PUBLIC MEETING

Ronald Reagan Building and International Trade Center
Oceanic Room
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

AND

Via ZOOM

Thursday, October 27, 2022
10:00 a.m.

COMMISSIONERS PRESENT:

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HEIDI L. ALLEN, PHD, MSW
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JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
RHONDA M. MEDOWS, MD
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 [10:01 a.m.]

3 CHAIR BELLA: Okay. Good morning. Welcome to
4 the October meeting of MACPAC. We are thrilled to kick
5 things off, and I'm going to turn it over to Kisha.

6 VICE CHAIR DAVIS: Good morning, everybody.
7 We're excited to have Linn and Jerry here to present on
8 collecting and reporting Medicaid race and ethnicity data,
9 so we will turn it over to you guys.

10 **### MEDICAID RACE AND ETHNICITY DATA COLLECTION AND**
11 **REPORTING: INTERVIEW FINDINGS**

12 * Mx. JENNINGS : Great. Good morning,
13 Commissioners.

14 The Commission is committed to prioritizing
15 health equity across all of its work, and during this work
16 cycle we've been examining opportunities to improve the
17 completeness and quality of Medicaid race and ethnic data.

18 In September, we provided background on race and
19 ethnicity data collection and reporting standards and an
20 overview of the challenges with these processes, and this
21 month we're continuing our discussion, and we're presenting
22 findings on our literature review and federal, state, and

1 stakeholder interviews.

2 I'll start by outlining the federal and state
3 priorities for improving race and ethnicity data, and then
4 I'll present our interview findings on state data
5 collection processes, and then Jerry will present findings
6 on state reporting processes and potential approaches to
7 improving data usability.

8 Next slide.

9 One of the Administration's priorities in
10 advancing health equity is to increase the usability of
11 federally collected race and ethnicity data, and the
12 Equitable Data Working Group identified data inadequacies
13 and strategies for improvement, including the
14 disaggregation of race and ethnicity data and leveraging
15 underutilized data sources to better understand these
16 disparities.

17 CMS has also prioritized improving data
18 usability, and CMS proposed requiring states to stratify
19 adult and child core set measures by race and ethnicity to
20 monitor disparities in health outcomes.

21 State Medicaid programs have also prioritized
22 health equity across their work, but most states are still

1 pretty early in their development process. These efforts
2 have initially focused on establishing infrastructure to
3 support state health equity plans and to improve the
4 disaggregation of race and ethnicity data to assess health
5 disparities, support outreach, and develop targeted state
6 policies.
7 In our interviews with states, they shared how
8 they use state Medicaid eligibility race and ethnicity data
9 for their program administration and are leveraging other
10 data sources, including managed care organization data, for
11 their own internal analytical work. For example, one state
12 is designing a database that will reconcile all the data
13 sources they're using, and they will be putting into a
14 hierarchical process for identifying the most complete and
15 accurate data on multiple risk factors, including race and
16 ethnicity data.
17 I also want to note that although they are
18 designing these processes to improve the completeness and
19 accuracy of their data, that is for internal work, so these
20 data won't be used for changing the Medicaid eligibility
21 data or any of the data that are submitted to T-MSIS.
22 To inform our work, we completed a literature

1 review and conducted 21 structured interviews with HHS,
2 CMS, state Medicaid officials, beneficiary advocates,
3 research experts, managed care plans, and application
4 assistor organizations. These interviews focused on how
5 race and ethnicity data are collected and reported, the
6 challenges with collecting and reporting these data, and
7 how to improve data usability.
8 To begin, state Medicaid programs collect race
9 and ethnicity data on applications, and these questions are
10 optional as race and ethnicity information are not a
11 requirement of Medicaid eligibility and they are self-
12 reported, as it is considered the best method for collecting
13 information an individual's identity. Additionally,
14 individuals, when completing these applications, may
15 receive assistance from application assisters or case
16 workers.
17 CMS provided states guidance with developing
18 their applications, including a model application, and the
19 model application includes race and ethnicity questions and
20 categories that align with the 2011 HHS guidance. States
21 have the option to use the model application, or with CMS
22 approval to modify it or develop their own. Some states

1 have used the model application, but many have made changes
2 or adopted a CMS-approved application.
3 Twenty-nine states have integrated applications,
4 and so they must also meet the requirements for other
5 benefit programs, including non-health programs. So in our
6 interviews with states that have multi-benefit
7 applications, officials noted that they did develop their
8 applications to meet both federal Medicaid and SNAP
9 requirements. The SNAP race and ethnicity requirements are
10 more specific compared to Medicaid.
11 Most interviewed states that modified the race
12 and ethnicity questions on their applications did so to
13 meet state-specific needs. For example, in one state, state
14 selection standards were determined by state statute, and so
15 they require 33 race and ethnicity categories to be included
16 on the application, including an option to not respond or
17 that they choose Unknown. These categories were developed
18 based on documented best practices and informed by community
19 stakeholder processes.
20 As we discussed in September, states vary in
21 their ability to collect race and ethnicity information
22 during the application process, and CMS uses two primary

1 criteria for assessing the quality of T-MSIS data, which
2 include data completeness and data accuracy, data
3 completeness being measured as the percentage of records
4 with missing values, and data accuracy is measured as the
5 number of combined race and ethnicity categories where the T-
6 MSIS analytical files, or TAF data, differ from the American
7 Community Survey Medicaid values by more than 10 percent.
8 There are 33 states that are missing over 10
9 percent of their data, and over half of the states have at
10 least one race and ethnicity category where the T-MSIS data
11 differ from ACS by more than 10 percent.
12 As we see on this map, which is the CMS data
13 quality assessment on the DQ Atlas, they have combined these
14 two measures into one data quality measure. Thirty-one
15 states are in the low and medium concern category, so these
16 are usable for data for analytical work. And then many
17 states also fall into this high concern or unusable data
18 category.
19 The majority of states and application assisters
20 that we interviewed highlighted similar barriers to
21 collecting these data. They shared that individuals don't
22

1 always feel comfortable providing sensitive information and
2 they might have concerns with how this information might be
3 used, or they fear that they might be denied coverage.
4 Additionally, race and ethnicity categories don't
5 always align with an individual's identity, and one
6 organization that serves primarily Middle Eastern and North
7 African populations shared that many of the individuals
8 would check Other or write in the country of origin rather
9 than selecting one of the categories provided. Sometimes
10 there was also confusion about how to answer race and
11 ethnicity questions given that an individual may not always
12 be familiar with this categorization of their identity.
13 The interviewees did provide suggestions for
14 improving applicant understanding of the questions and
15 trust in providing this information. A couple of
16 organizations have prioritized hiring individuals who have
17 a connection to the community that they serve, including
18 those who are prior Medicaid enrollees or speak the same
19 language or the same race and ethnicity as the clients they
20 serve. And some interviewees also suggested providing
21 information to individuals about why these questions are
22 asked and have trained assisters to clarify how the

1 information will be used, and this has made some applicants
2 more comfortable providing this information.
3 And I'm going to hand it off to Jerry.
4 * MR. MI: Thanks, Linn.
5 State Medicaid programs collect race and
6 ethnicity data through the state's eligibility systems,
7 which are then directed towards the state's Medicaid
8 Management Information Systems, or MMIS. States then
9 process the data from MMIS into CMS's preapproved format
10 before submitting them to CMS. States must submit one race
11 value and one ethnicity value for each individual that
12 corresponds to the categories available in T-MSIS. CMS
13 then repackages this data into TAF.
14 The majority of interviewed states did not report
15 having challenges with data processing, noting a simple
16 one-to-one match with eligibility information to T-MSIS
17 data fields. However, two states that have applications
18 designed to collect multiple race and ethnicity categories
19 had difficulties aggregating the data to meet the federal
20 reporting requirements, which only allow for the reporting
21 of one race and one ethnicity value.
22 For these states, the challenges significantly

1 effect data accuracy and completeness. For example, one
2 state's application allows for multi-race or multi-
3 ethnicity responses but their MMIS does not and defaults
4 them to null values. These null values are then
5 categorized as missing when the state submits to T-MSIS,
6 contributing to the state's high rate of missing data.
7 CMS provides technical assistance to states,
8 which includes providing states with tools for evaluating
9 the quality of their data. In our interviews, four of the
10 seven interviewed states mentioned regular communications
11 with CMS or its data contractor, Mathematica, regarding T-
12 MSIS submission quality or other data quality items. State
13 conversations with CMS focused on addressing the state's
14 priority data concerns. The four states that regularly
15 communicated with CMS all had high-quality race and
16 ethnicity data. Therefore, CMS did not identify race and
17 ethnicity data as an area of improvement for those states.
18 In addition to CMS data assessments, some states
19 also conducted internal validation and analyses to assess
20 data quality. For example, one state regularly monitors
21 changes in data quality within their eligibility system and
22 works with agency partners and MMIS vendors to improve

1 their data.

2 Based on our interviews, there are multiple
3 factors that contribute to the lack of usable race and
4 ethnicity data. There was also no singular solution that
5 stakeholders consistently pointed to in our interviews that
6 addressed all data quality and completeness problems. The
7 Commission could consider a variety of policy changes to
8 facilitate improving the usability of the data, which could
9 include recommendations to CMS regarding collecting race
10 and ethnicity data.

11 Suggested approaches for improving the applicant
12 response rate include updating the model application's race
13 and ethnicity question format and categories, provide
14 guidance to states regarding additional questions and
15 concerns, and updating training for Medicaid staff and
16 application assisters about why information is collected,
17 how it is used, and the potential benefits for the state
18 and its communities.

19 Suggested approaches for data processing include
20 increasing reporting options, such as allowing states to
21 report multiple race and ethnicity values and additional
22 CMS guidance for states on mapping race and ethnicity data,

1 specifically for states that collect values that are not
2 supported by their MMIS or by T-MSIS.
3 In December, staff will present draft
4 recommendations. We welcome Commissioner feedback today to
5 help focus our potential approaches.
6 VICE CHAIR DAVIS: Thank you both.
7 MR. MI: Thank you.
8 VICE CHAIR DAVIS: Can we actually go back to the
9 last slide, with potential approaches. So just a reminder
10 for Commissioners that our conversation today is really to
11 get additional feedback and comments for Linn and Jerry,
12 and that we are also driving towards recommendations for
13 our reports for the spring. So I'll open it up now for
14 questions.
15 I do want to say I just really appreciate the
16 thoroughness of the analysis in terms of the different
17 levels of really kind of looking under every rock, from the
18 beneficiary experience to the state experience to CMS.
19 Yeah, Laura.
20 COMMISSIONER HERRERA SCOTT: So I have three
21 questions. Can I just pepper them one right after another?
22 The first one on the data accuracy, was there any

1 difference whether it was paper, online? Did we see any
2 difference in the data accuracy based on how it was
3 completed, or that didn't come up in the focus groups or
4 the meetings that you had?
5 Mx. JENNINGS : So in terms of I think the data
6 that we have on the T-MSIS, Jerry can confirm this, that we
7 don't have a way really of distinguishing how it's
8 collected. But there are states that collect race and
9 ethnicity differently on their online and paper applications
10 because of how easy it is to update maybe on an online
11 versus a paper. And sometimes asked question differently on
12 an online allow sometimes for kind of a like a forced
13 response, where they can respond with their race and
14 ethnicity information or just say that they don't want to
15 respond, whereas on paper people can skip it.
16 So there might be differences. I just don't know
17 if we have specific data on that.
18 COMMISSIONER HERRERA SCOTT: Maybe to look at
19 that for the states where we know that the collection or
20 the way it's collected is different, just to think about
21 the future policy implications for improving usability.
22 And then of the states on the map you showed, on

1 the high concern, unusable, were there any lessons learned
2 from those states that we could kind of raise the tide, all
3 the boats will float, that we could help those states'
4 technical assistance, education? Like what is going on in
5 those states that puts them in high concern, unusable?
6 MR. MI: Yeah. To answer your first question
7 really quickly, going back, I think we could definitely go
8 back and take a look at the data collection methods and
9 maybe see if there's any relationship with their T-MSIS
10 data quality concerns.
11 Moving on to the second question, through our
12 interviews with states of varying data qualities we
13 couldn't really pinpoint one specific thing. There were
14 practices that states with really good data had that also
15 states without really good data had. And so there are so
16 many different points in the process where states can have
17 issues, that we weren't really able to pinpoint any
18 specific practice that was good.
19 VICE CHAIR DAVIS: Fred.
20 COMMISSIONER CERISE: Thanks. I appreciate the
21 reports. I just had a couple of comments, as you asked
22 for, with the focus on.

1 It seems there are two pieces. There are the
2 technical pieces that seem pretty straightforward. I mean,
3 we're still real early in this game. I mean, we shouldn't
4 be, but it seems like we still are really early. So the
5 technical things -- you talk about a model application, how
6 to map, you know, state responses to the federal reporting
7 -- you know, that ought to be pretty straightforward to
8 work through.
9 And then the other piece of how to collect and
10 get the input of the data, the front line, I think is worth
11 exploring more and commenting on. You know, you brought up
12 the issue of trust and do people feel comfortable reporting
13 the information, how is it going to be used.
14 And so assistance to states with things like, you
15 talked about having people that look like the applicants
16 and have similar experiences with the applicants will help
17 develop that trust. I mean, certainly something we've seen
18 on the provider side is it's helpful the more you're in the
19 community and look and feel like the community you're
20 serving, the more people are comfortable with that. And so
21 the technical assistance around training of people who are
22 accessing the information and being able to explain why

1 it's important would be helpful.

2 But I think you are, from my perspective, you're
3 focusing on the right things. And again, for those of you,
4 Heidi, Tricia, that looked at this, the technical things
5 seem manageable. It's a matter of putting them out there
6 and then setting the expectations that the states are going
7 to report.

8 VICE CHAIR DAVIS: Thank you, Fred.

9 You know, going back to that technical piece, I
10 think for a lot of us, at least for me, it feels so easy,
11 right, to say here are the things, here are the categories,
12 and to create that alignment. Is there another level of
13 complexity that we need to be commenting on or diving a
14 little bit deeper, especially in terms of that mismatch
15 between where the state might have a more extensive race
16 and ethnicity category than what CMS is looking for, and
17 then that creates an inherent mismatch and looks like their
18 data is not as good as maybe it should be? Is there
19 something that we need to be kind of diving in a little bit
20 more in that aspect?

21 Mx.JENNINGS: So I think there are a few
22 different things. You know, when you have a state that's

1 collecting Middle Eastern or North African category, I
2 think even providing guidance on like where do those align
3 with OMB or T-MSIS 2011 HHS guidance, and kind of where do
4 those categories fit, but not also expecting all the states
5 to collect those data if they don't make sense for the
6 populations they serve.
7 So one of the other things is that the model
8 application that states use kind of as their template does
9 allow for multi-race and ethnicity selection. So even if
10 T-MSIS isn't maybe designed to allow for that, I think
11 providing guidance on how to do that could be really
12 helpful in what we've heard from states.
13 So I think there are a lot of different elements
14 there. But I think also states are balancing a lot of
15 different things with these applications, with the
16 programs that are also trying to meet SNAP requirements or
17 that are trying to meet other state requirements. I think
18 although in some ways it does feel straightforward, I think
19 there are some things states are trying to balance there.
20 VICE CHAIR DAVIS: Thank you. Heidi?
21 COMMISSIONER ALLEN: Hi. I'm sorry. I missed
22 the presentation and all of the discussion [audio

1 interruption]. I was having technical difficulties. But I
2 have a list of comments that I wanted to make based on the
3 materials that we were sent.

4 One, why don't we talk about gender identity and
5 sexual orientation when we're talking about race and
6 ethnicity data collection? It seems to me like it's part
7 of a broader package of identifying disparities, and the
8 lack of gender identity and sexual orientation data means
9 that we can't even look at intersectionalities by race and
10 ethnicity if we wanted to.

11 So when we're making recommendations that we
12 update the system so that it allows us to have good race
13 and ethnicity data, I think we need to be asking for other
14 things that we need to be collecting too, to identify
15 disparities.

16 The second thing is I do think that are some
17 places where we could make some strong, clear
18 recommendations, and a forced choice is one of them. So
19 having it be that people have to say, "I do not want to
20 answer this question" instead of just leaving it blank I
21 think is really important. That really will identify it
22 for us the percentage of people who are concerned about

1 providing that data versus missing this, that could be
2 related to something else, which is just impossible to
3 interpret.
4 The third thing is, the literature has been clear
5 for several decades that if you're going to ask this
6 information you need to tell people why, and there's been
7 language around for just as long that was tested in focus
8 groups, that has demonstrated that it decreases people's
9 anxiety. And it feels like any time we ask for this
10 information we should be very clear about why we're asking
11 it, and we should be using a language that has demonstrated
12 that it reduces anxiety. So that seems like a clear
13 recommendation.
14 And the other thing is when I was reading the
15 material, there's a comment, I think, about that there are
16 like 46 different ways of requesting this data. And to me
17 that's not a concern at all if it can be aggregated to one
18 measure. It's only a concern if it can't be or if states
19 are aggregating it differently.
20 So that also seems like an area where we could
21 make a clear, substantive recommendation. It doesn't
22 matter if you use a bunch of different ways of measuring it

1 that help you answer important questions for your state.
2 The only thing that matters is that we're able to get to
3 these final numbers and that everybody does so in the exact
4 same way.
5 I am a researcher. It isn't actually that hard
6 to have a key. It isn't actually that hard to create that.
7 And T-MSIS needs to allow for more than one
8 option. The idea that it doesn't is ludicrous. It really
9 boggles the mind that a system that can accommodate
10 thousands of codes cannot accommodate one more. It seems
11 like such an easy fix, and it just doesn't make any sense
12 to me why that doesn't exist.
13 And then one thing that I would find really
14 helpful for analysis is a flow chart of the states that can
15 map to one standard and ones that can't, because it may be
16 that we're talking about 3 states or we could be talking
17 about 20 states. And it just isn't clear to me how big
18 that problem is. And maybe if we can identify it then
19 something can be done to work with those individual states
20 to help get them aligned with everybody else.
21 Because, you know, throwing out data because you
22 can't use it is just -- it's the worst kind of

1 inefficiency. Like you've done all of this other
2 investment of money and time and resources and technology
3 to get to the place where it's useless, that just doesn't
4 seem great.
5 So that's my comments. I hope I didn't duplicate
6 anything else. I apologize for --
7 VICE CHAIR DAVIS: No, thank you, Heidi. Those
8 were really helpful.
9 Others, before I make another comment?
10 Yes, Rhonda and then Dennis.
11 COMMISSIONER MEDOWS: I don't know if we are
12 going to discuss this later on or not, but it's not
13 something a matter of the states actually having the
14 systems to actually collect the data, analyze the data.
15 It's also what those systems are capable of doing and what
16 they bring, right?
17 We know that some of the products and services
18 that the states may be purchasing may actually, in fact,
19 hurt the efforts to actually accurately collect racial and
20 ethnic data.   They may already have some built-in biases,
21 depending on how old they are and how they actually use the
22 information and how they propose to project racial and

1 ethnic backgrounds of the population, right?

2 We have some systems that actually in the past

3 actually used the last name of the member and then

4 projected it on to the spouse and children, which may not

5 be, in fact, correct, right?

6 We have information where there are some systems

7 that have actually tried to use ZIP code data only and base

8 it -- "I know. This is what we had. This is all that we

9 had." I really want to make sure that we actually focus on

10 the effort of getting people to use self-identified

11 information. It's a higher bar, but it is a more accurate

12 bar, and it actually more appropriately represents who

13 these people are that we're taking care.

14 VICE CHAIR DAVIS: Thank you, Rhonda.

15 Dennis and then Darin.

16 COMMISSIONER HEAPHY: Thanks.

17 First, I think the recommendations you guys made

18 were really helpful, updating the model of application. I

19 think, to Heidi's point, expanding the categories is really

20 important but also providing that additional assistance and

21 guidance to the as assisters and just the application

22 themselves look great.

1 And to Heidi's point about the need to click data
2 on sexual orientation and general identity, for me,
3 disability status is better all the time. But the more I
4 engage in this, I think we just have to get this right
5 first. Do we need to get the racial and ethnic data
6 accurate, and then we'll get how do we look at this data
7 cross-cutting? So having a session on collection of
8 disability data, collection on race and on gender identity
9 and sexual orientation would really helpful, just where we
10 can understand what are the challenges in each of these
11 areas, because as we keep going through the racial and
12 ethnic data collection, I think someone stated earlier,
13 we're still at the beginning of this and trying to figure
14 it out. And so I think we need to do all of it but do it
15 in a way that just makes sense.
16 So, yes, Heidi, I agree with you 100 percent, but
17 I think having separate sessions would be, for me, really
18 helpful.
19 VICE CHAIR DAVIS: Thank you, Dennis.
20 Darin?
21 COMMISSIONER GORDON: At first starting where
22 Laura was at, trying to figure out if those who had

1 stronger data collection efforts, what were the themes --
2 and yes, those are complicated. Maybe coming at it from a
3 different perspective, have we been able to identify states
4 that have seen like improvements over time, like recently,
5 like trying to peel out what were some of the things that
6 they did that had the most impact on improving the quality
7 of their data? So, you know, maybe going at it from that
8 angle, that we may be able to identify some
9 recommendations, because that's what we're ultimately
10 looking for is improvement and maybe some of the recent
11 efforts made. We may be able to tease out some themes
12 there.
13 Thank you for the work, guys.
14 VICE CHAIR DAVIS: Thank you, Darin.
15 Tricia?
16 COMMISSIONER BROOKS: So maybe staff can refresh
17 my memory. I tried to scan the last work that we've done
18 on this, but SHADAC has done a lot of work and has worked
19 with the states to improve their reporting. Have we heard
20 from them directly in a panel?
21 Mx. JENNINGS: Well, so I think they were
22 actually -- they were part of the access monitoring last

1 year but not specifically on this topic. But we have
2 spoken with them in our interviews.
3 COMMISSIONER BROOKS: Yeah.
4 Mx. JENNINGS: And, actually, just to follow up,
5 I guess, on SHADAC, which also goes to Darin's point, they
6 did have a pilot study with New York State a couple of
7 years ago, and they specifically looked at the idea of
8 providing information to the trainers. So the trainers --
9 or the application assisters and navigators got like a
10 specific script on text to use when they were helping
11 individuals apply, and that, I think, if I remember their
12 results correctly, increased for race, I think, response
13 rates by 20 percent and for ethnicity by 8 percent. So that
14 was one of their methods, and then they did some updates, I
15 think, to their race and ethnicity questions and categories
16 as well. So I guess there are some studies out there that
17 are looking at how to do it.
18 COMMISSIONER BROOKS: Yeah. I mean, I think it
19 would be really helpful to hear from SHADAC in a panel
20 conversation, and I tend to agree with Dennis.
21 I asked the question when we were presented with,
22 I think, the chapter comments last year, where the focus

1 was on race and ethnicity but not on other types of
2 disaggregation, and the idea was -- I think there was
3 something added to the chapter to say this is our starting
4 point.
5 But I think if we try to tackle it all at one
6 time, then it will slow down the progress on at least
7 nailing some part of this and getting it right. So I tend
8 to agree with Dennis's perspective on that.
9 VICE CHAIR DAVIS: Thank you, Tricia.
10 Darin, your hand is up. Is that a new hand or an
11 old hand? Yeah, go ahead.
12 COMMISSIONER GORDON: Same hand, new question.
13 [Laughter.]
14 COMMISSIONER GORDON: Linn, just following up on
15 that one point that you just brought up about the assisters
16 and the improvement they saw, is there anything out there
17 on what percent of applications are completed with the
18 assistance of assisters or broker versus, you know, the
19 individual filling out the applications without any
20 assistance? I just think it will be helpful in
21 understanding, because if we just focus on the assisters,
22 that may be too narrow. And I just don't have a good sense

1 of what percentage of applicants take which path.
2 Mx. JENNINGS: Yeah. That's something we can
3 definitely look into.
4 I know from one of our interviews, they mentioned
5 that 75 percent of their applicants were in person, but
6 they had a county eligibility system. So it may differ a
7 little bit based on how it's set up, but that is something
8 we could look into more.
9 COMMISSIONER BROOKS: So Darin's comment prompts
10 me.
11 It's not just assisters and navigators. It's state staff
12 or county staff that are processing applications, taking
13 those over the phone. And even though the phone
14 applications are certainly a much smaller share than
15 online, I think that training needs to be directed at them
16 as well.
17 VICE CHAIR DAVIS: I'm hearing a lot of support
18 for the approach that you've laid out in terms of taking --
19 you know, looking at state data collection, looking at the
20 data processing, certainly hearing support for continuing
21 with the model application and also how states tie that to
22 other means of eligibility around SNAP and things like

1 that.

2 From the Commissioners, recognizing that we are
3 driving towards making recommendations on this and this is
4 the approach that we're looking to take, is there
5 additional information that we haven't covered that would
6 help to get there as we kind of progress throughout this,
7 throughout the year?

8 COMMISSIONER HERRERA SCOTT: The only thing is
9 education for the beneficiary, so to understand what states
10 are doing to educate people to fill it out or want to fill
11 it out. I don't know what the different states -- and to
12 the states that did better than others is, to Darin's
13 point, did they build in education that increased people
14 filling that out because they understand that? So just to
15 even understand where we're starting from on the education
16 side, as we think about not only collecting the data but
17 certainly the person filling out the application,
18 completing those boxes.

19 COMMISSIONER HEAPHY: Latinos, it depends on how
20 people will identify as new generations are -- they may
21 have multiple backgrounds. And so how are they
22 identifying? So we're not creating something for today

1 that's not going to be usable tomorrow, and so other trends
2 that we can see into the future.
3 COMMISSIONER HERRERA SCOTT: Yeah. Can I just
4 give one example of that?
5 VICE CHAIR DAVIS: Yeah.
6 COMMISSIONER HERRERA SCOTT: So a lot of the
7 applications say Hispanic, but many now identify as Latinx,
8 right? So, if they don't see Latinx, but they see
9 Hispanic, they may not put the two together and not check
10 at all.
11 COMMISSIONER HEAPHY: Might be Latinx and
12 European and just don't know what to put in.
13 VICE CHAIR DAVIS: Thank you, Dennis. Thank you,
14 Laura.
15 Yeah, Tricia.
16 COMMISSIONER BROOKS: In some of the reading
17 there, some states put a -- in addition to, you know, wish
18 to not respond or whatever, "I don't know."
19 COMMISSIONER HEAPHY: Exactly.
20 COMMISSIONER BROOKS: And I didn't get that out
21 of the recommendation as much or the detail there. I think
22 it's another piece of the pie that people are like, "Well,

1 I'd tell you if I actually knew."
2 CHAIR BELLA: So I guess I have a question about
3 that. Maybe Heidi. So, if we have a forced choice,
4 because we're trying to figure out if people just don't
5 want to share, if you introduce "I don't know," like how
6 does that -- how does that go with the forced choice? So
7 then you'd have "I don't know," "I don't want to share," or
8 you would be picking one? Then we would have an idea --
9 COMMISSIONER ALLEN: Yeah.
10 CHAIR BELLA: -- of how much education needs to
11 be done to help people make choices.
12 COMMISSIONER ALLEN: Yeah, exactly. You would
13 look and see what the percentages that say that they don't
14 want to say versus they don't know, and that gives you good
15 information about, you know, kind of the situation.
16 My guess is that, actually, "I don't know" would
17 be very low rate, but it's always good to have it there if
18 you're going to do a forced choice.
19 I had my hand raised because I was -- when you
20 asked for more information, one thing that I was -- that
21 piqued my interest, but I didn't really -- and I'd be
22 interested in learning more about is when states are

1 receiving data from numerous sources, so from like managed
2 care plans and other programs, how -- what the decision
3 tree they're using to determine what, you know, where they
4 use that information or don't use that information and
5 whether that then -- if there's conflict, that they then
6 don't use any of the information, that would be helpful for
7 me to understand too.
8 VICE CHAIR DAVIS: Thank you, Heidi.
9 Rhonda?
10 COMMISSIONER MEDOWS: I don't know if this is
11 helpful, but the idea of actually putting on an option that
12 says "I prefer not to share," actually, it can also then be
13 used to figure out, engage our outreach and education of
14 them about why we want it, what is being used for.
15 If everything used under this global bucket or
16 miscellaneous bucket of other, you have absolutely no idea
17 whether that meant the data got lost or they didn't
18 respond, they didn't understand the question. So at least
19 giving them that choice, I think that's actually an
20 important point. And thanks for bringing that up.
21 But I think you can also use it as a barometer of
22 how effective are we in actually making the case for them

1 sharing that information.

2 VICE CHAIR DAVIS: Yeah. That's a really great
3 point in terms of helping us to do the further analysis in
4 terms of education that folks need to know to understand
5 the why.

6 Yeah. Go ahead, Melanie.

7 CHAIR BELLA: When we talk to HHS folks, I mean,
8 I'm sure that there's things they would like to see
9 different too, right? And did they mention, for example,
10 "Boy, we wish we could have more than one field for this?"
11 I mean, there's people whose job it is to worry about this
12 there, I'm sure also would like to see some changes. And
13 I'm just curious if you got into any of that with the
14 federal officials.

15 Mx. JENNINGS: So it isn't something that they
16 specifically brought up, but what we did hear from HHS --
17 and I think CMS may be weighing on this as well -- is OMB
18 is looking into revising standards right now with, I think,
19 kind of new standards by summer of 2024. And so I think
20 although there might be things that they want, they, I
21 think, are kind of waiting for the lead from OMB there.

22 But we do have a call with CMS next week as well.

1 So we can follow up a little bit more on some of these
2 specifics. Yeah, the technical side.
3 CHAIR BELLA: I guess that makes me think that as
4 we think about recommendations, we should think about
5 making them to OMB as well. I would have thought the
6 agency would be driving that, but if it's coming from OMB,
7 let's not forget about them as a stakeholder in our work.
8 VICE CHAIR DAVIS: Thank you, Melanie.
9 COMMISSIONER HEAPHY: Can we also make the
10 recommendation that what's being done with racial and
11 ethnic data also be done for other populations, like folks
12 with disabilities and LGBTQ, et cetera?
13 VICE CHAIR DAVIS: I think so.
14 Other comments? Yeah, Sonja.
15 COMMISSIONER BJORK: Thank you. Is updating the
16 model application a huge endeavor? Does it make it
17 difficult for states and it's something that we want to
18 recommend as a -- is it like a once-in-a-decade type of
19 update, or does it get updated every year?
20 **Mx. JENNINGS:** So the model application hasn't
21 been updated since 2013, when it -- and so most states are
22 not updating their applications. I think they get CMS

1 approval and then continue to use the application. A few
2 states are developing changes, but I think it is maybe a
3 pretty large lift and requires not only changing the
4 application but then all the systems that follow. And
5 there could be some state capacity issues there, and that
6 might be an area where states might need support.
7 COMMISSIONER BJORK: Thank you.
8 VICE CHAIR DAVIS: To that point, would it be
9 helpful to specifically weigh in on that level of
10 assistance that states might need in terms of capacity for
11 updating systems for assistors? There's the technical
12 piece, but there's also -- we've talked a lot about the
13 education piece and that personal piece that states are
14 really going to need to continue to build out.
15 COMMISSIONER BJORK: It also speaks to the issue
16 of thinking of all the things we'd like to recommend to
17 change all at once and not recommending a change again next
18 year and the year after. So that foresight that we were
19 talking about of how people self-identify now and new
20 generations, as Dennis recommended, and try to do an
21 overall recommendation for a big update.
22 COMMISSIONER ALLEN: And following Sonja's point,

1 if it's once in a decade, we're there. It's time. It's
2 been a decade now. So, if we made recommendations and they
3 updated it next year, that would be once in a decade. So
4 it does -- I really do think that the opportunity to put
5 together a package of recommendations that could be
6 implemented as a whole is a really cool idea.
7 VICE CHAIR DAVIS: All right. Linn and Jerry,
8 can you remind us of the timeline of when this is coming
9 back to us?
10 Mx. JENNINGS: Yeah. We'll be back in December
11 with more kind of, I guess, specific recommendations based
12 on our discussion today, and then we'd come back in January
13 as well, potentially for votes.
14 VICE CHAIR DAVIS: Thanks. Anything else that
15 you need from the Commissioners? I think you've gotten a
16 lot of feedback or directions.
17 Mx. JENNINGS: Yeah. I think we've got
18 everything we need. Yeah. Thank you.
19 VICE CHAIR DAVIS: All right. Thank you.
20 All right. We will welcome Melinda and Lesley to
21 talk about improving access to Medicaid coverage for -- and
22 care for adults leaving incarceration.

1 All right. Go ahead. Thank you.

2 ### IMPROVING ACCESS TO MEDICAID COVERAGE AND CARE
3 FOR ADULTS LEAVING INCARCERATION

4 * MS. BASEMAN: Wonderful. Thank you,
5 Commissioners.

6 Today we will be speaking about improving access
7 to Medicaid coverage and care for adults leaving
8 incarceration. Medicaid covers a significant share of
9 justice-involved adults upon their return to the community.
10 Justice-involved adults are disproportionately low-income
11 people of color with significant behavioral and physical
12 health care needs.

13 Formerly incarcerated individuals are far more
14 likely to die of a drug-related overdose in the first two
15 weeks after release compared to the general population.

16 Many states have expanded their efforts to
17 expedite access to Medicaid coverage to encourage
18 continuity of care and address gaps in care for this
19 vulnerable population.

20 To better understand these efforts, we contracted
21 with AcademyHealth to interview state Medicaid and
22 corrections officials in 16 states about initiatives

1 focused on justice-involved adults. AcademyHealth partnered
2 with state university researchers to analyze Medicaid and
3 corrections data in two states.
4 Our work with AcademyHealth and this presentation
5 today focus only on justice-involved adults in local jails
6 and state prisons. Justice-involved youth generally
7 interact with different systems both at the state and local
8 level and have needs that are unique from adults. This
9 project also did not examine reentry for federal prisoners
10 who are under the jurisdiction of the Federal Bureau of
11 Prisons.
12 Next slide.
13 This presentation will cover relevant background,
14 including the Medicaid inmate exclusion policy and the
15 demographic characteristics and health needs of justice-
16 involved adults using MACPAC's previous analysis of the
17 National Survey of Drug Use and Health, or NSDUH, and other
18 national data. We will next talk about state strategies
19 for improving access to Medicaid coverage and care for
20 adults leaving incarceration, including pending Section
21 1115 waivers. This discussion largely focuses on key
22 takeaways from our work with AcademyHealth. Lastly, we

1 will speak about upcoming actions from CMS and next steps
2 for the Commission's work.
3 Medicaid is the payer of health care services for
4 eligible and enrolled individuals who are in the community
5 on probation and parole while correctional institutions are
6 responsible for health care costs while individuals are
7 confined to their facilities. Incarcerated individuals
8 remain eligible for Medicaid while incarcerated; however,
9 federal law prohibits the use of federal Medicaid funds for
10 health care services except in cases of inpatient care
11 lasting 24 hours or more. This prohibition on payment is
12 commonly referred to as the "inmate exclusion policy."
13 Medicaid is an important source of coverage for
14 individuals released from correctional facilities upon
15 their return to the community. This is particularly true
16 in states that have expanded Medicaid under the Affordable
17 Care Act. Among adults under community supervision between
18 2015 and 2019, Medicaid covered nearly one-third and over a
19 quarter were uninsured.
20 Justice-involved adults include those in state or
21 federal prisons and local jails, as well as individuals on
22 probation or parole, referred to as "community

1 supervision." Federal and state prisons house those
2 convicted of a felony who are generally serving sentences
3 of greater than one year. On the other hand, local jails
4 tend to house those serving shorter sentences or those
5 awaiting trial or sentencing. In 2020, more than 8.7
6 million people cycled through local jails, and the average
7 length of stay was 28 days.
8 By the end of 2020, roughly seven in ten adults
9 in the criminal justice system were under community
10 supervision and three in ten were incarcerated in a federal
11 or state prison or local jail. The sections outlined in
12 yellow here represent incarcerated individuals for whom the
13 Medicaid inmate exclusion policy applies.
14 Adults involved in the criminal justice system
15 are disproportionately low-income people of color. In
16 2020, Black individuals were incarcerated in state and
17 federal prisons at more than five times the rate of white
18 individuals. American Indian/Alaska Native and Hispanic
19 individuals were also more likely than white individuals to
20 be incarcerated. Additionally, justice-involved adults
21 tend to be poorer than the general population. As noted in
22 the memo, in 2014 dollars, the median annual income of

1 state prisoners prior to incarceration was $19,185, which
2 is 40 percent less than the earnings of non-incarcerated
3 adults.
4 Justice-involved adults report high rates of
5 physical and behavioral health conditions and disabilities.
6 In 2016, more than half of state prisoners reported ever
7 having a chronic physical health condition. Nearly one-
8 fifth reported ever having an infectious disease. More
9 than half had some indication of a mental health problem.
10 Nearly half met the criteria for substance use disorder,
11 and nearly half reported having at least one disability.
12 MACPAC's prior analysis of the NSDUH found similarly high
13 rates of behavioral health conditions of adults under
14 community supervision.
15 Justice-involved adults face barriers in
16 accessing both coverage and care. Medicaid-eligible adults
17 leaving incarceration often experience delays getting
18 coverage. Most of the states we interviewed reported
19 having the capacity to reinstate suspended benefits within
20 one day of release. However, a few of the states we
21 interviewed reported delays ranging anywhere from 2 to 60
22 days. In the appendix of your meeting materials, you can

1 see in Kentucky and Virginia, for example, most individuals
2 with prior Medicaid had their benefits reinstated within one
3 day of release.
4 All interviewed states also had mechanisms for
5 processing new applications prior to release, but this
6 process can take up to three months and is often not
7 started that far in advance.
8 Justice-involved adults report significant unmet
9 behavioral health care needs. In 2018, medication-assisted
10 treatment for opioid use disorder was not offered in
11 prisons in 20 states and in 93 percent of local jails. In
12 2016, less than half of state prisoners with serious
13 psychological distress in the preceding 30 days reported
14 that they were currently receiving treatment for a mental
15 health problem.
16 Behavioral health care access is also an issue in
17 the community. From 2015 to 2019, nearly one-third of
18 Medicaid beneficiaries under community supervision reported
19 an unmet need for mental health treatment. Black
20 beneficiaries with mental illness were less likely than
21 their white counterparts to report receiving treatment.
22 In our work with AcademyHealth, we found that in

1 Kentucky few than one in five individuals with a prior
2 diagnosis of opioid use disorder received medication-
3 assisted treatment within 30 days of release from prison or
4 jail.

5 I will now pass it along to Melinda to further
6 elaborate on the work with AcademyHealth and state
7 strategies.

8 * MS. ROACH: Thanks, Lesley, and good morning.
9 The health needs of adults in the criminal justice system
10 and higher burden of incarceration among certain
11 communities of color are spurring many states to think
12 about how they can improve outcomes for this population.
13 One of the ways they're doing this is by working to improve
14 transitions for individuals as they leave incarceration.

15 Through our interviews of state Medicaid and
16 corrections officials, we sought to understand how states
17 are facilitating access to Medicaid coverage and care for
18 individuals during reentry, as well as the challenges they
19 face in those efforts. In the following slides, I'll talk
20 first about existing efforts, those that states are already
21 undertaking without the need for additional federal
22 flexibility around the inmate exclusion, before

1 highlighting new Section 1115 requests to waive the inmate
2 exclusion and provide pre-release Medicaid services.
3 All of the states that we interviewed and most
4 states nationally suspend coverage for adults during
5 incarceration. Rather than disenrolling individuals who
6 enter prison or jail with Medicaid coverage, these states are
7 placing enrollees in a limited benefit category which
8 permits payment only for qualifying inpatient stays. This
9 not only facilitates billing in the event of an inpatient
10 stay, but also allows benefits to be reinstated more
11 quickly once the Medicaid agency is notified of an
12 individual's release.
13 As Lesley mentioned, many of the states we
14 interviewed had the capacity to reinstate benefits within a
15 day of release, but others reported that the process could
16 take significantly longer. Time to benefit reactivation
17 depended largely on how often corrections shares data with
18 Medicaid about who is leaving incarceration and whether
19 data sharing and changes to Medicaid eligibility are
20 automated or manual.
21 All of the states reported processing new
22 applications prior to release for eligible individuals who

1 are not enrolled at the time of incarceration. In
2 Kentucky, for example, that process starts when individuals
3 enter state prison.
4 Evaluations of pre-release enrollment assistance
5 programs suggest they can contribute to improved health and
6 better access to services following release. While many of
7 the states we interviewed had improved their ability to
8 activate coverage quickly upon release, they also
9 underscored the challenges that they face in doing so.
10 Cost is often a barrier to making data infrastructure
11 improvements such as automated systems and increasing the
12 frequency of data transmission.
13 States also emphasized how the short-term nature
14 of jail stays and unpredictability of jail release dates
15 can hinder those efforts to provide immediate coverage upon
16 reentry.
17 In addition to enrollment assistance, some of the
18 states we interviewed offer other targeted services during
19 reentry. This can include state-funded in-reach services
20 such as discharge planning and referrals to community
21 providers prior to release, sometimes in partnership with
22 managed care organizations, even though the inmate

1 exclusion prohibits payment for those services.

2 New Mexico, for instance, requires MCOs to
3 designate someone to work with correctional facilities to
4 support care coordination for individuals leaving
5 incarceration.

6 Many of the in-reach programs we learned about
7 were targeted to specific populations, such as those with
8 SUD or serious mental illness, and were sometimes limited to
9 certain facilities or parts of the state. States commonly
10 reported that the lack of sustainable funding due in part to
11 the inmate exclusion is a major barrier to expanding these
12 pre-release services.

13 In terms of targeted post-release services for
14 which Medicaid matching funds are available, many of the
15 states we interviewed offer a supply of medication as
16 individuals reenter the community. A smaller number use
17 Medicaid health homes to provide care coordination to
18 individuals who are recently released from prison or jail,
19 sometimes with a focus on certain populations like those
20 with opioid use disorder. And in Arizona, they've taken a
21 unique approach with 13 innovative clinics where probation
22 and parole offices are collocated with services to address

1 physical, behavioral health, and health-related social
2 needs.
3 Shifting focus now to new programs that states
4 are hoping to stand up pending CMS approval that would
5 permit federal match for services provided during
6 incarceration. As I noted already, many of the states we
7 interviewed see the inmate exclusion as a major barrier to
8 timely Medicaid coverage and services for adults leaving
9 incarceration. States reported that, despite some of the
10 progress that they made in more quickly reinstating
11 coverage, it can be difficult to align benefit activation
12 with an individual's release, particularly for people
13 leaving jail.
14 Even when benefits are immediately available,
15 individuals leaving increase often don't have relationships
16 with community providers or appointments arranged prior to
17 release. We heard a lot about how providers may not accept
18 appointments for people whose benefits haven't been fully
19 restored.
20 These are some of the factors driving states to
21 pursue waivers of the inmate exclusion. Twelve states are
22 seeking CMS approval to cover pre-release Medicaid services

1 under Section 1115 authority with the goal of improving
2 continuity of care and health outcomes for formerly
3 incarcerated individuals.
4 States also see the potential for these
5 demonstrations to prevent costly inpatient hospital and
6 emergency department visits and to reduce recidivism. At a
7 high level, they generally aim to do so by addressing the
8 most pressing physical, behavioral, and health-related
9 social needs of individuals awaiting release, and by
10 connecting those individuals to community providers.
11 At a more granular level, there is a lot of
12 variability in what states are proposing. No state is
13 seeking a full waiver of the inmate exclusion but, rather,
14 they are proposing different parameters related to
15 eligibility, benefits, and the duration of pre-release
16 coverage.
17 For example, with regard to eligibility, most
18 states would target Medicaid services to adult inmates with
19 certain medical diagnoses such as behavioral health
20 conditions while some would provide services to all adults
21 or also include youth.
22 The duration of coverage that states are

1 proposing also varies quite a bit, but most states are
2 looking at the period up to 30 days prior to release. And
3 most of the states would provide a limited set of services,
4 often including case management, while a smaller number are
5 proposing to offer full benefits.
6 CMS has not approved any Section 1115 requests to
7 waive the inmate exclusion and expand Medicaid-covered
8 services during incarceration. However, CMS has publicly
9 stated its support for increasing pre-release services and
10 its interest in working with states on those requests.
11 Some of the states we interviewed reported
12 progress in their negotiations with CMS and optimism that
13 their waivers may soon be approved. In addition to
14 potential action on state waiver requests, we're also
15 anticipating new CMS guidance. Under the SUPPORT Act, HHS
16 is required to convene stakeholders and issue a report to
17 Congress on best practices for improving care transitions
18 for individuals leaving incarceration, and we expect that
19 best practices report to be released soon.
20 The SUPPORT Act also requires HHS to issue
21 guidance on how states can use Section 1115 flexibilities to
22 provide pre-release coverage. It is unclear when that

1 guidance will be issued.

2 Moving forward, we'll continue monitoring
3 evolving state and federal policy with the expectation that
4 CMS will ultimately provide states with some amount of
5 flexibility to address the inmate exclusion through Section
6 1115 demonstrations. However, even if federal policy
7 barriers are addressed, there will be implementation issues
8 that affect whether these demonstrations achieve their
9 stated goals. Our interviews of states have started to
10 bring light to some of those implementation considerations,
11 such as whether there are adequate systems in place to
12 facilitate data sharing between corrections, Medicaid,
13 health plans, and community providers.

14 States will also need to consider who will be
15 providing Medicaid services in correctional facilities,
16 whether that be correctional staff, correctional health
17 vendors, or community-based providers.

18 These demonstrations will be the first time that
19 Medicaid has been permitted to pay for services during
20 incarceration, and so having rigorous and timely
21 evaluations of these programs will be important to
22 understanding their effects and to informing future policy.

1 In December, we'll return with an expert panel to
2 examine these and other considerations for implementing
3 Section 1115 demonstrations to waive the inmate exclusion.
4 Drawing on that discussion and the work presented here
5 today, staff will come back later next year with a
6 descriptive chapter for the June 2023 report.
7 We welcome your questions and reactions to the
8 information presented today as well as your feedback on
9 implementation considerations that you wish to explore with
10 the panel in December.
11 COMMISSIONER BROOKS: So thank you for this.
12 This is really enlightening in many ways. But I'm just
13 curious what differences we see happening in states that
14 haven't expanded Medicaid, because the incarcerated
15 population heavily leans toward male, and if they don't
16 have a kid, they're not going to be eligible for coverage.
17 MS. ROACH: So it's a great question. All of the
18 states we interviewed expanded Medicaid. We'll go back and
19 double-check that, but I'm pretty sure that's true. They
20 were partly selected because they were part of
21 AcademyHealth network of states that does -- excuse me,
22 cross-data analysis. But that's a great question that you

1 raise, Tricia. Obviously, this population is not covered
2 to the same extent in those states.
3 COMMISSIONER BROOKS: Yeah, I'm not -- I don't
4 know a lot about what other behavioral health services may
5 be available in states for SUD treatment. But indeed I
6 don't want to leave those states behind in terms of trying
7 to figure out a better way to deal with them.
8 VICE CHAIR DAVIS: Thank you, Tricia. I see
9 Martha and then Heidi and Rhonda online.
10 COMMISSIONER CARTER: Thank you. I would like to
11 see the Commission be bold on this one. Just like with the
12 IMD exclusion, it would be helpful to know what was going
13 on when the inmate exclusion was put in place and to
14 recognize what has changed in the landscape since that
15 exclusion was enacted. But one thing, for example, the
16 Department of Justice has said that an individual in
17 treatment or recovery from opioid use disorder has a
18 disability under the ADA. So there's a protection that is
19 in place for people. There are some caveats to that, and
20 you can, of course, go look at that yourself. But I think
21 my point is that we understand more about opioid use
22 disorder, we understand more about behavioral health issues

1 than we might have when the inmate exclusion was put in
2 place. And I think it's really time for it to be
3 eliminated so that people can have a continuity of care
4 through their period of incarceration, if they have health
5 or behavioral health or substance use disorder issues.
6 VICE CHAIR DAVIS: Thank you, Martha. Heidi?
7 COMMISSIONER ALLEN: Yes, thank you so much for
8 this work. I'm really excited about this topic, and I have
9 a number of comments. I'll try not to take too much time.
10 The first comment I'd like to make is that when
11 we write about this issue and we write about racial
12 disproportionality, I think it's really important that we
13 state that the reason there is racial disproportionality is
14 because of structural racism and discrimination at every
15 level of society. This isn't anything innate to race and
16 ethnicity. It's a clear result of, you know, centuries of
17 policy.
18 The second thing is that I think that we should
19 disaggregate jail versus prison, because it's really
20 conceptually difficult to put the two together. They're
21 really very different issues, whether somebody has been
22 incarcerated for 5 years versus the 28-day jail average.

1 And I would very much like, like Martha, support
2 recommending for people in jail that we revisit the
3 exclusion, because with telehealth we could envision a
4 world where people could actually have continuity of care
5 while they're in jail, so that there aren't even
6 disruptions to the services that they're receiving because
7 they can see their providers and how they're billed.
8 Additionally, I wonder if there's any prospect of
9 thinking of retroactive eligibility and payment for
10 providers that provide services for people in jail, much
11 the way that states have date stamps that they use so that
12 people who are pregnant can get services before they're
13 eligible for Medicaid, if that's some way to kind of
14 procedurally bypass the exclusion.
15 I think that as a social worker I want to say is
16 that jail and prison are a trauma, and that in itself, I
17 think, would impact health and mental health, and we should
18 think about it like that when we're thinking of the needs
19 of people who are leaving incarceration.
20 That's it for my comments. Thank you.
21 VICE CHAIR DAVIS: Thank you, Heidi. I see
22 Rhonda and then Angelo.

1 COMMISSIONER MEDOWS: So I don't know whether
2 it's in our purview or not, but I think it's definitely
3 related. When we're talking about everything from the
4 Medicaid perspective, from the Medicaid beneficiary, that's
5 our job. But the other piece of this, if not us or
6 AcademyHealth but someone, is the DJJ and Corrections
7 prospective. Like what are they putting in to help the
8 transition? What are they willing to contribute? How are
9 they willing to accommodate the changes that are being
10 proposed?
11 And I'm just going to say it for the record, and
12 that is there is a lot of politics between the two but
13 there are also some financial and budget implications of
14 moving. And so that needs to be kind of spoken to, right?
15 I'm having flashbacks to my old state days, where
16 getting health care information from DJJ was difficult
17 because they have their own systems. We weren't connected.
18 The same thing with Corrections. We had our own systems,
19 own budgets, own general assembly reports to be accountable
20 for what we were providing. So I think I'd like to see
21 some information about DJJ and corrections, about their
22 efforts.

1 And I do agree with separating jail from prison,
2 because again we have a whole other community to work with
3 and figuring out what they're going to put in to help or
4 assist in the transition of care, and the continuity of
5 care.
6 Does that make sense?
7 VICE CHAIR DAVIS: Thank you, Rhonda. Lesley, on
8 that point is there anything that we know now about
9 different kind of justice and financing around health care,
10 or is that more of a black box we'd have to come back to?
11 MS. BECKER ROACH: At the state level our
12 interviews were very much focused on collaboration between
13 Medicaid and corrections agencies. Most of the state
14 approaches that I described were really collaborative
15 efforts that couldn't have happened without sort of work
16 across agencies. So that was really critical, and it's not
17 always easy, certainly, especially when you're talking
18 about correctional agencies not just at the state level but
19 also at the local level with jails.
20 COMMISSIONER MEDOWS: What about DJJ? Were they
21 part of this?
22 MS. BECKER ROACH: Juvenile justice? So our

1 interviews didn't -- we didn't engage at the federal level
2 certain, and we did ask in our state interviews if they
3 were able to comment on juvenile justice initiatives. As
4 we mentioned, it wasn't a primary focus of this work. We
5 didn't engage directly with those officials.
6 VICE CHAIR DAVIS: Thank you. Angelo, then
7 Laura, then Fred.
8 COMMISSIONER GIARDINO: I have two questions.
9 One, I am interested a little bit in your view about
10 adolescents, since continuity of care and attention to
11 their health is a very good investment, long term. So I
12 would be really concerned about adolescents having
13 fragmented care and then leaving the juvenile justice
14 system and not having continuity of care.
15 Do you have a reason why you don't want to do
16 adolescents?
17 MS. BECKER ROACH: I think it's not that there's
18 not an interest. I think that we understood that at least
19 starting out I think we didn't want to bite off more than
20 we could chew, I guess, and so we chose to focus on adults
21 because they're involved in different systems, there are
22 different correctional administrators, and so there are

1 different sets of issues.

2 But it's certainly something that we could look
3 into or do some work on if that were of interest to the
4 Commission.

5 COMMISSIONER GIARDINO: I would just, you know,
6 from the Heckman equation, the earlier you provide services
7 the better the outcome is for the patient and the society.
8 So of the prioritization I would say adolescents are the
9 higher priority than folks that are way down the road. So
10 that's just my bias.

11 The other thing I'm interested in is this is
12 clearly a unique population, so I could just imagine
13 someone who is justice-involved leaving the system and then
14 ending up in a managed care plan that has nothing to offer
15 them.

16 So what's being done to make sure that this group
17 is characterized as a special group, a vulnerable group.
18 As Heidi said, they've experienced the trauma. They're
19 just not a run-of-the-mill enrollee in Medicaid. So I
20 think programmatically it would be naïve to think that they
21 should just go be put into, you know, Plan X and that
22 they'll be okay.

1 MS. BECKER ROACH: Yeah, I think that really
2 varies quite a bit across states, and I could maybe just
3 highlight some examples from the states that we interviews.
4 Many of them have contractual requirements for their plans
5 to do in-reach. I know others were sort of looking to
6 incentivize that type of managed care in-reach to
7 facilitate care coordination.
8 Two of the states that we interviewed have
9 Medicaid health homes that are trying to coordinate care
10 better for this population post-release, but I'm not sure
11 there's anything we can share that states are sort of doing
12 across the board necessarily.
13 COMMISSIONER GIARDINO: I guess I would just
14 really offer that our work from a policy perspective should
15 really put a focus on the fact that this is a unique
16 population, and by definition they need special programming
17 approach. They're not just the run-of-the-mill Medicaid
18 enrollee. They lost their liberty for a while, so this is
19 a very unique population.
20 Thank you. Your work was great, by the way. I
21 really enjoyed reading it.
22 VICE CHAIR DAVIS: Thanks, Angelo. Laura?

1 COMMISSIONER HERRERA SCOTT: I just have a couple
2 of questions. You talk about the delays in getting them
3 reengaged in care, but is there anything you can say about
4 the information pipeline for shutting off that care for
5 those that had coverage prior to, you know, jail or prison?
6 It seems to work pretty quickly that way but not quickly
7 going back to get them covered again. So that was the
8 first question. I'll stop and then go to the second
9 question. Anything you can say about the information
10 pipeline shutting off coverage?
11 MS. BASEMAN: That's another area that varies a
12 lot state to state in terms of how they receive the
13 information from Corrections about who was incarcerated,
14 the timeliness with which they receive that information,
15 and the frequency. And then similarly, as Melinda was
16 addressing, whether or not the benefits are turned off in
17 an automatic or manual fashion.
18 So we did hear, through our interviews from some
19 states, where they can do that rather quickly, other states
20 where it can be delayed, and we even heard in other states
21 where benefits are actually not ever turned off, just
22 because of administrative issues.

1 COMMISSIONER HERRERA SCOTT: So the same issues
2 on the front end as there are on the back end.
3 MS. BASEMAN: Yes.
4 COMMISSIONER HERRERA SCOTT: And then as we think
5 about turning on some of these back to the states that you
6 interviewed that do have Medicaid expansion, had care prior
7 to the event, you know, being incarcerated or put in jail
8 or prison. Is there any way to tie that information on the
9 back end? And I'm thinking just if you had a behavioral
10 health need, you know, as Heidi said, that in and of itself
11 is a traumatic event that would exacerbate. But usually
12 the event didn't just get started in prison or jail.
13 They've had whatever chronic conditions that they've had
14 prior to the event.
15 So is there any connection, based on the health
16 care information that exists prior to, on the back end, or
17 that's too clinical? You can say it's too clinical.
18 MS. BECKER ROACH: I guess I'll just point out
19 that among the states that we spoke to, they relayed that
20 there are regular health screenings of inmates, at intake
21 and at different times throughout their incarceration. I
22 think the way in which that information is used, we have

1 less insight into. So maybe I'll leave it there.
2 COMMISSIONER HERRERA SCOTT: Okay. And then last
3 question. Given some of the comments that were made about
4 we should go bold on this, at the very least, for those
5 that are jailed because of the short duration of time, is
6 there any data on the cost of care of not providing
7 coverage? So overdose, increased hospitalizations,
8 increased whatever, without that coverage? So as we think
9 about any potential policy implications, and kind of what
10 Rhonda was saying about the jockeying of dollars or the
11 movement of dollars, but just understanding what the
12 financial impact is to states without this coverage versus
13 re-enrolling in coverage.
14 MS. BECKER ROACH: Yeah. I mean, I think the
15 best we have is data from -- and it's limited data, but
16 from some state reentry programs, where they're providing
17 enrollment assistance and maybe care coordination to
18 certain populations prior to release. And we'd have to go
19 back and look at some of the details about sort of how
20 they're comparing, like the way in which they're evaluating
21 those programs. I assume they're comparing them to people
22 who are similarly situated but didn't receive those

1 services, and they are seeing improvements in access and
2 self-reported health outcomes. I think there may be more
3 limited information about costs.
4 But sort of to that question and to Martha's
5 comment, I think certainly the Commission could think about
6 weighing in on the inmate exclusion. I think we would want
7 to think about what type of evidence you would need to
8 start making some of those decisions and weighing policy
9 options. I think we view the work that we've done today to
10 set up a foundation potentially for that, but we would
11 definitely need to go back and I think do more work to
12 support any conversation around modifications to the inmate
13 exclusion.
14 VICE CHAIR DAVIS: Martha, to this point, and then
15 we'll go to Fred.
16 COMMISSIONER CARTER: This is actually a little
17 different point, but sort in the realm of not biting off
18 more than we can chew. Are we going to be able to look at
19 what happens when people are on parole? I had a really
20 enlightening conversation with a parole officer a couple of
21 years ago, and he said that people were not allowed to be on
22 Suboxone when they were on parole because that was

1 considered an opioid.

2 And so there's a lot of work to be done in this
3 area, and I don't know if we can go into that work as well,
4 but it's certainly a continuation of this.

5 VICE CHAIR DAVIS: Thank you, Martha. Fred.

6 COMMISSIONER CERISE: Questions. The first is
7 just your perspective, your take on the states that you
8 talked to, and Melinda you mentioned this a little bit. So
9 much of this depends on the interest among Corrections and
10 there's going to be huge variation across states, within
11 states. And I'm just wondering the sense of those that are
12 interested, is that largely driven by the people in
13 Corrections? Because it seems like the Medicaid folks are
14 a little more remote than those guys on that issue.

15 So where is the interest coming from, and then
16 sort of the willingness, or what's driving this, and what
17 sort of variation are you seeing? And then I've got a few
18 other questions for you.

19 MS. BECKER ROACH: Sure. So a lot of the
20 initiatives that we heard about were driven by governors'
21 executive orders in some instances, interagency task forces
22 that helped facilitate that cross-agency work, sometimes

1 state legislative mandates. Lesley, you can jump in if you
2 want to add. But I don't recall sort of states
3 characterizing one agency as sort of being more or less
4 interested in collaborating around this population. And I
5 think while there were challenges to doing so, all of the
6 states we spoke to actually felt like they had some pretty
7 strong partnerships between Medicaid and Corrections.
8 MS. BASEMAN: And importantly, even if it did
9 start as an executive order from the governor, it's
10 continued because they recognize the importance on both
11 sides of continuing this collaboration.
12 COMMISSIONER CERISE: So I'm intrigued. Heidi
13 made the point of sort of disconnecting prison and jail,
14 and they're different populations. It would seem like the
15 state's got a responsibility to provide care, and for the
16 people in prison, for a long time, it seems to me more of a
17 financial issue for states. Can you get Medicaid to cover
18 that care and get federal participation? Because you're
19 not talking about transitioning people in and out of care,
20 but it's a matter of they've got to provide services, and
21 if you can get Medicaid participation a state is going to
22 like that better.

1 The jail issue does seem to be one where, you
2 know, if you wanted to -- the importance of coordinating
3 services better, not losing coverage, where I can imagine
4 we continue coverage during this period.
5 It's intriguing to say, yeah, you still have
6 Medicaid while you're in jail so you can see your provider.
7 I can imagine all of the disparities that might produce
8 among people who, you know, providers they're connected to,
9 and so they are telehealthing in jail, and the rest of the
10 population that doesn't have the same access. So, I mean,
11 I can see how that could be tough.
12 But the idea, though, that you know someone who
13 is in jail is going to be connected to care the day they
14 leave is important, because I would imagine a number of
15 people, they may be eligible. They weren't receiving care
16 before they went in, so they were diagnosed with their STD,
17 with their hep C, with HIV. And so before you start
18 somebody on care that's going to need to be continued the
19 day they leave, it's going to be important to know that
20 they have those services available.
21 So something around, you know, continuous
22 coverage or assurances that people are going to have

1 coverage the day they leave, and the demos that talk about
2 giving drugs, giving supplies of drugs, those things would
3 seem to be pretty important.
4 And doing it in the context of a demo, we've
5 talked about this before, where you actually have a
6 demonstration, and you learn something from the
7 demonstration would be important because what do you do --
8 now I'm in a non-expansion state, so there are going to be
9 a lot of people who are not going to be eligible the day
10 they walk out of jail. And maybe it's 100 percent in those
11 expansion states where they do.
12 But what could a demo teach you about people who
13 are going to be eligible in jail, are going to be eligible
14 the day they walk out of jail? Can you start expensive
15 treatment for a chronic condition, or does it make sense to
16 do that if the day they walk out of jail they're not going
17 to be able to get coverage?
18 So there's a lot to work through, that would be
19 ripe for a demo, particularly around that jail population.
20 Thanks.
21 VICE CHAIR DAVIS: Thank you, Fred. Tricia.
22 Actually, Dennis and then Tricia.

1 COMMISSIONER HEAPHY: -- churn in general, and
2 what would be a redetermination when we get folks who cycle
3 on and off Medicaid, the cost to the states. So why don't
4 we look at this in the same vein and saying this is a
5 Medicaid issue that we have to ensure -- other people have
6 been saying this, but continuity of care, Medicaid
7 coverage. So why don't we just frame it within the context
8 of how we are taking on all of these other issues in the
9 same way? It seems as if it's very much the way that the
10 folks who are in the jail system for 28 days, it's a huge
11 loss, and it isn't in line with what we're doing in other
12 areas. So I see it as part of that.
13 COMMISSIONER BROOKS: I just had a question in
14 some of the states that have been trying some innovative
15 things. Has anyone used presumptive eligibility as a way
16 to at least get the ball rolling on a full application?
17 MS. BECKER ROACH: Tricia, I'm going to have to
18 go back and just double-check our notes, but I think all or
19 nearly all of the states that we interviewed were not using
20 presumptive eligibility. But we can also follow up with
21 you.
22 COMMISSIONER BROOKS: Yeah. I mean, I think that

1 some corrections facilities might say, you know, "We don't
2 have the bandwidth to go through the application process
3 with someone." But, you know, PE is a pretty simple
4 process, or can be. And even though corrections facilities
5 would not be considered a qualified entity under the rules,
6 there is the option for the Secretary to approve other
7 types of organizations.

8 So I think that's something worth exploring a
9 little more because I think it might be a simple way to at
10 least get things started.

11 And then I'm not sure how relevant this is, but
12 I'm just curious if we are aware of differences when states
13 have chosen to privatize corrections versus having them be
14 government-run, because I think there are some issues there
15 as well that may not lend themselves to really facilitating
16 what happens to someone after they're released.

17 VICE CHAIR DAVIS: Thank you, Tricia. Other
18 comments? I think I got everybody. Yeah, go ahead,
19 Jennifer.

20 COMMISSIONER GERSTORFF: I would be interested if
21 there's any data or information on housing stability for
22 this population before and after incarceration, and how

1 that might intersect with some of these services.
2 VICE CHAIR DAVIS: I think you got a lot from us.
3 There's lots of interest here.
4 You know, one thing I'll just add, as we're
5 thinking about the framing of this and the why, and I think
6 it's been said several times, but just thinking of this as
7 a special population, right? You said at the beginning
8 they are disproportionately poor, disabled, with behavioral
9 health issues, and then you add incarceration on top of
10 that, and that just makes them a high-risk population.
11 And so they are in this situation because they
12 have done a bad thing, but we don't need to continue to
13 punish them on a health side. So how do we make sure that
14 they are connected to care, all of the things that we are
15 talking about here, and that that doesn't continue to be
16 the barrier.
17 And I think because of them being such a special,
18 unique population, really honing in on the monitoring and
19 evaluation piece of that. So these often become a
20 forgotten population, so how are states being held
21 accountable, how are MCOs being held accountable for
22 providing care to these folks, that they aren't being left

1 behind, really prioritizing that continuity of care. If
2 they had a provider before incarceration, are they
3 connecting back up with that provider afterwards? Is that
4 something that we look at? Are we looking at if they were
5 receiving treatment, as Fred mentioned, you know, while
6 they were incarcerated, is that being continued without
7 delays and gaps in care during that transition? And so
8 really having special attention to that monitoring and
9 evaluation piece for this population.

10 I can't imagine that you want more from us, but
11 did you get enough to go forward? I imagine that when you
12 bring this back to us there will probably have to be a
13 whittling-down process of what we focus on, but we are
14 certainly excited to dig in here.

15 MS. BECKER ROACH: Great. We appreciate all your
16 questions and input, and we'll look forward to coming back
17 with you with more information in December.

18 VICE CHAIR DAVIS: Thank you, Melinda and Lesley.

19 CHAIR BELLA: Yes, thank you. Thank you, Kisha.
20 We'll get ready for our last session before we take a break
21 for lunch, which is to talk about the PHE and monitoring
22 the unwinding. Martha will join us.

1 [Pause.]

2 CHAIR BELLA: Process-wise, just everyone's
3 aware, Martha will give us her update. Then we will take
4 public comment on the three sessions we've just had, and
5 then we will take a break for lunch.

6 Welcome, Martha.

7 ### MONITORING THE UNWINDING OF THE PUBLIC HEALTH
8 EMERGENCY (PHE)

9 * MS. HEBERLEIN: Hi. Thank you.

10 So I'll begin today by providing some brief
11 background on the PHE and prior Commission work and then
12 quickly touch on the role of monitoring before reviewing
13 potential data sources and describing next steps.

14 So, as you are all well aware, during the COVID-
15 19 public health emergency, or PHE, states receiving the
16 6.2 percentage point increase in federal match may not
17 disenroll beneficiaries.

18 CMS and states have been planning for the
19 unwinding, but given the administrative task ahead,
20 concerns remain about the potential loss of coverage.

21 So the PHE is currently authorized through
22 January 11th, and as the administration has repeatedly

1 indicated, it will provide 60 days prior notice. So we
2 should know in mid-November whether the PHE will be
3 extended again or if states will begin the process of
4 redetermining eligibility and terminating coverage at the
5 beginning of the year.
6 So, in anticipation of this eventual unwinding,
7 the Commission has shifted its focus to a post-PHE
8 environment.
9
10 So, like many organizations, the Commission has
11 been closely following unwinding preparations. So, during
12 a special meeting in July, the Commission discussed
13 findings from staff interviews with state officials earlier
14 in the summer that described state planning activities.
15 States at that point felt that they had planned as much as
16 they could for the unwinding, and that additional certainty
17 around the timing or federal financial support was not
18 necessary.
19 MACPAC has also hosted three panels in
20 October 2020, January 2022, and most recently in September
21 that brought together state officials and beneficiary
22 advocates to discuss planning activities and areas of

1 concern.

2 So specific concerns raised by Commissioners
3 during these discussions as well as others include state
4 capacity to complete the growing backlog of pending
5 verifications, redeterminations, and renewals.

6 States have also noted -- or stakeholders have
7 also noted the risk to beneficiaries if states move rapidly
8 through the process, as there will be little time to
9 conduct outreach and implement strategies that facilitate
10 the process. So, given these concerns, monitoring state
11 progress will be a priority.

12 In conversations with the Centers for Medicare
13 and Medicaid Services, officials noted that they plan to
14 use every data source available to them to assess progress
15 and identify potential issues. These include existing data
16 sources as well as newer reporting requirements put in
17 place specifically to monitor the unwinding. Using these
18 data, CMS will provide states technical assistance on ways
19 to address these concerns.

20 So on to the specifics. States will be required
21 to submit to CMS a report that summarizes their monitoring
22 plans as well as baseline and monthly data for a minimum of

1 14 months on their post-PHE progress. In the renewal
2 distribution report, states will report their plans for
3 prioritizing, distributing, and processing renewals.
4 States are also required to report the approximate number of
5 renewals that they intend to initiate each month as well as
6 strategies to promote coverage, retention, and prevent
7 inappropriate coverage terminations, such as for procedural
8 reasons.
9 It is not clear if or when the state renewal
10 distribution reports will be made publicly available,
11 although some of this information is available in state
12 operational plans.
13 States will also be required to report baseline
14 and monthly data on specified metrics. The baseline report
15 is meant to serve as a starting point to track pending
16 eligibility and enrollment actions that the state will need
17 to address once they begin their unwinding period.
18 Monthly reports are designed to track progress
19 addressing pending actions throughout the unwinding period,
20 and states will be required to report data on pending and
21 completed applications and renewals and pending fair
22 hearings.

1 Additional data on the disposition of renewals
2 will also be reported, including the number of
3 beneficiaries renewed via ex parte or through a
4 prepopulated renewal form, those determined ineligible,
5 those terminated for procedural reasons, and those whose
6 renewal was not completed.
7 So, Commissioners, there are several tables in
8 your materials that list the specific metrics for both the
9 monthly and baseline reports.
10 At this time, CMS is still considering whether to
11 release these reports. So we aren't clear whether or not
12 we'll see these data.
13 So beyond the required reporting specifically
14 related to the unwinding, there are other data sources that
15 the Commission, CMS, states, and stakeholders can monitor
16 to assess state progress. However, quality concerns,
17 public availability, and the timeliness of their release
18 may limit their utility for real-time assessments.
19 The performance indicator data are intended to
20 provide consistent monthly metrics on key Medicaid and CHIP
21 enrollment and eligibility processes. States are required
22 to report performance indicator data for 11 topics,

1 including things such as call center statistics, the number
2 of individuals determined eligible and ineligible,
3 application processing time, and enrollment.
4 CMS issues reports with state-specific
5 performance indicator data. For example, CMS provides
6 monthly reports on enrollment measures, including the number
7 of applications, individuals determined eligible, and
8 enrollment. However, these data are typically released with
9 a three-to-six-month time lag.
10 CMS has also issued reports on the timeliness of
11 eligibility determinations for individuals who are
12 determined eligible using modified adjusted gross income or
13 MAGI as well as CHIP applications. Historically, these were
14 released on an annual basis. However, in light of the end
15 of the PHE, CMS plans to release these data on a quarterly
16 basis, but even so, there will be a lag in the release.
17 Administrative data from the Transformed Medicaid
18 Statistical Information System, or T-MSIS, can also be used
19 to monitor the return to routine redeterminations. T-MSIS
20 provides more detailed information on enrollment, such as
21 the basis of eligibility. However, these data are not
22

1 available as quickly as the overall enrollment data
2 reported through the performance indicator process. As
3 there's typically a lag of about eight months between the
4 time period being reported and the release of preliminary
5 T-MSIS data for public use, their timeliness limits the
6 utility for public. However, CMS has access to these data
7 beforehand.

8 States also collect a significant amount of data
9 that can be used to monitor the unwinding and may provide a
10 timely source for understanding state progress as well as
11 indicate where problems might exist. Based on an analysis
12 from January, the majority of states reported some
13 enrollment data publicly on their websites with 19
14 reporting them with less than one month delay. However,
15 these data are not always comparable across states.
16 Additionally, they don't include information such as
17 reasons for disenrollment that would be helpful for
18 interpretation.

19 Other types of data, such as pending applications
20 or call center data, are less common on websites.

21 In our discussions with states over the summer,
22 they all noted that they would be collecting data based on

1 the CMS reporting requirements. Many were still planning
2 what additional data they would collect, although some
3 shared that they planned to monitor specific data points
4 such as call center statistics.
5 Some states said that they planned to post data
6 publicly, although most had not determined yet what metrics
7 they would share.
8 As of September 20th, seven states had indicated
9 that they will have an unwinding data dashboard or
10 otherwise post data publicly.
11 The specific metrics that they will post and
12 monitor varies by state, as with everything in Medicaid.
13 So, for example, we looked at Nevada's unwinding plan,
14 which notes that the state will release a data dashboard
15 publicly on its website. The dashboard will be updated
16 monthly and include enrollment by week, call center
17 information, and state workload with things such as total
18 applications, pending applications, and account transfers.
19 Other states are planning on sharing the CMS-
20 required data reports. For example, Michigan's unwinding
21 plan notes that the state anticipates publishing the CMS-
22 required reports to a public-facing website. The plan also

1 notes that the state agency will create several internal
2 operational reports to support their efforts.
3 Both states that participated in our September
4 panel, Arizona and Pennsylvania, also noted that they will
5 be monitoring a number of data points including tracking
6 call center data.
7 So beneficiary advocates have noted the importance
8 of establishing or leveraging existing feedback loops with
9 stakeholders on the ground, such as advocates, plans, and
10 providers. CMS and many states routinely engage with
11 stakeholders on unwinding issues as well as on eligibility
12 and enrollment issues more generally.
13 National, state, and local consumer advocates and
14 assisters as well as media sources can provide important
15 information on how the unwinding is unfolding. For
16 example, individuals seeking coverage may contact advocates
17 for help understanding notices or responding to requests for
18 information. These groups can help identify areas of
19 potential confusion, such as wording on specific notices or
20 processing concerns, such as inconsistent application of
21 eligibility rules.
22 In addition, plans and providers may provide

1 additional feedback regarding beneficiary understanding of
2 their coverage changes. For example, individuals may first
3 learn they are no longer enrolled when they attempt to fill
4 a prescription or attend an appointment. If providers are
5 seeing an increase in the number of individuals unaware of
6 their coverage loss, this may indicate concern with the
7 notice process.

8 Similarly, plans may receive an increase in
9 complaints or inquiries from individuals about changes in
10 their coverage, which may be indicators of issues with
11 implementation. So, while this information may be
12 anecdotal, it could point to larger systemic issues that
13 warrant attention. These sources may also offer more
14 timely indicators of worrisome trends and provide insight
15 into consumer experiences with call centers and other
16 challenges for which data are not available.

17 I would also note here that stories of successful
18 renewals and transitions may be less common, as those
19 without complaints may not always make their experiences
20 known.

21 So, as I just walked through, there are a number
22 of data sources that can provide insight into how the

1 unwinding is progressing. However, the public availability
2 of these data, which measures are collected and reported,
3 and the timeliness and frequency of their release may limit
4 the ability for stakeholders to monitor progress in real
5 time.

6 Examining all possible data sources will provide
7 a more complete picture of what is happening, but gaps in
8 knowledge, especially as the process is initially
9 unfolding, will remain.

10 So staff will continue to monitor what data is
11 available and report back. We will also return at
12 subsequent meetings to focus on a variety of topics of
13 Commission interest. Specifically the discussion in
14 December, at the December meeting, we'll focus on easing
15 transitions in coverage at the end of the PHE. And in future
16 meetings, we'll discuss efforts to unwind other state
17 flexibilities.

18 So, with that, I'm going to go back to that
19 previous slide and turn it over for you to discuss.

20 CHAIR BELLA: Thank you, Martha. Very
21 informative.

22 I want to get feedback from Commissioners but ask

1 that we not -- the goal of this is not to give her a
2 hundred more things to monitor. The goal is to sort of
3 absorb what we have and be smart about this and
4 understanding -- this chart is really helpful -- and assume
5 that it can be a living, breathing, evolving document and
6 maybe used to put some public pressure on making more
7 things public. But let's try to be focused and sort of
8 prioritize where we think we can have the biggest impacts
9 as a Commission in the unwinding and the monitoring of
10 that.
11 And, Tricia, do you want to kick us off
12 COMMISSIONER BROOKS: Where to start? Well, I am
13 very concerned about the lack of commitment to data
14 transparency.
15 CMS has said on numerous occasions that they are
16 not going to release the data, other than what they're
17 already releasing. Certainly, they haven't committed to
18 the supplemental unwinding data report or the renewal
19 distribution report, but the data is going to be really
20 important.
21 While some states are stepping up and we hope
22 they'll serve as a model, there's no requirement for the

1 states to report the data either.

2 And to give you a sense of how this may unfold
3 with so many new data points, we have more than 80 data
4 points in the current performance indicator data, and on
5 top of that, we're asking for -- I don't know, Martha, if
6 you have a count in your head, 20 or so new data points.

7 Well, if the states aren't yet reporting the 80
8 that they've been required to report since 2013, how far do
9 we think we're going to get on these new data reports in
10 terms of getting all the states to report? Because there
11 is an option for the state to say on the report, "unable to
12 report." And, you know, unfortunately, CMS likes to scrub
13 the data, and I think that's helpful. But we can't let the
14 perfect be the enemy of the good in this case, and during
15 ACA implementation, they were putting out some weekly
16 reports.

17 I don't think we need every piece of data, but I
18 do think we need call center stats. I think we need the
19 share of procedural disenrollments. Just backing in to
20 enrollment data to figure out how many people are losing
21 coverage isn't going to tell you how many are losing
22 coverage inappropriately, and that's where the ASPE report

1 came in that was released in August saying they anticipate
2 45 percent of people who lose coverage will be disenrolled
3 for procedural reasons, 72 percent of kids, 64 percent of
4 Latinos. So I just -- the damage is going to potentially
5 be so severe in terms of disenrollment before we even
6 really have a good handle on how much damage is done, that
7 it will take years to recover. And we'll see an increase
8 in the coverage gap during this period of time.
9 So anything that we can do to really press
10 forward and to pressure both CMS and the states to release
11 their data, I think, is just going to be really critical,
12 including having Congress require it.
13 CHAIR BELLA: Thank you, Tricia.
14 Martha, I think key themes -- I mean,
15 transparency has been one of ours. We also have talked a
16 lot about procedural disenrollments and call center
17 visibility. So those feel, Tricia, like things we can
18 continue to try to keep an eye on and lend some voice to,
19 when appropriate.
20 Bob.
21 COMMISSIONER DUNCAN: Thank you. And I echo
22 Tricia's comments and yours, Melanie, on the transparency.

1 The other issue I am concerned about, again, in
2 regards to the ASPE report that Commissioner Brooks
3 highlighted, is it says disproportionately kids could be
4 negatively impacted by this. So, as they're collecting the
5 data, I'd like to see it from an age category, so we can
6 call that out but, again, in a timely fashion, not six
7 months after this has taken place.
8 CHAIR BELLA: Thank you, Bob.
9 COMMISSIONER HEAPHY: I'd like to know what CMS
10 is going to do with the data. Do they plan -- have they
11 told us what they're going to do with the data, how they're
12 going to use it to address gaps in care and coverage? It
13 would be helpful to know as well.
14 CHAIR BELLA: Martha, do you want to comment on
15 that?
16 MS. HEBERLEIN: Sure. When we spoke to CMS,
17 they're going to be looking at the data, and they have
18 regular technical assistance calls with states ongoing.
19 And I think they're going to use those avenues as well as
20 other avenues to work with the states to mitigate whatever
21 issues and try to understand from the starting point
22 whether it's a data concern. As Tricia said, they can say

1 they can't report certain things. So is it a data
2 reporting issue, or is it indicative of something else?
3 And then figure out sort of what the data might mean and
4 then how to work with states. So, if it's a reporting
5 issue, work with the reporting side of the state versus if
6 it's a processing issue, work with them. So I think
7 they're going to use their existing TA approaches after
8 they try to get a better handle of what the data actually
9 mean.
10 CHAIR BELLA: Thank you, Dennis.
11 Angelo?
12 COMMISSIONER GIARDINO: I guess my question is,
13 do we have any options here in terms of as a Commission?
14 So data transparency, particularly around very specific
15 indicators that are the canary in the coal mine, are pretty
16 fundamental. Is that a letter to somebody? Is that a
17 recommendation? Is that a statement? But what do we have
18 at our disposal to put a fine, fine light on that? And I
19 don't find that that's all that controversial to be all
20 about data transparency and say that there's some
21 indicators that we are really saying are essential to know
22 if the program is

1 delivering on what it says it is.

2 CHAIR BELLA: So we have talked -- I mean, we
3 have consistently been a voice for transparency, and I
4 think an ever-present question for all of us is when and to
5 whom should we be weighing in on these things, and so we do
6 need to continue to talk about that. I think we've tried
7 to be judicious when we use our voice so that people would
8 really listen to it, and it could be that we decide that
9 it's time to say something again or we could wait. You
10 know, I think it's that Angelo. So the biggest thing is
11 figuring -- right now is the opportunity to tell someone
12 something that we think is going to have some sort of
13 force, because it's coming from us, and because there are
14 so many people that have opinions on this, we're trying to
15 be, like, very deliberate about that.

16 COMMISSIONER GIARDINO: Yeah. So I would just
17 say, judiciously, before you fall off the cliff is when you
18 make this comment. So I would think right now is the time,
19 because to do some of this transparency, you know, in all
20 fairness to CMS and to the states, they need to get their
21 machinery going so they can do that. So I don't think you
22 wait till the car is going over the cliff to say you should

1 be doing this.

2 I think we know the car is getting very close to
3 the cliff, and, you know, this PHE is going to end at some
4 point. So I think we should be really clear in a very
5 responsible way, but the data transparency is essential.
6 That is an absolute fundamental element to policy work.

7 CHAIR BELLA: Thank you, Angelo. Martha?

8 COMMISSIONER CARTER: I've been thinking about
9 the most immediate feedback is going to be from folks on
10 the ground, you know, practices, community health centers,
11 the assisters, and so it's sort of like checking your tires
12 before you even get close to the cliff.

13 So how can we use that information? It's sort of
14 even pre-data. You know, this is anecdotally. How can we
15 use reports from folks in the field to say we think there
16 might be a problem here or we're seeing a whole lot of
17 people coming in for their appointments and they didn't
18 realize that they don't have coverage? How can we use that
19 information? I don't have a good answer. I'm asking you,
20 Martha.

21 MS. HEBERLEIN: I don't know that I have a good
22 answer either, Martha, from a Commission perspective. I

1 think CMS hears those stories and states hear those
2 stories, and I think, you know, experience from the ACA
3 would tell you that when they hear those stories and they
4 make the front page of the New York Times and other news
5 outlets, that encourages them to act. I mean it might be,
6 to Angelo's point, after the car is off the cliff. But I
7 think it does inspire them to act.

8 I think what we do as MACPAC with those data I
9 think is the question Melanie raised, like, how -- do you
10 guys want to use your voice and at what point does it make
11 the most sense to do that?

12 CHAIR BELLA: Yeah, I mean Angelo -- we can keep
13 talking -- we had a special session in July because we
14 thought there was like an immediacy to needing to use our
15 voice, and after that discussion we realized maybe it's not
16 the right time, right? And so we can continue to talk
17 about this. That's why Martha continues to come back, and
18 she will be back in December as we --

19 MS. HEBERLEIN: No, I won't. Rob and Linn will
20 be back in December.

21 CHAIR BELLA: Oh. Okay. The topic -- the topic
22 -- will be back in December. It's certainly an ongoing

1 discussion for us.

2 COMMISSIONER GIARDINO: Again, to Martha's point,

3 I think we have listened to the front, and I think there's

4 concerns, and if those concerns are as disastrous as some

5 quarters say, the data would show that. And if it's more

6 towards the other end of the continuum, the data would be

7 reassuring, and we'll show that it's not a disaster. So I

8 just feel like it's a pretty vanilla thing to formally say

9 at this point, since the PHE is imminent -- its ending is

10 imminent, those that hold the data have to commit to

11 disclosing it on a regular basis, and the perfect should

12 not be the enemy of the good. But like the procedural

13 disenrollments, the call center volumes, there's a handful

14 of these that should be -- whoever is controlling this --

15 and to me that's CMS and the state Medicaid directors --

16 they should be called to account. They should disclose

17 this.

18 CHAIR BELLA: Well, I'm going to channel my

19 former Medicaid director and former CMS hat to say I don't

20 think anybody is saying they don't want to be held

21 accountable. I do think it's fair to say that it would be

22 worse if we put out poor data right now and we create some

1 sort of hysteria among folks, particularly as we're trying
2 to convince people to go through the redetermination
3 process. And so finding that balance of when it is -- it
4 doesn't have to be perfect, but it has to be good enough
5 that people have a little bit of faith in the data.
6 Otherwise, we create a whole other set of problems.
7 COMMISSIONER GIARDINO: But that's exactly the
8 recommendation. So I would be the first to say please do
9 not put out inaccurate data, but please don't think you
10 have to have perfect data. So I think sometimes regulators
11 are so worried about the impact of things that are 98
12 percent accurate than 100 percent. So I don't know, I
13 think it's time to be clear on the fact that -- I'm not
14 saying they're not accountable, but not willing to say
15 you'll disclose it to me sounds a little unaccountable.
16 CHAIR BELLA: Tricia.
17 COMMISSIONER BROOKS: Just a little bit of a
18 separate point, and that is, I haven't heard anything about
19 discussions in Congress. I think there's still
20 opportunities that Congress could take action, but that's
21 going to happen between now and the end of the year. So
22 any public document we put out, whoever we address it to,

1 about data transparency and required reporting and timely
2 reporting needs to happen soon because if we wait until
3 January, whatever window there is for Congress to act will
4 be gone.
5 CHAIR BELLA: Thank you, Tricia. Other folks?
6 [No response.]
7 CHAIR BELLA: Okay. I'll tell you what. We'll
8 go to public comment, and then if anybody has any last
9 comments, we'll circle back.
10 So we will open it up to public comment on any --
11 Martha, sorry, you're stuck sitting there -- on any of the
12 three sessions that we've heard this morning. And I'll
13 remind folks in the audience to please introduce yourself,
14 the organization you represent, and we limit comments to
15 three minutes please.
16 Courtney, please go ahead with your comment.
17 **### PUBLIC COMMENT**
18 * MS. KING: Sure. Can you hear me okay?
19 CHAIR BELLA: Yes. Thank you.
20 MS. KING: Great. Thank you. My name is
21 Courtney O'Byrne King, and I'm the Medicaid state plan and
22 policy analyst for the State of Alaska. However, my

1 comment is more from my past life of 25 years within
2 juvenile justice, part of that working with Medicaid to try
3 to do some things.
4 I really want to say how much I appreciate
5 Martha's comment about evaluating the landscape when the
6 inmate exclusion was put into place and evaluating now in
7 terms of the existing landscape. I thought that was a very
8 good way of describing things.
9 So while I appreciate the work done with the
10 adult system, I do think it's critical to research the
11 issue in depth with the juvenile justice population. One
12 of the reasons I chose to work with juveniles was the
13 opportunity to work with developing, changing, growing
14 human beings, right? And so I think that same thing makes
15 the juvenile justice population, which is frequently the
16 child welfare population as well, creates a situation where
17 the access to services, the continuity of care, is even
18 more critical, because not meeting those needs in the
19 juvenile system creates problems on into the adult system,
20 right?
21 So I just want to emphasize the need to take the
22 juvenile justice part really seriously, and frequently

1 people don't because they're kids, right? They don't --
2 people view them differently.
3 I think that one other statement I want to make
4 is I don't think people have wrong systems. I think they
5 have systems that don't talk to each other, right? I was
6 involved with juvenile justice before computers were part
7 of the workplace, and so I've seen the development of the
8 use of reliance on technology and databases and things, and
9 I've watched these systems develop in Alaska as isolated
10 systems. DJJ, DOC, Medicaid, you know, they're all
11 different systems, and they were -- some of which were
12 designed at a time when interoperability and data sharing
13 was not understood or accounted for.
14 And the other piece of that is, you know, I think
15 making the changes -- and the project I worked on between
16 DJJ and Medicaid had to do with coverage and eligibility.
17 And the barriers that came up there were myriad, but I
18 think the primary one, in addition now to our own workforce
19 issues, is financial, the amount of money it takes to
20 either modify existing systems to communicate or implement
21 new systems. And to that end, I think that, you know, with
22 the federal emphasis on data sharing, a demonstration

1 option would be very helpful. And I also believe that, you
2 know, federal funding towards -- you know, kind of putting
3 the money where the mouth is in terms of wanting this kind
4 of communication to happen. Nothing is cheap when you're
5 dealing with systems that have confidential information.
6 The other piece, the question asked about where
7 the interest was coming from, I think at least in the State
8 of Alaska, you know, I think clearly there's a fiscal
9 motive for DOC because they have huge expenditures for
10 health care and services within their institutional
11 settings. Their databases present a whole other range of
12 problems, and especially given the fact that they're not
13 used to, you know, communicating health care information
14 outside of their system. At least that's my experience in
15 the state.
16 So I guess just all that to say I'm incredibly
17 supportive of this and would encourage you to expand or
18 isolate the juvenile population as you move forward.
19 CHAIR BELLA: Courtney, thank you for your
20 comments, and we're thrilled that being remote allows folks
21 in Alaska and others to join us. So we appreciate you
22 taking the time.

1 Do we have anyone else who would be interested in
2 making a public comment?
3 [No response.]
4 CHAIR BELLA: I don't see anyone. So anybody
5 have any last questions or comments for Martha? I guess my
6 closing thoughts and request to Kate and Martha and the
7 team would be, you know, you are always watching for when
8 it is time for us to say something or do something based on
9 what we know. We've been pretty clear about the areas
10 we're interested in in terms of what we think is important
11 and what our themes are. So I think when we choose to say
12 something, we're on the record with many of the things we
13 might want to say. And so you going back after this
14 discussion and, you know, talking about what you heard and
15 what is coming next between now and the end of the year and
16 factoring that in with congressional timing, we will defer
17 to your wisdom and put that in your capable hands, and
18 we'll look forward to having this next conversation -- not
19 with Martha -- in December.
20 Thank you very much for your work here.
21 With that, we are adjourned until lunch. We will
22 reconvene at 1:00 p.m. Eastern time. Thank you all very

1 much.

2 * [Whereupon, at 11:56 a.m., the meeting was

3 recessed, to reconvene at 1:00 p.m. this same day.]

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1 AFTERNOON SESSION

2 [1:00 p.m.]

3 CHAIR BELLA: Okay. Welcome back, everyone. We
4 will kick off the afternoon portion of our meeting.

5 We are going to start with the comments on CMS's
6 eligibility, enrollment. and renewal rule, and we have
7 Martha and Kirstin joining us.

8 First, let me say thank you before you even get
9 started. This is a monster rule with lots of good stuff in
10 it.

11 So we are very appreciative of what you're
12 bringing forward in front of us this morning -- or this
13 afternoon. And just to remind Commissioners, we will be
14 commenting on this rule. We are not commenting on every
15 single part of the rule. We will focus today on the areas
16 where we seek to comment.

17 Okay. I'll turn it over to the two of you.
18 Thank you.

19 **### PROPOSED ELIGIBILITY, ENROLLMENT, AND RENEWAL**
20 **RULE: SUMMARY AND AREAS FOR POTENTIAL COMMENT**

21 * MS. HEBERLEIN: Thank you. And this represents
22 a team effort. So it's just us at the table, but there are

1 many cooks in the kitchen for this one.

2 I'm going to begin today by providing some brief
3 background and the CMS goals for the proposed rule, and
4 then Kirstin and I will walk through the detailed
5 provisions and relevant MACPAC work before quickly touching
6 on next steps and turning it over to you for discussion.

7 So, on September 7th, the Centers for Medicare
8 and Medicaid Services published a Notice of Proposed
9 Rulemaking, or NPRM, that makes changes to the Medicaid
10 application, enrollment, and renewal processes. The rule
11 provides the first substantial changes to the enrollment
12 and renewal processes since the implementation of the
13 Patient Protection and Affordable Care Act, or ACA.

14 The ACA, along with the 2012 and 2013 rules
15 implementing its provisions, made significant changes to
16 these processes with the goal of making the program more
17 efficient, reducing complexity and effort for individuals
18 and program administrators, and integrating Medicaid with
19 the new health insurance exchanges. Many of these changes
20 were modeled after measures that were successful for
21 enrolling children in Medicaid and CHIP but were not
22 previously required of states.

1 So comments are due November 7th. It's unknown
2 when the rule will be finalized and is unlikely to be
3 implemented prior to resumption of redeterminations at the
4 end of the public health emergency. So just keep that in
5 mind.
6 So, building on these earlier rules, the
7 September proposed rule responds to President Biden's
8 Executive Orders directing agencies to strengthen Medicaid
9 and access to health coverage. The rule includes a number
10 of provisions designed to meet the administration's goals
11 of simplifying the processes and maintaining coverage for
12 eligible individuals, particularly children and individuals
13 who are dually enrolled in Medicare and Medicaid.
14 CMS also seeks to improve program integrity by
15 promoting accurate and timely determinations.
16 The rule covers many topics, as Melanie said,
17 including some areas where MACPAC does not have an analytic
18 body of work on which to draw and we will not focus on
19 today. So, for example, the proposed rule provides
20 additional detail on what documentation must be retained
21 and how long states must retain records, but those areas
22 have not been areas of work for us, so we won't be
discussing

1 them today.

2 On the next set of slides, Kirstin and I will
3 walk through some of the provisions in more detail and
4 highlight areas of prior MACPAC work that you can draw on
5 for our comments. In some cases, our prior work can
6 generally support where the agency is going, and in other
7 places, we can be more specific in our comments.

8 So, with that, I'll turn it over to Kirstin.

9 * MS. BLOM: Thank you. Martha, and good afternoon,
10 everyone.

11 So I'll begin our summary by walking through the
12 changes in the proposed rule that apply to the Medicare
13 Savings Programs, or MSPs. But I'm going to start with a
14 little bit of background.

15 The MSPs, as you guys know, are administered by
16 states and provide Medicaid coverage of Medicare premiums
17 and sometimes cost sharing to low-income Medicare
18 beneficiaries. There are four separate MSPs, each with
19 different income and asset limits, and they each represent
20 a mandatory Medicaid eligibility pathway.

21 The changes in the rule, however, focus on three
22 of those four: the Qualified Medicare Beneficiary program;

1 the SLMB, or Specified Low-Income Medicare Beneficiary
2 program; and the QI, or Qualified Individual program.
3 The proposed rule primarily makes changes that
4 are aimed at aligning MSP eligibility rules with those of
5 the Medicare Part D Low-Income Subsidy program, or LIS.
6 The LIS program, in contrast to the MSPs, is administered
7 by the Social Security Administration. LIS similarly,
8 though, provides financial assistance to Medicare
9 beneficiaries but this time for premiums and cost sharing
10 associated with their Part D prescription drug coverage.
11 In the rule, CMS proposes to align eligibility
12 for the MSPs with that of the LIS program because the two
13 programs serve a similar population of low-income
14 beneficiaries. Currently, the LIS income limit is 135
15 percent of the federal poverty level, which is the same as
16 the upper limit of the QMB, SLMB, and QI programs.
17 There's also an automatic link between the two
18 programs in that anyone who's eligible for the MSPs is also
19 eligible for LIS. However, the reverse of that is not
20 true. People eligible for LIS are not automatically
21 eligible for the MSPs.
22 So the changes in the rule focus on having states

1 better use the information from the LIS eligibility
2 determinations, information that SSA is required to
3 transfer to them and streamline eligibility for the
4 program.

5 So I'll walk through the changes and then talk a
6 little bit about our prior work in this area.

7 So the changes that CMS proposes are focused on
8 facilitating enrollment into the MSPs. CMS would start by
9 codifying in regulation the statutory requirements that
10 states accept data from the LIS application, which is
11 referred to as "leads data" in the rule, that the Social
12 Security Administration transfers to states on a daily
13 basis under current law. States are required to accept
14 that data as the MSP application.

15 Although this is possible under current law, CMS
16 believes that many states do not actually meaningfully use
17 that data, and in fact, CMS estimates that more than a
18 million people who are enrolled in the LIS program and who
19 would likely be eligible for the MSPs are not, in fact,
20 enrolled.

21 Accepting the leads data as the MSP application
22 would enable states to streamline the MSP eligibility

1 process and act on the application promptly. It also would
2 avoid states having to re-verify eligibility information
3 that the Social Security Administration has already
4 verified.
5 The proposed rule would also make changes to
6 streamline MSP income and asset methodologies to make it
7 easier for states to use the LIS data. Under current law,
8 states can align their MSP income and asset methodologies
9 with LIS by disregarding income and assets that LIS does
10 not count for purposes of eligibility, such as interest
11 income and burial funds, but not all states do this. So
12 the proposed rule would require that states accept
13 attestation for the types of income and assets counted for
14 the MSPs but not LIS, so states can use that leads data
15 more efficiently.
16 It's very technical, but hopefully, that makes
17 sense.
18 This avoids beneficiaries having to resubmit or
19 re-verify information that they already have provided about
20 those income and assets for the LIS application.
21 All right. The rule would also require that
22 states adopt the LIS definition of family size for the MSPs

1 by defining that as including at least the individuals
2 included in the LIS definition. So that's sort of very
3 much in line with the streamlining income and asset
4 methodologies but just wanted to note that here.
5 And then the rule would require that states
6 automatically enroll certain SSI recipients into the
7 Qualified Medicare Beneficiary, or QMB program.
8 So just a little bit of background, people who
9 receive SSI have a mandatory eligibility pathway into
10 Medicaid, and most states cover that group. And then SSA
11 determines eligibility, and they kind of automatically get
12 enrolled into Medicaid. Those are referred to as 1634
13 states.
14 Some states cover the mandatory group but require
15 a separate application for Medicaid, and then there are
16 eight states that do not cover the mandatory SSI group.
17 Those are the 209b states, which are named for the section
18 of the law that gave them that authority to do so.
19 So, to streamline enrollment for SSI
20 beneficiaries into the MSPs, the rule would generally
21 require that states deem eligible for QMB, anyone enrolled
22 in either the mandatory SSI or the 209b group. This is,

1 according to CMS -- and correctly because SSI beneficiaries
2 always meet the QMB eligibility criteria -- because the
3 thresholds for income for SSI are lower than the 100
4 percent threshold that the QMB program has in place.
5 Okay. So we have done work in this area. So
6 MACPAC, going back to 2017, we did a study with the Urban
7 Institute that looked at participation in the MSPs, to try
8 to figure out how many people of the eligible population
9 are enrolling, and we found that that was around 50
10 percent, which was consistent with some other studies that
11 had been done both prior to then and after.
12 So, to make it easier for states to use the LIS
13 data and improve participation and increase enrollment in
14 the MSPs, the Commission recommended in June of 2020 that
15 states align their MSP eligibility determination
16 methodologies related to things like income and assets and
17 household size, which are touched on in the rule, with that
18 of the LIS program.
19 And, with that, I'll turn it back to Martha.
20 MS. HEBERLEIN: So, under statute, all states are
21 required to implement an asset verification system, or AVS,
22 to verify financial resources electronically for those who

1 are applying for -- or receiving Medicaid under the aged,
2 blind, or disabled pathways. So these federal AVS
3 requirements were designed to make such checks timelier and
4 more accurate than those that are done manually as well as
5 reduce state administrative burden.
6 So the proposed rule seeks to address two issues
7 that states have raised about implementing AVS.
8 Specifically, it would clarify that the existing
9 requirements established under the ACA to rely on
10 electronic data to the greatest extent possible prior to
11 requesting additional information from enrollees also
12 applies to resources.
13 Additionally, the proposed rule would extend the
14 reasonable compatibility standards for income, which states
15 that if those are above, at, or below the standard, apply to
16 resources as well.
17 MACPAC's prior work has shown that states may
18 realize efficiencies through connections with electronic data
19 sources. In a study examining the effects of the ACA
20 simplification changes, the six states we interviewed
21 reported that electronic data interfaces facilitated high
22 rates of real-

1 time eligibility determinations, auto-renewal, and reduced
2 churn.
3 The changes to Medicaid enrollment and renewal
4 processes established by the ACA were intended to simplify
5 the process broadly. However, some of the changes in the
6 implementing rules were not fully extended to populations
7 that were determined eligible by not using modified adjusted
8 gross income. So they were not extended to the non-MAGI
9 populations. So this includes individuals who are eligible
10 on the basis of age or disability.
11 This proposed rule makes a number of changes to
12 align the non-MAGI application and renewal requirements
13 with those for the MAGI populations. So, specifically, the
14 rule codifies the requirement that states must allow non-
15 MAGI populations to submit applications and supplemental
16 forms through all of the same modalities provided to MAGI
17 populations. So that includes phone, mail, in person, and
18 online. Other sections of the proposed rule would require
19 states to provide all beneficiaries multiple modes of
20 providing additional information in response to requests as
21 well as reporting changes in circumstances.
22 Additionally, current rules require the use

1 of a pre-populated renewal form for MAGI populations if the
2 ex parte renewal process is not successful. So the
3 proposed rule would extend this requirement to non-MAGI
4 populations as well.

5 So, as I talked about, our prior MACPAC work,
6 including beneficiary focus groups and interviews with
7 state officials and other stakeholders, indicated the need
8 for multiple modes of communication, given beneficiary
9 preferences and comfort with technology. Furthermore, as I
10 just talked about, the prior work examining implementation
11 of the ACA showed state success in implementing these
12 streamlined renewal procedures for the MAGI populations.

13 So CMS has established minimum timeliness
14 requirements for states to determine eligibility at
15 application, but there's few timelines for beneficiary
16 responses. So the proposed rule would require states to
17 provide beneficiaries with a minimum number of days to
18 respond to requests for additional information at
19 application, renewals, and changes in circumstances.

20 The rule would also clarify that the clock starts
21 from the date the request is postmarked or the electronic
22 request is sent. The proposed rule would extend

1 these requirements to separate CHIP programs as well.

2 In prior MACPAC work that I just discussed on
3 beneficiary communications, stakeholders raised concerns
4 about the amount of time that people have to respond to
5 requests. Similar concerns about this timeline were raised
6 during panel discussions on unwinding the PHE.

7 So, while current federal regulations require
8 that Medicaid agencies promptly redetermine eligibility
9 between regular renewals whenever they receive information
10 about a change in circumstances that may affect
11 eligibility, they do not specifically address what agencies
12 must do in the case of returned mail. This section of the
13 proposed rule outlines steps the states must take when mail
14 sent to a beneficiary is returned to the agency and extends
15 these requirements to CHIP, separate CHIP.

16 Specifically under the proposed rule, states must
17 first check available data sources for updated contact
18 information. States must also attempt to contact
19 individuals to verify their forwarding addresses by mail
20 and at least one other modality, so like phone, email, or
21 text that the state gets to choose. If a state does not
22 receive a response from the beneficiary within 30 days, the

1 next steps depend on whether the forwarding address is in
2 state or out of state.
3 In prior discussions and a recent comment letter
4 to the Federal Communications Commission, MACPAC noted that
5 missing contact information can have coverage implications
6 for beneficiaries if they are unaware of actions that they
7 must take because they did not receive the notice.
8 The ACA required states to coordinate eligibility
9 enrollment processes between Medicaid, separate CHIP, and
10 subsidized coverage on the exchanges. So this was often
11 referred to as the "no wrong door policy." However,
12 implementation of these requirements has indicated issues
13 with how coordination is executed in practice.
14 So the proposed rule seeks to minimize gaps in
15 coverage as children shift between Medicaid and separate
16 CHIP. Specifically, the proposed rule will require that
17 interagency agreements between Medicaid and CHIP include
18 procedures for seamlessly transitioning individuals between
19 programs.
20 The proposed rule would also explicitly require
21 that Medicaid accept determinations of MAGI-based Medicaid
22 eligibility that are made by the CHIP agency and vice versa

1 rather than as an assessment of potential eligibility. It
2 lays out a number of different approaches to effectuate
3 this requirement.
4 The proposed rule would also require states to
5 issue a combined notice. Right now, it's encouraged when
6 an individual is determined ineligible for one program and
7 eligible for another. I will note here that the rule does
8 not make any changes to coordination with the exchanges.
9 So MACPAC's recent analysis on transition showed
10 that many children who disenrolled from Medicaid and CHIP
11 did transition to another program. However, it also found
12 that many of those who transitioned between programs
13 experienced gaps in coverage. For example, 18 percent of
14 children who transitioned from Medicaid to separate CHIP
15 and almost 17 percent of children who transitioned from
16 separate CHIP to Medicaid experienced a gap in coverage, and
17 an even greater proportion of children who transitioned
18 experienced a coverage gap when moving to the exchange.
19 Separate CHIP programs are permitted to charge
20 premiums, while in Medicaid premiums are not allowed for
21 children with family incomes below 150 percent of the
22

1 federal poverty level, or FPL. Under current regulations,
2 separate CHIP programs have the option to impose a lockout
3 period of up to 90 days when an individual must wait to
4 reenroll following nonpayment of premiums.
5 While states may disenroll individuals for
6 nonpayment in Medicaid, lockout periods are prohibited. As
7 of January 2020, 14 states have lockout periods in their
8 separate CHIP programs with 12 of those imposing a lockout
9 period of 90 days.
10 The proposed rule would prohibit states from
11 imposing lockout periods when an individual is disenrolled
12 for nonpayment of premiums. It would also prohibit states
13 from requiring payment of past-due premiums or enrollment
14 fees before that individual can reenroll, and states will
15 continue to have the option of disenrolling people from
16 nonpayment as well as requiring a new application for these
17 individuals to reenroll.
18 So MACPAC's prior CHIP recommendations supported
19 the elimination of premiums for families under 150 percent
20 of the federal poverty level, although it did not discuss
21 lockout periods, and this recommendation was made in part
22 to align with the prohibition in Medicaid.

1 So CHIP statute requires states to have methods
2 in place to prevent substitution of public coverage for
3 private coverage. To satisfy this requirement, some states
4 stipulate that a child must be without employer-sponsored
5 coverage for up to 90 days before enrolling in separate
6 CHIP. Waiting periods are not permitted in Medicaid, the
7 Basic Health Program, or subsidized coverage on the
8 exchanges. Currently, 11 states have waiting period.
9 The proposed rule would eliminate waiting periods
10 in separate CHIP, but states would still be required to
11 monitor efforts to prevent substitution and report annually
12 on the effectiveness of such strategies.
13 In 2014 and 2017, the Commission recommended the
14 elimination of waiting periods.
15 So, as for next steps, Commissioner input on
16 areas for potential MACPAC comments would be most helpful.
17 Based on our prior work and the discussion today, if you
18 want to comment, staff will draft a comment letter to
19 submit by November 7th. So that was clearly a lot.
20 So we're going to leave up this slide that
21 provides a summary of the provisions to help guide your
22 discussion on where you might want to offer comments, and

1 Kirstin and I will try to answer any questions that you
2 have.
3 CHAIR BELLA: Thank you very much.
4 I'm going to ask that we go in three chunks. One
5 is the presumption, and certainly my presumption is we are
6 commenting on this. Is there anyone that is uncomfortable
7 or did not intend to comment? Because Tricia will take you
8 outside, if that's the case.
9 [Laughter.]
10 CHAIR BELLA: So, anyone? I don't see any hands.
11 [No response.]
12 CHAIR BELLA: Okay. So we're moving ahead with a
13 comment.
14 Second, I'd like to see if there are any
15 clarifying questions, technical questions. Does anybody
16 want a refresher on what LIS is, what MSP is, what MAGI
17 is, or do you all feel ready to jump right in?
18 [No response.]
19 CHAIR BELLA: Ready to jump right in? Okay.
20 All right. Let's get started. Tricia, do you
21 want to start us off?
22 COMMISSIONER BROOKS: Sure. Overall, the

1 proposed rule is great. I mean, it does a lot of good
2 things moving the ball forward. We know, though, that
3 states are going to have significant challenges
4 implementing this, particularly implementing it during the
5 unwinding.

6 The guidance or the rule asked for feedback on
7 timelines, and I think the advocacy community has struggled
8 to say, oh, yeah, you need to do this now and this then.
9 So I think that's really hard to comment on and reflect
10 here.

11 I think also the memo indicated that there are
12 different tiers of timeliness standards that are being
13 proposed. I don't think there's an evidence base on those.
14 I think they all look pretty good, but I can understand why
15 we wouldn't comment on them.

16 I want to go back to the recommendation of CHIP
17 premiums under 150 percent and prohibiting them. There's
18 something funky in the regulations currently. I think CMS
19 made an attempt to align the requirements for Medicaid and
20 CHIP cost sharing and premiums, and we didn't quite
21 accomplish that. And if you read what's on the CMS website
22 compared to the reg, they don't actually align. We've

1 brought this to CMS's attention before, but I think this is
2 another good time that in this rule that we could raise
3 that, that there's no reason why that premium under 150
4 percent should exist. And I think that would help a little
5 bit in the transitions between Medicaid and CHIP.
6 The bigger problem with those transitions is the
7 required prepayment of premium, and there's a 30-day grace
8 period in CHIP, but it doesn't apply to that first premium
9 payment. And I think we could actually recommend that that
10 be collected post-enrollment and that that 30-day grace
11 period be allowed for that first premium, and it would give
12 families a little more time to get that under their belts,
13 if you will. So that's another piece I'd like to take a
14 harder look at or hope we'll comment on.
15 And then the returned mail was not totally
16 surprising, but in some ways it went as far as I would've
17 ever recommended that it go. And the required follow-up,
18 of course, is going to be very useful. We know when there
19 is follow-up that the response rate is going to improve. I
20 mean, you don't get one notice from somebody that you owe
21 money to and they stop at that and go, "Okay. Well, if you
22 don't pay then guess what? We're going to shut off your

1 electricity."

2 So I don't know if the Commission would be in a

3 position to recommend that any time action is required by

4 the beneficiary that there also be follow-up on those

5 occasions as well.

6 So I think those are the bigger things I wanted

7 to comment on. I do want to raise just another issue

8 that's somewhat related to the rule but not so much when

9 you talk about outside verification or ex parte, any of

10 those data-driven transactions.

11 States still have latitude to determine what they

12 consider to be reliable, and I think that CMS may have a

13 bigger role to play in saying, yes, your state unemployment

14 compensation database is reliable. Yes, your quarterly

15 wage data is reliable. And not leaving that to the

16 discretion of states, because I do think that discretion is

17 allowing states to not really make a lot of progress on ex

18 parte.

19 And again, I don't know that this is the time to

20 comment on the rule, but I do think that's an issue that we

21 should examine. We've all talked a lot about ex parte

22 renewal rates, and you still have at least a third, maybe

1 more, of the states that are less than 25 percent, and
2 probably more like 10 or 15 percent, because of the choices
3 that the state has made in how far it's going to go with ex
4 parte. And I think until we sort of mandate that these are
5 the data sources, you are required to use them, to some
6 extent states are already required to use them under the
7 Social Security Act section 1137.

8 So it's another area that I think we could
9 explore more in the future. Thank you.

10 CHAIR BELLA: Martha, did you want to comment on
11 any of those?

12 MS. HEBERLEIN: No, but I've been thinking about
13 1137 already, so thank you for flagging that.

14 CHAIR BELLA: Thank you, Tricia. Other
15 Commissioners?

16 COMMISSIONER MEDOWS: I think Tricia covered it.
17 We can all go home now.

18 [Laughter.]

19 COMMISSIONER BROOKS: I don't mean to shut people
20 up.

21 CHAIR BELLA: No, no. I mean, I think it's more
22 a reflection of you guys have taken a very big rule and

1 broken it down into commentable -- is that really a word? -
2 - actionable sections for us. You know, I'll take those
3 sections that Tricia didn't and just sort of say a big yes
4 on MSP and LIS and all of those changes. You know, it's
5 really nice to see an effort to bring non-MAGI and MAGI
6 together. Like that's been a long time coming. So I think
7 we're not hearing a lot of comment because you've done the
8 work.
9 Dennis, do you agree, or do you want to make any
10 comment?
11 COMMISSIONER HEAPHY: No. I'm really impressed
12 with the rule. I'm really amazed.
13 CHAIR BELLA: Martha.
14 COMMISSIONER CARTER: I'm still not ready to let
15 go of this timeline, people's response to, the time that
16 people have to respond to requests for information. I
17 know there's no research that says what is the best time,
18 but I think we can probably say that 10 days is not
19 enough, and that we support some extension of that time
20 frame. Can we go that far?
21 MS. HEBERLEIN: So the work we --
22 COMMISSIONER CARTER: Were you going to say that?

1 you weren't going to say that, were you?

2 MS. HEBERLEIN: I don't think I said it that
3 forcefully, but I think what we can pull from the
4 beneficiary focus groups that Tamara led as well as the
5 interviews with did with states and stakeholders, we heard
6 pretty consistently that 10 days was not enough. I know
7 you raised it in one of the PHE panels and other panelists
8 raised it, that 10 days was not enough.

9 So I don't think we can say that 15 is right or
10 30 is too much or it should be 45. Like I don't think we
11 have a basis for that. But I think we did hear
12 consistently in that research that 10 days was not enough.

13 CHAIR BELLA: Tricia and then Heidi.

14 COMMISSIONER BROOKS: It's just on the 10-day
15 issue. I think a tricky part that we've heard is that
16 states that try to align SNAP and Medicaid, and SNAP only
17 requires 10 days, still sends the notice for the joint
18 renewal to say you have 10 days. And yet states are
19 supposed to tell people how much time they have, what the
20 timeliness standards are.

21 And so another piece of this, at some point, is
22 for HHS to try to do a better job of aligning SNAP and

1 Medicaid, because that is still a big hole here in terms of
2 data-driven transactions and coordination. So just an
3 extra point.
4 CHAIR BELLA: Thank you, Tricia. Heidi?
5 COMMISSIONER ALLEN: Yeah. I just wanted to
6 endorse something that Tricia said about premiums post-
7 enrollment with a grace period. I think that's a really
8 strong suggestion, and I'm wondering if there's broad
9 enthusiasm for having that in our letter.
10 CHAIR BELLA: Comments from Commissioners?
11 COMMISSIONER HEAPHY: I thought that was a given.
12 I thought that was a yes. Yes?
13 CHAIR BELLA: Is anyone uncomfortable with
14 including that suggestion in our comments? Do we feel like
15 we have enough information, we know we understand the need,
16 the issue, it's been raised repeatedly as a problem?
17 COMMISSIONER BROOKS: Well, it's a problem. The
18 evidence base is a little trickier. I think the churn data
19 helped. You know, why would there be a gap for a kid to
20 move from Medicaid to CHIP or CHIP to Medicaid, and that
21 coordination piece is not working. But the premiums in the
22 Medicaid-to-CHIP area definitely are a problem.

1 What we don't have data on is what number of
2 children in states that are subject to premiums or
3 enrollment fees don't enroll in CHIP because the premium is
4 a barrier. I don't think those data are solid out there,
5 that we can pull from.
6 But certainly my experience in 14 years of being
7 a CHIP director is that that is a problem.
8 COMMISSIONER ALLEN: I'd like to follow up and
9 say that there is a very large evidence base looking at
10 enrollment in Medicaid to Marketplace, where premiums are,
11 to show a huge cliff in enrollment right at 138 percent of
12 federal poverty level, which was the whole impetus behind
13 the zero-premium plan. So I don't think we need to wait
14 for specific CHIP evidence. I think that there is
15 significant, robust literature on premiums for low-income
16 people and how that reduces enrollment.
17 And in this case, it's not that it's doing away
18 with premiums but it's giving people time to collect
19 themselves, and giving them a grace period if they don't
20 get in right away, which I think we're not even asking for
21 premiums to be abolished. We're just asking for it not to
22 impede enrollment.

1 CHAIR BELLA: I guess we are trying to be
2 consistent in how we think about evidence, and I'm not
3 saying we have to apply that here. I'm suggesting that we
4 ask Martha and Kate, take it back. I mean, we clearly want
5 to say something about this issue, and the saying-something
6 can be like we think it's an issue that needs to be
7 explored, or the saying-something can be you need to get
8 rid of this and do it this way instead. I think we need to
9 sort of have a moment to digest the comments and look at
10 our past work and what we know. But clearly, we can make
11 it something that we include in our comments.
12 Tricia?
13 COMMISSIONER BROOKS: So I think you can look at
14 the experience of the extended premium tax credits, which
15 are much more significant up to 150. So at some point
16 there was a determination made by CMS or HHS that indeed
17 150 was the marker. Heidi referred to them as the zero pay
18 plans. But I think that 150 mark has some evidence in that
19 action.
20 CHAIR BELLA: Martha, anything you want to say
21 here?
22 MS. HEBERLEIN: No, and I would just say I think

1 we can go back and look at the CHIP work that was done a
2 number of years ago, looking at premiums specifically in
3 some of the research pulled in for kids and see what else
4 we can maybe do to bolster that.
5 CHAIR BELLA: Heidi, anything else on that one?
6 COMMISSIONER ALLEN: No.
7 CHAIR BELLA: Okay. Thank you, Heidi and Tricia.
8 Other comments?
9 [No response.]
10 CHAIR BELLA: I we're going to get 28 minutes
11 back to use toward the comments for this rule, for us to
12 turn around quickly. Just last call from anyone, other
13 than to say it is a very complex, very thorough -- it's a
14 really strong rule, so kudos to the agency for putting it
15 out. But kudos to the team for making it so easy for us.
16 Typically we would wait to do public comment.
17 Someone had their hand up but the hand is gone.
18 Okay. We're going to move into the next session
19 then. We'll take public comment before our break.
20 Sean is back to talk to us about actuarial
21 soundness. So I will let him set the stage for how this
22 continues or is a variation from last month's conversation.

1 Welcome, Sean.

2 ### POTENTIAL CHANGES TO THE CONSIDERATION OF ACCESS
3 IN ACTUARIAL SOUNDNESS

4 * MR. DUNBAR: Thank you. Let me just get this set
5 up here. Sorry.
6 All right. Thank you, Melanie. Good afternoon,
7 Commissioners. For this session I look forward to
8 continuing our discussion on managed care rate setting and
9 getting the Commission's input on the ways in which access
10 is treated in the capitation rate-setting process.
11 Today I'll provide an overview of what we
12 discussed during the September public meeting and also
13 provide some background on the context for access as it
14 relates to managed care rate setting. I'll also present a
15 number of findings with respect to access which stem from
16 our prior work. We'll then spend some time getting your
17 feedback on potential areas for consideration that can
18 inform our response to anticipated rulemaking on access
19 once it's released.
20 At the September meeting, the Commission reviewed
21 findings from work to date on rate setting and risk
22 mitigation in Medicaid managed care. This included

1 findings from an expert roundtable on risk mitigation, a
2 study on rate-setting practices and actuarial soundness,
3 and research into managed care directed payments, as well
4 as some follow-up research that staff did in the policy
5 areas where Commissioners had indicated interest during
6 these presentations. That research provided some specific
7 insights into the role of access in rate setting that we'll
8 discuss shortly.

9 We also highlighted anticipated rulemaking from
10 CMS that will address several areas covered in this rate-
11 setting work, including access, directed payments, and in -
12 lieu-of services.

13 While we don't know what specific policy options
14 the administration will propose, Commissioners were
15 interested in further analysis and discussion on these key
16 areas. Today's discussion will focus specifically on the
17 role that access plays in rate setting and actuarial
18 soundness requirements, including state use of directed
19 payments.

20 To level-set for today's discussion, I'd like to
21 highlight some of the key findings -- well, key components
22 underpinning the managed care rate-setting process that

1 have some implications for access.

2 First, the 2016 update to managed care
3 regulations made a number of changes to the rate-setting
4 process. This included creating an expanded definition of
5 actuarial soundness and putting in place new requirements
6 for rate development and documentation. On a more
7 fundamental level, it was also the first time that access
8 and payment were linked.

9 In 2020, another round of updates to managed care
10 rules made some additional adjustments such as letting
11 states change rates by about 1.5 percent without submitting
12 a revised rate certification to CMS and making other
13 changes to risk mitigation mechanisms.

14 Actuarial soundness requirements provide states
15 and their actuaries with standards for how rates should be
16 constructed. Generally, rates must be projected to provide
17 for all reasonable, appropriate, and attainable costs that
18 are required under the terms of the contract, including
19 operation of the MCO, for the time period and populations
20 covered.

21 States and their actuaries must certify that
22 capitation rates meet this threshold, along with a number

1 of other key rules. Rates also need to be adequate to meet
2 all special contract provisions like directed payment
3 arrangements.

4 CMS also issues subregulatory guidance in a
5 variety of forms to continue to assist states and their
6 actuaries in understanding rate setting and actuarial
7 soundness requirements.

8 The annual rate development guide includes rate
9 development and documentation specifications for the rate
10 certification. For example, it describes the type of
11 information and level of detail that states must provide to
12 support projected benefit costs and trends. However, it
13 does not specify parameters that state actuaries must stay
14 within.

15 Directed payments also have implications for
16 access given that many states look to these arrangements as
17 a way to bolster access for beneficiaries. States must
18 incorporate the directed payment arrangement into managed
19 care contracts and capitation rates after they're approved
20 by CMS.

21 Lastly, professional actuarial guidance plays a
22 role from the application of generally accepted actuarial

1 methods to the guidance provided in the actuarial standards
2 of practice, or ASOPs, regarding the procedures that
3 actuaries need to follow to fulfill actuarial soundness
4 requirements.

5 Our interviews with states, actuaries, health
6 plans, and CMS identified several key themes related to the
7 role that access plays in managed care rate setting that
8 can help inform the Commission discussion today.

9 First, one takeaway from our prior work is that
10 state and federal processes focus on whether rates provide
11 all reasonable, appropriate, and attainable costs. But
12 current rules and guidance don't address how states and
13 their actuaries should demonstrate that actuarially sound
14 capitation rates are adequate to meet access and network
15 adequacy standards. Changes in the 2016 managed care rule
16 required that actuarially sound capitation rates must
17 ensure that MCOs can meet other regulatory requirements
18 regarding availability, capacity, and coordination and
19 continuity of care. But there's no specific mention in the
20 rule for how states should account for access in rate
21 setting or document compliance with these requirements
22 beyond the actuaries' assurance that the rates are

1 compliant with the rule.

2 This differs from other aspects of the rule which
3 define many of CMS's rate development standards in detail,
4 for example, standards for base data, projected benefit
5 expenses, and the development of trends, to name a few.

6 Furthermore, the annual rate development guide
7 does not indicate what documentation states must submit to
8 demonstrate compliance with actuarial soundness. In fact,
9 none of the rate certifications reviewed by MACPAC during
10 its rate-setting studies included explicit reference to
11 analyses to evaluate access to care or network adequacy.

12 In addition to being quiet on requirements for
13 how capitation rates relate to access and network adequacy,
14 federal rules and guidance, as well as some professional
15 actuarial guidance, are not clear on the extent to which
16 efforts to improve access could be factored into rates. In
17 other words, states and actuaries don't have guidance on
18 how they could appropriately adjust capitation rates to
19 account for access concerns. One example of this relates
20 to base data.

21 CMS has noted the importance that base data and
22 utilization assumptions play in ensuring that rates are

1 adequate to meet access and continuity of care for
2 beneficiaries. However, data oftentimes may not capture
3 unmet health needs, barriers to care, beneficiary
4 perceptions of care, or self-reported health status. Data
5 may not also capture services and supports that have a
6 meaningful effect on the health and well-being of
7 beneficiaries. As a result, capitation rates based on
8 these data may not reflect the level of access necessary to
9 meet the needs of beneficiaries.
10 Rules and the annual guidance don't speak to how
11 issues like this can or should be addressed, such as how
12 actuaries should account for access and continuity of care
13 when evaluating data.
14 Another finding was that professional guidance
15 doesn't necessarily indicate how actuaries should account
16 for access. Actuaries use professional discretion in
17 developing adjustments to capitation rates during the rate-
18 setting process with the ASOPs helping to guide actuarial
19 judgment. Professional guidance like the ASOPs are
20 particularly important when federal rules and guidance rely
21 on actuarial judgment to determine what is reasonable,
22 appropriate, and attainable, such as estimating trends and

1 administrative costs.

2 However, the ASOPs don't speak to access to care,
3 care continuity, or network adequacy standards. For
4 instance, actuaries don't have guidance on how they should
5 determine whether the underlying data used to calculate
6 rates represent adequate access.

7 During interviews, we asked states if they
8 examined whether managed care rates are adequate to allow
9 plans to comply with network adequacy and service
10 availability requirements or if they use any special
11 payment approaches to incentivize plan investments in
12 access improvements. Most states reported using contract
13 provisions and network standards to address access and do
14 not use the annual rate-setting process to address specific
15 access issues. States consistently reported that the rate-
16 setting process does not explicitly consider whether
17 capitation payments are sufficient to ensure MCOs can meet
18 network adequacy and access to care requirements.

19 Another finding across MACPAC's projects is that
20 it's not clear whether or how states align the goals of the
21 directed payment arrangements with other requirements
22 related to actuarial soundness. Current rules and guidance

1 don't address how states or their actuaries should
2 demonstrate that actuarially sound base capitation rates
3 and directed payments together meet access standards.
4 State actuaries noted in interviews with staff that in most
5 states they're not involved in determining the amount of
6 directed payments submitted in the preprint. Furthermore,
7 during the rate-setting process, there is little for an
8 actuary to review regarding the reasonableness and
9 appropriateness of the directed payment amount because the
10 amount has already been approved by CMS as part of the
11 preprint review.

12 Also, the ASOP related to Medicaid managed care
13 doesn't address how actuaries should account for directed
14 payments when assessing whether rates or special payments
15 are sufficient to ensure access to services in a timely
16 manner.

17 It is also unclear how CMS assesses directed
18 payments in light of actual soundness standards. In
19 practice, CMS actuaries rely on the states' actuarial
20 certification of the sufficiency of the overall capitation
21 rates. Also, the CMS actuarial review of directed payments
22 focuses mainly on checking for consistency with the

1 approved preprints.

2 Now I'd like to transition to the discussion for
3 today.

4 This slide provides a handful of questions for
5 the Commission's consideration on access as it relates to
6 the rate-setting process and actuarial soundness standards.
7 Our research shows that while federal rules incorporate the
8 consideration of access and the definition of actuarial
9 soundness, there is little guidance on how states,
10 actuaries, or CMS consider access as part of the rate
11 development, certification, and approval process.

12 Commissioners may want to consider whether the
13 current actuarial soundness requirements are sufficient.
14 For instance, should states be required to do more to
15 demonstrate that they have considered whether capitation
16 rates are sufficient to ensure access and document this in
17 the rate certification? Or should access monitoring be
18 separated from rate oversight altogether?

19 Another area for discussion is whether CMS could
20 consider a range of potential approaches to changing how it
21 examines whether capitation rates are sufficient to ensure
22 MCOs meet access and network adequacy requirements. For

1 example, should states note any access issues that were
2 explicitly taken into account when setting rates? Should
3 states be required to assess whether any gaps in access
4 were reported in the prior rate period and demonstrate how
5 the current rate certification addresses those?
6 With CMS poised to look at new requirements for
7 access measures with respect to rates, what do the
8 Commissioners think CMS should keep in mind when it comes
9 to potential considerations, such as how to reflect unmet
10 need and account for underserved areas or potential effects
11 like the impact any changes may have on budget neutrality
12 or state share requirements?
13 Another question to consider is whether any
14 additional changes should be made to directed payments to
15 address gaps identified in MACPAC's research, such as the
16 lack of guidance for how states should demonstrate that
17 base capitation rates and directed payments together meet
18 access standards?
19 The Commission previously voted on
20 recommendations in the June report but could provide some
21 more specific comments in response to the proposed rule.
22 Commissioners could also address what the

1 potential implications are for any changes to requirements
2 for complying with actuarial soundness, such as potential
3 additional burdens on states, effects on the timeline for
4 rate reviews and approvals.

5 As for next steps, I look forward to hearing your
6 thoughts on the material presented today, including any
7 priority areas you'd like staff to take note of and any
8 areas where you think additional digging needs to be done
9 ahead of the proposed rule. Staff will use the takeaways
10 from this discussion when preparing a draft response to the
11 proposed rule. Also, I wanted to flag that our next
12 discussion will focus on in-lieu-of services with respect
13 to rate setting.

14 During the discussion today, please remember that
15 our goal is to help the Commission think about where it may
16 be interested in commenting on access as it relates to
17 actuarial soundness standards and capitation rate setting.
18 The Commission doesn't need to take a position on the
19 issues until the rule is released.

20 Although this work is geared towards preparing
21 Commissioners for potential comments, it certainly doesn't
22 preclude the Commission from making any recommendations it

1 would like to make regarding managed care rate setting,
2 either in this report cycle or the next.
3 Now I will tee up those questions so you have
4 them in front of you, and, Melanie, I can hand it back to
5 you and the Commission for discussion.
6 CHAIR BELLA: It feels like a big one. Thank
7 you, Sean.
8 So I want to reiterate we know there's going to
9 be a rule coming out. We know we need to talk about some
10 things that are going to leave us well positioned to
11 comment on the rule. We know there are things that the
12 Commission is going to be interested in that are outside of
13 that rule that we're not going to be able to discuss in
14 detail or solve today, and so I don't want anyone to feel
15 constrained by not being able to sort of mention what's on
16 their mind, but I do want to create realistic expectations
17 that some of those things may be parking-lotted and brought
18 back while we kind of focus on some of the specific things
19 related to access and actuarial soundness in this context
20 for the purpose of a rule coming out.
21 So I just mean this is like a massive can of
22 worms that we're about to -- what do you do? I don't even

1 know what to say. And so let's keep that in mind. Let's
2 keep in mind that certainly we don't want to cut off
3 anything that people have in top of their mind, but I want
4 to create realistic expectations that we might not get to
5 all of that and where we would like to get some discrete
6 feedback are on the questions and the areas that Sean has
7 put up on the board.

8 Now, would it be too cliche if I go, Jenny, to
9 you first and have you kick us off?

10 COMMISSIONER GERSTORFF: Thanks, Melanie. So,
11 first, I just want to say, Sean, I thought you did an
12 excellent job in putting the materials together. It really
13 -- the briefing highlights the concern, and I felt like,
14 you know, very spot-on. And I'll kind of start by saying,
15 you know, as you highlighted, it's really a partnership
16 between the state and the actuaries to get to capitation
17 rates, and access is not one that the actuaries do a lot of
18 specific analysis that's defaulted. But when states do
19 identify access issues, then that comes into the
20 conversation for setting capitation rates, and we will
21 conduct analysis and do surveys and collect information
22 from plans and providers and make adjustments as

1 appropriate.

2 I think the lack of guidance specifically for the
3 documentation makes it hard to find in a rate certification
4 where that might be happening, so, you know, proposing to
5 CMS that the update their guidance to have a dedicated
6 section where we're responding to how rates might be
7 adjusted for access could be helpful.

8 And then so states are required to submit all
9 kinds of network adequacy information to CMS, and there's a
10 recent template that CMS put out to collect that
11 information on a more standard basis. And part of that
12 reporting, they have to identify if there are any
13 corrective action plans to address access issues that have
14 been identified. And that information is not always
15 communicated to the actuaries. So I think recommending or,
16 you know, encouraging that states have that on their radar,
17 that this is important for actuaries to be considering and
18 to help them quantify if there's a rate impact.

19 CHAIR BELLA: I'm sorry. Can you say that again?

20 COMMISSIONER GERSTORFF: Which part?

21 CHAIR BELLA: The part that you're not seeing or
22 that's not communicated to you. Can you give an example?

1 COMMISSIONER GERSTORFF: So if a state finds that
2 a health plan has an access issue, their network is not
3 adequate in some way, they will develop a corrective action
4 plan with the health plan. And so if they have identified
5 that and they have a corrective action plan, those are not
6 always communicated to the actuaries, but that information
7 is tremendously helpful in understanding what is underlying
8 the historical utilization that we have that's the basis of
9 our rate and how we might need to adjust it so that the
10 rates are adequate in the future and not just continuing to
11 reflect that disparity.
12 CHAIR BELLA: So there's low utilization in some
13 category of service for a certain plan and the state is
14 seeing that there's a cap. So what you're seeing in the
15 rate data is a much lower payment level and utilization
16 level than you would expect to see once the cap was
17 satisfied and the access issue is completed?
18 COMMISSIONER GERSTORFF: Exactly.
19 CHAIR BELLA: Okay. And do you then -- are there
20 best practices, are there states that are doing some of
21 that?
22 COMMISSIONER GERSTORFF: Yeah, I think the level

1 of communication between states and their actuaries varies
2 tremendously. Some states are much more integrated, and
3 they will -- even within the state, sometimes, you know,
4 finance and policy will be separated. And so when they get
5 too siloed, that tends to be where the actuaries are not
6 getting as much information as would be helpful.
7 CHAIR BELLA: That's really helpful. Thank you.
8 Any more comments for Sean at first pass? I'm
9 going to circle back to you to do cleanup, too.
10 COMMISSIONER GERSTORFF: Sure.
11 CHAIR BELLA: Okay. Sean?
12 MR. DUNBAR: Can I ask Jenny one quick follow-up
13 question? So is that template that the states submitted to
14 CMS and they just may not be sharing it with the actuaries
15 at the same time?
16 COMMISSIONER GERSTORFF: So it just came out
17 recently, and it hasn't been submitted to CMS yet. I think
18 that states have to start submitting it along with rate
19 certifications on -- that are submitted on or after this
20 October. So it's a brand-new thing. I don't -- so I
21 assume that actuaries will be seeing this as well because
22 it will be submitted with the certification, but there's no

1 guarantee to that, and how far in advance it will be
2 prepared and ready for actuarial review.
3 MR. DUNBAR: Thanks.
4 CHAIR BELLA: Rhonda, then Darin, then Angelo,
5 then Heidi, then Laura.
6 COMMISSIONER MEDOWS: So, Sean, that was
7 fantastic. You did a great job. And I want to say that my
8 answers to the questions, very good questions, posed are:
9 number one, no; number two, yes; number three, defining
10 access in a much better way, that is probably the primary
11 opportunity, right? So it's not just a number of people
12 providers that you have in your network, but whether or not
13 they actually have available appointments within an
14 appropriate time frame and whether or not people can
15 actually get to them in terms of geography. So number five
16 is yes, and then number six is there's an opportunity for
17 the plans and states to work together on those places where
18 there is a network deficiency that needs to be addressed
19 that goes beyond just being able to negotiate rates or
20 negotiate all those other things. There's simply not
21 enough of that particular specialty that's available, so
22 coming up with creative solutions to fill those holes.

1 But that's my humble contribution to the
2 questions. I think this is really well done and well laid
3 out.
4 MR. DUNBAR: Thanks. That's helpful feedback.
5 CHAIR BELLA: Thank you, Rhonda. Darin?
6 COMMISSIONER GORDON: Yeah, Sean, thank you for
7 this. I do think what Jenny said, she talked about the
8 state level, but I think it's also, you know, pretty clear
9 based on all of the discussion that it also exists at the
10 federal level, where you have access compliance and access
11 reporting going to CMS through one channel, you have rate
12 development and rate review going through a different
13 channel. But at the state level those are occurring,
14 although Jenny is right, in some cases that bridge is
15 connected at the state level. But it sounds like we've got
16 a solid first swipe at the federal level as well.
17 I think from just trying to break down that wall
18 is like step number one, kind of to Jenny's point that
19 information around the compliance with network adequacy or
20 network deficiencies should be provided. You know, what's
21 provided at CMS should be provided to actuaries as part of
22 their review. But also instead of creating -- it doesn't

1 even sound like step one is like let's create all this new
2 stuff. It's requiring that we're connecting dots of stuff
3 that's already required to be reported currently.
4 Because I think if actuaries have that
5 information, I think that will at least create the dialogue
6 or the questions that actuaries can present to the state as
7 they're reviewing the data in order to make sure that
8 they're not ignoring those issues. It just helps ensure
9 that there are probably fewer opportunities for things to
10 be missed.
11 And to one of the points that Rhonda makes, I
12 think one thing we all have to be cognizant of is not
13 always rate that is an issue as it relates to access. In
14 some cases it's the non-existence of certain provider types
15 in certain areas of your state. But, you know, with that
16 said, I think actuaries and states can have that discussion
17 and figure that out.
18 The other area where it feels siloed off, and
19 we've talked about this as a Commission multiple times, is
20 the directed payments. And in our broader definition of
21 directed payments, I mean, some of that is addressing
22 access issues. Whenever a legislature is increasing rates

1 by X percent for a particular provider class, that could be
2 in response to a network issue or to ensure continued
3 access.
4 So I think those two areas, there are already
5 channels, there are already expectations on reporting, in
6 that if we are to encourage or to suggest that that
7 information is provided to actuaries as part of the rate-
8 setting process so that the actuaries can take that into
9 consideration. You know, I've always said actuaries are
10 great. They are as great as the data they get. And if
11 we're omitting two large pieces of information then we're
12 going to get less than ideal outcome.
13 So those are my comments.
14 CHAIR BELLA: Thank you, Darin.
15 Sean and Kate, you know we like graphics, and so
16 I see a diagram coming up which is like information that
17 access monitoring information that's going here, and rate
18 information that's going here to CMS, and then what's going
19 from the state to the actuaries. And it begins to show a
20 picture about this need to connect the dots, and, you know,
21 is it a question of that we don't have what we need or that
22 it's not getting to the right places and there is not

1 enough transparency. And at some point, the plans and
2 providers become part of that picture as well, I think. So
3 thank you for those comments.
4 Angelo, then Heidi.
5 COMMISSIONER GIARDINO: So I'll echo everybody's
6 thought about Sean. That report was great. It was really
7 instructive. It really could be a thesis, I think, as it
8 was really instructive.
9 I just wanted to make a couple of comments. I
10 don't know where to go with this. But it seems to me, in
11 the last couple of sessions, actuarial soundness is a very
12 important element to managing a big program like Medicaid,
13 but it's really a macro assessment. It's a lot of stuff
14 that rolls up, and then a plan is deemed actuarially sound.
15 And I think I'm more interested in more what's happening at
16 the micro level, and maybe that's what Darin was getting
17 at. But I don't know how all the micro level kind of gets
18 attached to rollup.
19 So you can have an actuarially sound plan and it
20 doesn't have great network adequacy. It doesn't really
21 have all of the types of providers you want seeing the
22 patients, and the beneficiaries don't always get to see,

1 for example, the primary care provider that they want. So
2 in my community, families like to go to the private
3 practices to get their primary care. But the kids of
4 Medicaid can't do that. So there are a few big
5 institutional providers that they have to go to, and the
6 commercially insured individuals and others can go where
7 they want.
8 To me that micro issue, maybe actuarial soundness
9 is irrelevant to the issue that I'm interested in, which is
10 that the beneficiaries get to see the providers they want
11 to see in their own community. So I don't know where to go
12 with that. But I'm not sure actuaries are the people that
13 really are the ones that have to weigh in if the
14 beneficiaries are adequately served at the primary care
15 level. That may be too micro, and maybe that's somebody
16 else's responsibility.
17 My concern is that access to the primary care
18 providers is so downstream that in the actuarial soundness
19 calculation it gets washed out. So I kind of think
20 actuarial soundness is an important element to program
21 management, but it's really irrelevant to the beneficiaries
22 getting the services that they want from the providers that

1 they want. And so I don't know if that's part of this
2 discussion or not. But I understand you have to have
3 actuarial soundness. A lot of actuarially sound plans are
4 not delivering the services that I want to see going to the
5 beneficiaries. So again, I kind of think it's true, true,
6 and unrelated.
7 CHAIR BELLA: Sean, anything you want to say to
8 that?
9 MR. DUNBAR: Yeah. That's helpful feedback, and
10 I understand the different separation I think you're sort
11 of talking about. But, I mean, without knowing what will
12 be in the rule it's a little bit hard to project, but I
13 think there is something to be said about how do you make
14 any adjustments or something to reflect those kinds of
15 issue in rate setting. I don't know what the right answer
16 is, but if there are areas where you know there is some
17 sort of level of unmet need or underserved areas, are there
18 ways to think about that?
19 COMMISSIONER GIARDINO: Yeah. So can I throw
20 something out? During the ACA there was a period of two
21 years where the primary care providers had parity with
22 Medicare, and as you know in many states Medicaid primary

1 care rates are much less than Medicare.

2 So there was this natural experiment. I assume
3 there was some health services research done on that. I
4 just wonder if looking at when you enhance rates, does it
5 wash in any primary care providers? That, to me, would be
6 compelling information.

7 Now again, that was only two years so people had
8 enough common sense to know a former relationship with my
9 patients for two years and then the rates go back, so maybe
10 then I have to abandon people.

11 So I don't know how good that experiment was, but
12 I'd love to see some work that informs whether or not rates
13 do pull in some of the providers that traditionally have
14 not wanted to be in the Medicaid program. Clearly the big
15 institutional providers always come in. The safety net
16 providers come in. The academic centers come in, and there
17 are reasons why. But the more kind of people in the
18 community who have practices tend not to come into Medicaid
19 because at least at the very low level, it's actuarially
20 sound but at the very, very low level that Medicaid rates
21 are not enough to pay for their practices.

22 MR. DUNBAR: It's been a while since I've looked

1 at the evidence, so how research is studied, those impacts
2 of the payment bump. So I'd have to take a closer look at
3 that and maybe get back to you.
4 COMMISSIONER GIARDINO: Thank you.
5 CHAIR BELLA: Well, I think we have talked about,
6 just refreshing all of us, on what the findings were. If I
7 remember correctly, we all wanted, I think, the findings to
8 say that was a silver bullet. I'm not sure that's what the
9 findings said, or else there were some limitations. And so
10 it would be helpful to know this.
11 I do want to make sure that there's actuarial
12 soundness, there's rates, and there's access, and there are
13 more things than just rates influencing access and people's
14 willingness to participate in Medicaid. And just making
15 sure that we're keeping those things separate, I think, is
16 going to be really important.
17 We are always keeping an eye on access, and
18 access has many different layers. And so this is one piece
19 of that. So, Sean, please try to keep what we're talking
20 about, kind of keep them bucketed into the bigger access
21 and then sort of the more narrow pieces that the levers
22 might contribute to that access, please.

1 MR. DUNBAR: Yes, certainly.

2 CHAIR BELLA: Darin, you had a question. Is it

3 on this or is it on something else, in which case --

4 COMMISSIONER GORDON: It was a follow-up just

5 with Jenny real quick, because it's kind of hitting the

6 point that you just made.

7 Jenny, you could have an actuarially sound rate

8 for a health plan and there still exists this access issue,

9 I mean, from a Society of Actuaries. Is that a fair

10 statement?

11 COMMISSIONER GERSTORFF: Yes.

12 COMMISSIONER GORDON: Okay. So I think it's

13 getting to the point I think you articulated, Melanie. But

14 I just wanted to make sure that that was the case.

15 CHAIR BELLA: If feels like you were on cross-

16 examination, and Jenny said yes. Okay. Thank you.

17 Heidi, then Laura, then Fred.

18 COMMISSIONER ALLEN: Melanie, you told us you

19 wanted us to stay lively this afternoon, and so I'm going

20 to be a little lively because I really disagree. I've

21 heard the argument so many times -- well, it's not really

22 rates. It's X, Y, and Z -- and they do point to the fee

1 bump literature to show that the temporary fee bumps were
2 not that effective in inducing providers to participate.
3 But this is kind of like Uwe Reinhardt's article
4 about why U.S. health care prices are higher than any other
5 country, "It's the Prices, Stupid." Absolutely, if we paid
6 commercial rates across the board, access would be
7 different in Medicaid. Like that is just so obvious that
8 some of this is dancing around it. And I actually think
9 some of these very targeted little efforts that we make are
10 not good experiments because they assume that providers are
11 too nimble enough to respond to them, and that they believe
12 that they're going to be sustained in a way that makes it
13 worth to startup participation in Medicaid.
14 And if I were a provider, I wouldn't believe
15 that. You know, these are often very small bumps, they're
16 often very temporary bumps, and I don't know that they're
17 sufficient to really, truly change providers' behavior.
18 And I'm not saying that I disagree with the fact
19 that there are additional burdens with serving a Medicaid
20 population, whether they be the complexity of the patients
21 or the bureaucracy. Yes, and yes. However, we're not
22 afraid of complexity when it comes to cancer centers. Like

1 if the payment is right, the providers will build a whole
2 center around it, and there will be fountains and marble
3 lobbies.

4 I feel like this is such a fundamental source of
5 disparities that Medicaid pays less than other providers,
6 and I feel like, you know, what I would like to see is an
7 expert panel talking about ways of benchmarking. I know
8 it's complicated. I know that it's difficult. You know,
9 you might have to look within plans, like plans that serve
10 multiple payers, is there the same access for Medicaid as
11 there is for other payers in those plans? Maybe you have
12 to look across states, the states that are more generous.

13 But this is empirical. We can observe this. And
14 we can look at T-MSIS data to see if providers that say
15 they're participating in Medicaid are actually
16 participating in Medicaid. That's more along the network
17 adequacy.

18 But I would really like to see benchmarks for
19 access. I feel like access is one of those things that
20 everybody is responsible and nobody is responsible for.
21 There are all of these levers, and everyone points to the
22 other lever as being something that we should look at. And

1 yet if you talk to a Medicaid beneficiary, I mean, you
2 could randomly select them out of the hat, in any state in
3 this country, and you ask them what the biggest issue is
4 with Medicaid, they're going to say that it's access. It's
5 clearly something that all of the levers need to be
6 addressing.

7 I made a couple of notes around directed
8 payments, which I think are an important strategy,
9 particularly because they're directly targeting different
10 types of changes you want to see. It seems to me like it
11 would be important to have actuaries participate in the
12 setting of those directed payments, how much they're going
13 to be rather than just finding out later what they are.
14 And it also seems like actuaries should be able to look at
15 the data, see the increase in payments reflected in the
16 data to make sure that they are actually being used as they
17 said they would be, but also that they reflect the change
18 in utilization so that they work. And that's a missed
19 opportunity. Not having that in the regulations or the
20 guidance is a missed opportunity to really learn from this.

21 And if actuaries aren't determining if rates are
22 sufficient for access, who is? That's my question.

1 So I hope I, you know, got everybody else as
2 fired up as I am.
3 CHAIR BELLA: Laura. Thank you, Heidi.
4 COMMISSIONER HERRERA SCOTT: So I'll echo several
5 of the comments that were made, but specifically around
6 Question 3 and just thinking about the proposed rule that
7 we just heard about and the ability to leverage information
8 and data from one federal agency, for another federal
9 agency to streamline purposes. As we think about the data
10 that actuaries need to assess whether access is met or not,
11 whether we can look to HHS, and HPSA designations, which
12 are the health professional shortage areas, and what are
13 the criteria that they use to designate a site as HPSA for
14 network adequacy, that there's lots of them, you get loan
15 repayment to encourage docs, but could we use something
16 like that.
17 And this one's a little bit more fluffy, but
18 thinking about the work that the CDC has done on
19 vulnerability indexes, and whether or not something like
20 social drivers and something like that could be leveraged
21 to do risk adjustment in the capitation process as you
22 think about. So not all 15- to 20-year-olds are created

1 equal, but if you live in this ZIP code your access and
2 other health care needs -- pollution, if you're asthmatic,
3 you know, everything else -- is going to be different than
4 if you lived in another ZIP code.
5 You know, I worked at the Health Department years
6 ago. We did this in Baltimore City probably in -- I don't
7 even remember what year -- mid 2000s, 2004, 2005, that
8 showed a life expectancy difference of 20 years based on
9 which ZIP code you lived in. So could we use some of that
10 work to risk adjust as part of that access issue, thinking
11 about what the needs of the community are.
12 And, you know, we have two federal agencies that
13 have done a lot of work in this space and could that be
14 brought into 3 as we think about what else should we be
15 measuring to assess whether access is adequate?
16 CHAIR BELLA: Thank you, Laura. Fred?
17 COMMISSIONER CERISE: Well, those last two were
18 great comments. And I know we're not talking about the
19 rates but I can't help commenting on Heidi. I mean, we do
20 all of this. We've got Medicaid rates that say, you know,
21 this is what we're going to pay, and the federal government
22 has set these rates, and most people will do that, although

1 some people are saying that's not enough. And then we set
2 Medicaid as a percentage of that, and it just implicitly
3 devalues the care for the poor because it says we'll pay X
4 percent of Medicare.

5 So I know that's another conversation, but
6 because I do appreciate that, that's not the same as
7 actuarial soundness, how that gets down to the payers. But
8 in some sense, it's not that complicated.

9 And when you look at all the layering that we do,
10 we take a base and then we put a supplement and a
11 supplement and a supplement, and you add it up -- and I'm
12 thinking of Rob's old chart that shows that in a lot of
13 cases that ends up getting above Medicare, when you take
14 into account all the add-ons.

15 And so one thing that we could consider is,
16 looking at the actuarial soundness, that component, and
17 then the directed payments. We've had this discussion
18 around other supplemental payments. Could you just start
19 with transparency of payments, say what does the total
20 package look like, whether you do that by provider category
21 or however you break that down in some aggregate classes.
22 But what does the total package look like?

1 I do think that there's a role for directed
2 payments, because the state's going to have interests in
3 addressing these pockets of need. And I love the point you
4 just made, Laura, how we do know. I mean, complex cases,
5 complex patients, complex populations, they need systems of
6 support, and it's less likely to be able to sort of
7 navigate all of the needs without some kind of
8 infrastructure support is going to be as effective.
9 And so I guess I would look at what those
10 directed payments are intended to do and to be more
11 explicit about that. You know, if there's a specialty
12 service gap then show that you're addressing that with
13 those directed payments.
14 So that's my main comment around that. I do have
15 one other specific question, I guess, and it's around rate
16 setting and addressing pockets of need and the impact on
17 budget neutrality. I don't know if I saw this in the
18 write-up or not, but I understand a few states are looking
19 at that issue. You know, if I know for years I've been
20 underpaying the workers in home and community-based
21 services, and as a state I'm ready to address that and
22 raise that, a state maybe hasn't had to do that if that's

1 going to have a negative impact on budget neutrality. And
2 so what is CMS's kind of leaning or position on loosening
3 budget neutrality to address some of these longstanding
4 base rate shortfalls that they want to address?
5 MR. DUNBAR: That's a good question. I think I'd
6 want to spend some time looking at that a little bit more,
7 not knowing offhand how CMS might feel about that. But I
8 think there was something in Vermont's recently approved
9 1115 waiver, where I think they were given permission to
10 increase provider rates, even if it went above their budget
11 neutrality cap. But I'd need to take a look at that a
12 little bit closer, as an example.
13 CHAIR BELLA: Thank you, Fred. Tricia?
14 COMMISSIONER BROOKS: Thanks, Sean. So I don't
15 disagree that rates matter, but I think there is also a
16 cultural aspect, particularly in different provider types.
17 I don't see that in primary care or community health
18 centers the way I see it in other areas. So, you know, I
19 think it's been alluded to that we could set the rates at
20 100 percent of usual and customary and we're not going to
21 bring in every provider. So it's just an issue we have to
22 take into consideration.

1 However, I don't totally agree with Heidi that
2 every Medicaid enrollee has a problem with access because
3 there are tons of surveys that show that people are very
4 satisfied with their care, that they do believe that it has
5 enhanced their usual source of care.
6 So I think the issues with access are in
7 different pockets, and I'm not sure that we really
8 understand what those pockets are.
9 That's where we need to have a better sense of --
10 we know that there's issues with rural access. Well, short
11 of funding a community health center in a rural area, what
12 are managed care companies or Medicaid going to do to
13 mandate that this type of provider go to this place? And I
14 think this is where we've recognized that time and distance
15 standards may not be the best way to measure access, that
16 sometimes it's about do I need urgent, do I need emergency
17 care, do I need acute care, do I need follow-up care, and
18 I'm able to get that care in the timeline that is necessary.
19 I also think as we, you know, dive more into
20 access in the future that we have to try to start to
21 anticipate what are growing workforce shortages. I mean,
22 the workforce is not only not getting better, but it's

1 going to potentially get worse in the near future. And
2 where is it going to get worse, and where do we have to
3 focus some of our efforts there to shore up access?
4 So just a few thoughts to throw into the mix.
5 CHAIR BELLA: Thank you, Tricia.
6 I want to make one last comment and then turn it
7 back to Jenny.
8 I want to go back to -- I appreciate the fire
9 rousing, Heidi. I think the point some of us are trying to
10 make is it's not going to solve the problem just by
11 throwing money at it. We could throw money at it, and the
12 providers that don't want to see Medicaid folks are going
13 to offer to see them on a different day or in a different
14 room. We do need to step back and treat it like the way
15 Tricia said and look at the pockets, and we're talking --
16 many conversations we have in this for this Commission talk
17 about access. And this one is in the payment or actuarial
18 soundness context, but we really do need to be able to step
19 back and look at access across the program and all the
20 different places that it touches.
21 And so it's really just thinking about the
22 various levers, and access is much bigger than payment.

1 Again, we run up against it in many of the things that we
2 discuss here, and so I think that is what some of your
3 fellow Commissioners are saying, not that payment isn't an
4 answer, but I don't think anything has said it is the
5 answer. And just throwing money at it doesn't seem to be
6 the most prudent thing we could be doing in terms of trying
7 to actually solve some of the root causes.
8 Back to Heidi. Heidi, then Sonja, then Jenny.
9 COMMISSIONER ALLEN: I will concede that primary
10 care access is largely good, but I don't think specialty
11 access is good. And I think that's where the prices are
12 higher, and there's fewer providers. So they're able to
13 demand higher prices.
14 And I think that in terms of primary care, there
15 is a lot of good access, and people do have good
16 experiences, but when they need something else, including
17 dental and mental health as two stand-out examples, they
18 really, really struggle. And I've found that in all of my
19 access research. I've never found -- in fact, the study
20 that I did in Colorado that looked at just above and below
21 138 percent of federal poverty level of people going into
22 marketplace, even with marketplace having so much higher

1 cost sharing, there were more outpatient visits. People
2 had better access in marketplace, and it was very
3 expensive. So it was at a really high cost, and I don't
4 think -- I don't think that throwing money at it is a
5 solution.

6 I also agree that in the areas where we pay more
7 than Medicare, it's not obvious that we pay more than
8 Medicare, and I think that we're assuming a lot of really
9 sophisticated thinking on the part of small providers that
10 they understand what it means to serve a Medicaid
11 population in terms of what they get paid. And it's really
12 hard to understand with all of these different layers of
13 payment and the way that they change, whether it's just
14 like temporary fee bumps or temporary incentives.

15 But I would stand by that money in this case
16 really, really does matter, and if we really want to see a
17 country where we don't have three tiers of payment of
18 commercial, Medicare, and Medicaid, we do have to look at
19 the fact that we just pay less.

20 So that's my overall kind of point. We can
21 always look to examples of, no, in this case, it's a
22 bureaucracy, or, no, in this case, it's the complexity of

1 the patient, or in this case, they're well served. But I
2 think, in general, rates really do matter for access.
3 CHAIR BELLA: Thank you Heidi. Sonja, then
4 Dennis.
5 COMMISSIONER BJORK: Well, Thank you. I just
6 wanted to follow up on Laura and Fred's comments about
7 looking into how we might be able to have some
8 consideration in actuarial soundness about social
9 determinants of health.
10 If a community is very, very, extremely economic
11 disadvantaged or they've suffered from fires or hurricanes
12 and have been wiped out for several years and a slow road
13 to recovery, how can we consider that as we do the
14 soundness evaluation?
15 And then the second thing is, how can we also
16 come up with some way to look at the creative solutions
17 that happen that Tricia was referring to where it might be
18 a very rural community? And so there's not going to be
19 enough people there to support a particular specialist
20 working there full-time.
21 So the creative solutions about flying someone in
22 for a monthly clinic or providing transportation for people

1 to go down to one of the tertiary care centers or
2 supporting the infrastructure needed for telehealth or e-
3 consults and making sure that whoever wants to help support
4 that has some compensation for the administrative burden of
5 setting up those systems. How can the creative solutions
6 be considered within actuarial soundness, where normally we
7 really look to simply encounter data? And those encounters,
8 it took a lot more to get that encounter that you can see.
9 There was a lot more behind that appointment and that
10 service.
11 So I just was wondering if there are examples
12 that we could look at for how to consider those things.
13 CHAIR BELLA: Sean, do you have any immediate
14 comment, or do you want to take that one back?
15 MR. DUNBAR: I think that's a couple points, and
16 I wonder if some of that might trickle into the next
17 discussion around in-lieu-of services and how clarity
18 around that will help maybe bolster some of those things
19 that may not be getting captured in data or considerations.
20 So maybe we can revisit a part of that.
21 COMMISSIONER BJORK: I'm not meaning in-lieu-of.
22 I'm meaning regular Medi-Cal services that need much more

1 additional support to make them happen.

2 MR. DUNBAR: Got it.

3 COMMISSIONER BJORK: But I agree with you that

4 there's a relationship with in-lieu-of services, because

5 again, we're going to have to be creative to count them.

6 CHAIR BELLA: Jenny, have you seen anything?

7 COMMISSIONER GERSTORFF: Nothing comes to mind.

8 CHAIR BELLA: Fred?

9 COMMISSIONER CERISE: Do you think the Z Codes

10 will be helpful and identify that? And, Sonja, I don't

11 know if that's kind of what you were getting at.

12 COMMISSIONER GERSTORFF: They can be. That also

13 varies by state and by provider. Some providers use the Z

14 Codes, and some don't. But they can be helpful in

15 analysis, certainly.

16 CHAIR BELLA: Dennis?

17 COMMISSIONER HEAPHY: [Speaking off microphone.]

18 Sorry. They rely on administrative data to

19 determine access monitoring, to do access monitoring? Is

20 that true across the board? Because it seems how can you

21 assess using administrative data rather than utilization

22 and encounter data?

1 MR. DUNBAR: Yeah. That's a good question. I
2 feel like I need to go maybe take another look and get back
3 to you and take a look at what MACPAC has reported out in
4 its access monitoring chapter in June, and I think MACPAC
5 did some prior work on looking at MCO contracts -- I think
6 it was 2018 -- and noted some variation in terms of the
7 kind of access standards and the different data that they
8 used to monitor access and network adequacy standards. I
9 think some of it was grievances and surveys and encounter
10 data submitted from MCOs, and I'm sure some might use
11 administrative data too. But I don't have a certain answer
12 for you.
13 COMMISSIONER HEAPHY: Thank you.
14 And then in terms of Medicare and Medicaid, I'm
15 looking at D-SNPs and they're going to be increasing of
16 some D-SNPs. What's that going to mean, actual soundness?
17 We've got Medicaid on one side in Medicare on the other
18 side. We're actually going to come to a common
19 understanding of what soundness really -- actual soundness
20 means?
21 And just, in general, states are not going to be
22 able to bear the burden of -- economic burden of the rate

1 of increasing rates, rate settings, increase rates over
2 time, and the feds are going to have to step in and help
3 states out here, because there are access issues, and the
4 states don't have the means of meeting those needs.
5 They're going to break. I just don't think that's going to
6 work. I think Darin said that, something to that effect as
7 well.

8 But there are other things. I have here my notes
9 as well, if needed. That's a start. I guess also
10 separating actual soundness from rate setting, in my head,
11 I'm looking at saying why can't we look at those two
12 separate things, why they have to be together.

13 So thank you. It was great.

14 MR. DUNBAR: Yeah. Thank you for the feedback.

15 CHAIR BELLA: Jenny, last comments?

16 COMMISSIONER GERSTORFF: Sure. So, on the topic
17 of throwing money at it, I just want to make the point too
18 that if actuaries were to identify an access issue and say,
19 you know, I think we need to pay the provider's higher
20 rates, so I'm going to build that into my rates, but did
21 that unilaterally and without state policy direction, then
22 there's no guarantee that that money is actually going to

1 go through to the providers. So it can get stuck there
2 with the MCOs. It can go to their shareholders. And
3 that's where directed payments play a big part in rates.
4 So, as much as we all hate them, they do help to assure
5 that state policy goals are met and that funding gets
6 through to providers.
7 I think accountability on directed payments that
8 are intended for access is somewhere that we need focus,
9 and I know that that's been part of the conversations. But
10 some sort of outcomes measurement, when states are using
11 directed payments to address access, whether they're
12 maintaining it or improving it, we need to see that
13 somewhere, somehow.
14 And then along the lines of transparency, I think
15 one important thing is rate certifications are not required
16 to be provided to anyone but CMS, and I think there are a
17 lot of assumptions and information in the certification and
18 documentation that goes to CMS that should be also provided
19 to at least the participating health plans. But, in a lot
20 of cases, it would be helpful to providers as well to see
21 what assumptions are in these rates when they're
22 negotiating with health plans.

1 I think that's what I had, Melanie.
2 COMMISSIONER HEAPHY: Can I ask a follow-up
3 question? A few examples of state legislative directive
4 for payment arrangements that work that are good, that we
5 can look at.
6 MR. DUNBAR: Sorry. Examples of --
7 COMMISSIONER HEAPHY: Of state, in the state
8 legislative directive for payment, of payment arrangements.
9 MR. DUNBAR: Oh, the example we mentioned about
10 when the legislature specifies the amount.
11 COMMISSIONER HEAPHY: Yeah.
12 MR. DUNBAR: Yeah. I'd have to go back and
13 double-check that. Yeah. I think there might be some
14 information on that in the previous directed payment
15 research that was done last cycle. I can go take a look
16 and try to get back to you.
17 CHAIR BELLA: Fred.
18 COMMISSIONER CERISE: Just to follow up on your
19 point, I think there is room for more accountability on the
20 directed payments to see are we get -- what are we getting
21 for those as opposed to like so many supplemental payments
22 that are driven by -- you know, if it's an on-site source

1 of match, it's easier to do, and it can be directed, tied
2 to the source of match. And it's not necessarily tied to
3 the outcomes that the state has an interest in. And I
4 think there's a lot of room to define what you're looking
5 for out of those directed payments and are you getting as
6 opposed to sort of just spreading, spreading it around.
7 I don't know if that makes sense.
8 MR. DUNBAR: Yeah. And I think one of the things
9 that came out from the previous research on directed
10 payments is that CMS had released a new preprint template.
11 I think that went into effect July 2021. That had a lot
12 more detail and asked a lot of more questions in the
13 original preprint. So I think the hope is that there may
14 be more data becoming available that allows some questions
15 like that to be looked into a little bit better than the
16 previous preprint allowed.
17 So I think as we have a chance to look at more
18 data around that, it will be interesting to see if there's
19 some revelations there.
20 CHAIR BELLA: Okay. Any additional comments from
21 Commissioners?
22 [No response.]

1 CHAIR BELLA: On the directed payments piece, it
2 is an important part of this work. It's also we've made
3 recommendations. No one has been jumping up and down to
4 embrace those recommendations. It doesn't mean we can't
5 continue to beat that drum. It is very much a part of our
6 transparency and understanding all the data and all the
7 dollars that are going to all the different providers,
8 which is particularly important as we talk about who's
9 getting what and whether that influences their ability to
10 participate in Medicaid.
11 So maybe once we see like -- you know, every once
12 in a while, we should dust off some of our prior work and
13 see, in fact, where we might have opportunities to continue
14 to reinforce that, and I would put directed payments in
15 that category.
16 Sean, I hesitate to ask if you got what you need
17 from us.
18 MR. DUNBAR: Yes, I think so, but I won't be shy
19 to reach out to folks and follow up if I feel like I forgot
20 anything or if I have some additional questions. So thank
21 you for your input.
22 CHAIR BELLA: Well, you'll be back. You will be

1 back in December, right?

2 MR. DUNBAR: I look forward to talking to you

3 then.

4 CHAIR BELLA: Okay. Excellent. Thank you for

5 this work.

6 Thank you to the Commissioners for engaging, just

7 to keep this level of energy going for the next two

8 sessions, and it will be fantastic.

9 All right. Chris is going to join us. We're

10 going to talk about drug spending and rebates. Just a

11 second for transition.

12 [Pause.]

13 CHAIR BELLA: Welcome, Chris.

14 [Off microphone discussion.]

15 CHAIR BELLA: We have a power problem. Chris, do

16 you mind speaking over the power problem? Excellent.

17 We'll turn it to you. Thank you for being here.

18 **### TRENDS IN MEDICAID DRUG SPENDING AND REBATES**

19 * MR. PARK: Great. Thanks.

20 Today I'll be going through some analyses that we

21 did on recent trends in Medicaid spending and drug rebates.

22 First, I'll start with a quick background on Medicaid

1 payment and rebates under the Medicaid Drug Rebate Program.
2 Next, I'll provide analyses on Medicaid drug spending trends
3 from fiscal years 2018 to 2021. This is an update of a fact
4 sheet that the Commission published in 2019.
5 Then I'll present some new analyses on the composition of
6 Medicaid drug rebates, including how these rebates differ
7 for brand and generic drugs, and the distribution of rebates
8 across the basic and inflationary components.
9 In 2021, Congress gave us access to the actual
10 rebate amounts for individual drugs, which allows us to
11 better understand the effect of drug rebates at a more
12 granular level. Before that, we only had access to
13 aggregate amounts at the state level. This presentation
14 will be our first public release of these data.
15 This presentation is mainly informational and
16 does not lead to any specific policy options or
17 recommendations. Commissioners may want to comment on the
18 information provided and let us know whether they are
19 interested in any additional breakouts of the data.
20 Medicaid outpatient drugs are an optional benefit
21 that all states have chosen to provide. These are
22 typically drugs that are obtained only by prescription and

1 dispensed by pharmacies. They don't include drugs that are
2 paid as part of a bundled service, such as a DRG payment
3 for a hospital stay, but they can include physician-
4 administered drugs when a direct payment is made for the
5 drug.
6 As we'll go through in the next few slides, it is
7 important to remember that the net amount Medicaid spends
8 for prescription drugs reflects two components: first is
9 the payment to the pharmacy or provider for the drug, and
10 second is the rebate that Medicaid receives from
11 manufacturers.
12 There are several distinct transactions that are
13 involved when a person gets a prescription filled. One,
14 the pharmacy purchases the drug from the drug manufacturer,
15 and this often happens through a wholesaler. The state or
16 managed care organization pays the pharmacy for the drug
17 and professional services. The manufacturer may pay
18 rebates to the state and/or managed care plan, and then
19 states and managed care plans may also use pharmacy benefit
20 managers, or PBMs, as an intermediary to negotiate rebates
21 and pay claims.
22 This slide just shows these transactions

1 graphically, and you can see how they are distinct.

2 So there are two components to the states' fee-
3 for-service payment to pharmacies. There's the ingredient
4 cost and the dispensing fee. The ingredient cost covers
5 the pharmacy's estimated cost to acquire the drug. The
6 2016 Medicaid outpatient drug rule required that states pay
7 the actual acquisition cost for drugs. States have some
8 flexibility in how they establish actual acquisition cost,
9 including a state survey of retail pharmacy providers or
10 using the National Average Drug Acquisition Cost(NADAC)
11 Survey. This national survey is the most common
12 methodology.

13 The dispensing fee is intended to cover the
14 pharmacist's overhead and services to fill the
15 prescription. This is typically between $9 and $12 per
16 prescription. And the beneficiary may also pay some amount
17 of cost sharing depending on the state.

18 There are both federal and state limits on the
19 amount paid to pharmacies. There is a federal upper limit
20 that applies to certain multiple source drugs and has been
21 established at 175 percent of average manufacturer price,
22 or AMP. The 2016 drug rule makes any federal upper limit
that is less than acquisition cost equal to the acquisition

1 cost as determined by the NADAC survey.

2 States may also have their own maximum allowable
3 cost on drugs, and there can be some overlap between the
4 federal upper limit and the state maximum allowable cost.
5 Additionally, payments may be limited to the pharmacy's
6 usual and customary charge. States consider all of these
7 different payment methodologies and usually pays the lowest
8 of those amounts.

9 Under managed care, the MCOs typically pay a
10 similar methodology of ingredient cost and dispensing fee.
11 Most MCOs use a PBM to negotiate payment terms with
12 pharmacies, and the payment amounts may differ across
13 pharmacies.

14 The federal rule that requires states to pay
15 actual acquisition cost does not apply to MCOs. However,
16 plans must pay a sufficient amount to ensure an adequate
17 provider network.

18 Medicaid drug coverage is governed by the
19 Medicaid Drug Rebate Program, or MDRP. Under the MDRP,
20 drug manufacturers must provide rebates in order for their
21 products to be recognized for a federal Medicaid match. In
22 exchange, states must cover all of the participating

1 manufacturers' products, but they may limit use of
2 particular drugs through utilization management tools such
3 as prior authorization or a preferred drug list. But at
4 the end of the day, states must cover a drug to a certain
5 extent and cannot outright exclude coverage of a drug.
6 And just as a reminder, rebates are separate from
7 the state's payment to the pharmacy, so that's a different
8 transaction.
9 Rebates under the MDRP are established in statute
10 and are based on average manufacturer price. The key thing
11 to remember here is that there are different rebate
12 formulas for brand and generic drugs.
13 For brand drugs, there's a basic rebate that is
14 the greater of 23.1 percent of AMP or AMP minus best price,
15 and best price is defined as the lowest price available to
16 any wholesaler, retailer, provider, or paying entity,
17 excluding certain government payers.
18 For generic drugs, the basic rebate is 13 percent
19 of AMP, and there is no best price provision. For both
20 brand and generic drugs, there is an inflationary rebate
21 that kicks in if the drug's AMP has exceeded the rate of
22 inflation over time.

1 And until January 1, 2024, the total rebate a
2 state receives on a drug cannot exceed 100 percent of AMP.
3 After January 1, 2024, this cap no longer applies, and the
4 total rebate can exceed that threshold.
5 Besides the statutory rebate, a state can also
6 negotiate supplemental rebates with manufacturers.
7 Manufacturers may provide these rebates to ensure that
8 their products are placed on the state's preferred drug
9 list or have fewer restrictions on use.
10 The Patient Protection and Affordable Care Act
11 extended the federal Medicaid drug rebates to prescriptions
12 paid for by MCOs. Previously, the federal rebates were
13 only available for drugs paid for by the state on a fee-
14 for-service basis.
15 The statutory rebates go directly to the state,
16 and the MCOs are not involved in this transaction. MCOs
17 can also negotiate their own rebates with the
18 manufacturers. These are similar to state supplemental
19 rebates. The manufacturer offers them to plans in exchange
20 for preferred status on the formulary.
21 Before we start, I just want to go over some of
22 the terminology I'll be using in this presentation. "Gross

1 drug spending" is the amount that Medicaid paid to the
2 pharmacy or provider. It reflects the number of
3 prescriptions filled and the amount paid per prescription.
4 "Net drug spending" takes into account any rebates that the
5 state receives from manufacturers. Those included the
6 mandated rebates under the MDRP as well as any supplemental
7 rebates that the state negotiated with manufacturers.
8 Managed care plans can negotiate their own
9 rebates. However, we do not have access to these amounts,
10 and so they are not reflected in our calculations of net
11 spending.
12 Over the past four years, rebates reduced gross
13 spending by over 50 percent each year, and overall, net
14 drug spending is a little over 5 percent of total Medicaid
15 spending during each of these years.
16 Net drug spending has increased substantially
17 between fiscal years 2018 and 2021. This comes after
18 several years of low growth in net drug spending from
19 fiscal years 2015 to 2017. Increases in net drug spending
20 were larger than the increases in gross drug spending in
21 fiscal years 2019 and 2021. Some of this increase may be
22 due to the introduction of new specialty drugs because new

1 specialty drugs often have high costs and are more likely
2 to have rebates proportionally lower than the average
3 rebate on other brand drugs. Utilization of those products
4 is likely to pull down the average rebate and increase the
5 net drug spending faster than gross drug spending.
6 Another potential driver of the increase in net
7 drug spending between fiscal years 2020 and 2021 is the
8 growth in Medicaid enrollment due to state decisions to
9 expand Medicaid to the new adult group, as well as the
10 continuous coverage requirement attached to the FMAP
11 increase under the Families First Coronavirus Response Act,
12 both of which contributed to overall increases in Medicaid
13 expenditures.
14 One way for payers to manage drug spending is to
15 shift utilization toward low-cost generic drugs when
16 possible. As you can see in this graph, the generic fill
17 rate has increased slightly from 83.5 percent in 2018 to
18 84.7 percent in 2021.
19 There has not been a corresponding shift in the
20 distribution of spending between brand and generic drugs.
21 Even though the proportion of brand drugs has decreased in
22 terms of utilization, the share of spending for brand drugs

1 has increased from 82.2 percent to 83.9 percent over this
2 time period.
3 The increase in the proportion of brand drug
4 spending despite a decrease in the proportion of claims
5 reflects an increase in the average spending per claim.
6 The average spending for a brand drug has increased from
7 about $431 per claim to $631 per claim in fiscal year 2021.
8 This is about a 13.6 percent increase on an average annual
9 basis. By contrast, the average spending for a generic
10 drug has only increased about 5.4 percent on an average
11 annual basis.
12 As mentioned before, much of the recent growth in
13 drug spending has been attributable to high-cost drugs.
14 The share of prescriptions for drugs with an average cost
15 over $1,000 per claim has increased slightly from 1.2
16 percent of claims in 2018 to approximately 1.6 percent of
17 claims in 2021. However, the share of spending on these
18 drugs has increased substantially as they accounted for 46
19 percent of total spending in fiscal year 2018 but now
20 account for 54 percent of spending in 2021.
21 A similar pattern occurs for drugs with an
22 average cost over $10,000 per claim. The proportion of

1 these drugs in terms of overall prescriptions has slightly
2 increased each year, but they're still less than 0.1
3 percent of claims. However, they've been growing in terms
4 of proportion of overall drug spending each year, going
5 from about 13 percent of total spending in 2018 to 16
6 percent in 2021.
7 As mentioned before, states can receive drug
8 rebates through the statutory rebates as well as any state-
9 negotiated supplemental rebate agreements. The vast
10 majority of rebates, over 90 percent, are attributable to
11 statutory rebates. However, supplemental rebates have
12 increased as a proportion of total rebates each year
13 throughout this time period.
14 The rest of the slides I'll be going through will
15 focus on the statutory rebates.
16 As mentioned previously, the rebate formulas are
17 different for brand and generic drugs. In fiscal year
18 2020, the statutory rebate reduced gross spending on brand
19 drugs by about 61.6 percent and gross spending on generic
20 drugs by 8.6 percent.
21 The difference in the rebate percentages between
22 brand and generic drugs reflects differences in the rebate

1 formulas between these different products. Brand drugs
2 have a higher basic rebate calculated as the greater of
3 23.1 percent of AMP or the difference between AMP and best
4 price. And generic drugs have a rebate calculated at 13
5 percent of AMP. The inflationary rebate was also only
6 added to generic drugs in 2015, so the baseline for older
7 generic drugs is a more recent period and thus leads to a
8 lower inflationary rebate.

9 Another factor is the average cost of generic
10 drugs is much lower than brand drugs, and so the
11 professional dispensing fee makes up a substantial portion
12 of generic drug gross spending, but only a marginal
13 proportion of brand drug gross spending. The average
14 dispensing fee is about half the cost of a generic drug
15 claim, but only about 2 percent of a brand drug claim. So
16 rebates reduce the ingredient cost component of a drug
17 claim. That means the statutory rebate only applies to
18 about half of the cost of a generic drug compared to almost
19 all of the cost of a brand drug.

20 In fiscal year 2020, almost half of brand drugs
21 at the national drug code level received a higher basic
22 rebate based on best price instead of the minimum rebate of

1 23.1 percent. These drugs accounted for about two-thirds
2 of claims and just over half of gross drug spending. The
3 basic rebate for drugs receiving the best price provision
4 was over half, so 51.9 percent of gross drug spending,
5 leading to overall total rebates of 76.7 percent. This is
6 compared to a 23.8 percent basic rebate and 45 percent
7 total rebate for drugs receiving the minimum basic rebate
8 amount.

9 Both brand and generic drugs can receive an
10 additional rebate if the drug's AMP increases faster than
11 the rate of inflation over time. About half of brand drug
12 NDCs received the inflationary rebate, which accounted for
13 about 60 percent of claims and about 76 percent of gross
14 drug spending. Only about a quarter of generic drug NDCs
15 received an inflationary rebate, and that was about a
16 quarter of claims and a quarter of spending.

17 Drugs that get the inflationary rebate have
18 significantly higher total rebates than those that don't.
19 For brand drugs receiving the inflationary rebate, total
20 rebates were about 72 percent of gross drug spending
21 compared to about 27 percent of gross drug spending for
22 those that do not receive the inflationary rebate.

1 For generic drugs, those that received the
2 inflationary rebates had total rebates of about 21 percent
3 of gross drug spending compared to about 4 percent of gross
4 spending for drugs that did not.
5 Currently, the total rebate is capped at 100
6 percent of AMP. The American Rescue Plan Act of 2021
7 removes this cap on Medicaid rebates beginning January 1,
8 2024. If manufacturers do not change prices in response to
9 the cap removal, Medicaid rebates for some drugs would
10 exceed 100 percent of AMP, and total Medicaid rebates would
11 increase accordingly. In fiscal year 2020, approximately
12 4.7 percent of NDCs reached the rebate cap, and these drugs
13 accounted for about 5 percent of claims and 18 percent of
14 gross drug spending. For these drugs, removing the cap
15 would have led to total rebates over 130 percent of gross
16 drug spending on average.
17 Note one funny little thing in the total rebate
18 column. For those who went over the cap, you'll see that
19 the initial total rebate exceeded 100 percent of gross drug
20 spending, and that's because the amount of state -- that
21 the amount states and managed care plans paid to a pharmacy
22 may be less than AMP once beneficiary cost sharing or

1 third-party liability has been removed.

2 Without the rebate cap, Medicaid could have
3 collected an additional $4.1 billion in rebates, which
4 would have decreased total gross spending by an additional
5 5.6 percent.

6 As mentioned previously, many high-cost specialty
7 drugs are likely to have a lower rebate than other
8 products. Many high-cost drugs launch at a high price, but
9 do not increase prices substantially over time, so they are
10 likely to have lower inflationary rebates. Additionally,
11 many high-cost drugs are new products with limited or no
12 competition and, thus, have basic rebates that are closer
13 to the minimum rebate of 23.1 percent.

14 In 2020, average rebate percentages decreased as
15 drug costs increased. Rebates for drugs with less than
16 $1,000 per claim were about 56.2 percent of gross drug
17 spending compared to 52.1 percent for drugs with an average
18 cost between $1,000 and $10,000 per claim, and 43 percent
19 for drugs with average cost greater than $10,000 per claim.

20 So we use this information to update our existing
21 fact sheet on Medicaid drug spending trends. We would
22 appreciate any feedback that you have on these

1 data and if there is any other information you would like
2 to see or any things that you would like to see reflected
3 in the fact sheet. Keep in mind that there are some
4 confidentiality restrictions on disclosing rebate
5 information for specific drugs, so that may limit what we
6 are able to do publicly.
7 So I'll turn it back over to the Commission for
8 any questions or comments.
9 CHAIR BELLA: Thank you, Chris. You know that's
10 always dangerous to ask for any additional information.
11 You have put a lot in front of us.
12 Let's start with clarifying questions for Chris
13 on what he went through. Laura? And can we get the
14 virtual folks on the screen, too, so we can keep track of
15 their hands. Thank you.
16 COMMISSIONER HERRERA SCOTT: I don't know if it's
17 a clarifying question or just a question, but given the
18 number of drugs in the pipeline that are going to be over
19 the $10,000 price point, can you provide the history, the
20 rationale for the lower percentage for a rebate for those
21 newer drugs?
22 MR. PARK: Sure. It's not necessarily that they

1 have a different formula, but because a lot of them are
2 first-in-class treatments, they are not negotiating very
3 substantial rebates with private payers. And so those
4 rebates are likely to be less than 23.1 percent, so they
5 will only get like a 23.1 percent rebate. And then when
6 they're new to market, they haven't increased prices for
7 inflation, so -- let me go back here to -- yeah, so as you
8 can see, the drugs with the best price rebate are averaging
9 a rebate of around 52 percent versus those who don't are
10 around 24 percent of gross drug spending. And so a lot of
11 the new products will probably fall into that no category,
12 so they'll probably get a rebate around like the 23, 24
13 percent range. And then, you know, they would also kind of
14 be in this category for the inflationary rebate of having a
15 lower rebate as well. So that's why when you compare that
16 to other brand drugs, they are more likely to have a lower
17 rebate, is that they are new, they don't have competition.
18 COMMISSIONER HERRERA SCOTT: So it's mostly that,
19 because, I mean, that's the piece to watch out for the most
20 -- for me, as I think about the budgets that the states are
21 working with and the costs of these drugs and the number of
22 these drugs in the pipeline, if competition is a criteria,

1 does that need to be looked at for how states get rebates
2 in general? And maybe I'm not being clear because I don't
3 understand how all the rebates work, but certainly the new
4 drugs and the new drugs in the pipeline are really, really,
5 really expensive.
6 MR. PARK: Yeah, one thing I can add here is that
7 this just recently went into effect, but CMS had put out a
8 value-based drug purchasing rule where there will be
9 different best price rebate calculations for drugs under a
10 value-based contract. And so this may be an area where
11 those drugs may get a bigger rebate when they do not
12 achieve the outcomes that are intended, and so that is
13 something we can try to monitor in the future as to whether
14 many drugs may be under these types of contracts and what
15 states may be receiving on that end. But those may fall
16 under the supplemental rebate agreements and not the
17 statutory rebates.
18 CHAIR BELLA: Any more questions, Laura? Okay.
19 Heidi and then Fred.
20 COMMISSIONER ALLEN: Thank you, Chris. This is
21 so interesting, and I'm very novice of this. So I have a
22 couple of clarifying questions and a comment.

1 My comment is that I would love to a glossary for
2 this because I found myself really trying to scroll back to
3 remember what the different acronyms meant, just because
4 it's so new.
5 But my -- a couple of questions. One is I'm
6 having trouble wrapping my mind around the rebate cap and
7 what it means when the rebate is higher than the AMP. Can
8 you explain this like you were talking to like a five-year-
9 old?
10 MR. PARK: Sure. So AMP is the average
11 manufacturer price, and that is the price that
12 manufacturers receive when a wholesaler who distributes to
13 retail community pharmacies purchase that product. So
14 that's the average price basically to wholesalers.
15 That's not necessarily the price that states pay
16 to pharmacies. So that may be based on a different
17 benchmark, but it may be somewhat similar because the price
18 that states are paying is supposed to reflect acquisition
19 cost of the pharmacies.
20 So, when the Affordable Care Act was passed, they
21 put in this provision that would limit drug rebates to a
22 100 percent of AMP. That would mean that manufacturers are

1 essentially making no money off of a product dispensed to a
2 Medicaid beneficiary.
3 The American Rescue Plan Act is going to remove
4 this rebate cap, and this is something that MACPAC
5 recommended a few years ago in the 2019 June report. And
6 this would essentially allow the rebate cap to go above 100
7 percent.
8 Right now, because it's limited at 100 percent,
9 manufacturers can continuously increase the price, but their
10 rebate obligations don't necessarily increase. So they're
11 still not really making money on Medicaid, but other payers
12 may be paying more. And so this is a way where Medicaid
13 could -- like if manufacturers didn't change the price and
14 the cap goes away, as you can see, as I mentioned, total
15 Medicaid rebates could go up by about 5.6 percent. So
16 Medicaid could theoretically be making money on some of
17 these products because they're receiving a rebate higher
18 than what they paid to the pharmacy, and this would give an
19 incentive for manufacturers to either pay the full rebate
20 amount, because they are increasing prices faster than
21 inflation by a substantial amount, or they will lower their
22 prices, and that will benefit other payers as well. So
Medicaid may still come out with no cost, but

1 other payers may receive some benefit because the list
2 price has gone down.
3 COMMISSIONER ALLEN: That is so helpful. Thank
4 you.
5 It's really interesting, though. Do you think
6 that would make a manufacturer not want to participate in
7 Medicaid?
8 MR. PARK: I mean, that's always the possibility,
9 but the Medicaid drug rebate program is not on a product-
10 by-product basis. It's all of the manufacturer's products
11 are in or out, and so it's not easy for --
12 COMMISSIONER ALLEN: I see.
13 MR. PARK: -- a big manufacturer just to withdraw
14 from the program.
15 There's also requirements that they -- for some
16 of the other programs, like 340B or the VA, they also kind
17 of have to be in the Medicaid drug rebate program. So
18 there are some ties that will keep people in, and so this
19 is something that manufacturers will have to determine.
20 You know, a small manufacturer of one product, maybe they
21 would withdraw, but for the big manufacturers of the world
22 who have hundreds and hundreds of products, it's not

1 such an easy proposition.

2 COMMISSIONER ALLEN: What that makes me -- I
3 mean, one of the things, you know, MDMA is coming to market
4 for the treatment of PTSD, and it's one manufacturer. And
5 that's just something that I want to take a mental note of.

6 The other question that I had is when it says --
7 in our briefing materials, it said that these are for
8 medically accepted indications. Does that mean on-label
9 indications, or does Medicaid cover off-label indications
10 as well?

11 MR. PARK: It is definitely on-label indications,
12 but then there are -- there is language in the statute that
13 allows -- that says medically accepted indication also
14 includes medically accepted uses that are in certain
15 compendia, and so to the extent that this has become maybe
16 something that is a typical practice that professional
17 societies endorse and they are in those compendia, then
18 they would be required to be covered.

19 COMMISSIONER ALLEN: Thank you. You answered
20 both my questions so well. Thank you. I appreciate it.

21 COMMISSIONER HERRERA SCOTT: So, Heidi, just as
22 an example, hormone replacement for transgender, that's

1 off-label, but it's covered in the states that cover it.

2 COMMISSIONER ALLEN: Great. Thank you.

3 CHAIR BELLA: Fred.

4 COMMISSIONER CERISE: Do you get the information
5 on the supplementals from the managed care organizations,
6 like in how that compares to how the states do?

7 MR. PARK: We do not. What we have on state
8 supplemental rebates is an aggregate, and that's what's
9 reported on the CMS-64 that states submit for matching
10 purposes.

11 So, if I go back here -- yeah. It's fairly
12 small. I think that's about 5 percent of drug spending,
13 and I think what we've heard from -- anecdotally from
14 managed care plans and people who have worked with plans on
15 the rebates is that it's probably about a similar amount.
16 Because the statutory rebates apply to managed care
17 prescriptions as well, manufacturers are probably not going
18 to offer up very large rebates to plans because they're
19 already paying very large rebates under the statutory
20 rebates. And so, you know, a rough estimate would be
21 something similar to maybe what the states are receiving in
22 supplemental rebates.

1 CHAIR BELLA: Any follow-ups there, Fred?
2 [No response.]
3 CHAIR BELLA: Dennis, did you have a comment?
4 COMMISSIONER HEAPHY: Yeah. I was curious about
5 equitable access to prescription medication between MCOs
6 and folks in the fee-for-service system. Is that impacted
7 at all by the way the MCOs work versus fee-for-service?
8 MR. PARK: Certainly, MCOs could have different
9 formularies and different coverage requirements than what
10 the state has.
11 Based on the 2016 drug rule, states are supposed
12 to fill in around the MCOs. If the MCOs are not covering a
13 drug appropriately, you know, have excluded coverage, then
14 the state is supposed to pick that up on a fee-for-service
15 basis. So, in essence, the state is filling in any gaps
16 where the MCO has not met the statutory requirements of the
17 Medicaid drug rebate program.
18 We can't tell how often that may be occurring. A
19 lot of times, for certain drugs, like the hepatitis C drugs
20 when they first came out, the state just decided to cover
21 that completely on a fee-for-service basis initially
22 because of the difficulties and building that into the cap

1 rate and concerns that the plans may not have sufficient
2 funds in that first year to pay for sufficient access.
3 It's hard to tell through the data as to whether
4 plans or the states have any differences in utilization
5 patterns, to what extent is that driven by different
6 acuities in the population between the two programs. A lot
7 of times the fee-for-service program may a higher acuity
8 because the state is taking that risk from the plans, and
9 so it's difficult to say without kind of going back to some
10 of the discussion under Sean's presentation. It's like
11 this probably isn't where you would be measuring access and
12 equity. You'd probably need to do that through the access
13 monitoring system or potentially in the rate-setting
14 process.
15 COMMISSIONER HEAPHY: Or even just their
16 negotiating, that they're not having to follow the same
17 negotiation requirements of the state.
18 MR. PARK: Yeah. One thing that we've seen is
19 that a lot more states are starting to consolidate the
20 formularies so that they require the MCOs to follow a
21 single formulary, so things will be more equitable across
22 plans and also getting back to this sense of the state

1 technically is supposed to wrap around any portion that's
2 insufficient. And so, if everyone is following the state's
3 formulary, then essentially the state is covered to say,
4 like, they're supposed to follow formularies so we don't
5 have to wrap around anything.
6 And so we've seen that increasingly become more
7 common where either a couple states like California and New
8 York are just carving out the drug program completely into
9 fee-for-service, but other states are either requiring the
10 plans that have a similar formulary, particularly on
11 certain classes, or they've gone to a single PBM and
12 consolidated things across the state.
13 COMMISSIONER HEAPHY: Thank you. That's helpful.
14 And then one last question. Would you give us
15 the per-person spending amount, give us the per-person
16 amount spending that's been increased? You said there's an
17 increase in Medicaid enrollment. So I'm just wondering,
18 per person, how much spending has increased.
19 MR. PARK: Yeah.
20 COMMISSIONER HEAPHY: It may have been in that.
21 MR. PARK: Yeah. We didn't calculate that, but I
22 think spending -- or enrollment has generally gone up about

1 10 to 15 percent between 2020 and 2021. I don't know if
2 you --
3 COMMISSIONER BROOKS: [Speaking off microphone.]
4 MR. PARK: Yeah.
5 COMMISSIONER BROOKS: [Speaking off microphone.]
6 MR. PARK: Okay.
7 COMMISSIONER BROOKS: I'm sorry. It's closer to
8 20 percent over the pandemic.
9 MR. PARK: Yeah. Okay. So, you know, here we've
10 seen -- on this slide, we've seen net spending has gone up
11 about 17 percent. So per-person spending between 2020 and
12 2021 is probably not just due to enrollment. The people
13 who are staying on may not be getting drugs to the same
14 extent that other people normally would. Some of it
15 probably is due to people staying on through the continuous
16 enrollment requirement, but that's not the only explanation
17 there.
18 COMMISSIONER HEAPHY: Thank you.
19 CHAIR BELLA: Thank you, Dennis. Thanks, Chris.
20 Other comments or questions? Jenny.
21 COMMISSIONER GERSTORFF: So I loved these data
22 and tables. I thought it was really great.

1 A couple of things from the conversation that
2 could be interesting to look at, if it's possible and
3 allowable, rebates kind of summarized like you have here
4 and also generic dispensing rate by type of state delivery
5 system. So you've mentioned that a lot of states are
6 moving to a uniform PDL for their managed care programs,
7 and some are contracting with a PBM on behalf of the plans,
8 and then some are carving the pharmacy out of the risk-
9 based rates. I think looking at that information by state
10 type and kind of grouping them and maybe also over time,
11 before a state moved to a uniform PDL and then after, what
12 those look like.
13 MR. PARK: Okay. Again, we can certainly look at
14 that, but I would caution drawing too many conclusions
15 because we don't know like the differences in acuity and
16 what particular medications each population may actually
17 need.
18 COMMISSIONER GERSTORFF: Yeah, of course.
19 CHAIR BELLA: You good, Jenny? Okay.
20 I don't see any other hands.
21 COMMISSIONER HEAPHY: I guess one --
22 CHAIR BELLA: Dennis?

1 COMMISSIONER HEAPHY: Is there a way to measure
2 acuity and the data as you're looking at the costs?
3 MR. PARK: There is. We could use one of the
4 common risk adjustment models that are used for rate-
5 setting purposes to at least get a measure of acuity. The
6 challenge there is we would need to use the T-MSIS data,
7 and we still have some work to do to assess the quality of
8 the managed care encounter information to see if we have
9 what we believe is a sufficient amount of claims and a
10 sufficient amount of information.
11 One thing we may be able to do that doesn't quite
12 get at the acuity, if we've looked at particular classes,
13 well, at least everyone who's getting a diabetes medication
14 has diabetes, and so is there a difference in the mix of
15 drugs in that spending and things like that could be a
16 little bit of information that is partially acuity-adjusted
17 because we are only looking at a particular class.
18
19 COMMISSIONER HEAPHY: Thanks.
20 CHAIR BELLA: Okay. Chris, thank you very much.
21 I believe we'll see this in the form of a brief. Is that
22 right?

1 MR. PARK: Yes, that's the plan. We'll do the
2 update of the issue brief and include the new information
3 on the composition of the rebates.
4 CHAIR BELLA: Okay.
5 Fred?
6 COMMISSIONER CERISE:Can I just say one last
7 comment since you're going to do a brief? And you do such
8 a good job with those graphics. If you could do a picture
9 that explains how that rebate gets above AMP, that would be
10 very helpful. Like an example to put the numbers in that
11 equation, like Heidi was asking, do you know what I'm
12 saying?
13 MR. PARK: Yeah.
14 COMMISSIONER CERISE: Okay.
15 CHAIR BELLA: Thank you, Chris.
16 MR. PARK: All right.
17 CHAIR BELLA: Trying to get a graphic out, a new
18 graphic out of every session, at least one.
19 Okay. We're going to turn to public comment now
20 before we take a break. You can go, or you can stay, your
21 preference.
22 MR. PARK:I'm turning off the mic.

1 CHAIR BELLA: Oh, I thought you were coming back,
2 and I was going to be like, wow, great.
3 Okay. We're going to go to public comments. We
4 can take comment on the last three sessions. So we had a
5 session on our comments to the CMS rule. We had a session
6 on access and actual soundness, and then we just got
7 briefed on drug trend.
8 So I will open it up. If anyone would like to
9 make a comment, please use your hand icon, and I'll remind
10 folks to please introduce themselves, the organization
11 they're representing, and keep your comments to three
12 minutes or less.
13 [Pause.]
14 CHAIR BELLA: The audience did not hear me this
15 morning say to stay energized all day, because it does not
16 appear that we have any people wanting to make comments.
17 We'll give it just a little bit longer.
18 Otherwise, just for Commissioners and others,
19 we're going to take a break. We're going to come back at
20 3:30. We're going to have a panel, and actually -- yeah.
21 Coming back at 3:30 with our panel. We are going to be
22 short one panelist, which we can explain when we get back,

1 when we get back for that panel.

2 ### PUBLIC COMMENT

3 * CHAIR BELLA: So I do not see any public comment.
4 Thank you, everyone, for being so engaged. Thank you to
5 the team, and please rejoin at 3:30 Eastern time.

6 * [Recess.]

7 CHAIR BELLA: Welcome back to our final panel, I
8 guess our only panel of the day. But Henry and Katie, I
9 promise you, we are all high energy. We are ready to end
10 the day on a bang. Everyone has been instructed to have
11 the highest amount of energy today than we did this
12 morning, and we all have caffeine and sugar to make sure
13 that happens.

14 So we're thrilled that you're here. Thank you
15 very much. Asmaa, I'll turn it over to you to get us
16 started.

17 ### PANEL ON STREAMLINING DELIVERY OF HOME- AND
18 COMMUNITY-BASED SERVICES

19 * MS. ALBAROUDI: Perfect. Thank you.

20 Good afternoon, Commissioners. Today I'm pleased
21 to bring you a panel of experts to discuss streamlining
22 delivery of home-and community-based services, or HCBS. We

1 did have a last-minute change, and unfortunately Ms.
2 MaryBeth Musumeci is unable to join us. But I'm looking
3 forward to hearing from both Henry Claypool and Katie Evans
4 Moss.
5 I'll begin with a brief introduction of the
6 panelists. You have their full bios in your meeting
7 materials.
8 Next, and as part of this moderated panel, we do
9 have a number of questions related to three different
10 areas: access, administrative complexity, and design of
11 the Medicaid HCBS benefit.
12 HCBS encompasses a wide range of services that
13 include personal care, supported employment, and home-
14 delivered meals for Medicaid participants with significant
15 physical and cognitive limitations. These services are
16 designed to allow people to live in their homes or a home-
17 like setting and remain integrated in their communities.
18 However, the literature points to challenges in
19 accessing HCBS and administering the benefit. To better
20 understand the current challenge in HCBS delivery for both
21 beneficiaries and states, we have invited Mr. Henry
22 Claypool, an independent consultant and visiting research

1 scientist at Brandeis University's Heller School, as well
2 as Ms. Katie Evans Moss, chief of LTSS at the Division of
3 TennCare.
4 Our three broad domains are, again, increasing
5 access to HCBS, simplifying administrative complexity, and
6 finally, reconsidering the design of the Medicaid HCBS
7 benefit.
8 We will begin with our first domain, increasing
9 access to HCBS. We often hear that beneficiaries
10 experience challenges to accessing HCBS due to the
11 patchwork of services that they must navigate. For
12 example, beneficiaries may experience uneven access to
13 services based on varying provider availability within
14 states and eligibility for multiple waiver benefits that
15 each provide different benefit packages, so that they have
16 to choose one and forego the other.
17 Mr. Claypool, do barriers to access exist for
18 beneficiaries, and if so, what are those barriers and do
19 they differ by population?
20 MR. CLAYPOOL: Thanks for the question, and
21 please forgive me. I have got a lengthy list of barriers,
22 and I range into some of the other topics. It's an

1 unorthodox approach, perhaps, but bear with me.

2 I just first want to open with equity and
3 barriers to HCBS exist across the demographic groups that
4 are served by the program, as well as disability categories.
5 I hope we'll have time to explore the existing HCBS program
6 structure and how it likely exacerbates racial disparities.

7 Workforce, as I'm sure folks know, in home-and
8 community-based services is a crisis right now, and a
9 primary barrier to actually getting the hours you need is
10 having somebody that can show up to perform the work. This
11 is an area where the Commission may be able to make some
12 recommendations that address a systemic failure of the
13 program that comes from its institutional origins, so there
14 is a lot of potential.

15 Of course, housing is an interesting barrier to
16 services. If you don't have a place to live you aren't
17 going to be able to receive services, and unfortunately
18 there are some folks that end up in that situation.

19 And then the more general category is financing.
20 I think the range of fiscal effort invested in HCBS is
21 significant. Some states are less generous in making HCBS
22 available, and there are key special interest groups that

1 can have an oversized role in shaping how a state offers
2 HCBS services.
3 So the barriers continue, and it gets a little
4 bit arcane. The complex financial eligibility pathways are
5 difficult for beneficiaries to navigate. Again, nursing
6 home entitlement means that HCBS is an option, and it's
7 difficult for states to do things like add a presumptive
8 eligibility for home-and community-based services, so people
9 end up being discharged from a hospital to a nursing home
10 and they are already at risk of a long-term custodial stay.
11 Asset limits prevent people from better living at
12 home in HCBS, from having the resources they need to
13 maintain that home. Personal needs allowances don't keep
14 pace with community living expenses. Functional eligibility
15 varies across the different groups and programs in ways that
16 create siloes of populations, instead of really taking a
17 needs-based approach and allowing a more equitable
18 distribution across the populations. Access to information
19 about enrollment in HCBS is fragmented and siloed, again in
20 these population-based areas.
21
22 So you really wouldn't call HCBS a system. It's

1 a patchwork of programs.

2 And forgive this sweeping generalization, but
3 there are three major populations -- behavioral health,
4 developmental disabilities, intellectual disabilities, and
5 older adults and people with physical disabilities. I
6 shouldn't too quickly gloss over the fact that states use
7 1915(c) waivers and provide home-and community-based
8 services to other populations with targeted needs. There
9 are TBI waivers, technology-dependent children, and others.
10 But these three major groups I think constitute a core and
11 deserve some focus.

12 In behavioral health, of course, we have an IMD
13 exclusion, so the financing for that population is a
14 problem. They don't have a resource to draw on to provide
15 a robust set of services. So the need there is for deeper
16 investment in HCBS.

17 For older adults and people with physical
18 disabilities they are often enrolled in the same waiver
19 with the same services. The challenge is, in states that
20 don't provide very much state plan services, people go with
21 their needs unmet for a while until they reach the level of
22 care for the institution or the waiver, and then

1 they're enrolled and receive services. So there is likely
2 still unmet need in that population that is receiving home-
3 and community-based services in the community.
4 And then finally the intellectual and
5 developmental disabilities system. I'll use that word.
6 It's more of a system than others. It's been well
7 organized and it has community advocacy groups,
8 professional societies, providers, and state officials that
9 are really focused on managing a 1915(c) waiver, often a
10 kind of comprehensive waiver that offers residential
11 services and robust social supports. The problem is that
12 it's very oversubscribed and so states typically have
13 waiting lists.
14 But you can see, just from the landscape there,
15 that these disparities and differences in access are all
16 across these populations. And I better stop there because
17 I took about five minutes of the time.
18 MS. ALBAROUDI: Thank you. And, of course, Ms.
19 Moss, I wanted to give you an opportunity to comment on
20 that also.
21 MS. MOSS: Absolutely, and I echo what Henry
22 said. I mean, obviously in a state like Tennessee, just

1 like every other state, we are seeing the workforce
2 challenges. We are seeing the equity challenges, housing,
3 and financing challenges.
4 I will say all of you in this room know, my
5 predecessor is a household name, Patti Killingsworth, and
6 her development of our innovative programs across the HCBS
7 continuum, and I think is a great model.
8 As Henry was saying, in a lot of places you wait
9 until you meet the institutional level of care. Well, back
10 in 2010, when Patti developed the CHOICES for long-term
11 services and supports program there was an at-risk category,
12 so that's a lower level of need criteria, and then there's
13 the institutional category. So there is a continuum of
14 services. That program is for older adults and adults with
15 physical disabilities, and the entryway into that is either
16 the person's managed care organization, if they are in
17 TennCare, or if they're not, through our local Area Agencies
18 on Aging and Disabilities, or our AAAs. And the AAAs also
19 manage our older adults funding and the options program. So
20 they can counsel these individuals on if you're not eligible
21 for the Medicaid programs are you eligible for limited
22 funding through the

1 Older Americans Act funding.

2 And so when she developed the Employment and
3 Community First CHOICES program, which is for our
4 individuals with intellectual and developmental
5 disabilities, in 2016, she modeled that same kind of
6 pathway. So there is an at-risk group for children. For
7 adults under the age of 21, there is higher level of needs
8 throughout CHOICES group 4, 5, and 6.

9 And so certainly we still have the same workforce
10 challenges that every other state has seen, and that crisis
11 is exacerbating. I do think the way that we have
12 structured benefits so that there is a continuum really
13 helps folks access services ahead of crisis. It's not
14 always been that way, right. We have a very long waiting
15 list for individuals with intellectual and developmental
16 disabilities, but luckily through the American Rescue Plan
17 Act we used some of that funding to do what we can to
18 reduce that waiting list, so that now people can access
19 services before being officially in crisis and meeting that
20 priority categorization.

21 So absent that funding I'm not sure how long it
22 would've taken for us to get to that point, but at this

1 point we're in a really good position where people who need
2 services, absent crisis, can access those services.
3 MS. ALBAROUDI: Great. Thank you both.
4 In terms of how states and the federal government
5 could help increase access to HCBS for beneficiaries, Mr.
6 Claypool, based on your expertise can you discuss some
7 federal or state policy levers that you think could address
8 access barriers?
9 MR. CLAYPOOL: Sure. I would start with the
10 workforce, since I think it's pressing right now. There
11 could be much better rate-setting around home care or
12 personal care. It's not like any other provider in most
13 states. Rarely do these agencies receive a cost of living.
14 In many states it happens once every 10 years or something
15 like that. It's an underdeveloped area of policy, and I
16 would hope that people could take a look at the direct care
17 workforce, their needs, and make sure that rates are
18 appropriate so that the resources get to the frontline
19 staff that are actually paying for the services.
20 Another interesting issue is immigration.
21 Historically it's been a way that this workforce has been
22 comprised heavily of people that immigrate to the United

1 States. And there may be another opportunity in some
2 immigration debate in the future to address workforce that
3 way.
4 I think finding ways to pay the direct care
5 workforce for attention paid to the social determinants is
6 critical, like orientation and mobility, nutrition and
7 diet. They don't really need a lot more training in
8 clinical skills. They should receive better wages when
9 they help people move around and facilitate their day. The
10 challenge is that if this frontline workforce is seen as an
11 extension of a nurse, you'll typically medicalize the
12 person's routine, and therein a very sensitive role. So I
13 think paying deeper attention to how to justify more
14 compensation for the direct care workforce is critical, and
15 the social determinants are an opportunity.
16 Federal financing I think is key. That's the
17 only way we've seen real movement in HCBS. I shouldn't say
18 that. We've had significant rebalancing because states
19 have realized the efficiencies that the HCBS program
20 offers. But moving beyond that we've had to use things
21 like the health homes come with some enhanced match,
22 and Community First Choice has enhanced match. So I
think

1 going down that road of exploring ways to enhance federal
2 spending on the HCBS is appropriate.
3 I would just throw out another interesting idea.
4 What about provider taxes for home care agencies? There is
5 an ADRC infrastructure that is nascent or underdeveloped in
6 some states, and others have invested in it. But that's
7 how people learn about their services, and I think we need
8 more federal effort there.
9 Functional assessments are obviously key. If we
10 want to move towards more needs-based criteria instead of
11 just staying with kind of categorical eligibility I think
12 there is a lot of work that could be done by states on
13 making sure that their assessments all sync up.
14 And finally I would just want to mention the need
15 for better data. It's not just the Medicaid program that
16 is interested in home-and community-based services. The
17 federal government occasionally does something. The CLASS
18 Act was an attempt to expand these types of services. And
19 states are now experimenting with social insurance models
20 to provide this care. So I think we need better data and
21 we need to understand the type of need that is out there.
22 And finally I just would say we really need to

1 look at waitlist management for HCBS. You know, how are we
2 going to support states better to understand what that need
3 looks like, so they can plan for the future.
4 MS. ALBAROUDI: Great. Thank you. And Ms. Moss,
5 can you please discuss these approaches from a state
6 perspective?
7 MS. MOSS: Absolutely. I'm really excited to
8 hear Henry mention rates, first and foremost. Tennessee
9 also leveraged the ARPA funding to increase rates for one
10 of the programs for the first time in a number of years.
11 We were able to get our legislature to continue to fund
12 those, and so we've used ARPA funding to buy back what the
13 legislature has set aside in appropriations for those
14 rates. I don't think would've been possible without the
15 ARPA FMAP funding, and now we've got some momentum going in
16 those discussions.
17 Now from a rate perspective are we where
18 providers want to be and where direct support providers
19 need to be? No. They could get paid more at Target or
20 Panda Express, or any number of other places with less
21 requirements on their roles, less severity or need in their
22 roles. And so that's still a large challenge.

1 One of the things I think everyone in this room
2 is aware of is the federal restrictions, the federal
3 institutional bias in the statutory framework, and I think
4 that is one area that if we really want to see movement
5 it's going to have to be addressed at some point. We have
6 individuals go into nursing facilities who can't maintain
7 their home in the community. So then we say, well, we have
8 a housing problem. Well, if we had been able to help them
9 keep their home while they were in an institutional stay
10 maybe we wouldn't have that problem in some of those
11 situations. But as outlined in the federal regulations, we
12 do have that institutional bias at this point, if someone
13 goes into a nursing facility.
14 So from a high level, those are some of the
15 pieces that we would love to see addressed.
16 And then looking at flexibility on service
17 provision. In Tennessee, we always try to do great,
18 innovative things. We're looking at different value-based
19 payment models where we are providing rates and wages to
20 frontline workforce, or providing rates based on outcomes,
21 outcomes based on social determinants of health -- if
22 somebody achieves more independence, if someone needs less

1 hands-on care, less direct care. And so looking at how we
2 can move those pathways forward from a value-based payment
3 incentive model.
4 Another area that we are really pushing forward
5 is our enabling technology approach. One of the challenges
6 there is broadband is not reimbursable. So how do you
7 implement enabling technology in a rural area, or for a
8 family who can't afford internet service. That becomes a
9 challenge and yet that is not something that we are
10 permitted to include as a reimbursable service.
11 MS. ALBAROUDI: Thank you both.
12 Now moving on to our second domain, simplifying
13 administrative complexity. States have to navigate a
14 complex landscape of Medicaid HCBS statutory authorities.
15 They have to make choices about which ones to use, which
16 populations to serve, and which services to provide. For
17 example, states often manage several Medicaid HCBS benefits
18 at once that operate under different statutory authorities
19 and provide different benefit packages to different HCBS
20 subpopulations. Knowing this, the first question to the
21 panel is, what are the advantages and disadvantages in
22 terms of design, access, and administration of the range of

1 Medicaid HCBS authorities?

2 We'll start with Ms. Moss.

3 MS. MOSS: So I can speak from a Tennessee

4 perspective. In Tennessee, our long-term care programs for

5 individuals who are 65 and older and have physical

6 disabilities as well as our employment and Community First

7 Choice's program are run through our 1115 waiver

8 demonstration. All of TennCare is through an 1115 waiver

9 demonstration.

10 For a number of years, we've also operated three

11 1915(c) waivers, which serve individuals with intellectual

12 disabilities. Those are managed and operated on a day-to-

13 day basis by our Department of Intellectual and

14 Developmental Disabilities, a department that we work

15 really closely with.

16 One of the things that we are working on now and

17 have been working on for a couple of years, going on a

18 couple of years now, is integrating our 1915(c) waivers

19 into our 1115 waiver, and so what we hope to do -- because

20 the way our structure is right now, we have -- CHOICES has

21 started with those LTSS services in managed care, and our

22 employment and Community First Choice's LTSS are still fee-

1 for-service. They're not included in the capitated rate
2 for the MCOs and similar on the 1915(c) waiver side. What
3 we want to do is bring our 1915(c) waivers in so that the
4 HCBS is managed by our managed care organizations.
5 We really want to promote that integration of
6 physical, behavioral health, and LTSS and ensure that all
7 LTSS services operate as a wrap-around to the primary
8 Medicaid benefits and have that really strong coordination
9 between the two.
10 So that's where we're trying to get. We don't
11 have a bunch of other waivers in Tennessee from that
12 perspective and trying to get all of those consolidated for
13 ease and management and for the benefit of the members.
14 MS. ALBAROUDI: Great. Thank you.
15 And, Mr. Claypool, any additional thoughts around
16 the advantages and disadvantages?
17 MR. CLAYPOOL: Well, I wrote notes, and I was
18 only thinking about the waiver program. When I listened to
19 the question, it's -- ah, it gives me more opportunity.
20 So I'm just -- I have personal experience with
21 the Medicaid program. I was a beneficiary in Colorado, and
22 they used the home health benefit, and it was a nice way

1 for me to get fairly generous night support around the
2 needs that I had. So I had good experience personally with
3 the home health benefit.
4 I think there are medical components to it that
5 were addressed by consumer advocacy and came up with a
6 consumer-directed option. So for those of you that are
7 familiar with HCBS, these programs are often -- there's a
8 great desire for them to be directed by consumers or self-
9 directed, and so that experience with a skilled home health
10 service, I think, heightened the interest of consumers to
11 say, "I don't need a nurse supervising how my pants are put
12 on in the morning. Actually, I can do that better." So a
13 mandatory service like home health still has those
14 requirements.
15 Then states offering state plan services, like
16 personal care, that can be fairly generous. It doesn't
17 come with the same requirements of nursing supervision.
18 Depending on the state's fiscal effort, it can provide a
19 good amount of care.
20 But, of course, most states are really looking to
21 the 1915(c) waiver to provide the bulk of home- and
22 community-based services for the populations in need.

1 They're highly targeted services and supports to get to
2 specific groups. So that has a disadvantage or an
3 advantage, the budget certainty that the state gets with
4 being able to control the waivers' enrollment.
5 In the DD system, it's a very comprehensive --
6 there is typically a very comprehensive waiver, and that
7 provides social supports and actually really focuses on
8 more community integration.
9 I would say in the elderly and physically
10 disabled side, it's much more of a "Here is your -- we're
11 going to give you some personal care and some other
12 services around it."
13 So I don't know where those are advantages and
14 disadvantages. I would just quickly say that there's
15 fragmentation in how the states structure their waiver
16 programs across the different HCBS groups.
17 Obviously, the enrollment caps create waiting
18 lists, and I think the state variation in how states
19 structure their programs and offer the services can create
20 some disparities across the country that are not really
21 well understood or appreciated. But, if you come from a
22 generous state, you'll receive a lot more services than a

1 state that isn't as investing as much in HCBS, and that can
2 be a disadvantage.
3 MS. ALBAROUDI: Great. Thank you both for your
4 responses.
5 So, before we move into our final domain, we
6 would like to understand for those complexities that exist
7 in administrating HCBS, what federal policy levers or state
8 flexibilities could help simplify administration of home-
9 and community-based services.
10 Ms. Moss, if we can kindly begin with you?
11 MS. MOSS: I think -- so part of it is the
12 complexity around the different state waivers. Like I
13 mentioned earlier, Tennessee is trying to bring our 1915(c)
14 waivers into our 1115 waiver. That has been a two-year-
15 long process, and there is no end sight at this point. So
16 that is something that would be helpful to be able to move
17 forward.
18 Also, really looking at our "no wrong door" work
19 that we've been doing for a lot of years, I'm not sure how
20 effective that has been across the country. I know in
21 Tennessee, you know, obviously, we have challenges just
22 like everyone else does. We have been able to leverage our

1 AAAs to assist with make streamlining the application
2 process for individuals and eligibility and things of that
3 nature.
4 Also, workforce capacity, like we've already
5 mentioned, is really our primary struggle at this point.
6 People can get into programs, but, okay, so what? I'm in a
7 program. I don't have services. We can't find bodies to
8 provide those services. And so I really think that is
9 going to be our primary focus over the next several years,
10 if not longer, because getting at bottom what -- how do we
11 incentivize people to go into this work, especially when it
12 is low-wage work, especially when it is so strenuous
13 emotionally and physically, you know, and really creating
14 pathways for high school students, college students, to see
15 this as a rewarding career, to see it as a career ladder.
16 You know, where can you go? And at the same time, we need
17 people to continually go into it because you can't have
18 just a bunch of managers. We've got to have people
19 providing services.
20 So I think those are the key considerations right
21 now for all of us to start thinking through and try to
22 solve.

1 MS. ALBAROUDI: Great. Thank you.
2 Mr. Claypool?
3 MR. CLAYPOOL: So I'm answering a question on the
4 complexities that exist, right? And I have worked for a
5 while on this 1915(i) of the statute, and so I'm -- forgive
6 me. I may be pie in the sky, but it would be nice to have
7 a state plan service where you offered the bulk of the
8 services through that, and then you could build on top of
9 that some of the specialized services that would address a
10 broad range of different populations. And that would be
11 triggered when they reached the specific eligibility
12 criteria for that service.
13 And if you had a kind of consolidated state plan
14 service, it would go a long way towards, I think,
15 addressing some of the unmet need that's out there and at
16 least giving people a more direct approach to getting the
17 services that they need. Right now, it's just too
18 difficult for them to navigate.
19 So I appreciate the work that Tennessee is doing
20 and think that the model is great for integration there.
21 And just building on 1915(i), I don't know if
22 it's really worth the Commission's time, but thinking about

1 the fact that it permits enrollment triggers -- so, if you
2 set a target for enrolling in a state plan option and you
3 exceed that, you're able to get a five-year period where
4 you're going to pause enrollment, and then you can work on
5 how you're going to integrate the rest of the population
6 into your SPA.
7 So I'm curious if there aren't ways of making
8 sure that some of the existing authorities couldn't work
9 better, and of course, 1915(k) comes with the enhanced
10 match that a number of states have taken advantage of.
11 MS. ALBAROUDI: Great. Thank you so much.
12 Now moving on to our final domain, reconsidering
13 the design of the Medicaid HCBS benefit. So all states
14 provide some level of home- and community-based services to
15 beneficiaries. However, as mentioned earlier, states
16 differ. In the Medicaid statutory authorities, they use
17 the services that they provide in the populations they
18 cover.
19 MACPAC does have work underway around rethinking
20 the design of the Medicaid HCBS benefit to support both
21 increased access to HCBS as well as to simplify the
22 administrative complexity and the delivery of home- and

1 community-based services.

2 We would like to hear from each of you about some
3 key considerations you would recommend that policymakers
4 take into account in any effort to both increase access to
5 HCBS and simplify administrative complexity.

6 Specifically, Ms. Moss, can you discuss the
7 considerations from the state's perspective?

8 MS. MOSS: Sure. And I'm sorry if this feels a
9 bit like Groundhog Day. A lot of the discussion around
10 each of these is very much the same.

11 One of the things I think is a benefit in
12 Tennessee is that we do have statewide MCOs. We don't have
13 pockets of managed care, so that benefits vary across the
14 state or in different regions.

15 We do have our statewide plans with the same
16 requirements across the state, and I think that is somewhat
17 unique for us and as a benefit to our members.

18 Now, that being said, there's also, of course,
19 disparities in rural versus urban areas and access to
20 providers, and so part of what COVID has taught us, for
21 better or worse, is that telehealth is a very real
22 opportunity, telehealth through enabling technology,

1 through use of assistive technology, and those sorts of
2 ways.
3 Now, rural and urban is still a disparity there,
4 to some extent, because of what we were talking about
5 earlier with broadband not being a reimbursable service,
6 with internet access maybe being more spotty in rural
7 areas. And so there are challenges even in a state like
8 Tennessee where we have found some ways around those sorts
9 of issues.
10 MS. ALBAROUDI: Great. Thank you.
11 And, Mr. Claypool, can you discuss these
12 considerations in the context of what is most important to
13 beneficiaries when a state is looking to streamline access
14 to home- and community-based services?
15 MR. CLAYPOOL: Sure. And, like Katie, I get to
16 underscore a few points that I've made.
17 Take steps to bolster and protect the social
18 supports provided through HCBS as it becomes more
19 integrated with the broader health care delivery system.
20 To the extent that it's happening now, it varies, but
21 that's where we're headed. And the real challenge here is
22 that there are large clinical interests that will direct

1 how these services are provided, and it would be really
2 unfortunate if that occurs and we wipe out the qualitative
3 aspects of what comes with HCBS that are really focused on
4 the social supports that people need.
5 Just underscoring, be aware of over-
6 medicalization of the direct care workforce. I've talked
7 about how to get better compensation to them by paying them
8 for the social determinants.
9 Have strategies for dealing with the special
10 interests that shape the structure of these programs today.
11 Invest in peer-support models for people living
12 with behavioral health issues. Of course, CMS should
13 contract with some very robust TA center to help states
14 that are struggling with this, with a whole host of issues.
15 But I, just in closing, would reinforce to the
16 extent the ADRC, "no wrong door," however it's called, is
17 going to be able to be effective in communicating, they
18 need to have one stop where people can go and get the real
19 information that they need and not be sent to another
20 resource so that they can learn about the program from
21 someone else.
22 And I would finally say that looking at person-

1 centered approaches is important, but that language is easy
2 to articulate. But the practice is difficult to adhere to.
3 So more authenticity in person-centered practices, I think,
4 is needed in HCBS and in the delivery of health care more
5 broadly.
6 Thanks.
7 MS. ALBAROUDI: Thank you both for your time
8 today.
9 With that, I'll turn it back to the Chair to kick
10 off the discussion.
11 CHAIR BELLA: Well, I have several questions, but
12 that would probably be rude. So I will defer to my fellow
13 Commissioners to kick us off.
14 Dennis, you want to kick us off? I know you have
15 probably more questions than I do.
16 COMMISSIONER HEAPHY: I guess I'm hearing the
17 word "crisis," and I don't think people will understand
18 what the impact of that crisis is going to be in the next
19 five to ten years, if we just articulate what is the
20 outcome of that crisis going to be.
21 MR. CLAYPOOL: Yeah.
22 COMMISSIONER HEAPHY: What's it going to mean?

1 MR. CLAYPOOL: People won't get out of bed, or
2 they will languish in their wheelchair or they won't have
3 the right support during the day. And what happens then is
4 you'll probably fall back on an emergency management
5 system. Guess who gets called? The police. They'll
6 become involved. The firemen will be called to help
7 somebody who isn't getting the attention they need. Then
8 the state will also be involved because adult protective
9 services will have to play a greater role if we don't make
10 investments in this direct care workforce soon.
11 We're on this path right now. We have people
12 that are pretty creative and getting by without all the
13 hours that they're allotted, but yes. There is reason to
14 be concerned.
15 COMMISSIONER HEAPHY: Katie?
16 MS. MOSS: So I'd like to put on my rose-colored
17 glasses for a second and just pray that we are not in a
18 true crisis 5 to 10 years down the road, like an Armageddon
19 situation, but I do think we are seeing a drastic decrease
20 in availability of people who want to go into this field.
21 People have burnt out in this field, and people who just
22 won't stay here, you know, long term because they can get

1 paid better elsewhere.

2 I think all of the things Henry said, people are
3 going to be at home. They may be institutionalized. They
4 may be put in group centers for day services or moving more
5 toward backwards, right, less integration, more
6 segregation, less independence, which is what we don't want
7 to see.

8 Now, what we are trying to do -- and I know many
9 other states and even CMS is looking at solutions for
10 workforce development, and what we're trying to do from a
11 service perspective is encourage innovative ways to get
12 folks to a level of independence.

13 One of the things that we're really pushing among
14 our membership is looking at enabling technology and where
15 can enabling technology come in and help your loved one or
16 your child become more independent. From some of our
17 statewide American Rescue Plan Act funding, our Department
18 of Intellectual and Developmental Disabilities is starting
19 this incredibly innovative pilot called MAPS, Medicaid
20 Alternative Pathways for independence, and it's focused on
21 those kids coming out of high school or that high school
22 age 18 to 21, getting them set up on a pathway to

1 independence so that they don't become dependent on 24/7
2 support, so that they learn how to navigate their world
3 using technology, using things that are much more familiar
4 to them that have been around their entire lifetime.
5 And so I hope some of that is going to alleviate
6 some of the workforce challenges that we are seeing now.
7 It's not going to solve all of it, and certainly, I don't
8 think it can be solved until we see reduction in the
9 disparity and the rates paid.
10 COMMISSIONER HEAPHY: And then I guess -- because
11 for me, my big fear is that we see people cycling in and out
12 of the hospital on a regular basis, EDs, and nursing homes
13 that are understaffed. So it's not just an understaffing of
14 HCBS services, but an understaffing of nursing homes as
15 well, particularly as baby boomers age, we're going to
16 really see a hospital system under duress.
17 We talked about the three waivers, which I think
18 that sounded like alphabet soup to people. Can you come up
19 with what the benefits are, and what would it look like if
20 we did away with the waivers and just did the right thing?
21 What would that look like? How would it make your life
22 easier, Katie, if you didn't have to deal with waivers and

1 you had access to the resources you needed without having
2 to go through waiver hoops?
3 MS. MOSS: Do you want to take a first stab at
4 that?
5 MR. CLAYPOOL: Well, he called you out, so --
6 MS. MOSS. I know.
7 MR. CLAYPOOL: The state perspective.
8 MS. MOSS: But I wanted to delay for a minute to
9 think about that.
10 MR. CLAYPOOL: I'm happy to --
11 COMMISSIONER HEAPHY: I mean, are there benefits
12 to the waiver?
13 MS. MOSS: I mean, I think there are a lot of
14 benefits, especially in Tennessee for our waiver, and I
15 don't know how much of this you all have seen in the news,
16 but our TennCare III Demonstration, which was approved
17 about a year ago, builds in an opportunity for the state to
18 collect shared savings based on yet-to-be-determined
19 quality metrics. And we think those shared savings could
20 be significant in ensuring availability of additional
21 services, in eligibility for additional groups of people,
22 really using all of those shared savings, putting them back

1 into the Medicaid program.

2 So I think we are in a little different position
3 than other states because we do have this brand-new, never-
4 before-seen type of waiver that was approved by the last
5 administration. So I don't want to get rid of that.

6 COMMISSIONER HEAPHY: Henry?

7 MR. CLAYPOOL: So you mentioned the services, so
8 maybe it's important to just think about what is in a
9 waiver program for an older adult or a person with a
10 physical disability. And it's not a whole lot, typically.
11 It's personal care, some environmental modifications, maybe
12 a personal emergency device, and a couple of other
13 services. And in the developmental disabilities world, at
14 least in the comprehensive residential services waivers,
15 they often have a fairly extensive list of social services
16 that are there to support the individual during the day and
17 the residential services that come.

18 So they are quite different, not that the
19 populations don't have different needs, but it would be
20 interesting to see how moving to a state plan approach
21 could have some efficiencies or streamlining and making
22 sure that when people access certain services, they do so

1 on a needs-based criteria instead of just relying on the
2 category.
3 COMMISSIONER HEAPHY: One last question on that.
4 You used the words "medicalized" a couple of times. Any
5 difference between the medical model versus an independent
6 living model, like a nurse versus -- could you say like why
7 that's important to you?
8 MR. CLAYPOOL: You know, I could use that
9 personal experience again of noting that the activities
10 that are occurring really aren't medical in nature. They
11 are very much kind of subsistence, and, therefore, it is
12 confusing why somebody, a third party, needs to be
13 overseeing the services that are delivered to someone that
14 are really intimate and very personal. The individual is
15 best at describing how they should be done. And when you
16 put a clinical approach on top of this, you then move
17 towards training, that regimen, how workers do certain
18 tasks, and that inherently can create conflict. I was
19 taught that I have to do it this way. The preferences are
20 like this. Well, now you can see -- but, wait, I'm the
21 person that needs the help, and now you're telling me how I
22 have to receive the services.

1 So that is, I think, the essence of the conflict
2 with medicalization.
3 COMMISSIONER HEAPHY: Katie, do you have thoughts
4 on that?
5 MS. MOSS: We do have struggles with that as
6 well, so we have -- our state plan benefits have home
7 health and private duty nursing, which are evaluated on the
8 basis of our state's statutory medical necessity definition
9 that's also in our administrative rules. On the LTSS side,
10 you know, we have a less strenuous definition which is
11 permitted through our state statute. And so I completely
12 understand the point there. We do, I think, have a
13 tendency of overmedicalizing the services provided, which
14 is not a very person-centered approach. I think in
15 Tennessee we're moving away from that. We have a
16 Department of Intellectual and Developmental Disabilities,
17 which I think is the first state agency accredited by the
18 Council on Quality and Leadership, CQL, for person-centered
19 training. And so their focus is very much on what does a
20 person need, what do those services look like. And, again,
21 not to just use the phrase without meaning, but we really
22 are encouraging providers across the state and our managed

1 care organizations to do a more person-centered, to have a
2 very person-centered approach and to even attain that
3 accreditation through CQL, so hopefully focusing less on
4 the medical model, more on what the person needs, what that
5 support looks like, and making sure that the services and
6 supports that they are getting are what they want.

7 CHAIR BELLA: You're good. Thank you, Dennis.

8 Darin and then Sonja.

9 COMMISSIONER GORDON: Thank you. Thank you both
10 for spending time with us today and giving us this
11 information.

12 I'm curious. You know, we talked about the
13 institutional bias and doing away with the institutional
14 bias. We talked about, you know, at the same time -- and
15 Dennis brought this up as well -- challenges in staffing,
16 institutional settings as well as staffing in home-based
17 settings. And, Katie, you talked a little bit about this
18 with the ARPA funding and how that helped to try to put
19 more funding out there to try to alleviate some of the gaps
20 in staffing.

21 I'm trying to think, as we think about what we
22 can do and what we can recommend to CMS, you know, funding

1 appears to be one piece of the puzzle, which sounds like
2 ARPA has been helpful, although that doesn't go on forever,
3 although you said they've already had a commitment to
4 continue it at a state level. So I'm taking from what you
5 all said continuation of, you know, what -- the advances
6 some states have done in leveraging ARPA to try to address
7 workforce issues. But what else? What else is out there
8 that if you had your wish list, you know, one or two things
9 that we should be thinking about that we could be
10 recommending to CMS to help address what, you know, I think
11 you have said, and I agree is a very significant problem
12 that isn't easily solved?
13 CHAIR BELLA: It could be recommendations to
14 Congress as well on your wish list. We'll take both.
15 Right, Darin?
16 COMMISSIONER GORDON: Yes, absolutely.
17 MS. MOSS: Hi, Darin. Great to hear from you
18 today and to see you. One of the things I've already
19 mentioned is Internet access and broadband, I mean really
20 expanding what counts as a reimbursable service from
21 CMS's perspective. We can't drive forward on
22 technological advances without availing ourselves of or
enabling

1 individuals to get access to basic broadband services. So
2 that's definitely on the wish list as well as --
3 CHAIR BELLA: Let me stop you there. What's
4 blocking you? And are your managed care plans doing it?
5 MS. MOSS: So there's some funding and, man, I
6 don't have that off the top of my head. I just saw the
7 release the other day. There's some grant funding
8 available for broadband services. What is blocking us is
9 CMS, candidly. I believe we had that in one of our
10 iterations of an amendment. We had to take it out because
11 it is not an available service that can be reimbursed
12 because it can be used for other things, right? You have
13 Internet, you could use that for whatever. How do you
14 limit that to just this smart medication dispenser or
15 communicating with your doctor's office? Is the assumption
16 you're going to be doing things you shouldn't be online or
17 just using it for school or something that's unrelated to
18 your service needs? And I think that's part of the
19 challenge. What does that box look like? How do you
20 monitor that? Does it matter? And maybe that's one of the
21 questions.
22 COMMISSIONER HEAPHY: Isn't that called a dual

1 purpose? So if something is a dual purpose, if you use it
2 for something other than the medical purpose, then it's not
3 permissible. So if you can watch TV using the Internet,
4 then it has a dual purpose, one that's not medical, so,
5 therefore, you're not allowed to have that one. Is that
6 correct?
7 CHAIR BELLA: Let's put this one on the list,
8 Asmaa. I mean, Medicare's doing this. The plans are doing
9 it. I thought some of the Medicaid plans were doing it,
10 but let's -- this is a nice -- we like concrete ones like
11 this, and I know you're going to give us some bigger ones,
12 too. This is a good one for us to have on the list.
13 COMMISSIONER GORDON: This would, you know, if
14 you had to be creative through value-based purchasing kind
15 of arrangements, or in-lieu-of services, I mean
16 particularly if in the absence of that it means someone is
17 going to have to go into an institutional setting, I think
18 an argument could be made. So, yeah, I think that is a
19 helpful one. Give us more.
20 MR. CLAYPOOL: Well, if I could just pick up on
21 Katie's example, there is the ACP. It's funded out of -- I
22 think the FCC actually administers it. The broadband

1 providers get a subsidy, and it was funded in the
2 Infrastructure Act, and it has funding for at least
3 probably three years, and it allows the broadband to be,
4 you know, put into someone's home, assuming they're
5 connected, for little or no cost. So it does seem like
6 some interagency coordination on access to broadband is an
7 important component for recommendation.
8 But on Darin's question, how broad did you pose
9 that?
10 COMMISSIONER GORDON: Fairly broad. I mean --
11 MR. CLAYPOOL: Anything?
12 COMMISSIONER GORDON: Well, here's my concern --
13 Henry and Katie, you all tell me if I'm missing this.
14 Looking at the situation we have today -- and I think
15 Dennis actually commented on it as well. If you look at
16 authorized hours versus served hours, we have a problem
17 already today. And looking at all the demographic
18 information and the increased level of need that we all
19 know is continuing to come our way, I kind of feel like --
20 you know, I agree with Katie, nobody wants to wait for an
21 Armageddon situation, so I'm trying to think about levers,
22 whether it is for, you know, non-clinical, but also, you

1 know, you hit on as well where we see this also in some of
2 the clinical supports, too, all that are necessary to keep
3 someone in the home, we have a serious labor challenge.
4 Okay, technology can help to some degree, but there's got
5 to be some other steps that are going to have to be taken
6 so as to not fall into a situation where I'm concerned that
7 may result in some folks being institutionalized
8 unnecessarily because we don't have appropriate supports in
9 the community.
10 CHAIR BELLA: Can I add to that? When you were
11 talking about your list, can you tell us concretely what
12 you want to see in presumptive eligibility and what you
13 would want to see, Katie, in the example you used about
14 when someone's about to lose their home? Where could the
15 state come in, and what would it take to get your
16 legislature also bought in on something like that, like us
17 understanding those things? So, Henry, we want to hear it
18 all. I doubt if we're going to charge the Hill and try to
19 get nursing home mandatory service removed, but we're
20 trying to do everything we can to equalize the access to
21 home-and community-based supports and kind of take it from
22 that angle.

1 MR. CLAYPOOL: Yeah, I think, you know, because
2 Darin poses it in the right way, that this workforce is
3 rather fluid, and so there is an institutional bias, and I
4 do think that that has had an effect on suppressing
5 workforce wages, not -- I'm not an economist so I probably
6 shouldn't say anything like that, but the reality is that
7 this workforce probably isn't paid enough, and it's because
8 we've relied on some other factors. And so I do think an
9 investment is warranted. I don't know if that is a call to
10 Congress. I can't go back to these tools like enhanced
11 match. I don't know that it's a broad ARPA-type "here's
12 money for HCBS," but something that's more targeted that is
13 built into rate setting that has the federal government
14 looking at where shortages are and making sure that
15 workforce compensation in those markets is adjusted
16 appropriately so that those gaps can start to be filled.
17 But I think there's a lot of sophistication that needs to
18 go into this work, and, unfortunately, we haven't done much
19 of it at all. We've just relied on a home care agency or a
20 nursing home to pay the staff. And now I think we need
21 labor economists to come up with better strategies for how
22 we can stabilize the workforce.

1 On presumptive eligibility, you know, I'm not a
2 good state person, and I haven't run a program, so I just
3 know that you should be able to be discharged -- or you
4 should be admitted into HCBS on a presumptive basis so that
5 you don't lose attachment to your home, so that you can
6 begin to get services when it looks pretty clearly like
7 you're going to meet that need if you would get the same
8 services if they sent you to a SNF or a nursing home. So I
9 think the way I understand it is states have to go through
10 some elaborate steps to qualify for presumptive eligibility
11 on HCBS, but I'm not an expert, so I'll not go further.
12 MS. MOSS: Well, and I certainly wouldn't say I'm
13 an expert on this either. I mean, I know from my
14 perspective just historically, you know, I was previously
15 in our Office of General Counsel for TennCare for five to
16 six years, and what we got hung up on is 42 CFR 435.217,
17 which is about -- sorry --
18 CHAIR BELLA: I might call that an expert, but
19 okay.
20 [Laughter.]
21 MS. MOSS: Well, which requires implementation of
22 basically a service plan before enrollment. And so the

1 Sixth Circuit, there was a case out of Ohio in the Sixth
2 Circuit where they weighed in, and they said, you know,
3 services cannot be provided unless they're provided
4 pursuant to a person-centered support plan. And so person-
5 centered support plans are generally developed after
6 enrollment. And so there has already been this process
7 that kind of defeats the purpose of any sort of presumptive
8 eligibility. You can't receive services until you've met
9 all of those predetermined criteria, and then someone has
10 to get involved to actually build the service plan for you.
11 And so there's some complexity around, at least
12 from a state perspective, as far as how we can implement
13 services, how somebody enrolls in one of our HCBS programs
14 today, they were in an assisted care living facility for
15 the past two months, we're not going to reimburse that from
16 the date of approval because it wasn't pursuant to our
17 person-centered support plan. It pre-existed that plan.
18 It might be the same afterwards, but pursuant to that
19 federal statute, we won't be able -- and the price
20 litigation of the Sixth Circuit, we wouldn't be able to
21 support that.
22 So that may be a little bit too in the weeds as

1 far as, you know, some of the complexities around HCBS.

2 COMMISSIONER GORDON: Very helpful.

3 CHAIR BELLA: Not in the weeds at all. Asmaa, I

4 know you caught that cite, right?

5 MS. ALBAROUDI: Yes. We did some digging around

6 presumptive eligibility, and we are well aware of the

7 requirement to have a plan of care.

8 CHAIR BELLA: Let me just do a process check,

9 because we're technically at the end of your panel almost.

10 Do you have time for a couple more questions?

11 MS. MOSS: Absolutely.

12 MR. CLAYPOOL: Sure.

13 CHAIR BELLA: Okay. Darin, did you make it

14 through yours -- well, actually, are you guys -- you have a

15 couple more things on your wish list, big and small?

16 COMMISSIONER GORDON: And you can follow up with

17 a list, you know, on your plane ride if you all are

18 thinking about it. We'll take your suggestions even after

19 the fact. Thank you both.

20 MS. MOSS: Thanks, Darin

21 CHAIR BELLA: I do, Katie, want to just have you

22 answer, because when I asked you what the legislature might

1 support in terms of trying to help with some of the housing
2 issues, your look made me think that it's a challenge
3 everywhere. When you said before that that was a barrier
4 and that was an issue, how would you like to see that? How
5 would that work practically in a more logical sort of
6 environment?

7 MS. MOSS: Can you spell that out a bit more?

8 CHAIR BELLA: Yeah. So when we were talking
9 about how the person is at risk of losing housing and then
10 let's say there's an event, they go into SNF short stay,
11 but they lose the house. And I think your point was
12 nursing home payment that we're going to pay for now each
13 month is going to cost more than what maybe the monthly
14 mortgage would have been. Again, if we had sort of a
15 system that accommodated, recognized the payment to the
16 nursing home is equivalent to the payment to stay in the
17 house, what would you want to be able to do?

18 MS. MOSS: Yeah. So I don't think it would
19 impact. I think my face was maybe in relation to thinking
20 about our state legislature. It wouldn't be at that level.
21 It would be federal legislation. And really looking at the
22 personal needs allowance for individuals in nursing

1 facilities and those deductions. You know, we've got
2 institutional medical expenses. We've got other things
3 that can be allocated and then a $50 personal needs
4 allowance. When you look at HCBS, they've got three times
5 the federal benefit rate, 300 percent of federal benefit
6 rate for their personal needs allowance, which obviously
7 allows them to stay in their home.

8 And from a conceptual point of view, it makes
9 sense, right? If someone is in their home they have to pay
10 to live there. If they're in a nursing home you're
11 thinking, well, you're not going to live there. So the
12 question is always intent to return. Are you in a nursing
13 facility, and do you intend to return home? So you're in a
14 nursing facility longer than a short-term stay, right,
15 because that's what we see most often, and you don't have
16 independently wealthy family members who can pay for your
17 mortgage or your reverse mortgage, whatever you have going
18 on with your home situation. So six months, seven months
19 in a nursing facility and your house is gone.

20 So looking at is there equity there. Is there a
21 way to balance how we look at that post-eligibility
22 treatment of income. If our true goal is for people to

1 remain in the community or go to into a nursing facility,
2 say, for short term, for rehab, for whatever purpose, and
3 then return to the community, why isn't the way we look at
4 income incentivizing that? Why are we handicapping people,
5 for lack of a better term, you know, by not allowing them
6 to maintain that community residence when we know housing
7 is a huge issue across the board.

8 CHAIR BELLA: Excellent. Thank you. Sonja,
9 thank you for your patience.

10 COMMISSIONER BJORK: Sure. The conversation has
11 evolved since I raised my hand, but I wanted to throw my
12 support behind looking into presumptive eligibility and
13 what the options are, given the current situation. Because
14 the folks trying to handle things in an emergency, it's
15 just not possible to get everything in place in any
16 reasonable amount of time, to preserve all the things that
17 the individual might have in place. So I think that's
18 really important.

19 And then Dennis touched on, and Mr. Claypool
20 touched on, the importance of delineating some of the
21 personal care supports and making sure they don't get
22 medicalized and making sure they don't get absorbed as

1 systems start to change.

2 I also really like practical tasks, so perhaps we
3 could make a list of some of the examples that we need to
4 really be aware of and careful of. We don't have to do
5 that now, but just making it clear what those types of
6 services are that need to be protected. Thank you.

7 Chair Bella Thank you, Sonja. Kisha.

8 VICE CHAIR DAVIS: Thank you. This has just been
9 a fabulous panel. So much insight. And I appreciated the
10 wish list.

11 I wonder about the reverse of that. Are there
12 things that we should stop doing, especially in the
13 interest of streamlining? Are there unnecessary barriers?
14 Katie, you brought up the service plan before enrollment.
15 Does that change? Are there other things like that that
16 are getting in the way of really being able to provide the
17 care in the way you think it should be?

18 MS. MOSS: Really great questions that I did not
19 prepare in advance for or think of in advance when I was
20 thinking through this panel. Things that we should stop
21 doing. Henry?

22 MR. CLAYPOOL: Well, you don't have a bunch of

1 waivers now, do you?

2 MS. MOSS: We have three.

3 MR. CLAYPOOL: Okay. Well, certainly I think

4 there was some relief granted to states about a five-year

5 cycle and being renewed, and I know what happens at CMS is

6 people are busy shuffling paper, renewing waivers that

7 haven't changed or are barely static. So it seems like

8 there should be a way of streamlining that process so that

9 states are less burdened, and taking advantage of these

10 services, and that CMS can focus its time on things that

11 are of higher value instead of shuffling paper for the

12 purpose of complying with a statute.

13 MS. MOSS: No, and it's actually a thought not

14 completely responsive to where you're going, but a thought

15 nonetheless about streamlining waivers. From a CMS

16 perspective, there are very specific time frames for

17 approval and review of 1915(c) waivers. There is nothing

18 comparable on the 1115 waiver side. That would be super

19 helpful. I don't know if it would be helpful to CMS to

20 have the same rules across the board or not, but it would

21 be super helpful from a state perspective to have some

22 inclination of when we're going to have a resolution on

1 waiver amendments that are submitted.

2 CHAIR BELLA: Other questions? Comments? Fred.

3 COMMISSIONER CERISE: I have a quick question.

4 Katie, you said the ARPA funds were helpful in you

5 expanding services or maintaining services. I guess that's

6 a bit of an experiment in if you have more money, you can

7 maintain services.

8 So, I mean, is that a successful experiment that

9 you were able to increase rates and therefore solve the

10 problem or make progress toward solving the problem? And

11 then what happens when those funds aren't there anymore?

12 MS. MOSS: So that's a really layered question,

13 right, really loaded question. I think when the ARPA funds

14 came down we were, what, about three-quarters of the way

15 through COVID. We weren't sure what workforce was going to

16 look like. It was all very different. People were getting

17 homebound services instead of community-based services.

18 There were lots of exemptions for people who don't have to

19 go into the community to receive services because of COVID.

20 And we don't have a great way of measuring what would've

21 happened if, right.

22 From my perspective, I think the funding has

1 allowed some providers to continue to stay in business. I
2 think absent that they may not have been able to. In
3 Tennessee, I can't speak for other states but in Tennessee
4 our legislature has supported continuation of fees rate.
5 And to be clear, we don't mandate wages, direct support
6 provider wages, frontline worker wages in Tennessee. What
7 we have are rates that we pay to providers, and based on
8 our calculations that should equate to those providers
9 being able to pay frontline workforce $12.50, and then most
10 recently, $13.75. So that's where we are based on our
11 rates.

12 And our legislature has committed to supporting
13 those long term, so those aren't going away in Tennessee.
14 What's going to change is we are buying back that funding
15 for the next couple of years through the use of ARPA funds.
16 So I think in other states it looks very different. You
17 know, I don't know if they're going to fall off a cliff
18 from rates. I hope not, but I think that is a possibility
19 with ARPA funding.

20 COMMISSIONER CERISE: The other part of my
21 question is, is that going to be enough? You mentioned
22 immigrants, and that was a part of the workforce

1 previously, not that that's the answer. But is there some
2 other pipeline strategy that we're going to need necessary.
3 Because if $13 is it and that's going to be career-limiting
4 for a lot of people, so is there something, a broader
5 strategy there, that can be linked to other public programs
6 or something where, you know, you get your college tuition
7 paid after a couple of years of service, or one of these
8 other programs that you can develop a pipeline with.

9 MS. MOSS: Yeah. So let me be super candid on
10 the rate piece. I mean, we're not where we need to be. I
11 think any provider agency, any direct care worker across
12 the country would say $13.75 is nowhere near what they need
13 to be paid. They could get $18 an hour at Target. So that
14 is still very much a gap.

15 Looking at workforce pipeline, our MCOs are doing
16 some really great work with apprenticeship programs, with
17 high schools. We are building our direct competency-based
18 education process and workforce development plan to
19 encourage and incentivize, again using ARPA funds,
20 additional education, working to tie those to community
21 college, technical college credits. And in Tennessee,
22 individuals, we hope, starting in January, will be able to

1 access those college credits using Tennessee Promise
2 dollars, Tennessee Reconnect dollars, to support that, and
3 then also get incentive payments tied to accessing those
4 credits.
5 Now is that going to be enough to get somebody in
6 the door for a $13.75 job? Maybe for some people. Maybe
7 for short term. Not long term. I mean, we still have a
8 lot of work to do. And I know ACL has just rolled out a
9 direct support -- my brain is blanking --
10 MS. ALBAROUDI: Strategy? The caregiver
11 strategy?
12 MS. MOSS: No. The workgroup. The email came
13 out last week. Henry, help me here.
14 MR. CLAYPOOL: I'm sorry.
15 MS. MOSS: Darn. Anyway, there's a new group out
16 of ACL where they're focusing on nationwide workforce
17 development strategy and planning, and bringing together
18 economists and all sorts of other people to look at this
19 and to develop a nationwide strategy, because it's
20 certainly not something we're going to solve one state at a
21 time.
22 MR. CLAYPOOL: And just one thing that I've seen

1 recently is providers basically not taking people unless
2 they have a family member that's going to provide, or a
3 friend or something. They're bringing their caregiver with
4 them. I don't know that that's a reliable strategy, but I
5 do think that to fill gaps states should be looking at what
6 they allow for spouses and others to be paid.
7 CHAIR BELLA: Okay. Lightning round. You have a
8 magic wand. What else do you want us to know before we
9 wrap up? And like Darin or someone said, you can send us
10 your ideas, all day, every day. Like this is not a one and
11 done. But if there's anything else you want to get on the
12 table, we'd love to hear it.
13 MR. CLAYPOOL: I just was -- you know, I'm a big
14 fan of integration and so I'll speak to the duals, and
15 looking at what the MA letters this last year was calling
16 for D-SNPs to form enrollment advisory committees, or
17 something of that nature. I think that's a start, is
18 trying to educate the broader health care delivery system
19 about the value of home-and community-based services. And
20 I think getting consumers in front of clinical people and
21 financial people can only help.
22 But we need to find additional ways to help the

1 plans that are pursuing integrated care to really
2 understand the value here. It's not sufficient to acquire
3 a home health chain and then have them go out and have a
4 group of nurses doing services. They need to really
5 understand the value that these community-based
6 organizations have brought to the lives of people with
7 disabilities and older adults that live in the community,
8 and sometimes that gets lost on people in their clinical
9 training. So look for more strategies. I guess we'll have
10 to make the list of delineating the types of services and
11 how they need to be protected so that we can help people
12 understand why they're so important.

13 MS. MOSS: Yeah, I really think pie-in-the-sky
14 vision, a holistic view of the people that we support,
15 holistic care, not siloed, not segmented care where the
16 people serving this person are incentivized for looking at
17 and addressing all social determinants of health, where
18 payments are outcomes-based, positive outcomes-based,
19 incentivizing independence and receipt of services where
20 the person wants to be and how the person wants to be
21 served.

22 You know, we still have a way to go in Tennessee,

1 and we're in a really good spot, comparatively speaking.
2 But there is still lots of work left to be done.
3 COMMISSIONER HEAPHY: This may be a question for
4 Asmaa. What do we learn from rebalancing spending, and
5 what are the barriers to rebalancing spending, and where?
6 Have we found that rebalancing spending is really
7 succeeding?
8 MS. ALBAROUDI: Yeah, so MACPAC published a
9 report a couple of years ago regarding rebalancing, and one
10 of the barriers was state capacity and expertise around
11 HCBS. And correct me if I'm wrong, Katie, but I believe
12 that continues to be a problem in some states. But we know
13 since 2013, the funding towards home-and community-based
14 services has outpaced institutional care, so we know we're
15 on a good trajectory, but I think there's more that needs
16 to be done there.
17 And then separate from that, some of the other
18 findings from the report was that the institutional bias,
19 of course, in Medicaid, and then presumptive eligibility
20 was something that was called out as a fine thing.
21 COMMISSIONER HEAPHY: Thanks.
22 CHAIR BELLA: Okay. We are going to release our

1 panelists. You are welcome to stay. We're going to
2 continue chatting about this for a little bit. We're
3 really serious about as you have ideas -- you know, some of
4 the work MACPAC does is sort of a one-cycle thing. This is
5 not a one-cycle thing. This is a multicycle look at how we
6 can address some of these issues. So thank you very much
7 for your time today.
8 MS. MOSS: Thank you.
9 CHAIR BELLA: Okay. We have a little bit of time
10 for Commissioner dialogue, and then we'll take public
11 comment, and then we'll wrap for the day.
12 **### FURTHER DISCUSSION BY THE COMMISSION**
13 * CHAIR BELLA: Let me start with our remote folks.
14 Heidi, Rhonda, Darin? I see a no, a no. Anything?
15 COMMISSIONER ALLEN: I just, you know, thinking
16 about the low-wage workforce and family members of mine who
17 have been caregivers and just the physical toll that it
18 took on them, you know, lifting people and moving people
19 and bathing people, and how many of them are on Medicaid.
20 That's also kind of a connection that we know that 7 in 10
21 people on Medicaid are working, and I think a lot of them
22 are caregivers. I'd be interested to know kind of what the

1 real number percentage is.

2 But thinking about them both in terms of how will

3 they serve Medicaid patients but how do they themselves

4 maintain their health as Medicaid enrollees, is just

5 something that's going through my head.

6 CHAIR BELLA: Darin? Thank you, Heidi.

7 COMMISSIONER GORDON: Yeah. [Inaudible.]

8 CHAIR BELLA: What?

9 COMMISSIONER GORDON: Can you hear me?

10 CHAIR BELLA: Yes.

11 COMMISSIONER GORDON: Just tagging on to Heidi's

12 comment. I wondered that too, you know. We have a

13 workforce challenge in this space. Some folks in Medicaid

14 may be working as direct care workers. But we do have

15 limitations, right. You know, they work over a certain

16 number of hours they may lose their eligibility in

17 Medicaid.

18 You know, I think looking at that it would be

19 good to understand the statistic, because is there

20 something that could be done to not create artificial

21 barriers for those who are, one, willing to work in this

22 space, that are excited to work in this space, but are

1 fearful of working that extra hour or that extra shift that
2 they lose their benefits. It's something worth looking at
3 and better understanding the data, for sure, just to help
4 with the workforce challenge here.
5 CHAIR BELLA: I'm not sure if you can see all of
6 us but many heads nodding those comments, so thank you
7 both.
8 Folks in the room, comments? Dennis. You
9 digesting still?
10 COMMISSIONER HEAPHY: I want to get back to the
11 recommendations.
12 CHAIR BELLA: What's that?
13 COMMISSIONER HEAPHY: I want to get back to the
14 clear recommendation.
15 CHAIR BELLA: You can reserve the right to come
16 back.
17 COMMISSIONER HEAPHY: I will, definitely. I just
18 might harp on the idea of the crisis that it will be, a
19 real crisis that's coming, and we need to invest now. And
20 I think it's an equity issue because we don't have all the
21 data, and as a matter of fact, my organization is engaged
22 in research and so is the center that Henry is on, and

1 looking at is as an equity to HCBS in ethnic and minority
2 populations right now, to see what happens as a result of
3 that. We think at least increased burden on unpaid family
4 members and hospitalizations. But we'll see.
5 CHAIR BELLA: Okay. Asmaa, do you have what you
6 need?
7 MS. ALBAROUDI: Yes. This was very helpful.
8 Thank you very much.
9 CHAIR BELLA: Thank you for putting it together.
10 Why don't you stay up there just in case we have any
11 questions from the public.
12 CHAIR BELLA: Okay. We are going to turn now to
13 public comment. If anyone would like to make a comment,
14 please use your hand icon and introduce yourself and your
15 organization. And we would ask you to keep your comments
16 to three minutes or less, please.
17 It looks like we can start with Sarah Potter.
18 **### PUBLIC COMMENT**
19 * MS. POTTER: Unmute. Okay. I'm Sarah Potter.
20 I'm from North Carolina, and I just want to make a comment
21 about the crisis that we're in, and I'm not telling any of
22 you anything you don't know. And North Carolina is

1 particularly bad. We have 15,000 on our wait list now for
2 home- and community-based services and growing, and no plan
3 for eliminating it anytime soon.
4 But I just would like to give an example of a
5 young man whose mother died over a year ago. He has been
6 on the Board of the Disability Rights. He is currently the
7 co-chair of our DD council. He is actually the co-chair of
8 our Olmstead Stakeholder Committee, and he has been without
9 personal care help for months, and with the help of the
10 AHRQ, they've managed to get his enhanced rate up to $20 an
11 hour, and he still can't find anyone.
12 And so yesterday he went to the doctor, and the
13 doctor suggested he go into a nursing facility. And if
14 this man who has the help of DD council, the head of Health
15 and Human Services, the secretary of the state vocational
16 rehab -- if he can't get the help that he needs, I don't
17 know where we go from here.
18 And when he met with all of them last week, they
19 said to -- they put it off on him. He's in his 20s, and
20 they turned it back on him and said, "Go think about it,
21 and come back to us with some suggestions." Now that's a
22 problem. We're blaming the victim here. And he's got his

1 own home, but he can't get the staff to help him get out of
2 bed in the morning.
3 So I hope people keep writing in with their
4 suggestions. We need to change our $2,000 limit on Social
5 Security. He works for the Independent Living Center in
6 our town. If he can't navigate this system, then nobody
7 can.
8 And we shouldn't have a marriage penalty. We
9 throw up barriers, these artificial barriers, across the
10 board, and you all are highly intelligent. The comments
11 I've heard today are unbelievable. I can't believe that we
12 can't come up with recommendations.
13 And you talk about Congress and legislature. We
14 can't manage what we don't measure. If we don't -- in
15 North Carolina, we do a terrible job of collecting data
16 because they're embarrassed. They don't want it public.
17 They don't want the rest of the country to know how bad we
18 are. I think we're rated like 46th, but I think we might
19 even be lower than that. I don't know how many other
20 states haven't addressed 15,000 people on a wait list for
21 home- and community-based service.
22 And, historically, we have an institutional bias,

1 but that has to be addressed. I don't know what it takes.
2 Legislation to -- you know, I don't want to do what we did
3 to the mental health population so that they end up on the
4 street, but until we change our paradigm, nothing is going
5 to happen.

6 And thank you for the time to just rant, because
7 I get so upset. Thank you. I have a 35-year-old, and I'm
8 in my 70s, and I don't want to -- I've been working his
9 whole 35 years so that this won't happen, and when I hear
10 they're going to institutionalize this young college
11 graduate who has everything to offer his community, be
12 institutionalized in nursing home, I just -- I can't handle
13 it anymore. Thank you.

14 CHAIR BELLA: Well, we should be the ones
15 thanking you for taking the time to share your feedback.
16 There's ways to reach out to us, and we would welcome
17 continued input from you as a caregiver and certainly from
18 the person you're recognizing in North Carolina as we
19 continue this work. So thank you very much, Sarah.

20 MS. POTTER: Thank you.

21 CHAIR BELLA: Next, we have Pam Parker.

22 MS. PARKER: Thank you. I'm Pam Parker from

1 Minnesota. I work with the SNP Alliance, but I'd like to
2 speak as a caregiver today.
3 I have a 90 -- almost 98-year-old mother. On
4 Tuesday, I am going 400 miles north to live with her for a
5 while because -- and I do work for the SNP Alliances but
6 fortunately can be virtual. And I'm going there because
7 there are no caregivers in Northern Minnesota.
8 And a couple of the things -- and she's eligible
9 for everything. She's already in the waiver on the home-
10 and community-based service waiver, but there are no
11 bodies. And three things that -- some of which were
12 touched on and others weren't, I just wanted to say I've
13 been thinking about this a lot because of my personal
14 situation and also professionally with the work that we do
15 with SNPs.
16 But three things that come to mind is -- and I
17 think Henry mentioned something about market areas. That
18 is a definite issue for rural areas. There are two big
19 manufacturing plants up in that Northern Minnesota area
20 where my mother is, and they take all the people. And
21 there's just not -- the restaurants are partially open and
22 closed, even on weekends. The whole area up there is -- we

1 can't compete with -- for other kinds of labor, so that's
2 an issue.
3 And, if there was a way to tie the wages and the
4 payments somewhere more closely to the different market
5 areas in terms of where the wage competition is, I think
6 that's a thing to continue to consider.
7 The other two things that haven't -- I haven't
8 heard here yet is how transportation makes in-home care so
9 unviable financially for people in rural areas, and if
10 there were a transportation -- I don't know -- subsidy for
11 the workers in some kind of a way, if it was attached to
12 transportation, I think that would be of some help.
13 Another area that I think we have to do a whole
14 lot more thinking about is the issue of childcare, daycare,
15 to attract workers in this field. We had an aide that was
16 taking care of my -- or an aide that was maybe going to
17 take care of my mother for a while, and she wanted to bring
18 her two-year-old or one-year-old baby with her, and my
19 mother, you know, kind of freaked out about that. But I
20 actually -- and then, of course, it was against the rules.
21 But I actually was trying to talk my mother into it, saying
22 maybe this is the kind of thing that we need to do. They

1 put the kid in a little playpen or something and help out
2 while you're there. Maybe that's a model that could
3 actually work in some cases.
4 And so maybe we have to rethink about how we look
5 at all those kinds of things, and certainly daycare
6 subsidies for workers might be another way to attract
7 workers.
8 So I thought just from my own personal
9 experience, I'd throw these things at you. Thanks very
10 much.
11 CHAIR BELLA: Pam, thank you. We're used to you
12 sharing your wisdom on duals and integrated care, and it's
13 really helpful for you to share the personal story as well,
14 so thank you.
15 MS. PARKER: Thank you.
16 CHAIR BELLA: Okay. I don't see any other hands.
17 Do we have any other comments from Commissioners?
18 [No response.]
19 CHAIR BELLA: Those were pretty emotional and
20 moving comments and I think kind of reinforce why this is
21 really important for us and to make sure that we don't have
22 ivory tower glasses on when we're thinking about this issue

1 and like really getting input from the front line.

2 I think we'll end with that, unless Dennis -- any

3 final words?

4 COMMISSIONER HEAPHY: I don't want to end up in a

5 nursing home. I don't think anyone wants to end up in a

6 nursing home, and so we're really doing this for everybody.

7 It really is how we make sure service is available for

8 everybody.

9 CHAIR BELLA: It's good sentiment to end on.

10 Asmaa, thank you.

11 CHAIR BELLA: Commissioners, thank you.

12 MACPAC team and Kate, thank you.

13 Tech team, thank you.

14 Everybody, we will be back tomorrow. We'll start

15 at 9:30 Eastern time. So enjoy your evening. Thank you

16 for staying energized, and we'll see you in the morning

17 when convened.

18 * [Whereupon, at 4:58 p.m., the meeting was

19 recessed, to reconvene at 9:30 a.m. on Friday, October 28,

20 2022.]

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PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004
AND
Via ZOOM

Friday, October 28, 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
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, everyone. Welcome to
4 day 2 of our October MACPAC meeting. We are thrilled to
5 get started this morning talking about maintenance needs
6 allowance. So we have Asmaa and Tamara. I will turn it
7 over to you all while we get an echo issue resolved.

8 We're resolved. All right. We're ready to go.
9 Welcome.

10 **### MAINTENANCE NEEDS ALLOWANCES (MNA) FOR**
11 **BENEFICIARIES RECEIVING HOME- AND COMMUNITY-BASED**
12 **SERVICES**

13 * MS. HUSON: Good morning, Commissioners. Asmaa
14 and I are here this morning to talk about maintenance
15 needs allowances.

16 This is just an overview of our presentation
17 today. I'm going to begin with some background and then
18 turn it over to Asmaa to talk through the data.

19 We have begun exploring financial eligibility for
20 long-term services and supports, particularly for
21 individuals who use HCBS. And in particular, we are
22 interested in understanding what it costs for HCBS

1 beneficiaries to live in the community relative to their
2 state's maintenance needs allowances.
3 In order to begin to understand this topic, MACPAC
4 contracted with the State Health Access Data Assistance
5 Center, or SHADAC, to update a 2017 study by the Urban
6 Institute that examined maintenance needs allowance limits
7 relative to household expenditures.
8 But first, just to give a little bit of context
9 to frame our discussion, in order to access Medicaid LTSS,
10 individuals must meet financial and functional eligibility
11 criteria, which are set within broad federal guidelines and
12 so they can differ by state. In regard to functional
13 eligibility, Medicaid LTSS eligibility determinations
14 generally focus on level of care criteria rather than the
15 existence of specific clinical conditions. This is
16 particularly true for older adults and people living with
17 disabilities. And states use functional assessment tools,
18 which are sets of questions that collect information about
19 an applicant's health conditions and functional needs to
20 determine eligibility for LTSS and to create a care plan.
21 Functional criteria are typically defined by
22 everyday activities an individual is unable to perform

1 without assistance due to an underlying physical or mental
2 health impairment, including activities of daily living,
3 called ADLs, such as eating, bathing, dressing, and
4 transferring from bed, and instrumental ADLs, or IADLs,
5 such as housework, laundry, meal preparation,
6 transportation, grocery shopping, medication management, or
7 money management.

8 And most HCBS programs require that individuals
9 demonstrate an institutional level of care. And these
10 level of care criteria are determined by the state, and
11 therefore can also vary by state. For example, one state
12 may require a person to need assistance with three ADLs
13 while another state requires needing assistance with four
14 ADLs in order to be eligible for HCBS. And the functional
15 eligibility criteria can also vary by LTSS subpopulations.

16 Financial eligibility for Medicaid LTSS is
17 determined based on both income and asset limits. States
18 have the option to disregard certain types or amounts of
19 income. So in general, countable income includes earned
20 income, such as wages, and unearned income such as Social
21 Security benefits. It also includes income from trusts and
22 unemployment benefits. Countable assets may include cash

1 and other liquid resources such as stocks and bonds. Some
2 assets are excluded, such as a primary residence, household
3 goods and personal effects, and one automobile.
4 And in general, states are required to provide
5 Medicaid to individuals receiving supplemental security
6 income benefits, and the most common asset limits match
7 those of SSI, which are $2,000 for an individual and $3,000
8 for a couple.
9 There are many eligibility pathways in Medicaid,
10 as we know, but for the purposes of this research we
11 focused on the optional pathway referred to as a special
12 income level. The special income level pathway is an
13 optional pathway for those who have income up to 300
14 percent of the SSI benefit rate and who need a nursing
15 facility level of care. It provides states with an
16 opportunity for more flexibility in determining financial
17 eligibility, and 42 states and the District of Columbia
18 offer this pathway.
19 The majority of states use the SSI asset limits,
20 but a handful of states also use asset limits that are
21 higher. And this pathway is subject to post-eligibility
22 treatment of income rules, which is a set of rules for the

1 treatment of a person's income after they've become
2 eligible for Medicaid LTSS. These income rules apply to
3 both Medicaid beneficiaries living in institutions and to
4 HCBS waiver participants who come in through the special
5 income level pathway.
6 These rules calculate the share of income that a
7 beneficiary is responsible for, for paying for their care.
8 They include certain deductions such as a monthly
9 maintenance needs allowance, which I'll describe on our next
10 slide. Deductions also include an allowance for the spouse
11 of a married individual in which a beneficiary receiving
12 LTSS can direct some of their income toward the spouse's
13 income allowance limit. And these income allowance limits
14 can vary by state, and in some cases also vary by type of
15 LTSS used.
16 A maintenance needs allowance is the deduction
17 amount from an individual's total income that is intended to
18 support them living in the community by paying for some of
19 their expenses, such as room and board, as well as other
20 expenses not covered by Medicaid. These allowances are set
21 by states. There is no federal minimum, and so states have
22 discretion to set the allowance amount based on a reasonable

1 assessment of need. States also establish a maximum
2 deduction amount that is not to be exceeded by any
3 individuals in the state.
4 Some states set the allowance based on other
5 income eligibility thresholds, such as the medically needy
6 threshold or SSI limits. Some states also set allowance
7 limits that differ by waiver or by the beneficiary's place
8 of residence.
9 However, in the work we've done so far, we have
10 not yet analyzed how states set their allowance, but we do
11 know that in fiscal year 2018, allowance limits ranged from
12 $100 to $2,250 per month, and the median was just over
13 $2,000.
14 And now I will turn it over to Asmaa.
15 * MS. ALBAROUDI: Thanks, Tamara. Now I'd like to
16 take some time to discuss the results of our analysis, but
17 first I'll provide an overview of our methodology.
18 As noted earlier, our study updates 2017 Urban
19 Institute work by using their methodology and updating for
20 more current data. Our analysis also extends their work by
21 including a sub-analysis of individuals with and without an
22 LTSS need.

1 MACPAC contracted with SHADAC at the University
2 of Minnesota to explore both the financial resources and
3 household expenditures of older adults with low and modest
4 incomes who participate in the Health and Retirement Study,
5 or HRS survey. We narrowed our sample to a subset of HRS
6 respondents.
7 Our inclusion criteria were the respondent or the
8 spouse, when applicable, was at least 65 years of age,
9 resided in the community at the time of interview, and had
10 income that was no greater than 400 percent of the federal
11 poverty guideline, and that they also had complete
12 information on activities of daily living. We excluded
13 respondents that have long-term care insurance.
14 We used the Health and Retirement Study, or
15 again, HRS survey, which is conducted by the University of
16 Michigan and is a nationally representative, biannual
17 longitudinal survey. We used both their publicly available
18 as well as their restricted data for years 2016 and 2018,
19 and we also relied on the off-year 2017 publicly available
20 Consumption and Activities Mail Survey, or CAMS survey, to
21 identify household expenditures. And finally, we used 2018
22 state allowance limits from the Kaiser Family Foundation.

1 Before I review the results of the analysis, I'd
2 like to provide an overview of our study limitations. Our
3 original inclusion criteria was restricted to HRS
4 respondents who were either Medicaid-only or dually
5 eligible for Medicare and Medicaid. However, after running
6 a sample size analysis we found that the sample count was
7 too small to support further analysis. As a result, we
8 decided to change the inclusion criteria and expand it to
9 include individuals whose income was no more than 400
10 percent of the federal poverty guideline, which also aligns
11 with Urban's approach.
12 Second, we were unable to identify whether
13 respondents were accessing or could be eligible for home-
14 and community-based services. As a result, we relied on
15 ADL limitations as a proxy for LTSS need. We defined LTSS
16 need as some difficulty with two to five ADLs. What we
17 found was our resulting sample of LTSS need was small
18 relative to those with no LTSS need.
19 Given these sample size challenges, and HRS-
20 restricted data disclosure guidelines, we were limited
21 in our ability to share detailed data related to our
22 sample with LTSS need. As a result, any LTSS-specific data is

1 at the aggregate level and not by, for example, household or
2 respondent characteristics.
3 However, despite these limitations, our entire
4 study sample of adults aged 65 and older with modest means
5 are at some risk of receiving LTSS. For example, one study
6 found that approximately 70 percent of adults aged 65 and
7 older will develop an LTSS need. Another study found that
8 those with limited resources have a higher likelihood of
9 developing a serious LTSS need.
10 And finally, in terms of our last limitation,
11 other factors that affect household expenditures which are
12 not captured in this analysis, such as cost of living as
13 well as number of dependents, could also impact household
14 expenditures.
15 So keeping these study limitations in mind, I'll
16 now review some high-level information on the resources of
17 the study population as well as household expenditures.
18 Overall we found that our study population of
19 adults aged 65 and older had limited resources. According
20 to our analysis, the median annual income of our study
21 population was $16,984, and their countable assets totaled
22 $29,000. Given our particular interest in the LTSS need

1 population, some of whom are likely receiving or could be
2 eligible for home-and community-based services, we also
3 examined differences in resource levels.
4 We found that those with an LTSS need had more
5 limited resources than those with no LTSS need. For
6 example, compared to adults aged 65 and older with no LTSS
7 need who had a median income of $17,370, those with an LTSS
8 need had a median income of $12,738, and this was
9 statistically different.
10 We also found differences in home ownership,
11 where a higher percent of those with no LTSS need owned a
12 home.
13 As noted earlier, households in the study include
14 those with a CAMS respondent whose income is no more than
15 400 percent of the federal poverty guideline, 65 years of
16 age or older, and community based, and again, this
17 population is not limited to a Medicaid group.
18 We divided our preliminary findings into two
19 areas: household expenditures and state allowance limits.
20 First, in terms of household expenditures, our findings
21 indicated that 86.1 percent of household expenditures were
22 for essential expenses. This includes costs related to

1 housing, utilities, and even home maintenance. And half of
2 the households spent more than 82.9 percent of their income
3 on essential expenses.
4 In terms of our sub-analysis of LTSS need, we
5 found that for households with an LTSS in particular, the
6 data suggested they have lower household expenditures as
7 compared to those with no LTSS need.
8 Our next finding, and the primary area of
9 interest for our analysis, was around household
10 expenditures relative to state allowance limits. Our
11 finding demonstrated that roughly 40 percent of households
12 spent more than their state allowance limit. However, there
13 are several caveats to this data point. First, and as noted
14 during the limitations section, our study does not capture
15 other factors that may increase spending, such as cost of
16 living or number of dependents.
17 Second, additional studies exploring expenditures
18 relative to state allowance limits, which also capture
19 these other variables, are necessary to better understand
20 this finding. In terms of our sub-analysis, we found that
21 at least half of the households with an LTSS need had
22 essential expenditures that surpassed their state allowance

1 limits.

2 First, turning to our finding around household
3 expenditures overall, we were interested in the extent to
4 which our community-based population was spending on
5 expenses deemed essential, and again, this includes
6 mortgage or rent payments, utilities, home maintenance.
7 For some context, nonessential expenditures include
8 spending on trips, vacations, and hobbies.

9 We found that average essential household
10 spending represented 86.1 percent of total expenditures,
11 and nonessential expenditures comprised 13.2 percent.

12 Next, we were interested in examining household
13 spending by a range of household characteristics to
14 determine if certain characteristics could be indicators of
15 higher spending. For our study population, median annual
16 essential household expenditures for all households was
17 $21,352. For households with income below 200 percent of
18 the federal poverty guideline, their expenditures were
19 below $18,500, and for households whose income was between
20 200 and 399 percent of the federal poverty guideline,
21 expenditures were above $24,500.

22 MACPAC staff was also interested in understanding

1 the extent to which adults aged 65 and older used their
2 income for essential expenses. Overall, we found that
3 essential expenditures as a percent of income are at least
4 60 percent of household income for all income brackets, and
5 that half of the households in the study population spent
6 more than 82.9 percent of their income on essential
7 expenditures.
8 In terms of our sub-analysis, we found that
9 households with an LTSS need had lower overall essential
10 expenditures than those with no LTSS need. Specifically,
11 the data indicated that the median essential expenditures
12 for households with an LTSS need were $16,702 annually, and
13 this was statistically different than households with no
14 LTSS need, where median essential household expenditures
15 were $21,682.
16 Spending on housing differed by LTSS need, where
17 housing costs represented 52.4 percent of total
18 expenditures for households with an LTSS need, and this was
19 higher than households who reported no LTSS need.
20 As I mentioned earlier, one of our primary aims
21 was to identify if spending on essential expenditures
22 outpaces maintenance needs allowance for community-based

1 individuals. We looked at the percent of households whose
2 essential expenditures exceeded their state allotments
3 limit. Overall, for roughly 40 percent of households, both
4 married and unmarried households, essential spending
5 exceeded their state allowance by some amount.
6 Now looking specifically at maintenance needs
7 limits, we found that in states where annual allowance
8 limits were $12,000 or less, or roughly between $12,000 and
9 $15,000, at least 70 percent of households had essential
10 household spending that exceeded allowance limits by some
11 amount.
12 The data also suggested that some households in
13 states with more generous maintenance needs allowance
14 limits, such as states whose allowance limit was set at or
15 above the 2018 median amount, which was $2,024 per month,
16 had essential expenditures that exceeded their state
17 allowance limits. However, among this group, over half of
18 the household's essential spending was within their
19 relevant state allowance limit, meaning that their spending
20 on essential community living did not exceed their relevant
21 state allowance limit.
22 Now looking at our sub-analysis of LTSS need, we

1 found that even though households with an LTSS need spent
2 less overall on essential expenditures relative to those
3 with no LTSS need, at least 50 percent of households with
4 an LTSS need had essential spending that exceeded their
5 allowance limit. Our analysis found that households with
6 an LTSS need, 50.9 percent had annual essential household
7 spending that exceeded their relevant allowance by any
8 amount, 40.8 percent of households with an LTSS need had
9 essential spending that exceeded their allowance by 25
10 percent or more, and 31.9 percent of households with an
11 LTSS need had essential spending that exceeded allowance
12 limit by 50 percent or more.
13 This was statistically different than the percent
14 of households with no LTSS need, with the percent of
15 households who exceeded their relevant annual allowance by
16 any amount 25 percent or more, or 50 percent or more was
17 lower than households with an LTSS need.
18 Although our sample size was limited, this
19 finding suggests that LTSS need may be one of several
20 predictors resulting in spending that exceeds state
21 allowance limits.
22 I know that I reviewed a number of different

1 findings, but to summarize, our key takeaways were that we
2 found that most household expenditures was directed to
3 essential living expenses among community-based individuals
4 aged 65 and older, and for some households, essential
5 spending outpaced state allowance limits. However, given
6 that we were unable to restrict the study population to a
7 Medicaid group, some ambiguity exists around the allowance
8 limits and the role in meeting the needs of community-based
9 Medicaid beneficiaries.
10 Finally, additional research is necessary to
11 understand how these allowance limits are set as well as
12 their effect on both household spending for Medicaid
13 beneficiaries and their decision to live in the community
14 as opposed to an institution, keeping in mind that
15 allowance limits are one of several factors impacting such
16 a decision.
17 In terms of next steps, we would appreciate
18 feedback on the Commission's interest in exploring this
19 topic further. Some areas we can explore more include how
20 states approach determining maintenance needs allowance
21 limits and making a reasonable assessment of need. And we
22 can continue with work in this area to identify policy

1 considerations.

2 Thank you so much for your time today. I'll turn

3 it back to the Chair.

4 CHAIR BELLA: Thank you. I have to admit my head

5 is spinning a bit. Any time it feels like we know less

6 than we did when we started the work, it feels like that

7 means we should keep going in the work. I'm not saying at

8 all it's for lack of effort. For both of you it seems like

9 you've uncovered a lot of areas that we could do further

10 research in, to try to get a better sense of this.

11 Obviously, I'm putting my bias on the table, that

12 there's a lot more that we could do here. I'd love to hear

13 from the rest of you to see how you're thinking about what

14 we just heard.

15 Martha?

16 COMMISSIONER CARTER: Thank you for that

17 presentation, something I hadn't really put much thought

18 into before, so I appreciate that.

19 I would like to know more about how states

20 determine -- I think you mentioned that you might look into

21 that, how states determine that level of support and how do

22 they take into account cost of living, which is quite

1 different across the country. So how is that calculated?
2 MS. ALBAROUDI: Yeah. So that's an area that
3 we'd like to explore further. So we did some digging to
4 see if states have that information available, specifically
5 what factors they use to assess reasonable -- to assess
6 their maintenance needs limits, and really reasonable
7 assessment of need. And the one state that I kind of found
8 information on, they mentioned things such as shelter and
9 utilities as factors that they look at and sort of how much
10 it would cost to live in that region.
11 But I really found little to no information, and
12 I think that's something that we'd like to explore further.
13 COMMISSIONER CARTER: And differences, even
14 within a state, urban versus rural, there are just so many
15 variables. I can't imagine how a rate is constructed that
16 really suits everybody's needs.
17 CHAIR BELLA: Thank you, Martha.
18 Sonja, then Laura.
19 COMMISSIONER BJORK: Can you say a little bit
20 more about what was the barrier to getting the information
21 on Medicaid-specific?
22 MS. ALBAROUDI: In terms of the factors that they

1 use?

2 COMMISSIONER BJORK: No. In terms of the study

3 itself, how you said there -- we couldn't look at a

4 Medicaid-specific population. We had to look broader than

5 that.

6 MS. ALBAROUDI: Absolutely. So it was a sample-

7 size issue when we limited it to Medicaid-only and dually

8 eligible individuals, which was our original intent, but

9 the sample size was too small to support analysis. So we

10 had to expand that population.

11 However, even when we did, we found two studies

12 that sort of demonstrated or had evidence that led us to

13 feel that this population was worth exploring because they

14 could be at risk of having an LTSS need.

15 But I think that if we explore this area further,

16 it would be valuable for us to limit it to a Medicaid

17 population.

18 COMMISSIONER BJORK: Okay. Thank you.

19 MS. ALBAROUDI: Of course.

20 CHAIR BELLA: Urban had the same issue when they

21 did their first analysis; is that right?

22 MS. ALBAROUDI: Yes. Urban did not limit it to a

1 Medicaid population. It was for incomes -- for individuals
2 with incomes no more than 400 percent of the federal
3 poverty guideline.
4 CHAIR BELLA: So you have a good sense of how we
5 could get around that if we were to do additional work?
6 MS. ALBAROUDI: I think we'd need to look at what
7 data sets are available to help us support that approach.
8 I think we would want to identify a population that's
9 eligible for Medicaid that's currently receiving home- and
10 community-based services, that accounts for the factors
11 that I had mentioned, so sort of cost of living and number
12 of dependents. So I think we'd like to do more digging.
13 CHAIR BELLA: Great. Laura and then Heidi.
14 COMMISSIONER HERRERA SCOTT: So just a couple
15 questions. How does the maintenance needs allowance, the
16 amount that you -- the median that you provided, compare to
17 institutional monthly allowance? And I'm only saying that
18 based on the discussion we had yesterday about the biases
19 towards institutionalization. So how do those numbers
20 compare?
21 I have another question after that.
22 MS. ALBAROUDI: Oh, okay. So, for

1 institutionalized individuals, I think the federal minimum
2 is $30, but on average, the median is $50 as opposed to
3 home- and community-based services beneficiaries where in
4 2018 it was $2,024 per month. One of the reasons for that
5 is that HCBS beneficiaries are responsible for covering
6 room and board.
7 COMMISSIONER HERRERA SCOTT: Okay. But there's
8 no total number because of what it costs to
9 institutionalize someone monthly to compare it to the
10 monthly allowance for HCBS?
11 MS. ALBAROUDI: Oh, I see what you're saying. I
12 don't have that information right now, but I can definitely
13 kind of --
14 COMMISSIONER HERRERA SCOTT: Yeah, just to have
15 some frame of reference.
16 MS. ALBAROUDI: Of course. Yeah.
17 COMMISSIONER HERRERA SCOTT: Yeah. And then I
18 thought it was interesting that you used the median and not
19 the mean. So why did we choose that? Is it because the
20 swing is so big, and if we looked at the mean, does it
21 really change the numbers drastically depending on the
22 state?

1 MS. ALBAROUDI: Yeah. So we decided to use the
2 median partly for that reason, and the data that we had
3 available to us really highlighted the median, so it made
4 the most sense. And also, as noted earlier, we found that
5 any states that set their allowance at the median level or
6 higher were considered sort of, like, as more generous
7 allowance limit states.
8 COMMISSIONER HERRERA SCOTT: Okay.
9 MS. ALBAROUDI: So that was our approach.
10 COMMISSIONER HERRERA SCOTT: Okay. And then last
11 question --
12 MS. ALBAROUDI: Yeah.
13 COMMISSIONER HERRERA SCOTT: -- and this is more
14 of a fluffy question, so you may not be able to answer it.
15 Because so much of the budget is just to live, do we have
16 any sense of what's not happening or getting done, food, or
17 are there other subsidies that come into play, since a lot
18 of the money is just going to housing, electricity, and
19 things like that?
20 MS. ALBAROUDI: So, as part of the essential
21 expenses, we did look at food. So that was captured.
22 COMMISSIONER HERRERA SCOTT: Okay.

1 MS. ALBAROUDI: So, when we looked at the percent
2 of household expenses for spending, we did capture some of
3 that, but I think it's worth exploring sort of what this
4 maintenance needs allowance limit is intended to do for
5 HCBS beneficiaries. And, you know, we could do that.
6 COMMISSIONER HERRERA SCOTT: And do you end up
7 having to braid in other sources of funding benefits to
8 keep the person whole --
9 MS. ALBAROUDI: Yeah.
10 COMMISSIONER HERRERA SCOTT: -- if that's
11 available?
12 MS. ALBAROUDI: Sure.
13 CHAIR BELLA: Thank you, Laura.
14 Heidi?
15 COMMISSIONER ALLEN: Hi. Thank you for this, and
16 I'm sympathetic to how difficult it is to do this kind of
17 analyses with public data when you have to be limited by
18 the categories that exist and the sample size that exists.
19 I was a little confused, though, because the
20 presentation seemed to focus on two-plus ADL or IADL
21 limitations, but the materials that we were given often
22 focused on one or more. I was trying to wrap my brain

1 around it.

2 But one of the things I was having trouble

3 wrapping my brain around during the presentation is it

4 seems like one of your slides suggested that people with

5 the ADL limitations were more likely to exceed the

6 thresholds by 25 percent, 50 percent, 75 percent, and yet I

7 would expect them to be less likely because they have such

8 lower income. And so I'm just wondering if maybe I was

9 misreading the slide or if that was actually the case.

10 That doesn't seem right to me. I wonder -- or at least

11 that's not the relationship I would expect.

12 And I can't see the slide. Oh, there we go.

13 Yeah. So it looks like they're with an -- they're 50

14 percent to be over by any amount versus 38.5. I would

15 expect the opposite if they make less money.

16 MS. ALBAROUDI: Yeah. So I can answer your first

17 question and your second question. So I can start with

18 your first question regarding our focus on first two to

19 five ADLs, and then in some instances one ADL or IADL

20 limitation.

21 So we started off by only looking at two to five

22 ADLs. However, when we realized that there were some

1 sample size challenges and that we'd only be able to report
2 data at the aggregate level, we had asked SHADAC to include
3 a row in our tables that looked at a minimum of one
4 ADL/IADL limitation and then zero ADL/IADL limitation. So
5 part of that was sort of trying to maneuver the sample size
6 challenge and better understanding the population, which is
7 why we added that component to the study.

8 In terms of this finding, this is what we found
9 in the data. It was interesting because despite the fact
10 that households with an LTSS -- or individuals within LTSS
11 need had limited resources, they did exceed their state
12 allowance limits, and it was statistically different than
13 those households with no LTSS need. We could kind of
14 explore this area a little bit further to better understand
15 why these differences exist.

16 COMMISSIONER HERRERA SCOTT: Is it because
17 they're spending their money on essential things versus
18 unessential things? And why would we limit spending on
19 essential things but not limit on overall? It just seems
20 like it shouldn't be -- they shouldn't be higher income.
21 You know what I mean? Is it that the state rule is about
22 your essential spending?

1 MS. ALBAROUDI: Yeah. So the federal regulation
2 doesn't provide detail about how the maintenance needs
3 limit should be spent, and so we decided to focus on
4 essential expenses as they're likely the areas where
5 individuals would spend to support their community living,
6 but we do have in the memo information on non-essential
7 expenses as well.
8 COMMISSIONER HERRERA SCOTT: Okay. So I think
9 just to say it back, to make sure I get it --
10 MS. ALBAROUDI: Sure.
11 COMMISSIONER HERRERA SCOTT: -- the reason it's a
12 higher percentage is because they spend more proportionally
13 on things that they have to spend it on, like housing.
14 MS. ALBAROUDI: That's a fair statement. Yep.
15 COMMISSIONER HERRERA SCOTT: Okay. Thank you for
16 that. I appreciate it.
17 MS. ALBAROUDI: Of course.
18 COMMISSIONER HERRERA SCOTT: That's helpful.
19 CHAIR BELLA: Any other questions, Heidi?
20 COMMISSIONER ALLEN: Yeah. Actually, I'm just
21 thinking about the period of time we're in right now with
22 inflation and how just in every city in America, it seems

1 like the cost for regular goods and services and housing
2 and everything has really accelerated. Are any of these
3 states nimble in any way to changes in the economic
4 environment where consumers purchasing power goes so far
5 down based on, like, economic conditions?
6 MS. ALBAROUDI: So we don't have that information
7 today, but I think your point is well taken regarding cost
8 of living and inflation. And that is something that we
9 could keep in mind if we decide to explore this topic
10 further.
11 COMMISSIONER ALLEN: Thanks.
12 MS. ALBAROUDI: Of course.
13 CHAIR BELLA: My guess is that probably goes as
14 something we talk about as a policy consideration when we
15 look at how there might be things that would cause states
16 to make changes or adjustments. So that would be good to
17 put on the list.
18 Dennis, comments?
19 COMMISSIONER HEAPHY: Yeah. I wanted to know
20 more about the racial/ethnic divide there. As I was
21 looking at all the tables, I was looking at the different
22 rates of LTSS need versus no LTSS need by race and

1 ethnicity. Also, each table stood out for me. There were
2 different aspects of those where there where Black or
3 Hispanics that stood out. So I think if there's a way to,
4 like, highlight where there are disparities?
5 MS. ALBAROUDI: Yeah. So we did capture that
6 information by our different findings, and so, again, if we
7 decide to explore this topic further, we can definitely
8 sort of highlight those differences by race and ethnicity.
9 So I appreciate that comment.
10 COMMISSIONER HEAPHY: Good. They were in the
11 tables, but for me, if it had a category that said
12 disparities by --
13 MS. ALBAROUDI: Sure.
14 COMMISSIONER HEAPHY: I think I was as
15 overwhelmed as you were by all the information and things
16 that are going around my head is people who have subsidized
17 housing versus folks who don't, folks who have SSI versus
18 folks who don't have SSI, folks with SSDI. Like, there's
19 so many variables that go into this and the amount of
20 spending that people have. Do they pay for medications?
21 Are the medications out-of-pocket expenses? There are so
22 many variables here that I just -- in my life and in the

1 lives of so many other people. I'm wondering. Everyone is
2 so different. It could depend on what kind of insurance
3 they have. The variables are just incredible, and then
4 there's the Medicare cliff where expenses, your ability to
5 get -- there's so much. My hat is off to you for doing
6 this, and if I can get more information to you, I will.
7 As I started reading this, it just raised more
8 questions for me than anything else.
9 MS. ALBAROUDI: Yeah. And, actually, I
10 appreciate that comment about subsidized housing. These
11 are the things that we're looking for. So what are those
12 other factors that affect household spending? We had
13 provided two examples, cost of living and number of
14 dependents, but things such as like individuals who use
15 subsidized housing is important for us to think through.
16 COMMISSIONER HEAPHY: Yeah. And how is marriage
17 affected or being single affected, yeah.
18 MS. ALBAROUDI: Yep.
19 COMMISSIONER HEAPHY: The marriage penalty.
20 MS. ALBAROUDI: Right.
21 CHAIR BELLA: Tricia?
22 COMMISSIONER BROOKS: Yeah. I just want to go

1 back to the inflation factor and understand that. So
2 states have flexibility to establish their own allowances
3 with a minimum floor that CMS establishes in federal rules
4 or not?

5 MS. ALBAROUDI: So there's no federal minimum for
6 the maintenance needs allowance limits.

7 COMMISSIONER BROOKS: Any maximum?

8 MS. ALBAROUDI: So states can set their own
9 maximum.

10 COMMISSIONER BROOKS: Okay. But it's totally at
11 the state's discretion?

12 MS. ALBAROUDI: Right. That's right.

13 COMMISSIONER BROOKS: And there's nothing that
14 ties it to any kind of automatic adjuster like the FPL
15 always adjusts annually, nothing like that?

16 MS. ALBAROUDI: Not that I'm aware of.

17 COMMISSIONER BROOKS: Yeah. I think that's the
18 policy area. I think you pointed that out, Melanie. I
19 just wanted to pursue that a little more.

20 CHAIR BELLA: Okay. I'm going to say based on
21 today's discussion, based on yesterday's discussion, and
22 the interest of the Commission to really drill down on HCBS

1 and all of the things that go into it that there is desire
2 to continue the research. I think the questions you have
3 up there helping -- you know, we have what you've done. We
4 understand the limitations of that. So switching a little
5 bit more to the qualitative side and understanding how are
6 states doing this, what are those approaches, I'm sure
7 we're going to see quite a bit of variation. But I think
8 then being able to start to tease out what some of the
9 policy considerations are and then figuring out how we can
10 marry, kind of when we know what they're doing to what the
11 data are telling us, and how we can get more, like,
12 specific data that get around some of these caveats seems
13 like a very productive and extensive set of next steps
14 here.
15 So I think you are -- I didn't get the sense that
16 anyone was not interested in continuing down that path.
17 COMMISSIONER HEAPHY: I think better
18 understanding nursing home rates, like people in the two
19 states, what are the factors that lead to people going into
20 nursing homes? Are they economic reasons, or is it
21 hospitalization that leads to it? Because, again, you can
22 go straight from the hospital to the nursing home, no

1 problem. But going home, what are the barriers to actually
2 going home? Are they the economic barriers and not
3 necessarily -- are they economic barriers versus your
4 ability to actually care for yourself?
5 CHAIR BELLA: Yeah. I mean, again, weaving
6 together the conversations we've been having, looking at
7 things like presumptive eligibility, looking at the needs
8 allowance, all of those things, I think, have to come
9 together for us to understand barriers, financial and
10 otherwise, to people being able to receive services in the
11 community, return to community, all of those things.
12 Okay. Thank you, Dennis.
13 Any other comments from Commissioners? And, if
14 not, we have a little bit of time. So I'll go ahead and
15 take public comment.
16 Okay. We'll open this up to anyone in the
17 audience who would like to make a comment. I'll remind you
18 to please identify yourself and your organization and limit
19 your comment to three minutes or less. If anyone would
20 like to comment, please use your hand icon, and then we
21 will recognize you.
22 Claudia?

1 CHAIR BELLA: Claudia.

2 ### PUBLIC COMMENT

3 * MS. SCHOLSBERG: Thank you. First of all, I
4 really appreciate that MACPAC is looking into HCBS
5 eligibility. Both the sessions yesterday and then this
6 morning I think are focusing on some really critical issues
7 around barriers, certainly the conversation yesterday with
8 Henry Claypool and then earlier on the personal needs
9 allowance.

10 As a former state Medicaid director who spent a
11 lot of time on HCBS eligibility, I can tell you that with
12 MNIL, I believe in D.C. our MNIL is tied to an old AFDC
13 standard that dates back decades and has never been
14 revisited, and it has been definitely a barrier, and
15 particularly as it ties into spend-down, which is the one
16 topic I did not really hear discussed, and I would urge
17 MACPAC -- for example, CMS has -- part of the pending rule
18 on eligibility includes a very important new provision that
19 would allow states to treat -- there's a difference between
20 the way states treat and count income for HCBS versus
21 nursing home for spend-down purposes. And CMS has now
22 proposed a new rule that would eliminate that differential.

1 Basically in a nursing home you can use projected expenses
2 for spend-down, but in HCBS you have to use incurred
3 expenses, and so it's a very difficult process, one that
4 basically you can't really negotiate. So that's another
5 area that I hope MACPAC will focus on and support that
6 change.

7 But, again, I just want to emphasize how
8 important these issues are. The PNA, for example, in D.C.
9 is $100 a month for personal needs allowance in the home
10 and community, and, again, it hasn't been updated in
11 probably three or four decades. So, again, I just want to
12 encourage you to continue to explore this area. It's very,
13 very important.

14 Thank you.

15 CHAIR BELLA: Thank you, Claudia.

16 Do we have anyone else who would like to make a
17 comment?

18 [No response.]

19 CHAIR BELLA: Okay. It does not appear, so do
20 you both have what you need from us?

21 MS. ALBAROUDI: Yes. Thank you.

22 CHAIR BELLA: All right. Thank you very much for

1 this work. We look forward to it continuing.

2 All right. We will move into our next session.
3 We can't have a meeting without talking about DSH, so sure
4 enough, never fear, we have a DSH discussion on deck.
5 Aaron and Rob will be joining us.

6 Welcome to both of you. We'll let you take it
7 away whenever you're ready.

8 **### POTENTIAL RECOMMENDATIONS FOR STRUCTURING**
9 **DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS**
10 **DURING ECONOMIC CRISES**

11 * MR. PERVIN: Good afternoon, Commissioners. So
12 this presentation follows up on the Commission's discussion
13 of countercyclical DSH policies that we started in our
14 September meeting. So we plan to discuss three
15 recommendations today.

16 First, the main policy change we're going to
17 discuss is how DSH allotments are structured during
18 economic recessions. At the September meeting,
19 Commissioners reviewed a variety of approaches to structure
20 DSH allotments and the preferred approach that the
21 Commission agreed to was the one taken by ARPA, which
22 preserves total DSH funding and when a state's FMAP

1 changes. A remaining decision point for the Commission is
2 whether this ARPA policy should only apply during economic
3 recessions or also apply when there are other changes in a
4 state's FMAP during periods of normal economic growth.
5 Rob will then take over and talk about a
6 conforming change to our previous countercyclical FMAP
7 recommendation and outline a technical change that will
8 help states spend their DSH funding on a more rapid basis
9 by streamlining CMS' process for finalizing DSH allotments.
10 So, first, we're just going to review our DSH
11 allotment policy options. As a bit of background, total
12 DSH funding is limited at the state level by federal
13 allotments. Because of the way state and federal DSH
14 funding is calculated, a higher FMAP has the perverse
15 effect of lowering DSH funding available to providers.
16 Furthermore, the need for DSH payments is
17 countercyclical. Economic recessions cause uncompensated
18 care to increase at a time when state tax revenue goes
19 down. ARPA addressed this issue during COVID by
20 temporarily increasing federal allotments commensurate with
21 the increase in the federal match, such that total DSH
22 funding remained the same as pre-pandemic policy.

1 After reviewing other policy options at our prior
2 meeting, Commissioners concluded that ARPA was the
3 preferred policy approach because it best balances the
4 needs of the state versus the needs of providers.
5 So just to provide a quick refresher of ARPA DSH
6 policy, I'm going to walk you through the mechanics of how
7 this would work. So under pre-pandemic policy, federal
8 allotments were fixed at $13 billion. Total DSH funding is
9 calculated by dividing the federal allotment by the FMAP,
10 in this case 57 percent. $13 billion divided by 57 percent
11 means a total of $22.8 billion in state and federal DSH
12 funding available.
13 However, when the FMAP increases, like it did
14 during the public health emergency, that $13 -- there we
15 go. The $13 billion amount remains the same. However, the
16 increased FMAP results in total DSH funding and lower total
17 DSH funding. During the PHE, this amounted to over $2
18 billion less in total DSH funds available to both states
19 and providers.
20 Now, an ARPA-like adjustment is slightly
21 different. The ARPA policy preserves the same total DSH
22 funding as pre-pandemic policy regardless of the change in

1 the FMAP, in this case the same $22.8 billion. Under the
2 ARPA policy, the federal allotment is determined by
3 multiplying that total funding amount by the federal match.
4 22.8 times 63 percent results in a federal allotment of
5 $14.4 billion, or an increase in federal funds of about
6 $1.4 billion.
7 So this brings us to a decision point about
8 whether to continue this ARPA policy after the public
9 health emergency ends. So far, the Commissioner
10 discussions have focused on economic recessions, but
11 Commissioners may want to consider applying ARPA policy to
12 other FMAP changes during periods of normal economic
13 growth. The reason for this is that the FMAP adjusts
14 annually based on state per capita income, and states with
15 decreasing incomes have increasing FMAPs. As a result,
16 under current policy states that are getting poorer and
17 likely to have more need for DSH payments actually have a
18 reduction in total available DSH funding because of this
19 change. Making an ARPA-like policy permanent would help
20 address this issue, but may also result in negative effects
21 for states that have declining FMAPs because their per
22 capita income is growing faster than the national average.

1 To inform a policy discussion of this issue, we
2 looked at changes in total federal spending and state-by-
3 state effects of such a permanent ARPA-like adjustment.
4 Commissioners could choose to make an ARPA
5 adjustment temporary only during an economic recession.
6 I'm not going to read through the entire recommendation
7 language, but Option 1A represents this temporary change.
8 While Option B would apply only during periods -- or Option
9 B would apply also during periods of normal economic
10 growth.
11 At the federal level, we looked at what would
12 happen if we implemented an ARPA-like adjustment starting
13 in 2014 versus from 2020 until the end of the PHE.
14 Under Option 1A, the ARPA-like adjustment would
15 have been applied only during periods where Congress
16 increased the federal match, so 2020 onward, which is when
17 we see the biggest effects of this policy. For example,
18 from 2020 to 2022, ARPA's adjustment has cost the federal
19 government around $5 billion.
20 Under Option 1B, the ARPA-like adjustment is also
21 applied during periods of normal economic growth. This has
22 a minimal effect on total federal spending, but there are

1 differences state by state.

2 There we go. This one's going to be fun. To
3 show state effects of both policy options, we looked at
4 changes in DSH funding during a period of normal economic
5 growth and also during a period of a national recession.
6 Without an ARPA-like adjustment, federal allotments
7 increase with inflation while with an ARPA-like adjustment,
8 total DSH funding increases with inflation.

9 Under Option 1A and 1B, so during an economic
10 recession, with an increased FMAP, under this scenario all
11 states benefit, and it helps to avoid an 8 percent
12 reduction in total DSH funding without this adjustment.

13 Under Option 1B, during periods of normal
14 economic growth, you see smaller changes reflecting the
15 normally small fluctuations in the federal match from year
16 to year. Between 2018 and 2019, 23 states saw an increase
17 in their average FMAP of 0.8 percentage points because of
18 declining per capita income. These states would benefit
19 most from this policy. Under current law, these states had
20 lower annual increases in total DSH funding relative to
21 inflation, and two states actually saw cuts in their total
22 DSH funding year over year.

1 The ARPA-like policy would address this issue by
2 increasing federal allotments for these states such that
3 total DSH funding increases at the same rate as inflation.
4 Meanwhile, 13 states saw their FMAP decline by an
5 average of 0.6 percentage points because of increasing
6 state per capita income. Under the ARPA-like policies,
7 these states would receive smaller increases in their total
8 DSH funding than they would have without the ARPA
9 adjustment. Because this change is less than inflation, no
10 state would have seen a decline in total available DSH
11 funding year over year.
12 Meanwhile, 15 states would see no change in their
13 FMAP. This includes all 14 states with FMAPs of 50
14 percent, or the statutory minimum, and also D.C. which has
15 its FMAP fixed in statute. For these states, there would
16 be no difference between the two policies.
17 The implications of both policies are outlined on
18 this slide. Both policies would increase federal spending
19 commensurate with the increased FMAP while Option 1B would
20 also have minimal effect on federal spending during periods
21 of normal economic growth. Since there seems to be federal
22 spending implications, we plan on sharing Commissioners'

1 preferred option with CBO for a formal budgetary estimate
2 prior to voting on these recs.
3 For states, under both policies, states would
4 receive an increase in allotments when there is an economic
5 recession with an enhanced FMAP while under Option 1B,
6 state-by-state effects during periods of normal economic
7 growth would vary depending on the federal match.
8 For providers, under both policies, providers
9 would receive the same total DSH funding during an economic
10 recession, and under Option 1B, providers would also
11 receive the same total DSH funding during periods of normal
12 economic growth.
13 Finally, both policies would not have a direct
14 effect on enrollees, but they may directly help patients
15 served in DSH hospitals by maintaining their access to
16 services.
17 With that, I'm going to turn it over to Rob.
18 He's going to walk you through our final two
19 recommendations.
20 * MR. NELB: Thanks, Aaron.
21 So assuming the Commission does want to make a
22 recommendation to implement a countercyclical DSH

1 allotment, you may also want to revise the Commission's
2 prior countercyclical financing recommendation which
3 affects the FMAP.
4 So as a bit of background, in 2021, the
5 Commission recommended that Congress adopt a
6 countercyclical financing model similar to a prototype
7 developed by GAO. The model would trigger an enhanced FMAP
8 when more than half of states experienced increased
9 unemployment over two consecutive months, and this is a
10 standard that was found -- would have been triggered in the
11 past several recessions, but isn't too sensitive that it
12 would be triggered when there isn't a recession.
13 The Commission's recommendation also expanded on
14 the GAO model by discussing some more specifics about how
15 an enhanced FMAP would be applied to specific services and
16 populations. And, notably, the recommendation at the time
17 excluded DSH and other Medicaid funding that's capped by
18 federal allotments from the enhanced FMAP because of the
19 concern that total funding would decrease if the FMAP
20 increased.
21 However, if the Commission adopts the ARPA-like
22 change we just talked about, then an enhanced FMAP could be

1 applied to DSH spending during economic recessions without
2 negatively affecting providers.
3 Revising the Commission's prior recommendation
4 would also provide the Commission an opportunity to
5 reaffirm its prior recommendation, which has not yet been
6 adopted by Congress.
7 So here's the full text of the proposed
8 recommendation, and the third sub-bullet highlighted in
9 bold is the main part that we're proposing to change. I
10 won't read through all this, but it's worth noting that, in
11 addition to the GAO prototype the Commission recommended in
12 2021, a maintenance-of-effort requirement that would
13 preserve eligibility requirements, but that maintenance-of-
14 effort requirement is a little bit different from what was
15 applied during the COVID public health emergency, and that
16 under this recommendation, states would still be allowed to
17 conduct regular redeterminations.
18 Also, although we're proposing removing the
19 exception for DSH, this recommendation still preserves an
20 exception for non-DSH spending that has capped federal
21 allotments and other services that receive special matching
22 rates, such as the new adult group.

1 Last but not least, we are hoping to talk with
2 you about a potential technical correction that would help
3 streamline DSH allotment calculations.
4 So as you may recall, we heard during our
5 interviews that we conducted this past summer that delays
6 in finalizing DSH allotments affected some states' ability
7 to spend their full available DSH funds in a timely manner
8 early in the pandemic. For example, CMS didn't finish
9 finalizing 2018 DSH allotments until March of 2022.
10 States are given preliminary DSH allotments they
11 could draw down from to make payments, but until DSH
12 allotments are finalized, there's always a risk that CMS
13 may come back and recoup the funding from states if the
14 final allotments are less than what was projected. And so
15 states are hesitant to spend the money until it's
16 finalized.
17 Timely access to DSH funding is important to help
18 hospitals with cash flow challenges during economic
19 recessions. During the COVID pandemic, Congress stepped in
20 to address some of these challenges with a special provider
21 relief fund. But in future recessions, this type of
22 support may not be available, and so it's important that

1 DSH funding be made available in a timely manner.

2 When we followed up with CMS to learn more about
3 why it takes so long to finalize allotments, we learned
4 that one of the main reasons for the delay is this
5 requirement in statute that DSH allotments not exceed 12
6 percent of federal spending -- Medicaid spending in a given
7 year. And because states have up to two years to finalize
8 their spending for medical claims, it can take several
9 years for CMS to get the data that they need for this
10 calculation.

11 However, as I'll discuss, this limit has no
12 actual practical effect on DSH spending, so the delay
13 doesn't seem to have any benefit.

14 So here the figure on the left shows DSH spending
15 relative to total Medicaid medical expenditures, and you
16 can see, you know, when the limit was first put in place in
17 the early '90s, DSH spending was, you know, about 15
18 percent of total Medicaid spending nationally. But now DSH
19 is much lower, only 3 percent of total Medicaid spending.

20 And then at the state level on the right,
21 historically there used to be a few states that were close
22 to this 12 percent limit, but these states have since

1 expanded Medicaid under the ACA, and so since 2014, the DSH
2 allotments have fallen much below this limit. And so,
3 again, the 12 percent limit has no practical effect.
4 So here's the draft recommendation for this
5 technical correction: To provide states and hospitals with
6 greater certainty about available DSH allotments in a
7 timely manner, Congress should amend Section 1923 of the
8 Social Security Act to remove the requirement that CMS
9 compare DSH allotments to total Medicaid medical assistance
10 expenditures in a given year before finalizing DSH
11 allotments for that year.
12 That concludes our presentation for today. We'd
13 appreciate feedback on which, if any, recommendations you'd
14 like to make and, if so, what points to highlight in our
15 rationale. As Aaron mentioned, if we move forward, we'll
16 follow up with CBO for an official score, and then we'll be
17 back for a draft chapter and final recommendation language
18 for a vote at a future meeting, likely in the new year.
19 And then, of course, we'll be back in December to
20 present a draft of MACPAC's statutorily required report on
21 DSH, which will be included in our March 2023 report. Here
22 is a summary of the policy options to help guide your

1 discussion, and I'll turn it back to Melanie.

2 CHAIR BELLA: Thank you both very much.

3 Let's try to do what I think is the easiest one

4 first. Let's go to Recommendation 3. Can we go to the

5 separate slide?

6 Let's talk about this one. Does it make sense to

7 Commissioners? Does anyone have any -- Fred?

8 COMMISSIONER CERISE: A question. It makes

9 sense. Will the federal spend go up if states then, you

10 know, have real-time data and estimate higher and spend

11 their full allotment? Or do they do that retroactively two

12 years later anyway?

13 MR. PERVIN: The spending would theoretically go

14 up if the state's medical spending is low enough where

15 states are meeting kind of that or hitting that 12 percent

16 threshold. But in our estimations, it doesn't seem like

17 states are coming close to that 12 percent amount. I don't

18 know if that's actually answering your question.

19 MR. NELB: I think you're asking about -- so,

20 yeah, this -- because the 12 percent limit has no effect on

21 the allotments, they stayed the same but because -- states

22 may spend the money in a more timely manner. But there's

1 no net effect on -- the total federal spending will still
2 be the same.
3 COMMISSIONER CERISE: So if I have, you know, a
4 million dollars and I estimate I'm only going to spend
5 $800,000 because I'm afraid I don't want to go over and
6 have to do recoupment, if with this rule if I have real-
7 time data, I'm going to spend a million, is that going to
8 increase? Or do they go back two years later and spend the
9 million anyway?
10 MR. NELB: Yeah, historically the states have --
11 once the DSH allotments have been finalized, they would --
12 some states have requirements that they spend their full
13 allotments. It would be the same spending. And, of
14 course, this doesn't require states to spend their full
15 allotment. There may be other reasons why a state doesn't
16 spend their allotment. But in this case, if they want to,
17 they can do it in a more timely manner.
18 CHAIR BELLA: Darin, your hand went away. Is
19 that right?
20 COMMISSIONER GORDON: Yeah, it did. I was
21 curious about the genesis of the 12 percent, but it's
22 irrelevant given I n practice it's not -- it's not a real

1 cap. So I was curious if there was some rationale that was
2 there, but it doesn't seem like it's pertinent any longer.
3 CHAIR BELLA: Is anyone going to not like this?
4 What are we missing here?
5 MR. PERVIN: In our conversations with
6 stakeholders, we haven't run across anyone who explicitly
7 would not like this. Again, I think it's the fact that,
8 you know, when this was originally put into place, DSH
9 spending was 15 percent of overall medical spending, and
10 it's dropped down to 3 percent. So, you know, that was
11 1992, and so -- and then if you look at the chart on the
12 right, it slowly declined, like what you see there is the
13 state with the highest allotment compared to kind of their
14 maximum limit, and it keeps on declining year over year.
15 So in the stakeholders we've talked to, we
16 haven't run into anyone who wouldn't like this, but that's
17 not to say that couldn't change, I guess.
18 CHAIR BELLA: Is the Commission okay with having
19 this one come back to us? Obviously, we're not voting on
20 anything today. We're just giving a nod to saying we'd be
21 interested and supportive of it coming back. Is that --
22 COMMISSIONER GORDON: Can I say --

1 CHAIR BELLA: Yeah.

2 COMMISSIONER GORDON: I mean, just practically
3 speaking, I mean just to say it a different way, this
4 really isn't increasing DSH allotments. It's increasing
5 the state's ability to utilize existing allotments. So
6 it's hard to think of anyone that would have some deep
7 concern here. It's not having a practical change. It's a
8 sensible change to make it more clear and deal with the
9 timeliness issue.

10 CHAIR BELLA: Can you put the recommendation
11 language back up? Yeah, I mean, I assume in the chapter we
12 could reinforce, just be very explicit that this is not
13 doing anything to change the allotment or the money. It is
14 doing exactly what Darin said, which is what your lead-in
15 is referring to, about greater certainty and timeliness.
16 Okay.

17 Heidi?

18 COMMISSIONER ALLEN: I support Recommendation 3.
19 I'm just wondering if we were looking at the graph again by
20 Medicaid non-expansion states would it look different?

21 MR. NELB: So the --

22 MR. PERVIN: Yeah, I guess theoretically it would

1 look different. Both of these states that you see on the
2 right, both of those states are actually expansion states.
3 So I guess in theory a state that has not expanded
4 Medicaid, their Medicaid medical spending would be lower,
5 so they could be closer to the limit. But, I mean, even
6 those states are below 51 percent of what their limit would
7 be.

8 So we could figure out how to may be visualize
9 that in the chapter a little bit better.

10 CHAIR BELLA: Aaron, you're saying that this is
11 the state that is the closest, is still at 51. So any of
12 the non-expansion states are only under this.

13 MR. NELB: Yeah. Most states are much further
14 below it. Yeah, this is, I think, New Hampshire and
15 Louisiana. But also since the '90s there have been other
16 efforts that have -- you know, DSH has only been increasing
17 with inflation, whereas Medicaid spending has generally
18 increased faster than inflation. So yeah, this limit that
19 was put in place in the early '90s just doesn't have an
20 effect, even in a non-expansion state.

21 COMMISSIONER ALLEN: Thank you. That's helpful.

22 CHAIR BELLA: Tricia.

1 COMMISSIONER BROOKS: I probably should know this
2 from DSH school, but it's not where I got an A. Is there a
3 time limit on how long they can spend the allotment? I
4 mean, like in the CHIP allotment it's two years and then it
5 reverts back.
6 MR. PERVIN: Yeah, it's the same amount. So you
7 have two years until the end of your fiscal year to spend
8 down your full allotment.
9 COMMISSIONER BROOKS: So if CMS took until fiscal
10 year 2022 to finalize the 18 --
11 MR. NELB: They could do it. It's a prior period
12 adjustment. So there are some cases where they are
13 adjusting the payment even after those two years. But,
14 yeah, it just kind of creates more uncertainty for
15 everyone.
16 COMMISSIONER BROOKS: Thank you.
17 CHAIR BELLA: I'm going to move us off of
18 Recommendation 3, so let's go back to the top. I'm going
19 to also share a comment and a question from one of our
20 Commissioners, Bill Scanlon, who is unable to join us. So
21 bear with me while I make sure I get this correct.
22 I mean, to be clear, he's very supportive. He

1 supports the objective of assuring access for people
2 impacted by the business cycle. His concern is reinforcing
3 DSH allotments that are not based on valid measures of the
4 problem that would target money to those most in need.
5 So his question basically is do states have the
6 latitude to use enhanced general FMAP to provide hospitals
7 appropriate amounts of funding. So allowing them to use
8 just regular enhanced FMAP rather than tying it to this.
9 And I think the point he picked up is that in the briefing
10 material it indicates hospitals' problems during a
11 recession are uninsured and an increase in Medicaid, and if
12 the temporary increase in Medicaid allows them to take care
13 of that, does that ability to use it that way offset or
14 overcome or make up for the higher FMAPs in pass-on DSH?
15 Does that make sense?
16 MR. PERVIN: I think that makes sense, and I hope
17 I'm answering it correctly, but bear with me if I'm not.
18 But this would not really affect DSH payments. As you're
19 aware, DSH payments at the hospital level are limited by
20 both uncompensated care for the uninsured and also
21 uncompensated care for Medicaid beneficiaries. This does
22 not change that at all. It still makes sure that those

1 hospital limits are intact and DHS payments can't exceed
2 that amount.
3 And so that cap is still there, so there wouldn't
4 be a large change in where the DSH payments are flowing.
5 There's just a change in what the federal match is for
6 those DSH payments.
7 CHAIR BELLA: So you guys know. You could
8 channel Bill better than I can in terms of like you know
9 that he is very concerned about lack of transparency on how
10 some of the dollars are being distributed and whether DSH
11 is actually hitting what we need it to be hitting with
12 uninsured and Medicaid and all those things.
13 So if you're saying this doesn't exacerbate that
14 or solve this, it's sort of indifferent to that, that is
15 one answer. It sounds like that's what you're saying?
16 MR. NELB: And it sounds like maybe his other
17 concern is -- I mean, one of the policy principles I think
18 we talked about in September behind the ARPA approach is
19 that basically DSH would be matched at the same FMAP as
20 other Medicaid expenditures.
21 So we've talked before about DSH, how states have
22 a variety of ways they can support hospitals, you know,

1 increasing base rates, making other types of payments, or
2 making DSH. And so this policy approach, whether you do 1A
3 or 1B, is sort of agnostic to how you're using money for
4 DSH versus others.
5 There are a variety of state-specific reasons why
6 some states use DSH to maybe target safety net providers
7 whereas a base rate increase might go more broadly. But
8 this approach at least ensure sort of the same FMAP for
9 both services, not prioritizing one or the other.
10 CHAIR BELLA: Okay. I'm going to assume
11 something is coming back to us, and Bill is, through me, on
12 record now with having this question, at a minimum. And so
13 we'll just make sure that we can address it when he's able
14 to be here in person.
15 I'll open it up to other Commissioners for
16 comments, questions. Heidi.
17 COMMISSIONER ALLEN: So you might have answered
18 this but I'm just not entire sure in the previous question.
19 Would any decision we make in making these recommendations
20 change the states' incentives to expand or not expand
21 Medicaid?
22 MR. PERVIN: No. This would not. This policy

1 decision is kind of independent or agnostic towards whether
2 or not a state has expanded Medicaid or not.
3 COMMISSIONER ALLEN: Okay. Thank you.
4 CHAIR BELLA: Thank you, Heidi. Darin.
5 COMMISSIONER GORDON: So I know we're not taking
6 a vote, but I'm just trying to understand. So 1A, I think
7 Aaron you were saying, because its only impact is during a
8 recessionary period, and it benefits all states. 1B has
9 the consequence of, in non-recessionary periods, that some
10 states may see lower changes than they would otherwise.
11 Correct?
12 MR. PERVIN: Yeah, that's correct.
13 COMMISSIONER GORDON: Okay. I just wanted to
14 make sure that I was tracking that well. And I will come
15 back to Rob on the next one as it relates between the two,
16 but I feel the temporary one is more consistent with our
17 other policies, trying to address recessionary period and
18 not instill impacts outside a recessionary period. But I
19 think it's helpful giving us these two options, and I think
20 they're well thought out.
21 CHAIR BELLA: So Darin, you would go with 1A?
22 COMMISSIONER GORDON: Yeah.

1 CHAIR BELLA: Okay.
2 COMMISSIONER GORDON: It feels like 1B is
3 potentially evident. An impact outside of recessionary
4 periods -- it's creating another challenge, not necessarily
5 solving the countercyclical issue that we're trying to
6 focus on, is what it feels like. It has ancillary impact
7 outside of a recessionary period, 1B does. I think 1A is
8 most consistent with trying to address recessionary period
9 without having incidental impact outside of recessionary
10 periods.
11 CHAIR BELLA: Thank you. Angelo, then Fred, then
12 Laura.
13 COMMISSIONER GIARDINO: And again, I will preface
14 this with I'm not an economist. But I understand 1A and
15 the countercyclical and the risk there. In just a couple
16 of sentences can you say what the justification for 1B
17 would be in terms of making a permanent change that somehow
18 responds to normal economic development, which seems to me
19 that fixes itself.
20 MR. PERVIN: Yeah. So when we looked
21 implementing an ARPA-like adjustment, starting in 2014, we
22 didn't notice that there are some states that have an

1 increased FMAP and an increased federal match, and of
2 course an FMAP is kind of a lagging indicator of state
3 income so, you know, increases in FMAP is indicative that
4 the state's per capita income is going down.
5 And we noticed that there are a couple of
6 instances where that increased FMAP was larger than the
7 growth in federal allotments due to inflation, and so their
8 total DSH funding actually declined. So as the state's per
9 capita income went down, their DSH funding also went down
10 with it.
11 And so because of that we thought that kind of
12 basing that total DSH funding amount and increasing that
13 with inflation and having states that have an increased
14 FMAP actually get greater funding would kind of counteract
15 that because their need for DSH payments would still likely
16 be higher as their state income goes down.
17 Do you want to add to that?
18 MR. NELB: And I guess just more specifically, so
19 the Commission has sort of had a longstanding view that DSH
20 allotments should be targeted to the states and hospitals
21 that need them most, and so it comes down to a choice of
22 targeting, under the current policy, more funding is

1 targeted to states with higher incomes, and under Option 1B
2 more funding would be targeted to states with lower
3 incomes, which may be more indicative of their need for DSH
4 funds.
5 COMMISSIONER GIARDINO: So if we did go with a
6 permanent one -- and again, it's during normal economic
7 times so obviously there are other levers that states have
8 to keep their economies healthy -- what would the criticism
9 be of us, that we were now interfering in normal economic
10 times as well as during recessions? What would the
11 criticism be?
12 MR. NELB: I think it's the point here, I mean,
13 with any change DSH has winners and losers, right? So the
14 states with lower incomes would benefit under this policy,
15 but it's sort of more or less budget neutral and so the
16 states with higher incomes, you know, do get a slightly
17 less DSH allotment. So you can see rather than a 2.4
18 percent increase in their allotment they're getting a 1.5
19 percent increase. So those states would do slightly worse.
20 It's a very small adjustment, but there are
21 winners and losers, whereas under Option 1A there are only
22 winners, so it's a little easier to get support for.

1 COMMISSIONER GIARDINO: Yeah. I mean, I just see
2 the wisdom of 1A. 1B, I'll need a lot more convincing.
3 CHAIR BELLA: Fred.
4 COMMISSIONER CERISE: Rob just talked me into 1B
5 because, you know, it's a pretty modest adjustment. One,
6 it makes sense. It's consistent with our countercyclical
7 work, and that too goes with that.
8 But, you know, every year we put out a report
9 that says there's no relationship between DSH and states or
10 hospitals in need, and this moves in that direction, even
11 though it's a little, tiny bit. And so I think it is
12 consistent with the intent of the program, so I think I
13 would keep that on the table.
14 I think you said you'd have to get a score on
15 that because it looks like there will be a modest federal
16 increase based on that, but it doesn't look like a lot at
17 all, which leads me to my question.
18 This, I assume, is totally independent of
19 whatever scheduled DSH reduction does or doesn't happen?
20 Can you speak to that?
21 MR. PERVIN: Yeah. So under current policy and
22 next year, actually October of 2023, Congress is going to

1 be applying DSH allotment reductions by about $8 billion a
2 year. So that $8 billion amount would be applied to the
3 unreduced amounts. And so what we're proposing here is
4 just those unreduced amounts as kind of a function of both
5 total DSH funding and the federal match, and so those cuts
6 would be applied in the same way.
7 CHAIR BELLA: Fred, more. Laura? Kisha?
8 VICE CHAIR DAVIS: Thank you, Rob. That was
9 really helpful. I also lean towards 1B. I think you also
10 talked me into it, Rob. It sounds to me that that is
11 providing more support for the folks who really need it
12 when they need it the most and a way to respond without
13 necessarily waiting for a recession, when they really need
14 it.
15 My question is around, is there then a
16 differential impact on expansion versus non-expansion
17 states?
18 MR. NELB: Yeah, no, the FMAP is not affected by
19 whether a state expands or not. So it's just sort of their
20 state per capita income.
21 VICE CHAIR DAVIS: But I mean in terms of which
22 states are more likely to have the increase.

1 MR. NELB: Yeah. I think there's a mix of
2 expansion and non-expansion states both that have rising
3 income or decreasing income. So it's sort of not related.
4 Obviously, we've shown before expansion maybe affects state
5 levels of hospital uncompensated care and DSH payments to
6 hospitals affected by your levels of uncompensated care.
7 But this doesn't change that hospital-specific limit. It's
8 just sort of setting the state amount.
9 COMMISSIONER CERISE: Yeah, and in contrast to
10 some of our previous discussions on this, this has nothing
11 to do with your uninsured level or anything like that.
12 This is strictly related to whatever your per capita income
13 is that affects your FMAP. And the amounts are not enough
14 to sway any state. I mean, these are really modest shifts,
15 and the losers just get a less of an increase. And so I
16 can't imagine this having any interface in terms of states'
17 decisions to expand or not expand.
18 MR. NELB: And to be, also --
19 CHAIR BELLA: Can you guys, while you're talking,
20 can you go to Recommendation 2? Can we see the languages
21 so that we -- not 1A and 1B. Yeah. And then I'm going to
22 come back to this, but go ahead and finish. Sorry about

1 that.

2 MR. NELB: Oh, I just wanted to point out, I

3 guess, that the FMAP affects all Medicaid spending, so this

4 is sort of a routine thing per year, that if your state

5 FMAP goes down a state has to contribute more funding for

6 all their other Medicaid expanses. So it would have to

7 contribute more in DSH, but it's not like it's necessarily

8 a big change for the way other Medicaid spending works.

9 CHAIR BELLA: So what we're talking about is,

10 first of all, do we want to go forward with a

11 recommendation, one. Second of all, do we want to

12 basically add Bullet 3, so Bullet 3, correct?

13 MR. NELB: Recommendation 2 would apply

14 regardless of whether you do 1A or 1B.

15 CHAIR BELLA: Sorry. Because there's only one

16 recommendation, I was not thinking of it is -- this

17 recommendation, the first question is, do we want to make a

18 recommendation. Second question is does it include

19 basically sub-bullet 3? Is that an oversimplified way of

20 looking at it?

21 MR. PERVIN: I wouldn't say that's an

22 oversimplified way. That's the right way to think about

1 it.

2 CHAIR BELLA: So the last time that we had this
3 discussion there was interest and support for suggesting a
4 countercyclical adjustment to DSH, in line with our prior
5 thinking. Is everyone still on board with that?

6 COMMISSIONER GIARDINO: Yes. But again, I was
7 thinking about that in the face of a recession.

8 CHAIR BELLA: Yes. Understood.

9 COMMISSIONER GIARDINO: Not during normal
10 economic times.

11 CHAIR BELLA: Understood. So I just want to be -
12 - stake in the ground is we are going to proceed, and I
13 think the question is can we get it to a point where we're
14 giving them enough direction today on whether to bring it
15 back with a broader interpretation or not. So I've heard
16 from this side of the room. What about this side of the
17 room, on how to think about -- Jenny, do you have thoughts?
18 No? Tricia.

19 COMMISSIONER BROOKS: I think it would be helpful
20 if you could map out a theoretical scenario that says if we
21 do 1A, here's what it looks like over a couple of years,
22 and if we do 1B, maybe even at a hypothetical state level.

1 But it would just help me wrap my head around what the
2 differences would mean monetarily.
3 MR. NELB: We can do that. In the appendix of
4 your materials we have the state-by-state effects for the
5 one year, and I guess we could look at it over multiple
6 years, if that's helpful too.
7 CHAIR BELLA: All right. Can you try it one more
8 time. I mean, I'm where Darin is, and I think where Angelo
9 came in. I mean, I was very much thinking this is tied to
10 solving an economic issue or a point-in-time issue. So
11 make your best case again on why we should have the 1B in
12 there. Because I also am not really excited to have
13 winners and losers. So if there's a way to say it actually
14 addresses some inequities that we think are here, that's
15 one thing.
16 But the winners and losers thing I think is
17 throwing me a bit, because that is not exactly -- we don't
18 actively seek to create winners and losers among states if
19 we don't feel like we're solving another problem related to
20 DSH, which you're saying this doesn't solve any of the sort
21 of underlying problems related to DSH.
22 COMMISSIONER HEAPHY: Like I said, that was my

1 issue, the idea that it's a minimal loss. The idea that
2 winner or loser, minimal, just doesn't sit right to me.
3 MR. NELB: Maybe I can try first and then we'll
4 go, but yeah. So we started this discussion focused on
5 countercyclical and the ARPA, right, and thinking about the
6 different options, and the Commission concluded that the
7 ARPA approach was best during economic recession.
8 I think underlying that approach is the sort of
9 policy principle that a state's DSH funding shouldn't
10 change when their FMAP changes.
11 So I guess, as we've been thinking about, you
12 know, our goal of sort of more rational DSH policy of
13 applying kind of consistent principles, the question is
14 whether you should apply the same principle during normal
15 economic growth as you have during a recession.
16 It doesn't have a huge effect, but on the edges,
17 implementing 1B does seem to move towards the goal of more
18 DSH funding towards the states that need it most.
19 There are winners and losers under this policy,
20 but you could argue that under the current policy, there
21 are also winners and losers. So, under the current policy,
22 states that get poorer, you know, lose out on total DSH

1 funds, and under 1B, the states that get poorer would get
2 more DSH funds and sort of just keeping that policy
3 principle in place that the DSH funding shouldn't change
4 when your FMAP changes.
5 It's up to the Commission to decide. We're not
6 advocating one or the other, but we wanted to make sure you
7 had the information you needed and trying to think about
8 how some of the principles you've articulated at various
9 meetings could come into play as you're trying to weigh
10 this decision.
11 CHAIR BELLA: Thank you.
12 Verlon and then Bob.
13 COMMISSIONER JOHNSON: Thank you, Rob. You were
14 very helpful in answering a question I had, but I just
15 wanted just in my mind make sure I have this right.
16 So for Recommendation 3, we're supportive.
17 Recommendation 2, it sounds like it doesn't have an impact
18 whether we look at 1A or 1B, but I think based on your
19 conversation, I am actually leaning towards 1B. So that
20 was helpful for me. Thank you.
21 CHAIR BELLA: Thank you, Verlon.
22 Bob?

1 COMMISSIONER DUNCAN: Rob, you answered part of
2 what I was asking about. Currently, there are winners and
3 losers anyway with the economic times.
4 But for another clarification under 1B, I think I
5 heard earlier when we say loser, they don't get any less
6 than what they currently get. They just don't get any
7 extra, right? So, in reality, they're not losing anything.
8 They're just not gaining as much as the states that saw
9 less economic impact?
10 MR. PERVIN: Yeah, that's correct.
11 We looked at 2018 to 2019, and so we looked at
12 inflation and then also the FMAP changes between those two
13 years, and in that year, the states that had lower FMAPs,
14 yeah, they just had less growth in their federal funding.
15 It's not that their federal funding went down.
16 COMMISSIONER DUNCAN: Thank you.
17 CHAIR BELLA: I hesitate to ask. So, from a CBO
18 scoring perspective, easier to score 1B because they're not
19 trying to predict recessions? Let's say that we were still
20 a bit undecided. Which one is going to give -- the most
21 conservative approach would be to get the highest score so
22 we understood what the maximum score could be. Which one

1 of those is more conducive to a score? The permanent one?

2 MR. NELB: To be clear, when we did our

3 countercyclical FMAP recommendation before, there isn't

4 actually a sort of score associated with it. It's sort of

5 whatever the enhanced FMAP is would affect the amount, and

6 so we left some of the details to Congress.

7 So, on 1A, the score just is sort of -- there is

8 a cost, but it just depends on what Congress decides the

9 FMAP to be.

10 And then on 1B, I think as we found, the line is

11 basically the same. So, in some years, it's technically a

12 few million dollars higher. Other years, it's a few

13 million dollars lower. It would probably just wash out to

14 be zero, but we would get their score.

15 If it helps inform the decision-making, we can

16 certainly ask for both scores, but really 1B would be the

17 one where they have to do some analysis. 1A is sort of

18 just up -- it's just sort of proportionate to whatever the

19 FMAP increase ends up being.

20 CHAIR BELLA: Okay. Verlon has indicated where

21 she is. Where is everyone else?

22 Angelo, you needed to think more. Where are you

1 right now?

2 COMMISSIONER GIARDINO: At this point, I'm not

3 supportive of 1B, and I don't know if you want to know why,

4 but --

5 CHAIR BELLA: You don't have to tell me why yet.

6 I might come back to that.

7 Now I'm just going to straw poll everyone

8 Fred?

9 COMMISSIONER CERISE: 1B.

10 CHAIR BELLA: Laura?

11 COMMISSIONER HERRERA SCOTT: [Speaking off

12 microphone.]

13 CHAIR BELLA: No 1B.

14 Kisha?

15 VICE CHAIR DAVIS: B.

16 CHAIR BELLA: Sonja?

17 COMMISSIONER BJORK: Undecided still,

18 CHAIR BELLA: Undecided.

19 Jenny?

20 COMMISSIONER GERSTORFF: I lean towards B.

21 CHAIR BELLA: B.

22 Kathy?

1 COMMISSIONER WENO: Leaning towards B.

2 CHAIR BELLA: Martha, you leaning?

3 COMMISSIONER CARTER: Also leaning towards B. It
4 was really helpful to have this discussion. I came in not
5 thinking that I would be able to support that because it
6 seemed like a leap from where we had been, but
7 understanding how the underlying principles support this,
8 actually, I'm pretty good with 1B now.

9 CHAIR BELLA: Tricia?

10 COMMISSIONER BROOKS: Leaning toward 1B. I'm not
11 sure I'm firmly ready to take a vote, but --

12 CHAIR BELLA: Rhonda?

13 COMMISSIONER MEDOWS: B. This discussion helped
14 me get there.

15 CHAIR BELLA: Heidi?

16 COMMISSIONER ALLEN: B.

17 CHAIR BELLA: Bob?

18 COMMISSIONER DUNCAN: Leaning towards B.

19 CHAIR BELLA: Darin?

20 COMMISSIONER GORDON: A.

21 [Laughter.]

22 CHAIR BELLA: I'm going create my own category,

1 which is not -- yeah. I guess I'll say undecided. I lean
2 toward A. It doesn't mean I'm against B. I think it means
3 I would still like to understand. I feel like maybe I
4 don't fully understand if there's any other effects that
5 we're not thinking of. I do appreciate you trying to bring
6 us back to overall principles of what we're trying to do.
7 So my suggestion -- and I'll look around the room
8 -- is that you bring it back with B, because we can always
9 take that piece out, and we bring that back. We'll have
10 some more discussion. If there's any additional -- Tricia
11 had asked for some additional information. If there's
12 anything else that you think can help that may be just
13 detailing out a little bit more, then we would also have
14 Bill to be part of that discussion.
15 Laura?
16 COMMISSIONER HERRERA SCOTT: Just because we've
17 been discussing the transparency and how those dollars are
18 used as well, I know what the intent of 1B is, but do we
19 know that's what would actually happen? Right? So that's
20 part of my struggle, not only because of the criteria that
21 you set forth, you know, is it solving another purpose, I'm
22 not sure that it is right now. But then to the

1 transparency issue, does it accomplish the intent of what
2 1B is proposing? And I'm not sure it does that either. So
3 those are my questions.
4 CHAIR BELLA: And, Dennis, I took for granted
5 that your earlier statement puts you on the 1B camp, but I
6 should confirm that.
7 COMMISSIONER HEAPHY: No.
8 CHAIR BELLA: Oh, it doesn't? Okay.
9 COMMISSIONER HEAPHY: No. Because I was
10 wondering, similar to what you were saying, asking Kisha.
11 Is it solving a problem? Is 1B actually going to solve the
12 problem, or is it actually just going to be used for
13 something else?
14 CHAIR BELLA: Thank you.
15 Is everyone comfortable, though? We'll bring it
16 back. It's the most expansive option, and we'll see what
17 other information there might be to help the rest of us get
18 there. And, again, I realize it reaches a point where there
19 is no more information, and that's fine too. We do not
20 have to prolong this in December, but I think there's still
21 a bit of exploration you can do and a bit of thinking we
22 can do. But clearly, we do want to move forward with the

1 recommendation. So thank you very much.

2 Any last comments or questions from

3 Commissioners?

4 COMMISSIONER HEAPHY: I guess my question would

5 be, would everybody go for 1A if 1B wasn't --

6 CHAIR BELLA: Well, 1A is how we had it, what

7 they brought back to us, and so yeah.

8 COMMISSIONER HEAPHY: Right. I just want to make

9 sure. Okay.

10 CHAIR BELLA: Yeah.

11 Okay. Do you have what you need?

12 MR. PERVIN: Yeah, I believe so. Thank you for

13 that conversation. This is really helpful.

14 CHAIR BELLA: Okay. Thank you very much.

15 All right. We're in the home stretch. I'm going

16 to turn it over to Kisha.

17 VICE CHAIR DAVIS: All right. The final session

18 of the day. Let's welcome Joanne.

19 We're going to start to do comments on another

20 potential comment letter, responding to the Request for

21 Information on the "Make Your Voice Heard: Promoting

22 Efficiency and Equity Within the CMS Programs."

1 [Pause.]

2 ### MACPAC RESPONSE TO REQUEST FOR INFORMATION - MAKE
3 YOUR VOICE HEARD: PROMOTING EFFICIENCY AND EQUITY
4 WITHIN CMS PROGRAMS

5 * MS. JEE: All right. Home stretch. So this
6 session will focus on a recent CMS Request for Information.
7 The title is "Make Your Voice Heard: Promoting Efficiency
8 and Equity Within CMS Programs."

9 This afternoon -- or I guess it's still morning -
10 - I will provide an overview of the key areas in the RFI
11 and then go over some of the areas in which the Commission
12 may wish to comment.

13 Our proposed comments really draw from prior
14 Commission work and meeting discussions, which is our
15 typical way of commenting.

16 A couple further points about the comments, the
17 RFI specifically asks about actions that CMS can take. So
18 proposed comments would really focus on administrative
19 actions rather than actions that would require an act of
20 Congress.

21 The aim of this response would really be to
22 complement recent comments that the Commission has offered.

1 As you know, we've been responding to a lot of rules and
2 comment letter -- request for information lately. So,
3 rather than being redundant, we thought it might make sense
4 to try and be complementary.
5 All right. So CMS issued this RFI in September
6 and through it seeks input on four primary topic areas.
7 Specifically -- well, I should also say that CMS seeks
8 these comments across all of its programs, but, of course,
9 we'll just limit our comments to the areas within our
10 purview.
11 With respect to the first topic on access, CMS is
12 really looking for comments on personal perspectives and
13 experiences in accessing care, including personal
14 anecdotes, and on the second topic on provider experiences,
15 CMS is seeking to understand factors affecting provider
16 well-being and distribution and their experiences in
17 providing care to their patients.
18 So given the focus of those two topics, we don't
19 anticipate commenting on those, rather we'd focus more on
20 the last two which are advancing health equity and the
21 public health emergency flexibilities.
22 Comments are due on November 4th, which is a week

1 from today.

2 Okay. So, through the RFI, CMS seeks comments
3 for areas that the agency can focus on to address
4 disparities, including, for example, policy and program
5 requirements. Here, Commissioners, you may wish to
6 reiterate the need to improve the quality and availability
7 of race and ethnicity data given MACPAC's extensive work
8 and meeting discussions on this topic.

9 Obviously, based on the conversation yesterday,
10 your work to think about ways to address the collection of
11 race and ethnicity data truly is ongoing, but we could
12 stress the importance of addressing those data concerns so
13 that states and CMS can identify disparities and develop
14 strategies for addressing them.

15 You also could consider commenting or reiterating
16 your June 2022 recommendation that CMS further standardize
17 and improved T-MSIS data collection to allow for cross-
18 state comparisons. And just a quick reminder here that
19 that recommendation was a part of a broader recommendation
20 on developing a system for access monitoring.

21 Another area in which you might wish to comment
22 is to refer back to the mandatory core set comment letter

1 that we just issued on the NPRM, which stressed the
2 importance of stratifying race and ethnicity data as well
3 as for providing states with additional guidance so that
4 they can begin to ramp up for that reporting in 2024.
5 And just going back to that access monitoring
6 recommendation, you could reiterate that recommendation
7 here, and that recommendation spoke to several different
8 aspects of such a monitoring system. But it did emphasize
9 that it should prioritize certain -- monitoring of certain
10 services and populations for which there are known access
11 concerns, and this includes, for example, children with
12 special health care needs, people with disabilities, sexual
13 and gender minorities, as well as beneficiaries of color.
14 We could also point to our work on integrated care
15 for the dually eligible beneficiaries, which found that
16 given the proportion of dual-eligible individuals who are
17 Black or Hispanic, that furthering integration of the
18 programs of Medicaid and Medicare could be helpful for
19 advancing health equity for this vulnerable population.
20 The RFI asked for ways that CMS could support
21 accommodations for people with disabilities or language
22 needs. We have prior work looking at beneficiary

1 communication preferences. So you could stress here a key
2 finding from that work, which is that multiple modes of
3 communications are necessary to reach beneficiaries, and
4 the need for ongoing work to address persistent challenges
5 for accessibility of communications for individuals who use
6 assistive technologies.
7 So staying with advancing health equity, you
8 could also consider providing some targeted comments on
9 enrollment and eligibility processes. Obviously, this is a
10 topic that you all have been discussing quite a lot
11 recently, given the unwinding of the public health
12 emergency and our prior letter responding to the access
13 RFI, which was in April, provided extensive comments on this
14 area and referenced a lot of MACPAC's prior work related to
15 streamlining and automating eligibility and enrollment
16 systems. And you will be offering further comments on this
17 in response to the NPRM, which Martha and Kirstin discussed
18 yesterday.
19 So, rather than repeating all of those comments
20 in this letter, we could consider commenting on
21 opportunities for streamlining eligibility and enrollment
22 processes in areas where you have begun to touch on; for

1 example, ex parte determinations. There seems to be
2 renewed focus on this, given the conversations around the
3 unwinding, and we have heard from states about some of the
4 challenges with respect to using ex parte, such as being
5 able to connect to data sources and resource constraints
6 for making needed system changes.
7 Your letter could also reinforce the Commission's
8 view on the need for streamlining eligibility determinations
9 for Medicare Savings Programs, the MSPs and enrollment in D-
10 SNPs, or the dual-eligible special needs plans. That also
11 will be referenced in the NPRM comment letter that you'll be
12 issuing shortly.
13 We had noted in January of 2022 in proposed rule
14 comments that converting MMPs, the Medicare and Medicaid
15 plans, to dual-eligible special needs plans, that there are
16 concerns about the processes and assistance available to
17 beneficiary enrolling in the D-SNPs and the importance of
18 having supports in place to help people do so.
19 And, finally, we could reiterate the need for
20 additional guidance for states for implementing default
21 enrollment in the D-SNPs, which is something is believed to
22 help facilitate enrollment and retention in those plans.

1 However, we know that states face some challenges in doing
2 default enrollment.
3 All right. So, turning to the fourth topic on
4 the impact of COVID-19 waivers and flexibilities, most of
5 the Commission's work so far has really focused on
6 unwinding other continuous coverage requirements, and you
7 have previously noted the -- but you have previously noted
8 the importance of understanding other aspects of the
9 unwinding, including the impacts of the COVID-era
10 flexibilities and whether or not those have any
11 implications for future policy.
12 We know that states are considering this question
13 now as they go about their unwinding because it is more
14 than just the continuous coverage requirements. So there
15 is, I think, ample opportunity for learning from states on
16 that, but the information on that, I think, is still
17 emerging.
18 So, Commissioners, you could express your support
19 for CMS's efforts to understand the effects of these PHE
20 flexibilities and their investigation of some areas in
21 which the experience from states during the PHE time might
22 inform future policy changes.

1 In prior work, the Commission has noted, for
2 example, that there might be opportunities for streamlining
3 provider enrollment processes and specifically for
4 providers serving patients in different states, and this is
5 one of the areas of flexibilities that was present during
6 the period of the PHE.
7 And as well, we had previously commented -- this
8 is a little bit older, but I'll just mention it -- about
9 considering opportunities for streamlining program
10 integrity, and that might sort of relate to some of the PHE
11 flexibilities during the COVID era where there were some
12 changes to the -- temporary changes to the policies and
13 some potential learnings from that area as well.
14 And, lastly, the Commission has talked a lot
15 about telehealth and understanding the effects of
16 telehealth during the PHE, and we know now that there's a
17 lot more data on telehealth than there ever has been, and
18 so, again, we think that that presents an area for great
19 learning opportunities.
20 All right. So, lastly, Commissioners, you may
21 wish to reiterate your comments that were shared during the
22 -- or in the April comment letter on the access RFI, which

1 related to the importance of transparency of this and all
2 future RFI processes. This RFI process largely uses the
3 same submission process that the access RFI process was,
4 and that involves using -- you know, submitting comments
5 through an online portal. But it is unclear whether or not
6 information submitted for this RFI will be made public.
7 Okay. So those are the primary areas. We will
8 draft a response or comments to this RFI. We will
9 incorporate your feedback from today, and just one more note
10 that the turnaround time for this is really fast. So we'll
11 get this out to a subset of you for an expedited review
12 after today.
13 Thanks.
14 VICE CHAIR DAVIS: Thank you, Joanne. That was a
15 very comprehensive list, and I think it was a really good
16 reminder of the work that we've done over the last couple
17 years. Much of the work that is listed here are things
18 that we have just done, certainly with COVID and the work
19 on health equity, so a good reminder of what we've been
20 doing.
21 I will start with just a question that I expect
22 not to have an answer, but is there anything that folks

1 want to take off the list that we don't feel like we have
2 enough information for or don't want to dive into in the
3 letter?
4 [No response.]
5 VICE CHAIR DAVIS: I didn't think so.
6 All right. Tricia.
7 COMMISSIONER BROOKS: All of the above in terms
8 of commenting. I really trust the staff here to know what
9 we've delved into enough to comment on, and it sounds like
10 it's a chapter book. So I hope you already started to
11 write it, Joanne. You've got a little time left, but I'm
12 in favor of everything.
13 VICE CHAIR DAVIS: Thanks. I see Martha, then
14 Heidi, then Rhonda.
15 COMMISSIONER CARTER: Thanks, Joanne, and thanks
16 for working on this so fast.
17 I was thinking about some of our older work, and
18 although specifically this RFI looks for strategies -- so
19 some of the work that we've done may not actually have --
20 we haven't actually gotten to the point of strategies, but
21 looking back at our maternal health work, I mean,
22 certainly, we have a strategy there on at postpartum

1 expansion. And we've talked around other work that I don't
2 think we fleshed out enough.
3 Looking at behavioral health, adult and
4 pediatric, I don't know if we've come up with strategies,
5 but I'd want to think about that because I didn't take the
6 time to do that.
7 Substance use disorder. Again I don't know if
8 we've gotten to strategies, but I want to think about that
9 a little bit more, and I will do some of this thinking too.
10 I just didn't have a chance.
11 Justice involved; we got a little bit of work
12 there.
13 We definitely did some work on transportation
14 around inequities, and that's an urban/rural kind of thing
15 and the types of services that people are using the net
16 for. I'm piling on here and I apologize. But at least I
17 want to think about these things, and of course, telehealth
18 is huge.
19 MS. JEE: So, on the postpartum coverage, that
20 was a recommendation for Congress, and I think the strategy
21 in this letter, just proposed strategy, because the RFI is
22 asking for actions that CMS can take was to limit our sort

1 of comments in that area. We could think about how to sort
2 of note the importance of that, of the postpartum and the
3 pregnant women work, though.

4 And then on BH, there were some recommendations
5 for guidance letters and so forth.

6 And I don't remember what we said about NEMT, but
7 I can look into that.

8 CHAIR BELLA: I don't think we're trying to
9 reiterate everything we've ever done, so just appreciate
10 that you're going to go back and do some more thinking,
11 Martha. I also appreciate these are due in a week, and so
12 really, I want to make sure that we're all good with the
13 kind of key areas that have been called out where we think
14 our voice can lend some support, just to restate we aren't
15 viewing this as an opportunity to reinforce all of the work
16 we've done in all of the prior areas.

17 VICE CHAIR DAVIS: I think, Joanne, you even
18 mentioned, you know, rather than restating everything,
19 using just where we can link to some of the work that we've
20 already done and highlighted as an opportunity to not
21 overstuff the letter.

22 MS. JEE: Yeah, because it would be really long.

1 [Laughter.]

2 MS. JEE: But, yeah, definitely just make some
3 references to some of the key pieces of work.

4 One thought I actually had was to try and sort of
5 limit it to some of the more recent ones in, like, bigger
6 topic areas, but we can think about how to thread that
7 needle the best way possible.

8 VICE CHAIR DAVIS: Thanks, Martha.

9 Heidi.

10 COMMISSIONER ALLEN: Thank you so much for this.

11 Maybe one of the things is I was really hoping
12 that we could emphasize under monitoring access to care or
13 recommendations around the beneficiary survey, there is a
14 sentence in there, but I'm wondering if the reason that you
15 didn't emphasize it is because it would require funding
16 from Congress. Is that why?

17 MS. JEE: Yeah. Like I said, we were really
18 focusing on administrative actions.

19 COMMISSIONER ALLEN: Yeah. I think, though, that
20 just emphasizing the need or basically the lack of data,
21 that we don't have any data on unrealized access and that's
22 why we made those recommendations, just this is a good

1 opportunity to make that point.

2 And, similarly, we don't have gender identity,
3 sexual orientation, or disability listed under the data
4 issues, and yet one of the very clear findings for me
5 looking at the transgender, LGBTQ brief is that you were
6 using data from five years ago, because we do not have any
7 good Medicaid data, and you were using like an extremely
8 small sample of Medicaid enrollees to try to assess access.
9 And without collecting that data, we really don't know
10 anything, and we have to rely on whatever random surveys
11 are out there.

12 So I would love to see that we at least recognize
13 that that data is not being collected, and that that is an
14 issue for monitoring disparities and access.

15 And also related to the data, I think that -- and
16 I'm wondering how others would feel about emphasizing the
17 fact that we're losing so much data because states can't
18 pick more than one race ethnicity for T-MSIS, and that that
19 is just such a simple administrative fix, as would be
20 developing a key that allows states to uniformly aggregate
21 up from the different categories that they're using, so
22 guidance on, you know, if you -- basically so that every

1 state could get to the same place in T-MSIS and use the
2 same decision-making. The missing-ness in T-MSIS, we know
3 is partly related to that, and that is something that is
4 squarely in the hands of CMS. And I would like us, if
5 people feel comfortable, to kind of emphasize that fix.
6 COMMISSIONER JOHNSON: Just in case you didn't
7 see me applauding and saying yes, I want to stress that as
8 well. I think that that - again, Heidi, that's just such a
9 quick and easy fix in my opinion, and it's so important.
10 I mean, you know, we saw the Census Bureau. They
11 did that 20 years ago, and so how do we make sure that
12 crosses over to such an important program as Medicaid with
13 so much information. So I just want to reiterate that.
14 And sorry for jumping ahead, Kisha, but I just
15 had to throw that in there. Thanks.
16 VICE CHAIR DAVIS: That's okay. I appreciate the
17 add-on support. Thanks, Heidi and Verlon. Rhonda?
18 COMMISSIONER MEDOWS: All right. I'm going to
19 apologize in advance if these are things that you've
20 already discussed, but I just have important questions, or
21 at least important to me.
22 When you've discussed this before, has there been

1 any emphasis on defining what type of data and how we
2 acquire it? I'm speaking more specifically about self-
3 identification, each individual's demographic information
4 as opposed to the use of perhaps dated algorithms that have
5 been used in the past to do with racial and ethnic
6 language, all those kind of data fields? Have we proposed
7 or recommended any efforts to do the outreach to the
8 Medicaid beneficiaries and educating them on why we want
9 the data, what it would be used for, and actually trying to
10 work to alleviate some of their trust issues despite some
11 of them perhaps being justifiable?
12 And probably the last thing is on the access.
13 Have we recommended the ongoing assessment with
14 beneficiaries of what their access issues and concerns are?
15 I'm just putting that out there. Maybe you've already done
16 it or maybe it's not really part of the scope of the work
17 that's outlined. But those would be some of the things
18 that I would really like us to think about.
19 MS. JEE: Yeah, on the data collection, that's
20 something that Linn and Jerry have really been working on
21 and was part of the discussion yesterday, and they did note
22 that having beneficiaries self-report is really sort of the

1 gold standard. And I think that there's a lot more work to
2 come to that, on that, from the Commission. So I'll be
3 waiting to learn more about that one. But, yes, we can
4 definitely note that.
5 And then on the beneficiary sort of assessment of
6 their access issues, I think the -- you know, I would just
7 refer you to the access monitoring system recommendation
8 that the Commission made in June 2022, and that included a
9 recommendation for fielding a beneficiary survey. But we
10 can note that as well.
11 COMMISSIONER MEDOWS: Okay. Have you already
12 done the assessment of what systems and tools or really
13 what vendors people are using state-wise to do the data on
14 race, ethnicity, gender identity, ability? Do you already
15 know that or -- there's tons of vendors out there selling
16 solutions. My concern is that they may rely on those as
17 opposed to they could be conservatively higher volume of
18 work to actually go out and get some identification
19 arrangement.
20 MS. JEE: Yeah, I mean, I think Linn and Jerry
21 have -- like I said, they're exploring sort of options and
22 approaches for getting beneficiaries' self-report data,

1 including educating beneficiaries about sort of like why
2 those data are being collected. I'm not sure that they've
3 investigated necessarily the vendors for those data, but I
4 can check and get back with you. But their work is
5 focusing on, you know, the model application and changes
6 that might be considered for that and that beneficiary
7 education piece.
8 COMMISSIONER MEDOWS: Everything else is fine.
9 It's really well laid out. Thank you.
10 COMMISSIONER HEAPHY: Is it possible to just say
11 they should not be using presumptive data? Because, I
12 mean, that's such a common practice. Just make that
13 statement that presumptive data should not be used in the
14 collection of -- or determining race/ethnicity data or it
15 is bad practice.
16 COMMISSIONER ALLEN: I'm not clear where you're
17 talking about where the presumptive data -- we have
18 enrollment data which comes from when people fill out the
19 application themselves, that's from them. And if they have
20 an assister, it's from whatever the assister puts in. And
21 then there are people who skip it. Are you talking about
22 algorithms that are used in research?

1 COMMISSIONER MEDOWS: They're used in --
2 COMMISSIONER ALLEN: [inaudible] last names?
3 COMMISSIONER MEDOWS: Well, yeah, they use the
4 Zip code, the geography, the last names. They attribute
5 one person's last name to the whole family as if the family
6 is only one race and ethnicity.
7 COMMISSIONER ALLEN: I think --
8 COMMISSIONER MEDOWS: Sometimes they actually use
9 it to do programmatic efforts and interventions. They
10 don't just use it -- it's not just limited to research,
11 unfortunate. That's where --
12 COMMISSIONER ALLEN: Yeah, I definitely think
13 that we would need to see -- I don't think that there's
14 been any presentations on imputation, which is a different
15 issue than collecting data. I would be very interested in
16 seeing how states are doing, when and why states are doing
17 imputation and how. But I don't think we've ever talked
18 about that that I'm aware of.
19 MS. JEE: No, we haven't really talked about
20 that.
21 VICE CHAIR DAVIS: And, you know, it sounds like
22 that's probably continuing our race and ethnicity data

1 conversation, you know, that we had yesterday morning, but
2 I don't know that it's necessarily directly related to this
3 letter, other than, you know, support for or encouraging
4 self-reported data as really being that gold standard that
5 we should be striving for.
6 Other comments? Dennis, did you have other
7 comments on the letter?
8 COMMISSIONER HEAPHY: Just looking at collection
9 of data from a sexual perspective. You can actually do
10 that cross-referencing and not siloing data in a way that
11 you can't best tabulate -- I'd like to see the letter to
12 report on the readers.
13 COMMISSIONER GERSTORFF: I have a couple of
14 things. Tying together a lot of the conversations we've
15 had the last couple of days, I don't know if this might be
16 an opportunity to bring in strategies on the direct care
17 workforce. I feel like we've heard some innovative things
18 and suggestions from public comment and from things that
19 we've discussed. So that could be an area.
20 And then I think we've heard from a panel talking
21 about ex parte redetermination issues with alignment of
22 income counting standards and some other things with other

1 programs, like SNAP and Medicaid. I don't know if that
2 might be an area to comment as well.
3 VICE CHAIR DAVIS: Thanks, Jenny. Other
4 comments?
5 [No response.]
6 VICE CHAIR DAVIS: I think the only other thing I
7 had to add was in the monitoring access session, we have a
8 long list of folks that we want to make sure that we are
9 paying attention to, and based on the conversation
10 yesterday, including justice-involved folks as part of that
11 kind of special population that we want to make sure we're
12 paying special attention, and certainly in the last section
13 highlighting the -- I think overall when we're thinking
14 about COVID, you know, don't waste a good pandemic. There
15 were certainly lessons learned and flexibilities and as
16 much as we can show, you know, the benefit of things that
17 should be continued, telehealth probably being one of them,
18 and, you know, you already have that outlined in a solid
19 way. But I think those are some of the things that we want
20 to make sure that we're emphasizing.
21 Other thoughts? Joanne, do you have what you
22 need from us? Any other further clarifications?

1 [No response.]

2 VICE CHAIR DAVIS: Okay. Thank you. I'll turn
3 it back to you, Melanie, for public comments.

4 CHAIR BELLA: Thank you, Joanne. Have a fun
5 weekend writing that letter. We'll look forward to
6 reviewing it.

7 Okay. We're going to open it up to anyone who
8 would like to make a public comment on today's sessions.
9 I'll just remind folks please introduce yourself and the
10 organization you are representing and keep your comments to
11 three minutes or less. We'll open that up now.

12 **### PUBLIC COMMENT**

13 * [No response.]

14 CHAIR BELLA: All right. We have no public
15 comments.

16 We'll go back to the Commissioners for any last
17 questions, thoughts.

18 [No response.]

19 CHAIR BELLA: Oh, yeah, it is a birthday. That's
20 right. We will wish Jenny a happy birthday. Did anybody
21 want to sing? Probably not.

22 [Laughter.]

1 CHAIR BELLA: Probably not. Thank you for
2 joining us on your birthday. What a special way to spend
3 it, yes.
4 Okay. Any other business for the Commission?
5 Kate?
6 EXECUTIVE DIRECTOR MASSEY: No.
7 CHAIR BELLA: Dennis?
8 COMMISSIONER HEAPHY: No. I'm just so grateful
9 to the staff [inaudible] staff this week.
10 CHAIR BELLA: Yeah. Many of us were saying our
11 heads hurt after many of these sessions, which is a good
12 sign. So thank you. Thank you to the team. Thank you to
13 Kate. Thanks to the tech team and to the Commissioners.
14 And we will be back December 8th and 9th for the December
15 meeting, so we are adjourned. Thank you, everyone.
16 * [Whereupon, at 11:30 a.m., the meeting was
17 adjourned.]
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