health homes, maternity
11 care, and behavioral health. Reporting now by states is
12 voluntary, but Congress made reporting for the child core
13 set and the behavioral health measures of the adult core
14 set mandatory beginning in 2024.
15 Commissioners, you may recall that in March 2020,
16 we had a chapter in our report describing factors that
17 affect state readiness for mandatory reporting.
18 The proposed rule describes some of the key
19 requirements for reporting on the child core sets and the
20 behavioral health measures of the adult core set as well as
21 the health home core set measures. All states and some of
22 the territories will be reporting on the child and adult

1 core sets, and states that have implemented health homes
2 under Section 1945 and Section 1945A of the Social Security
3 Act will report on those applicable measures.
4 The proposed rule requires the Secretary to
5 identify and annually update the core sets in consultation
6 with states and stakeholders, and largely use the process
7 that is currently used for updating the child and the adult
8 core sets. States will be required to adhere to the
9 Secretary's guidelines for reporting, and those guidelines
10 will be issued annually and include information on which
11 measures will be required for reporting, measures that the
12 Secretary will or can report on behalf of states, and ones
13 for which states will have extra time to report. The
14 Secretary's guideline will also include information on the
15 specifications for measure calculation as well as
16 requirements related to stratification of the measures.
17 States will be required to report on fee-for-
18 service and managed care populations, for certain settings,
19 and providers, as listed on this slide, and dually eligible
20 individuals.
21 CMS also proposes to allow the Secretary to
22 establish a phase-in for reporting of certain measures and

1 certain populations as well as new measures that might get
2 introduced into the core sets. The proposed rule also
3 calls for stratified reporting of measures but proposes a
4 gradual phase-in of that requirement, and the schedule is
5 listed on the slide.
6 The proposed rule requires states to report on
7 children enrolled in separate CHIP and Medicaid and then
8 the two populations combined. The rule acknowledges that
9 children churn on and off of the programs and move between
10 the programs, and indicates that the Secretary's guidance
11 will provide information for attribution of those
12 populations into either of those categories of kids. So it
13 will basically tell them how to report on those children
14 that move.
15 The rule also requires reporting on pregnant
16 women and individuals covered under the separate CHIP
17 unborn child option.
18 So given the Commission's prior work looking at
19 state readiness for mandatory core set reporting, there are
20 a number of areas that you may wish to consider reporting
21 on. For example, you could comment on the overall phase-in
22 approach, given our findings regarding states' need for

1 sufficient lead time to prepare for the mandatory
2 reporting. You also could comment on the rule's gradual
3 five-year phase-in of stratified reporting.
4 With respect to stratification, the June 2020
5 chapter on health equity and in other MACPAC work
6 emphasizes the need to address health disparities and
7 improve data collection. As Linn and Jerry noted for you
8 yesterday, we have other work ongoing in this area.
9 You may wish to comment on the stratification
10 phase-in approach designed by the Secretary as proposed in
11 the rule versus one determined by states, which CMS
12 considered. And as I mentioned, a key goal of the core set
13 is to ensure consistent reporting by states.
14 State burden is another area where you may wish
15 to comment. In March, we described state burden and
16 capacity constraints and considerations for mandatory
17 reporting. As a reminder, in the proposed rule CMS
18 highlights efforts that the agency is taking to streamline
19 reporting for states, including reporting on behalf of
20 states.
21 CMS also requests comments on the TA, or the
22 technical assistance needs of states. Our chapter

1 emphasized that states will need ongoing TA in a number of
2 areas, which are listed on the slide here, and these were
3 all areas that the states themselves identified to us when
4 we spoke with them in the process of writing that chapter.
5 Commissioners, you also could comment on the
6 requirement for state adherence to the technical
7 specifications that will be issued by the Secretary. The
8 rule described, as our chapter did, that sometimes states
9 deviate from the technical specifications of the rules, and
10 they do so for various technical reasons. But CMS has
11 historically allowed it. The rule would no longer permit
12 such deviation in pursuit of greater consistency of
13 reporting.
14 CMS requests comments on whether to require
15 reporting of children in S-CHIP separately or combined with
16 Medicaid children, and reporting of pregnant women enrolled
17 in separate CHIP. These requirements would be new and the
18 proposed rule says that they are intended to ensure that
19 quality data are available for these populations that are
20 sometimes left out of reporting.
21 So given the fact that there is notable churn
22 among children and movement between Medicaid and CHIP,

1 those children are not necessarily captured in the core set
2 reporting as it currently occurs. And as a reminder, we
3 have talked a lot about disparities in maternal health, and
4 capturing that population in the core set reporting
5 provides an opportunity to capture additional data on them.
6 And lastly, you could comment on the need for
7 timely and specific guidance. So even though this rule
8 does provide some information on the broad-brush strokes
9 and the framework for the mandatory reporting, it does so
10 at a pretty high level. And it does indicate that there
11 will be future guidance, but it doesn't actually say when
12 that guidance would need to be issued.
13 The Commission has stressed before that states
14 will need to know what is required of the reporting so that
15 they can take steps to prepare, and that guidance really
16 needs to be specific.
17 Okay. So I know I ran through that really
18 quickly, but I would appreciate your thoughts and reactions
19 to these areas for comments that were noted. And for next
20 steps, as always, we will take your inputs today, we will
21 draft the letter, and we'll be sure to submit it by the
22 deadline in October.

1 So I will turn it over to you.

2 CHAIR BELLA: Thank you, Joanne. Are you sure
3 you want to give us all these opportunities of areas we
4 could comment on? Kidding.

5 MS. JEE: I'm kind of a risk taker.

6 CHAIR BELLA: All right. Can we go back to the
7 slides so we can kind of go through the last two or three
8 and make sure that we're covering all the areas that you
9 mentioned? So Commissioners, we're going to comment on
10 this and give Joanne feedback, and then we'll transition to
11 the RFI. Who would like to kick this off with comments?
12 Tricia?

13 Is your microphone on, Tricia?

14 COMMISSIONER BROOKS: Sorry. I thought it was.
15 There it is.

16 For full disclosure, I sit on the work group, and
17 have for the past, I think, four years, and I think it's
18 sort of important to understand the timeline and also the
19 rigor with which those technical changes may be made to the
20 core set.

21 My experience is that the process has become much
22 more rigorous now for the work group, and I definitely

1 support what the rule says about institutionalizing the
2 work group. But there are very specific technical
3 specifications that must be submitted when a rule is
4 proposed, that the work group considers. The work group
5 is, I don't know, 35 people or more across sectors, a lot
6 of representation from the states. And so there is a lot
7 of emphasis on feasibility, on state use of the measures in
8 Medicaid and CHIP.
9 So by the time the measures get into the pipeline
10 I do feel like there's a very strong process by which they
11 are considered by the group. And it requires a two-thirds
12 vote in order to either recommend a measure for inclusion
13 or to be removed from the core set.
14 So I think some of the Secretary's work is
15 already done by the time those measures come to the
16 Secretary for final determination, because the work group
17 does not hold the final decision-making capacity. It is
18 HHS.
19 And the statutory change has been out there for
20 four years. We would've had six years to prepare for 2024.
21 And I'm a little worried because when you think about the
22 timeline, the 2024 core set probably won't be published if

1 we stick with the timeline for the past few years, until
2 December of 2023. And then they have to write up the
3 guidance and everything else. I'm a little worried that
4 we're not going to see mandatory reporting in 2024, when
5 you consider that timeline unless the Administration
6 decides not to make any changes to the core set in that
7 year.

8 The other thing I think to be aware of is that
9 standardization, it talks about several states deviating
10 from the specifications right now. In the last report,
11 states reported a total of 640 measures, and only 16 of
12 those deviated from standard specifications. Also, 12 of
13 the core set measures have been in place since 2020.
14 They've been in there for 12 years already for reporting.
15 And 15 measures are HEDIS measures that states also require
16 plans to report.

17 So there's a lot that goes into this, and what I
18 worry about, I think we're ready to move forward, with the
19 exception of how this timeline has worked unless the
20 Secretary chooses differently. I really would like to see
21 us push for urgency and expedited guidance. You know, just
22 hold over the 2023 for 2024 and move forward sooner rather

1 than later.

2 In terms of stratification, one of the comments
3 they asked for, the way the rule is written, unless I'm
4 wrong, is that they basically allow the states to choose a
5 percentage of the measures that they're going to stratify,
6 and then having 25 percent of them by year 2, and then 50
7 percent in years 3 and 4, so technically 50 percent by year
8 4, and then 100 percent.

9 They ask whether the Secretary should mandate
10 which measure are stratified. And I would like to see us
11 comment yes on that because at least for a portion of the
12 measures, because that's the only way we're going to have
13 that comparability that we're looking for. And going back
14 to my point on the deviation, same thing there. There's no
15 reason to not have consistency across the board in these
16 particular measures.

17 And I guess I would like to see which
18 stratifications be specified by the Secretary, and I hope
19 we can do that.

20 The only other thing is I worry about the size of
21 the separate CHIP program populations in some states.
22 Forty million kids in Medicaid, 33 million are in straight

1 traditional Medicaid and another 4 million are in Medicaid
2 expansion, CHIP-funded Medicaid expansion. So you've got
3 less than 3 million kids in separate CHIP programs. And
4 the Pennsylvanias, Floridas, and New Yorks of the world,
5 those are important, but I think some of the smaller states
6 that have really, really small S-CHIP populations I think
7 are going to struggle with reporting those populations
8 separately as well as any kind of stratification.
9 And one last thing that the Secretary asked for,
10 or the rule asked for, is comment on other demographic
11 factors that should be specified, and I would really love
12 to see us say that, absolutely, managed care plans, other
13 factors that are important to whatever populations should
14 be included. There shouldn't be any restrictions on that.
15 CHAIR BELLA: Thank you, Tricia. Other
16 Commissioners? Does anyone have concerns with any of the
17 areas that Tricia raised, where she would like to comment.
18 Stratification is very consistent with what we've been
19 talking about as is clear guidance.
20 Can we flip to the next slide please, Joanne?
21 Does anyone have comments on state burden, TA? I don't
22 know why we have an echo still. Sorry, guys.

1 No comments? No other comments from
2 Commissioners? Kisha.
3 VICE CHAIR DAVIS: Just this one and the last
4 one, just thinking about the timing and recognizing that
5 there is a balance that has to happen to allow states time
6 to get this data. But I also find as we're collecting data
7 there is always a push to delay, to wait for perfect data,
8 and we're not going to get perfect data. And so there
9 needs to come a point when we move forward and release and
10 recognize that it is imperfect and show transparency and
11 where there is missing-ness, as Heidi likes to say, but not
12 continue to delay, delay, delay. We really want to start
13 to see the outcomes.
14 CHAIR BELLA: Bob.
15 COMMISSIONER DUNCAN: To both Tricia and Kisha's
16 comments, I just wanted to highlight again I do think it's
17 important that CMS be prepared to provide that technical
18 assistance and other resources to help states navigate and
19 put this together, but both use the words "consistency" and
20 "transparency" and "effectiveness" in those measures. And
21 when we get to the next slide I'll highlight, I think it's
22 ironic that Medicaid was set up for kids and pregnant women

1 in its original implementation and that's one area that we
2 are failing in effective measures that we need to look at.
3 CHAIR BELLA: Bob, would you like to comment on
4 this?
5 COMMISSIONER DUNCAN: As I was just saying,
6 Medicaid's original intent was to take care of children and
7 pregnant women, and that appears to be the area that we are
8 not collecting sufficient data in, and we definitely need
9 to encourage that we do that and there is a consistency and
10 effectiveness in those measures across states.
11 CHAIR BELLA: Rhonda?
12 COMMISSIONER MEDOWS: Just a comment to add.
13 When you're talking about collecting data on race,
14 ethnicity, and language, gender identity, all of those
15 different things, as well as various levels of ability and
16 disability, what I have not seen in this is the need to
17 actually have a communications strategy for the actual
18 beneficiaries. So you're not going to get self-reported
19 data unless you actually work with the population that's
20 impacted, and that needs to occur at both CMS and at the
21 state level. I just think this is an important element
22 that needs to be called out and to be included in the

1 recommendations going forward.

2 CHAIR BELLA: Thank you. Tricia, last comment,

3 so we can move to the next, and then Fred.

4 COMMISSIONER BROOKS: I was just going to comment

5 to Rhonda that the CAHPS survey, which is a patient

6 experience, is in the core set, but it is an area that has

7 not been published, reported on in any significant way, at

8 least at a national level.

9 COMMISSIONER MEDOWS: Can I respond to that? I

10 don't know that the CAHPS are sufficient. I don't believe

11 that it's actually been reengineered to address what

12 beneficiaries may feel when they're asked something. It's

13 a small segment of the population that gets surveyed, that

14 the questions that are asked in the survey are sufficient.

15 CHAIR BELLA: Thank you, Rhonda.

16 Fred. And then we are going to move on.

17 COMMISSIONER CERISE: Yeah. And this may be in

18 the next one. I don't remember, but the special

19 populations reporting on pregnant individuals and CHIP, I

20 would support including that as well. I mean, I think

21 that's an important element to pull in. That distinction

22 doesn't seem real meaningful to me.

1 My understanding is they're covered for
2 pregnancy-related stuff but not other stuff, and sometimes
3 that can contribute to differences in the way that they're
4 treated during their pregnancy. So I think looking at
5 their outcomes collectively would be important.
6 MS. JEE: Right. In separate CHIP, you can cover
7 pregnant women and then you can cover pregnant women
8 through this unborn child option, and so the rule would
9 require reporting for those populations in the core sets.
10 COMMISSIONER CERISE: Yes. I would support that.
11 CHAIR BELLA: Joanne, are there any areas that we
12 did not give you feedback on that you'd like to raise right
13 now?
14 MS. JEE: No. I think it's pretty
15 straightforward. We have a lot to draw from, from the
16 chapter, so that's helpful. Thank you.
17 CHAIR BELLA: Okay. Tamara, we're going to turn
18 to you for the RFI.
19 Thank you, Joanne.
20 MS. HUSON: Wait one second for the slides to
21 show up.
22 [Pause.]

1 * MS. HUSON: Okay, great. So, on July 27th, the
2 House Energy and Commerce Committee minority staff released
3 a request for information titled "Disability Policies in
4 the 21st Century: Building Opportunities for Work and
5 Inclusion," and this RFI asks a series of questions about
6 what can be done to remove barriers to meaningful community
7 living for people with disabilities.
8 And the RFI identifies three priority areas,
9 which you can see on the screen. First is access to long-
10 term service and supports; second, accommodations in the
11 community; and third, barriers to integrated employment.
12 And there are many questions under each of these
13 three sections, particularly the first area of access to
14 LTSS, and this is where MACPAC can focus its comments based
15 on our prior work.
16 In particular, we have conducted work on HCBS
17 waiver waiting lists, barriers that states face when trying
18 to increase access to HCBS, and estate recovery. These
19 three pieces of work are all relevant to some of the
20 questions raised in the RFI.
21 So, to start, the RFI asks a couple of questions
22 about waiting lists for HCBS waivers. In 2020, MACPAC

1 analyzed Section 1915(c) and Section 1115 waiver documents
2 for all 50 states and D.C. We compiled selected
3 information on waiver capacity and waiting list management
4 into a compendium. We conducted stakeholder interviews,
5 and we described the results of that work in an issue
6 brief.
7 This slide highlights a few of the key takeaways
8 from that work that we could potentially include in a
9 comment letter. To highlight just a couple of those
10 takeaways, the first is that while waiting lists vary in
11 their size, the length of a waiting list is not a precise
12 measure of unmet need for HCBS wavier services. In
13 particular, eligibility screening for waiver services
14 happens at different times in different states, making it
15 difficult to compare waiting lists across states.
16 Stakeholders also noted that beneficiaries may
17 get their LTSS needs met through services covered under the
18 state plan or through support from family caregivers while
19 they wait for an HCBS waiver slot to become available to
20 them. So it's difficult to judge how many people on
21 waiting lists are actually going without any HCBS because
22 states do not track how individuals meet their care needs

1 while waiting for waiver services.

2 And at the time of our interviews, we heard from
3 many states that they were experiencing or anticipating a
4 growing need for waiver services, and some anticipated
5 increasing difficulty meeting those needs in the future.

6 MACPAC has not conducted any follow-up work on
7 HCBS waiting lists since, but there are other available
8 sources of information out there, such as the Kaiser Family
9 Foundation's annual survey that reports out information on
10 waiting list by state, including the number of individuals
11 on waiting lists and average wait times by population.

12 Another topic of interest in the RFI is how
13 Congress can help reduce Medicaid's institutional bias.
14 Shifting the balance of Medicaid spending on LTSS from
15 institutional services to HCBS has been a federal and state
16 policy goal for several decades, and at the national level,
17 this was achieved in 2013.

18 MACPAC wanted to better understand the factors
19 that affect states' efforts to increase access to HCBS, and
20 so in 2020, they contracted with RTI International, and RTI
21 conducted stakeholder interviews and developed case studies
22 of five states.

1 We published that final contractor report titled
2 "Examining the Potential for Additional Rebalancing of
3 Long-Term Services and Supports" in 2021, and that report
4 discusses the six barriers that you see listed on the slide
5 which are additional areas for comment, and for the sake of
6 time, I want to highlight two of these areas.
7 The first is that a persistent and growing LTSS
8 workforce shortage is a primary barrier to increasing HCBS,
9 and this is an issue which has been exacerbated by COVID,
10 and MACPAC published an issue brief on the HCBS workforce
11 earlier this year.
12 Second is that a lack of executive and
13 legislative champions is a barrier to increasing access to
14 community-based services, and that states also have a
15 limited number of staff available with expertise to
16 administer complex HCBS programs.
17 Lastly, to talk about estate recovery, as you'll
18 recall, MACPAC published a chapter in its March 2021 report
19 to Congress on estate recovery, and that chapter included
20 three recommendations. The RFI specifically seeks feedback
21 on MACPAC's first recommendation to make estate recovery
22 optional. MACPAC has not conducted any further work on

1 estate recovery since the chapter. So we propose to
2 highlight some of the information found in that chapter to
3 reaffirm that recommendation that we made.
4 Prior to 1993, estate recovery was a state
5 option. Reverting estate recovery back to a state option
6 could give states increased flexibility, allowing states to
7 cease recovery if they determine the return on their
8 investment is low, while still permitting other states that
9 find estate recovery useful to continue the practice.
10 Many stakeholders that we spoke with during the
11 course of this work supported making estate recovery
12 optional, with some noting equity concerns such as how for
13 heirs of beneficiaries with modest means, the retention of
14 an inherited home of modest value could provide some
15 protection from poverty or housing instability.
16 We also heard about the effects of estate
17 recovery on people seeking Medicaid coverage. We heard
18 about how some people choose to forego or delay Medicaid
19 LTSS for fear of estate recovery in losing their home, but
20 we also heard how the awareness and understanding of estate
21 recovery policies by the general public and by Medicaid
22 beneficiaries is low.

1 Finally, the RFI also asked about other financial
2 eligibility policies that apply to individuals who use
3 Medicaid LTSS, such as asset limits, and as part of our
4 work in estate recovery, MACPAC contracted with researchers
5 at the LeadingAge LTSS Center @Umass Boston to review the
6 health and retirement study, and in general, the results of
7 that study showed that the assets of older adults enrolled
8 in Medicaid are quite modest, with many having little to no
9 wealth. For example, three-quarters of beneficiaries had
10 net wealth below $48,500, and for those age 65 and older,
11 the average home equity held by the total sample was about
12 $27,000.
13 So, for next steps, based on feedback from you
14 all at today's session, we will prepare a comment letter in
15 response to the RFI, and we'd just like to note that
16 comments are due on September 26th.
17 With that, I will turn it back and look forward
18 to your feedback. Thank you.
19 CHAIR BELLA: Thank you very much for talking us
20 through that so clearly.
21 Open it up for Commissioner comment. Bill.
22 COMMISSIONER SCANLON: Thanks.

1 I have comments in a couple of areas. One is the
2 question of HCBS being sort of an optional service and
3 nursing facilities being a mandatory service. I know
4 that's been a discussion both at the Commission and
5 longstanding sort of in the policy circles, but I'm not
6 sure it's a productive discussion because even though
7 nursing facilities have been a mandatory service, when you
8 look across the states in terms of what states provide with
9 respect to nursing facilities, it varies tremendously. So
10 that even though within it, it's a mandatory service,
11 there's incredible latitude that states have in terms of
12 what is going to be delivered.
13 Secondly, I think as we heard yesterday -- and
14 I'm a firm believer in this -- it would be totally
15 impractical to have a Medicaid program without coverage of
16 nursing facilities. So, in my mind, energy should be
17 devoted elsewhere.
18 The question of sort of whether HCBS services
19 should have -- be not optional but sort of mandatory brings
20 me back, and maybe I'm too far back in history to sort of
21 1981 when we had virtually zero HCBS services. And it was
22 only when the states got the ability to think about

1 controlling their budgets did they actually start to
2 embrace HCBS.
3 Maybe we've passed the point that HCBS would be
4 strong enough that we would not have to worry if we took
5 away some of that sort of budgetary discretion, but at the
6 same time, I think the waiting lists tell me that states
7 are still concerned about the budgetary implications of
8 covering the service.
9 So I worry about sort of what the reaction would
10 be, and it may be a function of how you change the coverage
11 of and the ability to control the coverage of HCBS services
12 within the state program.
13 With respect to the waiting lists, I think it's
14 important to understand sort of the composition of those
15 waiting lists. We have different populations of people in
16 need that are receiving LTSS, and I've seen data before
17 that there's very big differences between people that --
18 I'll call them -- that are sort of above 65 versus under 65
19 in terms of whether they're on a waiting list and how long
20 they're going to be on a waiting list.
21 You used the word "state management." I think
22 setting priorities within waiting lists is an important

1 thing. The issue that people can be served while they are
2 on the waiting list, yes, that can happen, but we have to
3 be very careful about making an assumption that informal
4 supports are going to be available and they're going to do
5 the job adequately.
6 The families to me have always been sort of the
7 balancing factors sort of in this equation. We're going to
8 not have someone in a nursing facility where their needs
9 are being met 24/7, hopefully, with good quality, to
10 sending them to their home and we're going to provide some
11 support. But we're not going to provide 24/7. So the
12 question is, who fills the gap, and even more important, is
13 the gap being filled?
14 I think attention to how you manage the waiting
15 list is very key to assuring that people get the services
16 that they need.
17 Thank you.
18 CHAIR BELLA: Thank you, Bill. I think a lot of
19 the work that we'll be kicking off with the core benefit
20 does actually sort of shift the focus away, in ways that
21 you're talking about, but helpful comments for this letter.
22 Thank you.

1 Martha. And then, Rhonda, your hand is up. It
2 may be up from last time. If not, I'll go to you next and
3 then Dennis. So, Martha?
4 COMMISSIONER CARTER: Yeah. Thank you.
5 Could you go back to the slide on estate
6 recovery? I want to make sure that we have what we need to
7 comment strongly on this. We had a quite robust discussion
8 when we dealt with this issue.
9 Even though you spoke it, it's not stated here
10 that we're really concerned about the equity issue, and
11 that as you said, families that have a little more
12 resources sometimes figure a way around estate recovery and
13 families with more modest means don't. And it has the
14 potential of perpetuating intergenerational poverty. So I
15 think that's an important issue for the Commission, and I'd
16 like to make sure we highlight that.
17 Do you need anything else? Like I said, we had a
18 pretty robust discussion. Do you need anything else from
19 us to continue our comments there?
20 MS. HUSON: Yeah. We can certainly pull in more
21 of that equity piece from the chapter, from the work that
22 we did and make sure we highlight that. Otherwise, I think

1 we do have what we need from the work that we previously
2 did.
3 As I stated, the RFI is really looking for
4 feedback on our recommendation. So I think our goal here
5 is just to reinforce the recommendation that we did and
6 highlight some of that work. Thank you.
7 COMMISSIONER CARTER: Great. Thanks.
8 CHAIR BELLA: Thank you, Martha.
9 Dennis?
10 COMMISSIONER HEAPHY: Thanks.
11 I've just been listening intently to what folks
12 are saying, and I'm sitting here and wondering, how do we
13 make sure we remove all the barriers to employment to
14 folks, the spend down? And we talked about the state
15 penalty is a really big one because people turn 65 and then
16 they run into trouble. I think we have to look at this
17 turning-65 issue as well, because once people turn 65, the
18 amount of income they can have decreases, and the asset
19 tests are all different. So I think that's something we
20 really need to examine here.
21 I do think we have an obligation to do that.
22 What are the barriers, and how do we help states to do away

1 with those barriers? I think there just needs to be a will
2 to make sure that we're not discriminating against
3 populations that could be in the workforce, and this is an
4 equity issue. It's a population, folks with disabilities
5 in general. So I would like to see it framed as what can
6 be done by Congress to work with states to remove these
7 barriers to employment and just to hopefully include in the
8 community, because I just don't think it's -- it boggles my
9 mind that someone could be on a waiting list for eight
10 years and they're functionally a quadriplegic and their
11 parents are in their seventies taking care of them. That
12 just seems unconscionable to me, and it's also, I think,
13 budgetarily from the state perspective, even if it's not
14 costing the state money, it's a burden on the families not
15 being able to work, not being able to really provide the
16 sort of care the person needs. It really needs to be
17 examined.
18 So I think that's what I want to say right now on
19 it.
20 CHAIR BELLA: Thank you, Dennis.
21 Rhonda?
22 COMMISSIONER MEDOWS: Just a simple request to

1 have race, ethnicity, as well as all other social
2 demographic information added to the populations that are
3 currently impacted by estate recovery, also a little of a
4 ZIP code analysis. Are we seeing it more harshly applied
5 in areas that are historically just low income and low
6 resource, and are we perpetuating ongoing poverty by doing
7 this? That's a question from me, but I think the data and
8 the analysis is important.
9 CHAIR BELLA: Okay. Thank you.
10 COMMISSIONER HEAPHY: Can I ask a question to
11 Bill? In terms of the bar that's set for people to go to a
12 nursing home versus being eligible for HCBS, do you think
13 that there's any sort of remedy that can be done to make
14 sure that nursing homes just don't check the box after you
15 get into the nursing home versus having that much more
16 stringent set of requirements for folks who get HCBS?
17 COMMISSIONER SCANLON: My experience has been
18 that there seems to be incredible variation across the
19 states in terms of what the standard is for being, quote,
20 "nursing home-eligible" with respect to your condition.
21 And to be honest, this is really going back in
22 history, but we have one sort of randomized control trial

1 where we looked at sort of people that were nursing home-
2 eligible, and the question was, who went in the nursing
3 home?
4 With no services being provided by the public
5 programs, only 13 percent sort of ended up going into
6 nursing homes, and people are living in the community with
7 incredible needs in terms of disabilities and medical needs
8 because of basically the heroism of their informal
9 supports. And I think we really need to keep that in our
10 mind as we're making policy because we are only serving a
11 segment of the population that has very, very genuine
12 needs.
13 COMMISSIONER HEAPHY: And do you have thoughts on
14 AARP's report on the need to reimburse family members who
15 are engaged in this work?
16 COMMISSIONER SCANLON: There's no question that
17 these people are doing sort of heroic work and deserve sort
18 of some type of compensation for that, but the issue is the
19 volume is so great. When I said earlier that states have
20 concerns about the budgetary implications, thinking about
21 how one might sort of engage in supporting informal
22 supports with financial compensation, it's a very daunting

1 sort of question to be raised.

2 COMMISSIONER HEAPHY: Do you think it's something

3 we should look at here?

4 CHAIR BELLA: I'm going to table this.

5 COMMISSIONER HEAPHY: I'm sorry.

6 CHAIR BELLA: I'm going to suggest that we can

7 talk about this as we go into the --

8 COMMISSIONER HEAPHY: I'm sorry.

9 CHAIR BELLA: No, no. No apology. -- in the

10 HCBS core benefit, but for purposes -- and we can have a

11 very, like, hearty, more in-depth discussion about that,

12 probably not for this particular sort of comment at this

13 point in time.

14 Other questions or comments?

15 It is important, Dennis, for sure.

16 COMMISSIONER HEAPHY: Oh, thank you.

17 CHAIR BELLA: You know me. I'm anxious to get to

18 the dual session on time.

19 [Laughter.]

20 CHAIR BELLA: Tamara, do you have what you need?

21 Just to clarify, the estate recovery, just so

22 everyone is clear, is asking people to comment on our

1 recommendation. So we're obviously going to comment that
2 we applaud that recommendation, but perhaps our comments is
3 more trying to make sure people understand why we made it
4 and the importance of it and why it remains important. So
5 I just wanted to provide that clarification so that
6 Commissioners that are reviewing the letter understand what
7 the comment is actually on.
8 Okay. Are there any other areas, Tamara, that we
9 didn't touch that you need to get a yea or nay on?
10 MS. HUSON: No, I don't think so. This has been
11 helpful. Thank you.
12 CHAIR BELLA: I'd just like to make sure that we
13 always do this, but appropriately appreciate that E&C is
14 looking at this and asking for comment on these areas and
15 planning to make this, I think, a pretty big priority
16 because it is also very in line with the priorities that
17 we've identified for some of our future work. So it's
18 exciting to see that.
19 Okay. Also, any last comments for Joanne?
20 Anything anybody came up with since we switched?
21 [No response.]
22 CHAIR BELLA: No? Thank you. Thank you in

1 advance for turning these around quickly so that we can get
2 them out on time. Very much appreciate that.
3 Okay. Thank you, Commissioners. We're going to
4 transition into the last panel of the day, which is on
5 integrated care for duals.
6 Drew and Kirstin are going to lead us through
7 this.
8 I would just say for Commissioners, we spend a
9 lot of time on D-SNPs or dual-eligible special needs plans
10 and capitated models, and so recognizing that not all
11 states have capitated models, it's really exciting to hear
12 about what's going on with some fee-for-service-based
13 options.
14 So, Kirstin and Drew, turn it over to you, and
15 we'll say thank you in advance to our panelists.
16 **### PANEL ON INTEGRATING CARE FOR DUALLY ELIGIBLE**
17 **BENEFICIARIES IN MEDICAID FEE-FOR-SERVICES (FFS)**
18 * MR. GERBER: Good morning, everyone. In June the
19 Commission recommended that Congress authorize the
20 Secretary of the U.S. Department of Health and Human
21 Services to require that all states develop a strategy to
22 integrate Medicaid and Medicare coverage for full-benefit

1 dually eligible beneficiaries. About 20 states do not
2 enroll dually eligible beneficiaries in Medicaid managed
3 care, and therefore must look to other policy levers to
4 design an integrated care strategy and advanced
5 integration.

6 We are glad to have three state Medicaid
7 officials with us virtually today. Each panelist will have
8 10 minutes to present about their experience establishing
9 an integrated care model, or planning to integrate care,
10 for dually eligible population outside of Medicaid managed
11 care and about available approaches under consideration.

12 Panelists will also talk about the challenges
13 they face working in integrated care in a fee-for-service
14 environment, and the Commission will have time for Q&A.
15 There will also be time for Commissioners to further
16 discuss the policy levers mentioned and provide feedback to
17 staff on areas of interest for future work after we excuse
18 our panelists.

19 I'll briefly introduce our speakers, and their
20 full bios can be found in your materials.

21 First, we'll hear from Kelli Emans, the
22 Integration Manager for the Home and Community Services

1 Division within the Aging and Long-Term Support
2 Administration in Washington State. In her current role,
3 Ms. Emans oversees the managed fee-for-service Health Homes
4 Program as well as implementation of enhancements in the
5 state's contracts with dual eligible special needs plans.
6 Next, we'll hear from Katherine Rogers from the
7 District of Columbia. Ms. Rogers is the Director of the
8 Long-Term Care Administration within the Department of
9 Health Care Finance. Under her leadership, the district
10 has made operational improvements to LTSS and laid the
11 foundation for the district's current efforts to better
12 integrate Medicaid and Medicare services.
13 And finally we'll hear from Olivia Alford, who
14 serves as the Director of Delivery System Reform for the
15 Office of MaineCare Services, Maine's Medicaid agency.
16 Recently Ms. Alford's work has focused on delivery system
17 changes related to behavioral health care, multi-payer
18 payment reform for primary care services, and moving
19 MaineCare payments into alternate payment models.
20 If the Commission is ready, we will begin with
21 Ms. Emans from Washington.
22 * MS. EMANS: Okay. Can you guys hear me all

1 right? Do you want me to go ahead and get started? Okay.

2 Well, good morning. First of all I want to thank
3 the Commissioners for inviting me to speak about the
4 Washington Financial Alignment Demonstration. We are very
5 proud of what we've built in partnership with CMS, and we
6 see it as a model for other states who are seeking to have
7 a coordinated duals strategy but don't operate in a managed
8 care environment or in a hybrid environment and need
9 something to build from.

10 If you can go back to the previous slide for just
11 one moment.

12 First, before I start talking about the model
13 it's important to understand where our state was at in
14 terms of how services were delivered in Medicare and
15 Medicaid and how that played a large role in both the
16 options available to a state and how we can leverage
17 available tools and resources or build on an existing
18 system to achieve enhanced integration.

19 When we started planning our duals strategy in
20 Washington in 2011, our landscape was primarily fee-for-
21 service, both for Medicare and for Medicaid. So behavioral
22 health was delivered separately through fee-for-service

1 models, and our LTSS system was and continues to be fee-
2 for-service, as well as on the Medicare side, primarily
3 folks were served through fee-for-service Medicare as well.
4 Next slide, please.
5 Now that you have a little bit of understanding
6 of the landscape, I want to address one of the key barriers
7 to integration before I talk about our strategy and our
8 model. One of the biggest challenges, I'm sure you all are
9 aware, in the development of integrated models, is how to
10 get started and how to fund it. And we know there are a
11 number of realities that drive the need for integration,
12 and we recognize these drivers in Washington, just like
13 other states. But we needed an up-front investment and we
14 lacked Medicare knowledge in our Medicaid delivery systems
15 to take the first steps forward.
16 So in 2011, Washington submitted and was selected
17 to receive $1 million in funding through CMS's State
18 Demonstrations to Integrate Care for Dual-Eligible
19 Individuals. CMS provided state support to design a
20 demonstrate proposal that described our structure, what we
21 could implement and monitor in an integrated delivery
22 system and payment model. And Washington used the money to

1 hire dedicated staff and to stakeholder its model. Without
2 this infusion of funding to support development of a
3 strategy Washington wouldn't have had the tools that we
4 needed to create an informed strategy that stood the test
5 of time.

6 So we have the up-front investment, and then we
7 started in July 2013, we started our demonstration, and in
8 the beginning, we received 90/10 match for eight quarters,
9 which allowed us to sustain our program as we were
10 building.

11 Then in 2016, just as the match was running out,
12 we received our first shared savings check and another in
13 2017. And as the shared savings began coming in, we were
14 starting to break even, even though our enhanced match had
15 ended, and it gave us those talking points that we needed
16 to be able to go back to our state legislature to ask them
17 to continue to support our program.

18 In 2018, shared savings continued to come in, but
19 we were actually at a point where we were now able to -- we
20 weren't just breaking even, we were actually making a
21 little bit of money that we could invest back into the
22 program, and that's been really critical over time as well,

1 as we've needed to make adjustments to our program.

2 From 2018 on we've continued to receive shared

3 savings and to date we've received $98.7 million in shared

4 savings, and we continue to invest that into the program as

5 well.

6 So two key points are up-front investment and

7 shared savings that could be reinvested. It presented a

8 win for Washington and are really what sustained the

9 program and made it a success. And we've been able to

10 garner legislative and leadership support even in critical

11 budget times for our state.

12 Next slide, please.

13 I do want to go back to the beginning where I

14 talk a little bit about the stakeholder engagement that was

15 funded through CMS. I think it's really important to note

16 what stakeholders said they wanted in a delivery system.

17 So when we asked our stakeholders to identify core

18 elements, they said make it based in community

19 organizations that are accountable for costs and outcomes;

20 integrate services across medical and social services;

21 create a single point of contact and intentional care

22 coordination; create flexibility to allow for local

1 variances; place an emphasis on the preferences of
2 individuals; provide strong consumer protections;
3 capitalize on what is working; and apply lessons learned.
4 Next slide, please.
5 So based on that the planning, guidance, and
6 stakeholder engagement, that resulted in the distinct
7 Washington Health Homes Model that we have today. It is
8 jointly managed by the Health Care Authority and Department
9 of Social and Health Services. But it's based in
10 communities and it's delivered at the local level.
11 The state contracts with lead entities, and these
12 are primarily Area Agencies on Aging or other community-
13 based organizations who are responsible for the
14 administrative functions, data collecting, reporting, and
15 contract and payment of the network of care coordination
16 organizations.
17 And the CCOs, as they are called, include a broad
18 range of system partners, like FQHC, behavioral health
19 agencies, Area Agencies on Aging. And this was really
20 intentional so that the services are delivered in a way
21 that most aligns with individuals' preferences and
22 connections to the community.

1 Health Home care coordinators deliver services
2 face-to-face and are qualified and trained by the state to
3 deliver Health Home services.
4 So the intent of Health Home, it's an intensive
5 service delivery aimed at actively engaging clients on
6 behavior change and integrating at the local level. This
7 had made our community-based organizations really critical
8 and leverages their community connections to achieve a
9 higher level of health equity by using tested community
10 partners to deliver services.
11 Next slide, please.
12 I'm going to touch lightly on targeting of the
13 model. This is an intensive model, and it's robust, and
14 it's best suited for a targeted population. We really
15 focus on data analysis to drive service delivery, and
16 that's helped create success in the program of targeting it
17 to the most needy population. We use a predictive risk
18 modeling tool and take into consideration clients' age,
19 gender, diagnosis, and mediation to create a prospective
20 medical risk score. And then based on that risk score we
21 know who would most benefit from the high-intensity care
22 coordination and where the most likelihood is that there

1 would be reduced cost.

2 Next slide, please.

3 Okay. So I'm going to talk a little bit about
4 where we're going. Based on the lessons we've learned and
5 the successes of the Health Homes Program, we are seeking
6 approval from CMS for certification. Next year will be our
7 10th year in the demonstration. And certification would
8 alleviate the administrative burden and network instability
9 caused by short-term extensions. While the managed care
10 Financial Alignment demonstrations are transitioning,
11 Washington's Health Home Model will continue to exist for
12 the fee-for-service duals population.

13 Like I said previously, when we developed the
14 fee-for-service demonstration, the landscape in Washington
15 looked very different, and as we are now moving to leverage
16 our D-SNP contracts to enhance integration and continuity
17 of care for the broader duals population through our work
18 with Arnold Ventures, we want to ensure that our highest-
19 risk subset of individuals have access to this enhanced
20 care coordination through Health Homes, however they choose
21 to receive their services.

22 So to achieve these dual policy goals we worked

1 with CMS to include state-specific requirements that D-SNP
2 plans must offer a Health Home program and utilize the
3 existing structure and network for a fee-for-service
4 demonstration. This aims to maintain continuity of care at
5 the client level, when clients are transitioning through
6 different systems of care. And to do this we're going to
7 be leveraging the model of care in 2023.
8 Starting with the fee-for-service strategy that
9 recognized our state's unique landscape allowed us to test
10 and learn and continue to build onto our system and evolve
11 our strategy over time as our delivery system shifts and
12 the needs of our community shift.
13 Washington continues to leverage the lessons
14 we've learned about the critical nature of care
15 coordination across different systems of care, even in
16 financially integrated system, in creating its integrated
17 approach that values the service delivery recipients say
18 that they want.
19 So Health Homes is the model that's worked for
20 us, but states could take lessons learned from this model,
21 a targeted coordination infrastructure and strategic
22 partnerships and apply it to other areas of the system or

1 duals strategy.

2 So thank you very much for inviting me to speak
3 today, and I think my contact information is on the last
4 slide, where you'll see more information.

5 MR. GERBER: Thank you, Kelli. And now we'll
6 move to Katherine Rogers of D.C.

7 * DR. ROGERS: Thank you and good morning. Thanks
8 so much for including the district. We're happy to be
9 here. I don't have any slides. I'm just going to speak
10 from my notes and hopefully will move through this in a
11 linear fashion.

12 In the district, Medicaid covers about 300,000
13 residents. It's a small place but we cover a large
14 proportion of the population here. Our traditional
15 Medicaid managed care program has usually covered children
16 and families. After the Affordable Care Act it was
17 expanded to include childless adults. But our aged, blind,
18 and disabled populations, which have typically comprised 20
19 to 30 percent of our Medicaid enrollment, variously over
20 time, have generally remained in our fee-for-service
21 program. Of course, this population includes our dual
22 eligibles, it includes SSI-receiving adults, other disabled

1 adults, a small number of non-dual elderly folks, and, of
2 course, our level of care population who might be served in
3 institutional long-term care services and supports or in
4 our HCBS waivers or Medicaid state plan home and community-
5 based services.
6 In early 2018, there was an internal work group
7 convened here at DHCF, a Medicaid agency tasked with
8 assessing options for improving the management of the fee-
9 for-service population, which, depending on how you define
10 who we're talking about, was about 50,000 people at the
11 time.
12 We have had different sort of population- or
13 program-specific care management programs over time, most
14 obviously our 1915(c) waivers, which have offered intensive
15 care management of various stripes. We had, and we
16 continue to have, two health homes. There is also a
17 variety, throughout the district, a variety of non-Medicaid
18 community-based case management support programs affiliated
19 with different district government places.
20 The analyses that were conducted as a part of
21 this work group flagged a few things for areas where the
22 Medicaid agency had the greatest sort of potential energy,

1 where we could do something that would have, you know, most
2 likely to make an impact, and these areas were primarily
3 behavioral health, our duals population, and our long-term
4 care users.
5 And those last two overlap a lot because most of
6 our duals are not long-term care users but most of our
7 long-term care users are duals. And for those long-term
8 care users our primarily obligation is their long-term
9 care, in addition to cost sharing. Particularly we saw
10 patterns of high utilization of inpatient stays where our
11 cost-sharing applications were significant.
12 Unrelatedly, we had increased our interactions
13 with our D-SNP health plans, which through 2018 there were
14 three of them. These health plans have been operating in a
15 D-SNP in the district since 2013. Like many Medicaid
16 programs, we sort of talked to them for a while, we talk to
17 them about once a year to sign their agreement. But in
18 2017, a couple of folks here at the agency had initiated an
19 effort to increase our interaction and collaboration with
20 the health plans as a mechanism to see like, here's
21 something we designed for duals; how can we leverage it to
22 improve their care?

1 The timing of all of this was fortuitous because
2 ultimately then the integration standards for D-SNPs were
3 issued, and while this was all fresh and top-of-mind for us
4 here in the district we were like, oh, look at this. We
5 could use this opportunity to move the needle a little bit
6 farther for this fairly large swath of duals who have
7 historically been enrolled in our D-SNPs.
8 At the time -- and before I move on, I do want to
9 talk about that increased collaboration with our health
10 plans. At the time we had started having quarterly
11 meetings. We shored up our reporting requirements in the
12 State Medicaid Agency Contract, or SMAC. They would send
13 us their reporting. We would meet and review their
14 reporting. These were all things that were new at the
15 time, but they certainly, again, put this sort of front-of-
16 mind as an opportunity we could leverage to build on
17 something we already had.
18 So with all of this kind of swirling about, the
19 agency coalesced around sort of a multi-pronged strategy
20 for addressing some of the persistent sort of coordination,
21 integration, and fragmentation, all of those meaning
22 different things, but all of the concerns we had about the

1 management of our fee-for-service population. Ultimately
2 it moved the agency towards the goal of moving the entire
3 Medicaid program, in a future state, into comprehensive
4 Medicaid managed care.
5 The agency announced this goal in 2019, and said
6 over the coming years we're going to take various steps.
7 None of them -- we're not starting today and moving
8 everybody all at once, but we're going to tackle several
9 different things that will ultimately advance us towards a
10 long-term vision of moving most, if not all, Medicaid
11 populations into comprehensive Medicaid managed care
12 through different vehicles.
13 This included a couple of different things at the
14 time, in 2019, some of them targeted the behavioral health
15 identified needs. One was the implementation of a first-
16 of-its-kind 1115 waiver delivery and behavioral health
17 services. That's now been incorporated into our Medicaid
18 state plan authority.
19 We are also working to integrated community-based
20 behavioral health services that have historically been
21 carved out of our Medicaid managed care contracts, into
22 those contracts and integrating behavioral health services

1 more comprehensively into a whole-person model of care.

2 That's more outside my wheelhouse than what I'm
3 going to talk about next, which is our integrated programs
4 for our dual eligibles.

5 The District has been working now for more than
6 10 years -- I personally have contributed over a period of
7 more than 10 years -- to launch the District's first PACE
8 program, and it is to open its doors in January. I can
9 obviously hardly contain my excitement about that, but this
10 sort of ties into other efforts where we see we have some
11 traction with our duals population and integrating Medicare
12 and Medicaid benefits, so that one entity can have the full
13 visibility into all the services a person is accessing,
14 whether that's acute and primary care or long-term services
15 and supports. PACE is a big part of that, and so we're
16 delighted that this timeline is kind of coalescing
17 together.

18 But, again, back to our D-SNP work, using our
19 existing D-SNP program to launch the District's first foray
20 into a managed care version of our 1915(c) services and our
21 elderly and persons with physical disabilities waiver as
22 well as some state plan, home- and community-based

1 services.

2 And we're also working to continue to leverage
3 our SMAC, and we've learned a lot about Medicare over the
4 past few years, but leveraging out increasing knowledge of
5 the Medicare program to support what is a fairly
6 significant duals population in our mental illness program,
7 historically 10 to 13 percent of our total enrollment,
8 including partial and full-benefit duals.

9 Throughout all of this, what we really tried to
10 do is work to expand or enhance existing programs that we
11 already have and are already operating to cover new things
12 or new people. So, in 2020, we carved in some non-dual,
13 non-level of care, adults with disabilities, mostly our
14 SSI-receiving adults, into our existing Medicaid managed
15 care program.

16 I mentioned before the integration of community-
17 based behavioral health services into the District's
18 Medicaid managed care contracts, and that work is ongoing.

19 The last couple things I'd like to say, I
20 probably used the word -- I hope I've used the word
21 "incremental" a couple of times, but I think that's been a
22 really key focus of our approach. How do we target pieces

1 of our program and make changes in one area? These are not
2 small changes, by any stretch of the imagination. We're
3 working on programs that serve, in some cases, thousands of
4 people, but how do we make them incremental, build on
5 existing work that we've already done, instead of feeling
6 like we're starting from zero and we have to unpack a whole
7 bunch of stuff all at once and create something that is new
8 for everybody all at once in the range of tens of hundreds
9 of thousands of people all the same time, which can feel
10 extremely overwhelming.

11 That takes me to my latter point, which on the
12 stakeholder engagement side, I think that's also made it a
13 little easier for our providers. We have providers who
14 some years ago might have been serving only fee-for-service
15 populations, and now they have folks in multiple programs,
16 and they're adapting. It hasn't always been easy, but it
17 meant that through incremental changes, their entire census
18 that they were serving wasn't subject to change at and
19 given -- you know, in any one programmatic change. So it's
20 made the process -- you know, some people probably don't
21 like that. It makes it hard because there are different
22 kinds of changes coming at different stages, but it has

1 made it, again, incremental and potentially easier for some
2 folks to manage as time goes by.
3 I guess, I think I'm at my time, but the last,
4 truly last thing I will say is our duals programs are
5 voluntary in nature. So, in one sense, that's positive
6 because they're competing on the value-add of an integrated
7 program, and so they're -- the thing that will cause people
8 to enroll in state is really about the benefit of having
9 Medicare and Medicaid together and having that
10 simplification for a person who has the programs.
11 At one public meeting, one of my colleagues
12 announced our D-SNP program dual choice is designed to be a
13 one-stop shop for Medicare and Medicaid, and community
14 members said, "What took you so long?" We're trying to
15 move the needle in that way, and I think a lot of folks are
16 receptive. It does mean that if they want to choose a non-
17 integrated program, they can go back to what could be more
18 fragmented or uncoordinated care, and that's a choice that
19 they have. And we want to make sure that they have
20 choices, but the goal of moving forward to integrated care,
21 there is some flexibility there and some movement in the
22 enrollment side.

1 So I'll stop there because I think I have run out
2 the clock, and I will turn it over to Olivia.
3 MR. GERBER: Thank you.
4 Olivia with Maine, can you --
5 * MS. ALFORD: Thank you so much.
6 I have to say that recognizing that Maine as
7 being invited to speak at somewhat of a low achiever -- and
8 I say that jokingly because I think we do understand and
9 agree with are status as minimally integrated at this
10 point. However, we do want to talk today about some of the
11 reasons, the challenges, the decision-making, and some of
12 the strategy we do have that may again not exactly be in
13 the form of capitated or integrated financial models.
14 Next slide. So, briefly about Maine, Maine's
15 Medicaid program importantly I sone of the remaining states
16 that has zero managed care, as you may know, within our
17 delivery system. Instead, we have really focused
18 historically on multi-payer alignment on alternative
19 payment models than on delivery system reform effort. So
20 we're going to talk a little bit today -- I'm going to talk
21 a little bit today about how regardless of the model,
22 thinking about how care is actually delivered at the

1 practice level and what the care transformation of an
2 integrated model actually looks like and feels like to a
3 person remains a really critical point across the nation
4 but especially for Maine.

5 Things that are on the slide, Maine is also
6 considered the oldest state in the country. We have the
7 highest median area, and we have over 21 percent of our
8 residents over the age of 65. We are also largely rural,
9 which you likely know. These factors make this
10 conversation particularly unique for us, and I'm going to
11 walk you through some of the ways that that's played out
12 for us and as far as our 116,000 dual-eligible members and
13 our 65 percent of those which are full duals.

14 Next slide.

15 This is an analysis we did back in 2019, and
16 actually, we had talked with Washington a lot. We had done
17 peer-to-peer learning with them. They had spoken to our
18 advisory committee on LTSS. We have a health homes base as
19 well. We have high-risk models in our health homes program
20 we are targeting. We thought that the managed fee-for-
21 service approach may be something that Maine is interested
22 in. Again, we have alternative payment models. We fully

1 understand and agree with the challenge that we are making
2 investments that are being -- savings being accrued to the
3 Medicare program based off of the investments we are making
4 in the Medicaid program.
5 So we were excited about that opportunity. CMS
6 put out there again in 2019, very engaged. We did this
7 analysis about where were the eligible beneficiaries that
8 could potentially, you know, not an MSSP, not in a Medicare
9 Advantage, that could be part of this. And the green, if
10 you can't see, is all the ZIP codes were that was less than
11 50 people who were even there, live there, let alone would
12 have ended up in the model. Clearly, that presents some
13 challenges with implementation and actual, again, care
14 transformation at a practice level but also
15 methodologically regarding calculations of shared savings.
16 So, unfortunately, we sort of shifted. As
17 Katherine described, we shifted to a -- we're doing
18 incremental approaches. Let's focus a little bit more on
19 our D-SNP contracts for the short term in some of the
20 foundational work we need to do to build up to something
21 bigger in the future.
22 This is not the only time where the disbursement

1 of duals has become an issue for Maine. It also comes up
2 with CMMI model such as CHART, although that wasn't the
3 only reason we didn't participate in that model.
4 Next slide.
5 So Maine, like everyone else has mentioned, is
6 seeing the trend of more Medicare Advantage uptick and also
7 more D-SNP enrollment. Again, it creates a good
8 opportunity. We've appreciated the federal guidance. We
9 took the coordination mandate to do something really
10 innovative in Maine, which I'll talk about a little bit
11 next, but we do have five coordination-only D-SNP plans
12 that we work with, and I'll talk about the last few years
13 with them.
14 Next slide.
15 Oh, you lost audio for me? You can't hear me?
16 [No response.]
17 MS. ALFORD: Kelli and Katherine, can you hear
18 me? [No response.]
19 MS. ALFORD: Okay. It's like someone is nodding
20 at me, but yeah.
21 [Pause.]
22 MS. ALFORD: Good to see you, Katherine.

1 DR. ROGERS: I'm not sure we have audio from the
2 main room.
3 MS. ALFORD: Yeah. I don't think they can hear
4 us.
5 MS. EMANS: They're unmuted, and we can't hear
6 them either.
7 COMMISSIONER DUNCAN: Can you hear me?
8 MS. EMANS: Yes.
9 DR. ROGERS: So it must just -- I'm not sure what
10 it is, then.
11 MS. ALFORD: Yeah. They messaged us. I guess
12 this is a direct message. They told me they lost audio.
13 They're trying to restore sound, so I think it is --
14 CHAIR BELLA: Can you hear us now, Olivia?
15 MS. ALFORD: Oh, yes.
16 CHAIR BELLA: Yes. Excellent. Sorry about that.
17 It looks like you guys were having a great
18 discussion. Kelli and Katherine were nodding, so we're
19 envious. So you may need to go back a couple slides. I'm
20 sorry.
21 MS. ALFORD: Oh, okay. Yes. I was confused
22 because I was like I think they can hear me, but it's just

1 you all.

2 Where did I cut off?

3 CHAIR BELLA: Do you mind just starting -- you

4 can start on this one. That would be great.

5 MS. ALFORD: So we started -- we're going to talk

6 a little bit today about our D-SNP strategy. We are seeing

7 enrollment increase, like other states. We have

8 coordination-only contracts, as you all know from your

9 report. So I'll talk a little bit about that in the next

10 slide.

11 We, similar to D.C. -- next slide -- had

12 essentially very little contact with our D-SNP partners for

13 a long period of time, and it was sort of situated within

14 the organization, the Medicaid agency, in a very

15 operational part of the agency versus anything related to

16 strategy.

17 So we took it under delivery system reform a few

18 years ago, began to have an actual -- you know, quarterly

19 meetings with them, engaging the D-SNP partners around even

20 relationship building but also data collection and

21 strategy.

22 We took the coordination requirements and did

1 something that Maine is really proud of, an innovative
2 effort to have the D-SNPs fund their nursing facilities to
3 connect directly to our state-wide Health Information
4 Exchange to fulfill the admission, discharge, transfer
5 notification. It actually resulted in 60 additional long-
6 term care connections, which is two-thirds of our nursing
7 facilities.
8 Again, this gets to my repetitive point here that
9 we are trying to do things that actually trickles down to
10 delivery system reform, not just payment alignment, though
11 we certainly want to achieve financial alignment and
12 integration as well. We require the D-SNPs to also
13 coordinate with our LTSS coordination agencies.
14 We do have many alternative payment models. Two
15 large ones, just to call out some ways that we've
16 incorporated duals into those, we actually -- the dual
17 status feeds directly into methodology and reimbursement
18 for a few of our models. We are an official aligned care
19 with the CMMI primary care first models or primary care
20 reform. That was something, again, to really ensure that
21 we are building that multi-payer alignment so that a
22 critical mass of patients at any level can be treated in

1 the same way. That's important for a rural state when
2 you're talking about these small numbers.
3 Then, lastly, as we really started to -- and
4 began to adopt the term from the report -- to build our
5 integrated care strategy for Maine, we have -- you know,
6 looking back, we weren't calling it that, but we've
7 collected requests for information on managed care
8 strategies, potential alignment opportunities, and we are
9 really excited about our next step to procure a vendor to
10 formally assess Maine's strengths, weaknesses,
11 opportunities, and threats around dual, dual eligible
12 integration. And this was -- before your report came out,
13 we -- I had been really a champion of this effort because I
14 have worked from the policy writer position up to a
15 director level, and I've seen, as your report acknowledges,
16 how deep dual knowledge needs to run in the organization
17 for any kind of effective decision-making or management
18 could take place.
19 So we need additional support in that front,
20 which I'll talk a little bit back on next -- about on the
21 next final slide -- or second-to-last slide.
22 So we are really in the capacity-building stage.

1 We are understanding what we do and don't have, how would
2 we operationalize or manage future change. We are very
3 excited to see things like the Center for Health Care
4 Strategies, Medicare Academy opportunity be released to
5 states. There is significant capacity needs, let alone the
6 financial investments that Kelli, you know, rightfully
7 called out to actually do some of these things, but even
8 just knowledge is needed. We need to build that up. We
9 don't have any dedicated staff to this effort currently,
10 that we anticipate we'll be identifying a need for that.
11 As we move forward in Maine, because of what I've
12 talked about and where we are, we anticipate needing
13 flexibility and coordination with CMCS and ideally with
14 CMMI as they roll out additional models. We think it's
15 important that that flexibility remains in the systems to
16 make a strategy that works for each state. We have
17 experienced some challenges working between CMMI and CMCS
18 regarding explaining their models to one another and trying
19 to connect them to support as a state and actually doing
20 something around some of these populations, the dual
21 populations specifically.
22 And the last slide is just really to say what's

1 been said, but really, clearly, that Maine wants to move
2 forward. We just want to -- we are very focused on making
3 sure that what we do actually has tangible benefits to
4 members and communities, local and infrastructure in the
5 state. And we take integration to mean both financially
6 but also, again, at the care delivery level.
7 We are very optimistic that we will actually be a
8 leader in a few years in this space. So thank you for
9 having us today.
10 MR. GERBER: Great. Thank you all for presenting
11 today. I think we are ready to move into a Q&A.
12 CHAIR BELLA: Excellent. Thank you very much.
13 As you might imagine, I have a lot of questions,
14 but I'm going to hold those and see if others would like to
15 go first. Who has questions for the panelists?
16 Dennis?
17 COMMISSIONER HEAPHY: Yep. I have questions for
18 Kelli. Is LTSS carved out, or is that part of the CCO?
19 MS. EMANS: LTSS is whether fee-for-service for
20 all. All LTSS in Washington is delivered fee-for-service.
21 It's not in managed care.
22 COMMISSIONER HEAPHY: So the CCO is coordinated

1 with -- the CCO care coordinator would coordinate the LTSS
2 as well as the -- as well as HCBS and medical and
3 community-based service needs?
4 MS. EMANS: That's correct, yep. So they're
5 coordinated with the different systems of care, often in
6 partnership with -- so, in Washington, our long-term care
7 system, our case managers are actually state staff or area
8 agency on aging staff. So the role of the outcomes care
9 coordinator is to partner with that case manager and to
10 have kind of a holistic picture of the individual's care
11 needs and making sure they're making the connections to the
12 right systems of care.
13 COMMISSIONER HEAPHY: I think you may have said
14 this. So there's a face-to-face care coordinator? Are
15 they telephonic? How does that work?
16 MS. EMANS: They are face-to-face. That's one of
17 the strengths of this model is the rapport building and
18 face-to-face connections. So there's three levels of
19 services that are delivered. The care coordinators deliver
20 six distinct services, but they're done face-to-face.
21 During the pandemic, of course, we've shifted a
22 little bit, but our care coordinators are now beginning to

1 go back out face-to-face. Some of them were meeting in
2 front yards, meeting across the street to deliver the
3 service, but yes, it is a face-to-face service, unless the
4 client requests otherwise.
5 COMMISSIONER HEAPHY: And then is there any
6 concern about conflict of interest with the care
7 coordinators? Like, for example, an MCO is a care
8 coordinator, may represent the insurer rather than the
9 person's interests. So how does that work within the fee-
10 for-service system that you've developed, the health homes?
11 MS. EMANS: Yeah, that's a great question.
12 So there are health homes within our managed
13 care, so for Medicaid only, and for our duals demo
14 participants, and there is a separation in many ways,
15 particularly with the fee-for-service system. There's a
16 firewall, per se, that you don't have the same people
17 managing the program, the same person helping with
18 authorization of long-term care doing health home services.
19 The other thing that I would say is that there's
20 very intentional training provided to care coordinators to
21 ensure that we don't have conflicts of interest. I don't
22 know if that specifically addresses your question, and I

1 could come at it from a different angle, if that would be
2 helpful.
3 COMMISSIONER HEAPHY: I think that's helpful.
4 Just two more questions. One is do you have
5 rebalancing requirements in there?
6 MS. EMANS: Well, Washington has been rebalanced
7 since about the late '80s, so we don't have -- I mean, over
8 like 80 percent of our LTSS recipients are receiving care
9 in the community. We have very small nursing facility
10 utilization in Washington. So no, there is no explicit
11 rebalancing requirements within our Health Homes model.
12 COMMISSIONER HEAPHY: And where do most of the
13 savings come from that you've accrued over the years?
14 MS. EMANS: It's on the Medicare side. So it's
15 primarily in medical services. It's no in LTSS
16 utilization. Actually, when individuals are receiving
17 Health Home services we don't see a decrease in LTSS. We
18 actually see an increase in individuals receiving necessary
19 services. Where we do see a decrease it's on the medical
20 side of unnecessary visits, hospitalizations, and ER
21 visits.
22 COMMISSIONER HEAPHY: Thanks. I guess for the

1 three folks, and that is what measures do you use for
2 quality -- HEDIS? CAHPS? Do you use your own in-state
3 measures as well?
4 MS. EMANS: Yeah, so we have a set of measures
5 that are required through our demonstrations that report.
6 I don't have them all in front of me, but we are not just
7 using HEDIS measures. We have a whole core set of measures
8 that are required under our demonstration.
9 COMMISSIONER HEAPHY: Thanks.
10 CHAIR BELLA: We can get you those, Dennis.
11 Those are publicly available. Martha and then Sonja.
12 COMMISSIONER CARTER: Thank you. Great session.
13 As I've said in previous sessions, the duals population is
14 an important and growing population for the community
15 health centers, FQHCs, and while health centers have quite
16 a bit of experience in quality metrics and care
17 coordination, there are also challenges to including FQHCs
18 in these integrated models, well, for lots of reasons, but
19 one of the main ones is because of the way the health
20 centers are paid.
21 So I heard Washington State specifically mention
22 working with FQHCs, and I wondered how that, you know, sort

1 of some of the detail. I know that's probably more than
2 you can get into here, and how the other states integrating
3 the FQHCs. It seems, from some of our previous sessions,
4 that some of the national models that have been put forth
5 have not considered including the FQHCs, which I think is a
6 grave oversight. So I'd like to hear your thoughts on
7 that.

8 MS. EMANS: I can specifically answer the
9 question. The FQHC encounter rate is separate so Health
10 Homes would be a separate contract and they would be paid
11 the Health Home rate for the specific Health Home service
12 that they're delivering. So they would have a separate
13 contract and then paid a separate rate outside of their
14 typical encounter. So we're not actually touching the -- I
15 don't want to say normal, but the traditional FQHC
16 reimbursement methodology is outside of that. And I'm not
17 an expert in FQHC methodology, but I do know how we
18 contract with them.

19 MS. ALFORD: I can jump in too. It's similar in
20 a few ways. All of our models, actually, essentially up to
21 this point, have been outside the PPS. So in addition to
22 the prospective payment system, and that's been allowable

1 and advised by CMCS for some of these efforts.

2 However, I fully agree that it is problematic,
3 essentially, that that's, especially CMMI efforts, which
4 are intended to serve both Medicare and Medicaid as
5 innovation projects, oftentimes exclude, again for
6 complicating reasons, FQHCs.

7 In our primary care reform and in our care
8 organizations include FQHCs, and it just takes a lot of
9 additional decision-making and complexity to do that. But
10 again, they are a critical source of care.

11 So I think it does get extremely complicated.
12 It's an area where integration is challenged, and if there
13 are recommendations that think about how can the federal
14 government support that sort of conversation and not to
15 derail any opportunities for FQHCs to enter into the
16 alternative payment models with states. We are pursuing
17 those conversations as well, but especially around duals it
18 does get a little bit -- it gets in the weeds very fast.

19 CHAIR BELLA: Thank you. Sonja?

20 COMMISSIONER BJORK: I was wondering, as you've
21 been developing your program, can you talk a little bit
22 about the reaction of the providers to this big change, you

1 know, both primary and specialist providers? Have they
2 been accepting? Has there been resistance? How has it
3 gone?
4 MS. ALFORD: Which change are you talking about?
5 COMMISSIONER BJORK: The whole idea of
6 integration and just a different approach to taking care of
7 their Medicaid-eligible duals.
8 MS. ALFORD: Yeah. you know, I think it's been
9 positive so far. Previously, Maine had operated a primary
10 care case management program for a long time, and it
11 actually didn't include duals. They were excluded. So
12 they were not getting paid for a large portion of their
13 population through those care management fees.
14 As we shifted to this new model with primary care
15 as a center point for this conversation anyways, we made
16 sure we could include duals and so they could think about
17 it from their whole practice. They could think about all
18 the members they were seeing and develop their strategy
19 around a whole population, whereas Health Homes has always
20 included duals.
21 This gets into, again, some of the duplication
22 conversations that fee-for-service states have to have with

1 CMCS, with all the regulations and different sections of
2 the Social Security Act, and sometimes having to create
3 these artificial distinctions between programs and
4 populations.

5 So with our new programs we have kind of
6 dissolved all of the artificial separations, and the
7 practices are pretty supportive of the approach. We did a
8 whole exercise of surveying behavioral health, primary
9 care, and population health level entities around their
10 familiarity with LTSS, and we found that there was a lot of
11 variability, including some very low levels of
12 understanding of LTSS systems. So another whole track we
13 have been working on provider education and just the actual
14 coordination of the two systems so that they can best
15 actually achieve the outcomes that we're wanting them to
16 achieve.

17 And then Maine, in general, I think there are
18 lots of opinions about whether we should move to managed
19 care or not, but at this point we've held back in support
20 of some of our broader foundational building around rate
21 systems reform and things that really are necessary,
22 regardless of what we do in the future for managed care.

1 COMMISSIONER BJORK: Thank you.
2 CHAIR BELLA: Okay. I have questions, one or two
3 for each of you. Katherine, I'm going to start with you.
4 And just for context I think you guys know this, but we've
5 made recommendations along the lines of supporting states,
6 providing them funding to build capacity and to have
7 dedicated resources. Most recently we made a
8 recommendation for states to have a strategy. So we're
9 always trying to understand like what policy levers do
10 states still need and where is that someplace that we could
11 weigh in as we support them in various delivery systems.
12 So that's why this conversation is really important for us.
13 Katherine, I would say to you, so one question is
14 just do you have the policy levers you need, and what do
15 you want us to hear that would be helpful to you? And
16 number two, one of the things that we're thinking about,
17 particularly with the latest rule and looking where CMS is
18 going with FIDE-SNPs and HIDE-SNPs and exclusively aligned
19 enrollment, just the issue of shared savings for states.
20 And I'm wondering, as the district is moving more toward
21 HIDE or FIDE or wherever you're planning to end up, is
22 shared savings a concern for you?

1 So kind of twofold. Do you have the policy
2 levers you need, and what are you thinking about shared
3 savings?
4 DR. ROGERS: Thanks. So for the first question,
5 when I was thinking about what else could we use to help
6 us, I wouldn't say necessarily that we don't have the
7 policy levers we need. I think Olivia had on one of her
8 slides we need a lot of support, and we are, frankly,
9 getting a lot of support. We have been meeting with ICRC
10 for like four years at this point. We get a lot of help
11 from a lot of different CMS directions, our ICRC meetings,
12 we meet with MMCO. We obviously had a lot of engagement
13 with our local folks when we were standing up the policy
14 authority, and even just planning in advance of that.
15 It does feel, like what I notice on Olivia's
16 side, that I just wanted to echo, was if we're to have a
17 duals strategy it needs to also sort of be integrative at
18 the CMS level too. So we've had this conversation about
19 our duals stuff here but also the conversation over here
20 about our Medicaid program. And so it feels like that.
21 You know, it still feels a little bit separate, even though
22 we're talking about integration in the duals conversation.

1 And so it's sort of like we've been trying to
2 blend a lot of different expertise here, and I know that
3 that's also a question at the federal level too. And so I
4 think it's sort of the same -- it's probably the same need
5 in both places and that we're having conversations, it
6 sounds like a lot of people at the table, but having
7 conversations with everybody together to advance what the
8 federal government would like states to be doing as far as
9 having a comprehensive and coherent strategy at the state
10 level of district level.
11 The other thing, and it's interesting, the
12 question about FQHCs because a lot of our provider and
13 stakeholder engagement, you know, it can be hyper-local,
14 and especially if you live in place that is only tens of
15 square miles instead of a large state. Some of our
16 provider populations are small communities, organizations
17 like our home and community-based providers. But the FQHCs
18 are another big one, and I think that it's helpful to
19 understand or connect with CMS or others in the federal
20 government about getting some, I guess -- and I'm not
21 exactly sure what I'm asking, but like national direction
22 or support on the engagement in some of those specific

1 service areas or provider areas so that we are not trying
2 to reinvent the wheel every time we engage with a specific
3 provider community, understanding that some of those
4 provider communities are hyper-local. I totally get that.
5 And now I've forgotten your second question. Can
6 you please repeat it?
7 CHAIR BELLA: Yeah. It was just about shared
8 savings.
9 DR. ROGERS: Well, I think this is sort of why we
10 are pointing in this direction. Honestly, from a sort of
11 policy perspective, we have been very busy just trying to
12 get some programs started, so it's not like front-of-mind
13 operationally at this time. But where we started in 2018
14 was this idea of we have these folks that are very
15 expensive to both programs, and that fact that they are
16 expensive is not being coordinated at all. So that was one
17 of the things that led us here, so that's something that we
18 certainly intend to examine more appropriately in the
19 future. It hasn't been on our plates just recently.
20 CHAIR BELLA: Thank you. Olivia, similar
21 question. As you're going down -- and I very much
22 appreciate the consistent point about what's happening at

1 the delivery level and the provider level -- what do states
2 in your position need from an organization like MACPAC? Do
3 you have the levers you need and it's more you need some
4 dedicated resources, or is there anything else that we can
5 provide states like you as you try to become a leader in
6 this space over the next few years?

7 MS. ALFORD: Yeah, I think, again, to me, I
8 appreciate mandates, at times, when they are helpful to
9 advance directives. So again, I am personally supportive
10 of asking states to have a strategy. I think levers like
11 that are helpful, can be helpful when designed
12 appropriately. So maybe something around what that
13 requirement would look like so that we don't end up just
14 adding burden to the state facilitating with resources
15 attached, something that will be meaningful for us. So I
16 think that recommendation can be meaningful and can really
17 help us if it has resources attached.

18 I do agree that there's been a wonderful level of
19 support from the federal government on these topics with
20 the different offices, the coordination and the ICRC and
21 everything, and a lot of guidance.

22 And so levers-wise, I'm always going to advocate

1 for reduced administrative burden associated with
2 demonstration and 1115 waivers and other things that really
3 make it very, very difficult for a state to move into those
4 opportunities. We don't have the staff to dedicate full
5 FTEs to every waiver, every demonstration, the data
6 collection pieces. You know, it's really considering the
7 level of requirements around some of these things, to see
8 if they can be reduced.
9 CHAIR BELLA: Thank you. And Kelli, first of
10 all, I'm pulling for you to get certification.
11 Congratulations. Not that that means anything but it's
12 excited to see that you're poised to even be able to ask
13 for that, so that's wonderful.
14 You guys have talked to a lot of other states who
15 are interested in the managed fee-for-service. From where
16 you're sitting, Kelli, are there policy levers other states
17 need to be able to go do that? That would be one thing.
18 And just overall, as you're looking to put Health Homes in
19 your D-SNPs and you're going to have this option available
20 for people that want to remain in fee-for-service or who
21 are in a managed setting, is there anything else you need
22 from that lens too?

1 So kind of overall question. What other support
2 do you need from MACPAC, and from a state, trying to do
3 what you've done, is there anything else you would say on
4 their behalf?
5 MS. EMANS: Well, those are loaded questions.
6 Yes, I talked about it before, but when we talk to other
7 states about the model that we've developed I think it
8 feels overwhelming. And I think I would also say that that
9 feels true in the discussion of HIDE models.
10 And so I think one thing that I would say is I
11 try to be very mindful to take it apart and try to teach
12 the different elements that could move instead of the full
13 scope. And so both in the Health Homes model or trying to
14 create an integrated system within a fee-for-service
15 delivery model, and even in the D-SNP conversations, I
16 understand that there is like the gold standard, but many
17 of the states are nowhere close to being there. And so
18 trying to take it apart and make it usable and take pieces,
19 describe the policy levers in a way that states can
20 actually move forward. And I think it was Katherine that
21 said incrementally multiple times, and Olivia said the
22 staffing, right?

1 So we need to be able to make incremental steps
2 based on our knowledge at the time and the staff resources
3 that we have. So that would be a key thing for me.
4 And then shared savings is critical. So both
5 times when we've tried to move our strategy forward, we've
6 had opportunities that provided us an up-front investment
7 to allow us to have dedicated space to do the work, because
8 we're Medicaid folk trying to learn Medicare, and we want
9 to do better. I think most states want to do better. But
10 we lack the up-front investment at the state level because
11 there's not a strong awareness at the state leadership
12 level always about what is being asked.
13 So I think that would be my two things is that
14 the recognition of the up-front investment and then
15 incremental change is, I think, going to be most effective
16 for states, and shared savings. Shared savings is
17 critical. We tried to look at a shared savings model when
18 we were looking at a way to make the Health Homes program
19 available in D-SNPs, and it was a very challenging
20 conversation to move forward. So I think some additional
21 thinking or policy levers around what options could be
22 available for shared savings or for alternatives would be

1 really helpful.

2 I don't know if that answered all your questions.

3 CHAIR BELLA: Yeah, you did. I can see a quote

4 now, "Shared savings are critical," in our next report,

5 attributed to you.

6 Well, we are at our time so I want to be

7 respectful of the three of you. Please know that this is a

8 priority area for us and we will continue to do work in

9 this area, and a point very well taken and good reminder

10 that we're always consulting states along the way. So if

11 there are things you think about that you want to get on

12 our radar screen, please don't hesitate, and I'm sure we

13 will not hesitate to reach back out to you as well.

14 But thank you for spending time with us this

15 morning, and thank you, more importantly, for all the work

16 you're doing. Thanks so much.

17 Going to Commission discussion now, or did you

18 guys want to tee up anything before we turn into that?

19 MS. BLOM: We can go to discussion.

20 **### FURTHER DISCUSSION BY COMMISSION**

21 * CHAIR BELLA: Great. Thank you for putting that

22 panel together.

1 Do folks have comments?

2 Dennis.

3 COMMISSIONER HEAPHY: I'm thinking.

4 CHAIR BELLA: You're thinking?

5 COMMISSIONER HEAPHY: I am. What I keep thinking
6 about is the Medicare and Medicaid dollars just don't work
7 together, and so how do states when they're trying to
8 integrate care -- how do they do that when they have two
9 sets of payers that don't work well together? That's what
10 I'm trying to -- in my head, they're doing all this work in
11 the states, but they don't have control over the dollars,
12 how they spend the dollars. I think that for me is like --
13 you hear about all these changes to the D-SNPs and
14 everything going on and integration and services, and yet
15 one of the primary barriers to care is dollars and control
16 over those dollars.

17 So that, I think, is something -- I don't know if
18 that's something we can talk about, but I think that's
19 critical, especially if it's Massachusetts, also move from
20 an MMP to a D-SNP. That's something we're thinking about
21 in Massachusetts. Yeah. So any model would be hampered by
22 the lack of control over the Medicare and Medicaid dollars.

1 CHAIR BELLA: Yeah. I mean, I think as we do the
2 work, it's the shared savings obviously is an issue. It's
3 kind of solved in managed fee-for-service in a way,
4 although it has not been easy for them to measure and to
5 verify that there was Medicare savings and write those
6 checks.
7 But the shared savings in D-SNPs is not, and
8 that's -- we do the work later this year on MMP
9 transition. I think it's an issue, Dennis, that we need to
10 bring up.
11 I'd also be interested in understanding more
12 about how Washington's shared savings feature with the
13 health homes is or is not going to carry when they put
14 those health homes into the D-SNP because she alluded to
15 that at the end, but if felt like it was too complicated to
16 try to get into now. But that, I think, is an important
17 thing, would be helpful to understand.
18 COMMISSIONER HEAPHY: And one other piece would
19 be they're the conflict-free piece, because that's really
20 important to beneficiaries is that the care coordinator is
21 conflict-free. And so it seemed like Kelli was saying
22 something about they worked to make sure that there's a

1 firewall there to protect -- to make sure the care
2 coordinators are representing the beneficiary and not the
3 insurer.
4 MS. BLOM: Yeah. And that's a good point. I
5 took notes about that as well. I think that that's
6 something we haven't -- that could be maybe an incremental
7 change type of thing we can consider, because I think Kelli
8 was saying that there's like a separation between the care
9 coordinator and the plan. But we would want to ask some
10 more questions about that. So that's a good area.
11 COMMISSIONER HEAPHY: Something with that too, is
12 the care coordinator part of the care team, or are they a
13 separate coordinating entity?
14 MS. BLOM: Right. I think in the MMPs, they're
15 part of the team.
16 COMMISSIONER HEAPHY: Exactly.
17 MS. BLOM: But I think maybe there could be some
18 other options or other ways of structuring that in
19 different models.
20 CHAIR BELLA: Some of the acronyms, maybe you're
21 all familiar, but ICRC is then Integrated Care Resource
22 Center. It's a CMS-funded resource center that is there to

1 work with states on these things. Obviously, the MCO is
2 the duals office, and then CMCS is the Medicaid part of
3 CMS, so a couple other things.
4 You know, if I was queen, we would be
5 recommending every year that states get dedicated resources
6 for this. I mean, we hear that over and over and over, and
7 we are not going to see movement here until there is a way
8 to support them. And I think Washington was able to
9 leverage health home money for eight quarters until the
10 savings paid off, but that up-front investment and the
11 dedicated resources are so important, so constantly finding
12 ways to continue to reiterate that, even if it's just, you
13 know, are ways just to be appreciative of the legislation
14 that has been introduced that would provide some support to
15 states, I think, is important.
16 Laura.
17 COMMISSIONER SCOTT: I was just wondering based
18 on the comment that was made earlier about how expensive
19 the care is and the lack of integration. Has there been
20 any kind of financial analysis to look at coming up with a
21 number of potential savings that would then go back to the
22 states to offset -- to be that up-front investment? So

1 give me the money today for the savings I promise you
2 tomorrow, but have we done the analysis to say if we braid
3 the money, integrate, and coordinate the care, we can
4 expect the savings of X, and we'll give you a portion of
5 that up front to start moving in that direction. Has there
6 been any kind of analysis like that?
7 CHAIR BELLA: I think there's been various sort
8 of state calculators that have attempted to say if you
9 wanted -- you know, if you're going to integrate, this is
10 what you could expect, or backing into to say, like, in
11 order to have savings, you would need to have this type of
12 reduction on the Medicare side in particular, because those
13 are easier and quicker.
14 But I think so much depends on the current
15 utilization of hospital and post-acute services because the
16 states vary so much, and also, if you're coming from a
17 state that has been managed versus not, like all of those -
18 - but I think there have been some work that would allow
19 you to understand. The work I've seen is, again, more --
20 you know, in order for a state to recognize savings, you
21 would need to see changes on the Medicare side in this
22 magnitude. That's the way I've seen it, more so than

1 putting it all together.

2 But the financial alignment demonstrations did
3 put them all together and make assumptions about what you
4 could get because of reduced duplication and coordination
5 and all those things. So that would also be kind of work
6 along the lines of what you're talking about.

7 COMMISSIONER SCOTT: Or the outcomes from PACE in
8 the markets that have PACE programs, and how has that
9 worked? And is there an opportunity to move in that
10 direction? Because to your point, it depends on the
11 inpatient utilization, the problem is it also depends on
12 the coordination. So you get into this unfortunate cycle
13 of admit/discharge, admit/discharge, because no one is,
14 like, intervening to coordinate that care to put in place
15 whatever the patient needs, beneficiary needs to stop that
16 cycle.

17 CHAIR BELLA: Comments over here?

18 COMMISSIONER JOHNSON: I may have missed some of
19 the conversation. I stepped out.

20 But more around the certification piece of it, is
21 there anything that we can learn or so around that form a
22 Commission perspective to kind of help ease that burden a

1 little bit more for other states, if they can get into that
2 process?
3 Let me ask them over there.
4 [Laughter.]
5 CHAIR BELLA: Does everybody understand what the
6 certification issue is? I mean, I'm going to oversimplify
7 it, but Washington's demonstration is an Innovation Center
8 demonstration, and so what the Innovation Center does is
9 allows the Secretary to make things permanent if certain
10 quality and cost tests are met. So Washington now has been
11 doing this for 10 years and is trying to get the approval
12 necessary to make this not a demonstration anymore so that
13 it can be a permanent program for them.
14 Okay. A couple other things. I mean, to make it
15 simpler is really important, right, even when we're in our
16 work, figuring out how to talk about the levers and even
17 some of the acronyms, and then also the extent to which we
18 can continue to get the state feedback on what a strategy
19 would look like in their given state, I think, is
20 important.
21 Martha, I see your hand.
22 COMMISSIONER CARTER: Yeah. Thanks.

1 I had two comments, but you really addressed one,
2 and it was so obvious in Washington State's presentation
3 that up-front investment is key to developing these
4 programs, and so I think that's one point.
5 The other is the FQHC one that I think everybody
6 is sort of avoiding, and I wondered if the Commission could
7 take some position on this to recommend that -- I'm not
8 sure who the players would be. HRSA's Bureau of Primary
9 Health Care and NAC at least and whoever else, really put
10 their heads together and figure out how the FQHCs can be
11 involved in these integrated models. It's so right in line
12 with what FQHCs do. So the barriers should just --
13 You lost me?
14 [Pause.]
15 COMMISSIONER CARTER: Can you hear me?
16 UNIDENTIFIED: Those of us on the virtual can
17 hear you.
18 COMMISSIONER CARTER: Oh, nice. Well --
19 CHAIR BELLA: We can hear you.
20 COMMISSIONER CARTER: Now you can hear me?
21 CHAIR BELLA: Yes.
22 COMMISSIONER CARTER: Well, that's funny. Okay.

1 Well, where did you drop off?

2 CHAIR BELLA: I think you were saying -- well,

3 the last thing we heard was HRSA when you referenced you're

4 not sure who would get in the room.

5 COMMISSIONER CARTER: Oh, yeah. HRSA's Bureau

6 for Primary Health Care and NAC and whoever else needs to

7 be at the table to come up with some national guidance on

8 how FQHCs can be involved in these models, because it's so

9 right up the line for the health centers to be involved in

10 these integrated models. So it just seems ashamed that

11 everybody is dancing around it, and we really need to just

12 recommend that it gets worked out.

13 CHAIR BELLA: Thank you.

14 Anyone else have comments before we go to public

15 comments?

16 Laura.

17 COMMISSIONER SCOTT: Just one last comment, which

18 I think Washington mentioned a couple of times in addition

19 to what we've already discussed around up-front investment

20 and shared savings, just administrative burden and

21 simplifying wherever and whenever we can.

22 CHAIR BELLA: Yep, agree. I think that's

1 Verlon's, having been on the other side, wants to see some
2 administrative simplification as well.
3 Okay. Martha, we can certainly continue that
4 conversation. I actually thought these -- at least two of
5 the three who addressed it very much were -- had FQHCs top
6 of mind in trying to figure out how not to let PPS
7 interfere with the ability for the FQHCs to participate.
8 So I found that actually promising.
9 COMMISSIONER CARTER: Yeah, me too. I think I
10 heard that some national guidance would be helpful.
11 CHAIR BELLA: I think Olivia did allude to that,
12 yeah, for different provider communities -- or maybe it was
13 --
14 COMMISSIONER CARTER: Yeah. I can't remember
15 who, but yes.
16 CHAIR BELLA: Okay, wonderful.
17 Drew and Kirstin, before we go to public comment,
18 what else do you need from us?
19 MS. BLOM: We're going to take this back and
20 talk. We could potentially follow up with D.C. about -- or
21 sorry -- with Maine about the FQHCs and maybe shed a little
22 more light on that, and then I think we need to think about

1 -- I'm interested in D.C.'s approach, the incremental
2 steps, and like carve in some things slowly. So maybe
3 that's something we could bring back to you guys.
4 I think we're good for now.
5 CHAIR BELLA: Excellent. Well, thank you for
6 putting that panel together.
7 All right. We will go to public comment. We are
8 open for comment on this session or the first session,
9 which was about our comments on the couple of -- the rule
10 opportunity and RFI opportunity by Energy and Commerce.
11 So, if you would like to make a comment, please use your
12 hand icon, and I'll remind folks to please introduce
13 themselves and the organization they represent and ask you
14 to keep your comments to three minutes or less.
15 **### PUBLIC COMMENT**
16 * [Pause.]
17 CHAIR BELLA: Okay. It looks like not everyone
18 else is as excited about this as I am. But now this is a
19 wonderful way to end the day. Thank you very much for
20 this.
21 Any last comments or questions from
22 Commissioners?

1 Kate, anything you want to say to the group?
2 MS. MASSEY: Nothing from my end. I would just
3 thank everyone for their participation and engagement, so
4 thank you.
5 COMMISSIONER HEAPHY: I'd like to -- for the
6 first conversation, just how many states are in compliance
7 with Olmstead? And how can we move the states to integrate
8 in compliance as part of this conversation around HCBS? I
9 think we can't have the conversation without talking about
10 the Olmstead requirements, whether or not states are
11 actually in compliance or have a plan in place to become in
12 compliance.
13 CHAIR BELLA: Thank you.
14 All right. We are set to be back here in
15 October. In the meantime, we'll have a couple of comments,
16 comment letters posted.
17 I want to thank the MACPAC team, as always, for
18 getting us prepared and for a great couple of days and Kate
19 also, and congratulations on your first meeting in the bag.
20 Exactly.
21 All right. Thank you, everybody.
22 * [Whereupon, at 11:19 a.m., the meeting was

1 adjourned.]