

Meeting Summary for MAPOC (Full Council) Zoom Meeting

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Quick recap

The team discussed the potential changes in federal policies under a new administration, and the findings and recommendations from a study on home and community-based services. They also discussed the need for reestablishing rate parity for behavioral health services, the potential of a new gene therapy for sickle cell disease, and the updates from various committees. The conversation ended with a sense of excitement and optimism about the potential of this treatment to improve the lives of patients with sickle cell disease.

Next steps

- DSS to submit application for CGT Access Model funding by February 28th.
- DSS legal team to review terms of agreements between manufacturers and CMS for sickle cell gene therapies.
- DSS to estimate costs and budget for sickle cell gene therapies in upcoming appropriations process.
- DSS to work on state plan amendment to participate in value-based agreement for sickle cell gene therapies.
- DSS to modify data systems to collect required data for CGT Access Model.
- DSS to partner with community organizations and academic centers to provide education and support services for sickle cell gene therapy.
- DSS to continue discussions with healthcare systems about becoming authorized treatment centers for sickle cell gene therapies.
- DSS to carve out payment for sickle cell gene therapies from inpatient bundle.
- DSS to update fee schedules and standardize rate review process across provider types.
- DSS to explore alternative payment methodologies, including for FQHCs.
- DSS to conduct deeper analysis of HCBS utilization and value.
- DSS to review and potentially update standardized assessment tool for HCBS waivers.
- DSS to provide update on coverage issues for dually eligible individuals obtaining durable medical equipment.
- DSS to provide basic information on respite home certification tiers and options for individuals with behavioral health needs to the Complex Care Committee.
- Bill Halsey (DSS) to provide presentation on Medicaid reimbursement for special education care to the Complex Care Committee.

Summary

Federal Policy Changes and State Plan

In the meeting, Bill Halsey discussed potential changes in federal policies under a new administration, focusing on waivers, regulations, and policies. He clarified that these changes could be implemented quickly, while others requiring congressional approval might take longer. He also addressed questions about the security of the state plan and potential changes to federal match for certain programs. Andrea added that while the state plan might be secure, the state could be required to end one program to access federal dollars for another. The team also discussed the potential for changes in covered benefits under the family planning benefits. Representative Susan Johnson inquired about the duration of the state plan, to which Bill responded that it is ongoing and only waivers require a 5-year renewal process.

Medicaid Study Rate Study Discussion

In the meeting, Nicole Godburn (DSS) discussed the second phase of the Medicaid Rate Study. She mentioned that the study was conducted in partnership with Myers and Staffer, and the results were posted on the DSS Website. The study compared Medicaid reimbursement rates to Medicare and peer states, with a focus on services such as behavioral health, dental, and autism. The results showed that Connecticut's rates were generally lower than those of the comparison states. Sabrina raised concerns about discrepancies in the data and the date used for comparison. Julia from Myers and Staffer clarified that the study used a standard timeframe of January for rate comparisons and that the error in the presentation was due to an outdated table. The team agreed to address further questions after the presentation.

Improving Home and Community Services

Julia discussed the findings and recommendations from a study on home and community-based services. She highlighted the need for improved documentation of Medicaid methodologies and the consolidation of separate fee schedules for providers. Julia also recommended continuing to monitor access issues and expanding the use of alternative payment models to improve quality and cost containment. She noted that service utilization in Connecticut was predominantly in residential supports and suggested a review of the current service array to ensure alignment with state goals. Julia also recommended adopting standardized, evidence-based assessment tools for eligibility and person-centered planning. William agreed with these recommendations and emphasized the need for a thorough analysis of HCBS services to understand why costs are higher in this area. He also stressed the importance of developing a rate review process to monitor market changes and ensure rates fall within a benchmark percentage.

Reestablishing Rate Parity and Medicaid

Bill, Nicole, and Julia discussed the need to reestablish rate parity for behavioral health services between children and adults, as the current system creates a rate cliff when children become adults. They also emphasized the importance of shoring up Medicaid core services and improving access monitoring tools. Julia clarified that the rates for Federally Qualified Health Centers (FQHCs) were generally lower than in peer states, and that most states use an Alternative Payment Methodology (APM) to provide additional payment to FQHCs. The team also discussed the need for a standardized process for updating fee schedules and the potential adoption of an APM to improve quality and value of services. Representative Tammy Nuccio raised concerns about the current rate-setting process, suggesting a more structured approach with clear benchmarks and a predictable schedule for updates.

Addressing Data Concerns and Reimbursement

In the meeting, Rep. Nuccio expressed concerns about the data presented, which he believed did not accurately reflect the situation. Jason Moran, Vice President of Healthcare Analytics Solutions, agreed with Nuccio's concerns, stating that the current methodology has no mechanism for review and adjustment. He also mentioned that the number of DME providers in Connecticut has declined significantly due to the current reimbursement methodology. Rep. Johnson raised questions about the coding methods used and how they differ between states. Julia clarified that while standardized code sets are supposed to be standardized, states make policy decisions about what they include or exclude in the code. Dr. Suzanne Lagarde pointed out an error in the slides presented, which incorrectly suggested that health centers in Connecticut were paid more than comparison states. The team agreed to correct this error. Mark Schaefer expressed concerns about the validity of the data presented for hospital reimbursement, stating that it might lead to mistaken conclusions about the adequacy of

hospital reimbursement. William acknowledged these concerns and indicated that they would be addressed in future work.

Medicaid Rates and Service Utilization

In the meeting, Rep. Lucy Dathan raised concerns about the difficulty constituents face in accessing Medicaid services due to low rates. Julia clarified that comparing Medicaid or Medicare to commercial rates is challenging, as costs differ across providers and policies. Rep. Dathan also questioned the inclusion of hospital tax dollars in the rate study, which Julia confirmed was not included. Sabrina from a Federally Qualified Health Center (FQHC) expressed concerns about the lack of meaningful rate increases over the years, attributing this to systemic issues within the Medicaid program. Sheldon raised questions about the report's findings on HCBS waiver services, particularly regarding service utilization and eligibility. Ellen Andrews emphasized the importance of using Medicare rates and conducting a utilization analysis to understand the value of services provided. Christine clarified that Connecticut uses the InterRAI as the basis for its universal assessment tool, which is standardized, and evidence based. Rep. Johnson inquired about the inclusion of the CHES program in the home care aspects of the study, which Bill clarified was not included in the current analysis.

Gene Therapy for Sickle Cell Disease

Co-Chair Senator Saud Anwar, Representative Johnson, Dr. Dalal, and Dr. Terranova discussed the potential of a new gene therapy for sickle cell disease, which has been approved by the FDA and is required to be covered by Medicaid. The therapy, Keshevi and Liszgenia, is potentially transformative for individuals living with severe sickle cell disease, reducing the number of crises, and allowing them to pursue a more normal life. However, the treatment is highly involved, risky, and costly, with a list price of 2.2 million for Cashev and 3.1 million for Lufthania. The team also discussed the outcomes-based agreements negotiated by CMS with the manufacturers, which could be valuable in the future. The CGT Access Model for Sickle Cell Disease Treatment was presented, which includes funding opportunities for states to support the model. The model includes requirements such as tracking data about patients, providing a standard access plan, and providing additional support to members receiving the treatment. The team also discussed the long and complex journey patients would undergo if they chose to get this treatment, including apheresis, fertility preservation, and intensive chemotherapy. The team also discussed the potential gaps in access for patients and the need for additional wraparound services. The presentation concluded with a discussion on the timeline for the State RFA and the terms of agreements between the manufacturers and CMS.

New Treatment for Sickle Cell Disease

The meeting discussed the potential of a new treatment for sickle cell disease, which could be a game-changer for patients. The treatment, costing around \$2 million per patient, is currently not covered by Medicaid, but the FDA approval means it must be covered. The discussion also touched on the potential for other innovative payment models for therapies. The team agreed that the treatment could be cost-effective in the long run, considering the reduction in hospitalizations and other healthcare costs. The conversation ended with a sense of excitement and optimism about the potential of this treatment to improve the lives of patients with sickle cell disease.

Committee Updates and Challenges Discussed

The meeting focused on updates from various committees. The Women and Children's Health Committee and the Care Management Committee shared their progress, with the latter planning a meeting on January 15th to discuss Mercer updates. The Complex Care Committee also had a meeting scheduled for January 16th, with discussions on comparing Medicare and

Medicaid reimbursement data. The committee also discussed the challenges faced by dually eligible individuals with durable medical equipment and the need for higher-tiered rest home certification to address homelessness among senior citizens. The next MAPOC (Full Council) meeting will be on February 14, 2025.