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HOW CAN THE BIDEN ADMINISTRATION IMPROVE THE MEDICAID PROGRAM?

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Panel Discussion:

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P R O C E E D I N G S

MR. FIEDLER: Hi, my name is Matt Fiedler, and I'm a fellow with the USC-Brookings Schaeffer Initiative for Health Policy. I'm very pleased to welcome all of you to today's USC-Brookings Schaeffer Initiative panel discussion, on how the Biden administration can improve the Medicaid program.

I want to start by introducing our four excellent panelists. I'm pleased to welcome Val Davidson. Val is president of Alaska Pacific University. She was previously lieutenant governor of Alaska and commissioner of Alaska's Department of Health and Human Services. I'm also pleased to welcome Dan Tsai. Dan is the assistant secretary for MassHealth in the Executive Office of Health and Human Services, in the Commonwealth of Massachusetts. Third, we have Jen Wagner. Jen is the director of Medicaid Eligibility and Enrollment, at the Center on Budget and Policy Priorities. And, fourth, we have Vikki Wachino. Vikki is the CEO of Community Oriented Correctional Health Services. She was previously deputy administrator at the Centers for Medicare and Medicaid Services, where she oversaw Medicaid and CHIP.

So, to start, just to give you a sense of how the panel is going to proceed, we're going to have each of our four panelists share some brief opening thoughts, and then we'll turn to question and answer, including some questions from the audience. Many of you submitted questions in advance, but if you have questions during the panel, you can ask them via Twitter using #ImprovingMedicaid, or you can send them to events@brookings.edu. So, we're excited for the panel, and with that I want to turn things over to Val, for her opening thoughts.

MS. NURR'ARAALUK DAVIDSON: (speaking in Native language). My Yup'ik names are (speaking in Native language), and my English name is Val Davidson. I'm from Bethel, Alaska. My mother's family is from Koyukuk, and my father's family is Kassakou, or where he's not Yup'ik, and he's from Port Orchard, Washington.

I first want to say that, wherever we are in this country, it's really important to acknowledge the original inhabitants of the lands, where we're fortunate to work, play, and live. And, today, I'm speaking from Anchorage, the traditional homelands of the Dena'ina people, and we honor

their stewardship of this land, since time and memorial, and we take their charge, of protecting these lands, very seriously.

So, I'm going to try to get through my introductory comments without sounding like an auctioneer, at the end of the auction. I think we have four goals, really. One is to stabilize Medicaid. Two is to strengthen the public health system, which we certainly have seen we need it. The pandemic certainly brought that to light. Three, remove barriers to coverage, beyond the public health emergency, because, quite frankly, if we're able to do it during a public health emergency, we should be able to do it during our regular course of business. And, then fourth, really pursue, you know, what are the legislative proposals that we can continue to build on, that were kind of left on the table, or taken off the table, during some of those earlier Affordable Care Act negotiations.

So, the first one, just with regard to stabilizing Medicaid, it's really -- you know, some of it is undoing things, that have happened recently, shall I say, and so, you know, especially considering that the Supreme Court has granted Arkansas and New Hampshire's petition to have their work requirements heard by the court. You know, it's everything from addressing work requirement limitations, healthy adult opportunities, which really are code for Block Grants, which I'm not a fan of, and we know that Tennessee was awarded a Block Grant -- approved for a Block Grant Waiver, at the 11th hour, and, you know, other kinds of things that are just really not helpful, limitations on retroactive eligibility, and periodically eligibility checks, stringent eligibility redeterminations, and those kinds of things.

With regards to the second goal of strengthening public health system capacity, you know, as states are planning their budgets, what they need most of all, right now, is really assurance and certainty, well, as much certainty as we can provide, in these really uncertain times, from the federal government, and so, extending the Public Health Emergency, for example, through the end of fiscal year 2020 will help, sorry, 2022, will help by extending access to temporary increases and the Medicaid match rate, eligibility requirements, including continuous coverage.

We can also do things like, or we should do things like, expanding the use of 1115 waivers, during the Public Health Emergency. For example, we could create a new eligibility group,

where Medicaid could provide marketplace coverage for people up to 200% of the federal poverty level, and then, you know, what about Medicaid Disaster Relief Funds, to cover the cost of treatment of uninsured individuals who have contracted COVID-19? What about their housing needs, their nutrition supports, and other COVID related expenditures?

And the third goal, removing the barriers to coverage, past the Public Health Emergency. The -- there were policies -- we should be able to work with states to transition polices that expand eligibility, streamline enrollment, that were adopted under emergency authorities, to permanent authorities, after the Public Health Emergency. So, you know, for example, delaying and staggering renewals, redetermination of processes, and also suspending the payment error rate measurement reviews.

We can also incentivize states to take up options to support coverage, like removing the five-year ban for recently pregnant women, using presumptive eligibility for more groups to expedite enrollment, provide 12-month continuous enrollment for children, and simplifying application communication, and signature requirements, and eligibility determinations, which has always been a challenge for certain populations, especially in rural states' indigenous populations, where English may not be our first language.

And then the fourth category, and I won't say a lot about this one, just in the interest of time, are, you know, what are the opportunities for legislative proposals, to really broaden the ACA and Medicaid expansion, that were not possible during the last round of negotiations of passage of the ACA. So, hopefully I didn't speak too fast. I spoke definitely really, really fast for a Yup'ik, but hopefully not too fast in English. With that, (speaking in Native language).

MR. FIEDLER: Thank you. So, next up, we have Dan Tsai.

MR. TSAI: Great, thanks, Matt, thanks, folks. Thanks for having me. It's -- this is obviously a very timely discussion. It's quite a time in our nation, particularly for healthcare, for individuals and populations that have been underserved, historically, and so, I'm looking forward to the dialogue on this panel.

So, I think I would say four things, coverage, affordability, equity, and innovation, and as a little bit of context from the Massachusetts perspective, where I'm the Medicaid director, you know, I'm -- that relate to those four pieces. So, we have a strong commitment to universal healthcare coverage, in Massachusetts. We're very proud of having the lowest rate of healthcare un-insurance in the country, and part of that involves a very strong and robust role for the Medicaid program, in the state, of which the Commonwealth had a version of Medicaid expansion, pre-ACA, and also a way of thinking about the subsidized coverage, beyond just the 138% FPL line, the Medicaid where you have much more of a -- in Massachusetts, it's an affordability schedule, with tools that are approved through our Medicaid 1115 waiver, that actually help make QHP marketplace coverage, for low income folks, more affordable as well.

So, that -- those are some of the things that have been critical in us maintaining, but the rate of healthcare coverage that we've had in the Commonwealth. Now, the other piece of context here, in Massachusetts, is a real commitment to add scale delivery system reform, where, from the Medicaid side, we have pushed forward -- we have a landmarked 1115 waiver, that we actually negotiated with Vikki and team, agreed to, on November 4, 2016, with a very specific date in mind on that, and have about 75 to 80% of our eligible lives in MassHealth in a fully at risk ACM model with very strong primary care and other components of that.

So, when I backup, I'm thinking kind of a coverage, affordability, equity, and innovation, coverage and affordability, certainly, you know, we have a perspective in Massachusetts, I'm sure other colleagues on this panel will talk about. There are a number of states that, you know, are in different positions of that, that account for about 30% of the population of the country, and certainly thinking about what does affordable subsidized coverage look like, in the context of that, and leverage that CMS has, relative to financing other policy pieces, would be really important.

From our experience in Massachusetts, you could say thinking creatively, for any state, about how to use Medicaid in a more elevated fashion, through -- in the role of Medicaid, through both 1115 waivers, and how you think about other pieces of that, so what we think have a very important continuum, in part, and not only coverage and stability of insurance coverage in any sort of market. So,

coverage and affordability would be a really big piece, and then equity innovation -- equity and innovation, I think those go very much hand in hand. Certainly, I think, most folks are aligned around the push to move away from a fee-for-service, a very fragmented system, without integrated behavioral health and things of that sort.

There are a lot of things that, at the federal level, you know, healthcare is very local, and states do have their own Medicaid programs, but direction coming out of CMS, policy pieces about CMS thinks about 1115 waivers, what's willing to be financed or not, flexibility and how to quickly move through pieces, and in particular, alignments for things coming out of CMMI, which has, you know, a lot of stuff from Medicare, historically, not a lot from Medicaid. In fact, many states, if we just wanted to cut and paste the CMMI Model, for delivery system innovation, and do that in a particular state, in many instances, that's not actually possible from a Medicaid contract standpoint.

So, there are substantial things there, that I think can push the envelope, by setting direction and flexibility for delivery system reform, but also in, and including with a very specific lens of equity, in addition to cost, quality, and member experience, for a range of populations, and that includes things that can be very targeted, so, thinking about different ways of addressing maternal populations, where health outcomes have -- are very clearly linked to racial disparities, as well, and also for justice involved populations, which I think Vikki is quite passionate about, all the way to the broader pieces, around how the role of the Medicaid program, flexibly, for the right, you know, populations, being able to invest dollars in things, like housing supports, nutrition, etc., as well. Well, I'll pause there, and I look forward to dialogue and discussion with this group.

MR. FIEDLER: Great, thanks, Dan. Next up, we have Jen Wagner.

MS. WAGNER: Thanks so much, Matt, and thanks for having me here. So, my work at CBPP focuses, largely, on improving the on the ground experience, of people applying for or renewing Medicaid, and the state agencies that administer these programs. Fortunately, there are many things the Biden administration can do to streamline access for eligible people, many of which are actually kind of technical changes that can fly under the radar a little bit, in this politically charged environment.

Now, expanding Medicaid is -- eligibility is a critically important effort, but there are many people who are currently eligible, but not enrolled, and many more who must overcome major obstacles to enroll, or frequently lose coverage, even though they remain eligible. This most often occurs, due requests for paper documentation, for things that could be verified electronically, or outdated methods of sending notices through the mail, and requiring people to complete and return forms, on short timeframes.

Sometimes, it’s inaccessible call centers or websites that require lengthy account setup procedures and identity proofing. This sludge in the system prevents eligible people from accessing Medicaid. A few of these problems could most easily be addressed through legislation, but in many instances, the Medicaid regulations, already in place, provide the foundation on which these improvements can be built.

For example, regulations require states to first check data sources, to see if they can confirm an enrollee’s ongoing eligibility before sending them renewal paperwork, a process known as ex parte renewals. This is usually an automated process, in the state’s eligibility system, that saves the state considerable caseworker time, and minimizes the risk that eligible individuals will lose coverage because they didn’t receive a form, didn’t return it, or the state agency was behind in processing paperwork, but states, very significantly, on how many of their renewals are completed ex parte, from none at all, in a few states, to over 75% in other states.

So, there’s a huge opportunity here, to promote improvements. First and foremost, the CMS should reverse a Trump era policy that prevents people with no accountable income from getting an ex parte renewal, and requires states to get a signed form from those individuals. Beyond that, states could provide state -- a CMS could provide state detailed guidance, on the different scenarios they face and technical assistance to improve this process. It sounds straightforward, but it’s really complicated and more assistance would help.

Turning to another example, most people enrolled in SNAP, formally food stamps, are eligible for Medicaid, and SNAP information is usually very current and thoroughly verified. Medicaid

agencies can use the information from the SNAP case to expedite Medicaid enrollment, as well as complete Medicaid renewals for people receiving both benefits. There are a variety of approaches that are already in law or guidance, that allows states with either immigrated or separate administrations of SNAP and Medicaid, to leverage this information to streamline processing.

But not enough states are taking advantage of this, and instead are imposing burdensome processes, on applicants and enrollees. This is another area where CMS could promote these opportunities and help states implement these policies.

One more example is returned mail. The previous administration was pressuring states to cancel Medicaid coverage, if someone's mail was returned as undeliverable. This is a huge disservice to the many enrollees with unstable housing or unreliable mailing addresses. Instead, CMS should shift more of the burden to states, to make sure that they have updated addresses. This can be done through cross matches, with United States Postal Services, getting more recent contact information from other programs, like SNAP, and taking advantage to managed care organizations, that may have more current information. Further, states should be required to take proactive measures, when mail is undeliverable, such as reaching out to the client, via phone or a text, to get updated information.

There are many more examples, but I'll stop there, to say that, fundamentally, CMS needs to focus on ensuring all eligible people are enrolled, and stay enrolled, through streamlined, accurate, and human centered processes. Through guidance, technical support, and a healthy dose of accountability where necessary, CMS can guide state programs towards this vision.

MR. FIEDLER: Great, thanks, Jen, and then for a final opening statement, I'm going to turn things over to Vikki.

MS. WACHINO: Thanks, Matt. Thanks, everyone, for joining today. I wish everyone who's joining today good health and wellbeing, recognizing that we're all experiencing a very difficult winter together.

My remarks are -- will address three topics: COVID, coverage, and equity. Obviously, COVID is top of mind for all of us, and COVID is job one, for the incoming Biden team, addressing both

the health -- public health and economic consequences is an imperative, and although many of the highest profile policies concern public health agencies, NIH, CDC, FDA, Medicaid plays a key role, and although we're today to talk about how to make Medicaid even better, I just want to start by acknowledging the -- that Medicaid has really probably never played a more important role, than it is right now.

We, all of us, every day, are worried about our health. We want access to testing, to treatment, to vaccinations. If you're a poor person in America, add to those concerns a recent job loss, and the imperative, and the daily struggle, to keep food on your table, and a roof over your head. And what Medicaid brings to that is not just the confidence that you'll be able to get healthcare when you need it, but a degree of financial security, that you won't have to pay for things out of pocket, and that, I think, is really underpinning part of the pandemic response, and so, the leading roles do go to NIH and CDC, I would, it being awards season, nominate Medicaid, for best supporting actor because of the role it's playing in supporting people, the role it plays in supporting providers, many of whom under unprecedented financial stress, and the stress of responding to a rapidly evolving situation, and supporting states because Medicaid is the single largest federal source of support to states, and, already, the Biden administration has done what's probably the most single important thing, which is signaling to states that they very likely extent the Public Health Emergency, through 2021, which means that a temporary fiscal relief, that Congress enacted last year, will stay in place, and that a lot of the program added flexibilities, that states and providers have used to respond to the pandemic, will also remain.

Now, all that being said, there are -- there's more that could be done to really maximize the role Medicaid is playing, and, as Val noted, there are things that states asked for, through 1115 authority, to expand coverage in a variety of different ways, that have not moved forward. There is this very growing -- significant and growing behavioral health need in the country. We had very high levels of mental health and substance use disorder, before the pandemic, and every indication is that that's growing significantly, and Medicaid is one of the nation's leading financers of behavioral health. So, I

think, that there are things around peer supports and expanding services in communities, that's it really essential to move forward right now, as well as advancing home and community-based services.

Home and community-based service in Medicaid get less attention than many other parts of the program, historically, but they help seniors and people with disabilities stay in their homes, and now, as the need to stay in place and the consequences of social isolation are with us, I think there's a very powerful business case to be made for expanding access to HCBS, and that can be done at the state level, and more could be done at the federal level, and, in fact, the Biden campaign had proposals to advance some of that.

On coverage, I think that the administration has already set a very clear intention about restoring some of the very damaging cuts in access and affordability, that the Trump administration put in place. Last week, the Biden administration signed an executive order, asking HHS and other agencies to review policy, that hinder access and affordability, rather than promote it, and I think that that is a very clear signal, that things are going to be very different at HHS, in a welcome way. I would hope that some of the first policies that get reexamined are the polices that some states have moved forward, with the encouragement of the Trump administration, to require Medicaid beneficiaries to prove that they are working or looking for work, under penalty of losing their coverage, and what we've seen, over the past few years, is that those policies caused significant numbers of people to lose coverage, or are costly for states to implement, and don't have an impact on employment, all of which were outcomes that were foreseeable at the time they were promulgated, but we now have the research to document it, and as well as, as Val alluded to earlier, is Block Grants, which really don't have a place in the Medicaid Program.

Third and finally, equity, I think, the course of the past year, has amply demonstrated the need to move forward with more equitable policies, in every sector of the United States, and it was heartening that it -- one of the first things that the Biden administration did was establishing executive order on equity. Like, literally, the fireworks weren't done on -- weren't going off on the mall, before it -- before the new president came in and directed every agency in the federal government to review its policies, with the goal of advancing equity, for people of color, for people in other marginalized groups,

and for people who experience persistence, poverty, and inequality.

And agencies will have discretion in how to interpret that, and what programs to highlight. I would make the case that Medicaid is essential to equity. Medicaid serves millions of people, who've experienced persistent poverty and inequality. One in five -- oh, I'm sorry -- one in -- yeah, one in five of its enrollees are Black, one in four are Hispanic. And so, looking at barriers to coverage, looking at barriers to access, I think, is really essential, an essential part of advancing equity in our society.

Beyond coverage, I think that there are also a number of ways that the new administration could move forward in actually developing care models and approaches, that are specifically targeted to some of the communities, that don't yet have trust in the healthcare system. Dan mentioned the Innovation Center before, and he's absolutely right. A lot of those models have been very Medicare driven. Wouldn't it be interesting for Medicaid and the Innovation Center to partner together and get a lot of input from people with lived experience, on how to overcome barriers to trust, and barriers to access, in some of our most disadvantaged communities, both rural and urban.

Wouldn't it be interesting to kind of synthesize some of what we've learned about public health, and there are big disconnects between the healthcare system and public health, not just in Medicaid, but generally, and to leverage Medicaid's flexibility and authority, to help better incorporate some public health interventions into healthcare. I could really see Medicaid leading the way here, and I -- my hope would be, at the end of four years, Medicaid has really earned the statue for best supporting actor in a pandemic driven economic downturn.

MR. FIEDLER: Great, thank you, Vikki. So, I want to delve deeper into a lot of the issues that all of you raised in your opening remarks. But to start, I want to just take a step way back, for the sort of non-Medicaid experts, that may be with us today.

Given that each state is -- has primarily responsibility for operating this Medicaid program, how can the federal government shape Medicaid policy? What are the basic levers it has to pull on? Vikki, I know you've sat on the federal side of the program. So, can you give us just a sort of quick overview of what the tools the federal government actually has are?

MS. WACHINIO: Well, I could get very wonky, very fast, and I will tell you my first intro to Medicaid policy was writing the administrations chapter of the Medicaid resource book, that the Kaiser Family Foundation put out, and so, that was my proving ground. So, I'll give you the wonky answer, and then I'll give -- then, I'll try to boil it down. So, the wonky answer is that the federal government sets guidelines and minimum requirements, and states carry them out. Congress sets the big rules, CMS can regulate, and within the options that are available to states, and there are many of them, there's a -- Medicaid is a program with really enormous flexibility and a range of options. CMS makes decisions, when states come to them wanting to take up different options. It also, as Dan and Val alluded to, has waiver authority, which is an authority that Congress gives CMS to waive some of the provisions of federal law, and CMS also has an oversight responsibility.

When I think about it, though, I think that CMS's role really boils down to three things. One is leadership. I think the federal government has a very important role in establishing direction and priorities, and opening doors, and because of its position at the federal Level, also can extend to other agencies and help move, you know, agencies along, HUD, Labor, DOJ, and they can move CMS. So, leadership is one.

Day to day management, CMS is not as big an organization as it looks, but -- so, it's essential that the day-to-day management of the staff and the interactions with states go as smoothly as possible and line up with priorities, and then partnership with states. And Medicaid is unusual in healthcare programs, in that -- and it's split, between federal and state roles, and so, I think, really, part of CMS's responsibility is encouraging states, listening to states, embracing great ideas, when they come up, and helping to, then, to move forward, while also sticking to those kind of federal parameters.

MR. FIEDLER: Great. So, I also want to look at this from the sort of state perspective, and sort of acknowledge the elephant in the room, which is the state budget situation, and, you know, more broadly, the COVID-19 pandemic. How are states feeling about their budget outlooks, at the moment, and, you know, how do you expect that to shape how they approach Medicaid policy, in the near term? I expect a lot of folks will have thoughts, but, Dan, since you're the current state official on the

panel, I'm curious to get your take on that question.

MR. TSAI: Yeah, I don't even think it's the elephant in the room, it's just the thing that everyone -- so, it's no secret, any state is going to be facing tremendous pressure from a revenue standpoint, at the same time it's facing tremendous need, not only from a coverage standpoint, when you think of safety net programs, but everything it takes to respond to COVID and also the economic impact, more broadly, for individuals in different communities, from everything that's going, as a result of COVID.

So, so, there's an economic -- a deep economic pressure, no question about it. I think states are in a range of different places, and the support from the federal government is critical here. For a state like Massachusetts, the last thing we will be considering is anything that impacts the robustness and integrity of, you know, coverage in the Medicaid program, and at the same time, we have realities to solve for, from the fiscal standpoint, and in the midst of COVID, there are tremendous additional economic things, whether it's the cost, right now, for states administering -- supporting administration of vaccines, where there is federal discussion on that, to provide a relief, and so on.

So, fiscal stability, so the -- and, Vikki, I think you said -- indicated they might -- we all read it as the PHE is extended until 12/31. We're going to budget and plan for that. That level of fiscal sustainability is incredibility important because you're not budgeting a month -- quarter to quarter, what's several hundred-million-dollar swings, potentially, in revenue. That allows us to start to think a little bit more, and so, we're very thankful for that. However, there's still a cliff at the end of it, and the economic pressures that we exist in right now, with COVID, you know, we can all be optimistic, but there are going to be challenges still, through the end of the year, and so, continued support from the federal government, where states have balanced budgets, I think it's going to be that much more important to preserving the integrity and robustness of Medicaid. Different states have very different approaches and pressures that they're facing, what they might do to solve for some of those fiscal cliffs.

MR. FIEDLER: Okay.

MS. WAGNER: In one place where this might play out in a very real way is, you know, when the continuous coverage provision ends. So, right now, in exchange for that enhance FMAP, states

can’t terminate Medicaid coverage for most enrollees, unless they request it, die, or move out of state, but when that ends, states are going to have to kind of catch up on a lot of deferred work and review their caseload. One concern is that strong budget pressures will make states do that very quickly, very inefficiently, and that will lead to a lot of eligible people losing coverage, again, because of these paperwork barriers and things.

So, it’s another opportunity for the CMS, the new CMS, to build on the guidance that was issued at the end of last year, and make sure that states take a very deliberate and accurate approach to this, that doesn’t just, you know, pressure people off, and we’ll let them come on later, it would save money in the meantime, and make sure that eligible people retain coverage.

MR. FIEDLER: Are there other -- just following up on this, do people see a sort of -- so, you alluded to this sort of guidance on the wind down of the continuous coverage provision, when it, you know, eventually reaches its end, early next year, or past that, whenever that may be. Are there other federal levers here that you all view as important in sort of creating a productive context at the state level?

MS. WACHINO: I think, Matt, in the context of the COVID relief discussions last year, there was discussion about increasing the fiscal relief to states, and, you know, I think that that’s worth bearing in mind, that the current fiscal relief is very, very helpful, but state budgets are in a very challenging -- remain in a very challenging place, and I think it is worth considering whether there is more that could be done, at the federal level, to support states.

MR. TSAI: One thing I would just add to that, I think the Medicaid directors have been saying this, for federal relief going to providers, as a part of COVID, which is critical to maintaining access, you know, there are a lot of providers with a very strong Medicaid footprint, some of which benefitted very much so from the federal funding, and some of it which, in some examples, we couldn’t understand why, literally were bypassed on some of those pieces.

So, the federal support, to date, is important, even as -- and even more important going forward, and I do think there is an important role for a -- from a Medicaid perspective and safety net providers, which also correlates to providers who provide access in a whole range of other things, in

communities where COVID has had most of an impact, and the very questions around equity and disparity has come up. So, you know, those are the types of things that I'd also encourage folks to be thinking about, in addition to just some of the broad relief pieces or the financial participation rate for Medicaid to FMAP these.

MR. FIEDLER: Great. So, I want to switch gears a little bit, and, you know, one of the major priorities for a Biden administration is likely to be finding a path to coverage for people who are under the poverty line and in states that haven't expanded Medicaid. So, you know, let's assume for the moment that, as a Biden campaign proposal obviously envisioned, creating a new federal program to cover this group in the non-expansion states, but let's assume there's no legislative changes. You know, what tools does CMS have to bring new states in? And, you know, Val, I know you were responsible for Alaska's Medicaid program, when it expanded. So, I was just sort of curious what your perspective is, on how states think about these decisions and what's effective in making expansion attractive.

MS. NURR'ARAALUK DAVIDSON: Well, I would say for states who haven't expanded Medicaid, come on in, the water's warm. But I would say that, you know, our challenge in Alaska, we really struggled, and we tried to do it with -- during the Walker administration, we tried to do it with the legislature they included in the budget, they took it out, and, ultimately, we ended up actually having to take administrative action, which was litigated, and we won.

But we were very fortunate that we were working with a very friendly CMS crew, at the time, including Vikki, and one of the things that made a huge difference for us is that we were in a really challenging economic time, in Alaska, and we pitched it as not only is this going to cover more people, our view was Alaskans can't work, they can't hunt, they can't fish, all of those things that Alaskans hold dear, and we can't learn if people aren't healthy enough to be able to do so.

So, all of the folks who are really you've got to pull yourself up by your own bootstraps kinds of folks, we were like, great, how are they going to do that, if they're not healthy enough to do so? And the reality is healthcare ended up being the only bright spot in our economy, during that time period, and in four years, we were able to provide coverage in munici -- Alaska's a small state, these are big

numbers to us, but they might not be big numbers to you, we were able to extend -- we were able to cover 79,000 more people in those four years, including about 55,000 Medicaid expansion folks, and we did it with fewer state dollars than we did before, than we had before, and some of that was really because of our relationships with tribes, and I would not -- I would not overlook that.

So, those of you who are in states that have significant tribal populations, and there are 34 states who have tribes in your states, we were able to work with Vikki and her crew to be able to ensure that the tribal -- tribal claiming policy was really viewed very broadly, so that if three things come together, if you have a Indian health service beneficiary, and that means it's a Alaska Native or American Indian person, like me, who's also a Medicaid beneficiary, who receives their care -- and the word -- the magic language is through an IHS facility, that reimbursement, to this date, is at 100% federal match. So, before, it was always construed very, very narrowly, and so, if you crossed the threshold of that facility, then 100% FMAP no longer applied.

And so, we know that we have -- we have to refer services. Some facilities don't have a cardiologist, and so, when that patient gets referred, we made the argument that if it's a patient who started in the Tribal Health System, who's moving to a non-tribal health facility, and we have a care coordination agreement, where two things happen. One, we wanted to be able to get 100% FMAP for that service, but it's also better continuity of care for our patients and our beneficiaries because before, when they left our system, they would go, and what's happening with follow up care, etc., and those are two different systems.

And then the other thing we asked for and we were able to get is that -- in a state like ours, in Alaska, there are very few roads. I come from a region that is the size of the state of Oregon and has no roads connecting any communities, literally no roads, 58 federally recognized tribes, no roads connecting any communities, and so, when a person needs healthcare, if they have -- if they don't have Medicaid coverage, and thank God many of us -- many folks do, it could be a $1,000 plane ticket from that community to the next medical center, and that's in the region, in Bethel. If they need to go beyond that, to Anchorage, then that's another $500, and so, a person can have an appointment in theory, but if

we don’t have the resources to be able to extend that, then they have a -- they don’t have an appointment in practice, and so, we worked very intentionally with our Tribal Health System in Alaska and with CMS to ensure that expanding Medicaid coverage in Alaska was something that -- that was really beneficial for our state.

I think the challenge that we have is that, you know, for the folks who are not interested in doing Medicaid expansion, they’re just -- they’re just true nonbelievers, and I -- they’re -- you know, what I saw, certainly, sitting at that table, advocating for a Medicaid expansion, for, you know, over 50 hearings, answering over 350 questions, is there was nothing I could say, there was no science, there was no detail, there was no information, no data point, that I could provide, that would satisfy their underlying, I think hate might be too strong of a word, but their extreme dislike for a Medicaid expansion.

So, that was Alaska’s experience, and, ultimately, I think the only way that we made it work is we had a governor, at the time, who Medicaid expansion was a serious campaign promise. When I was hired, when I interviewed him for the job, we laugh about that all the time, the question I asked him was, if Medicaid expansion was a -- was a campaign promise, and you’re not actually going to do it, and do whatever it takes to do it, I’m not coming. And he was like, nope, we can do that. I said great, let’s talk about tribes next. And then -- and, ultimately, you really need a strong leader, who’s going to say, you know what, I’m going to do this, I’m going to do it no matter what, even if it involves litigation. And it was tough, but -- but we were able to get there.

MS. WACHINO: I think, Matt, what Val’s example illustrates is two things. I mean, one is just the importance of state leadership on Medicaid, generally, and on expansion, in particular, and the second is, you know, there are things, to your question, Matt, that are tools, that are at CMS’s disposal, to help when there’s a need to help. I think the -- the challenge is doing the things that are actually expanding access to coverage, not contracting it, and in Alaska’s case, through Val’s leadership, and I will say I learned an enormous amount about access in Alaska, through Val’s education and leadership.

I think before the -- before we worked with Alaska, there had been a lot of restrictions on transportation, and we hadn’t really seen transportation as so key to access, but once Val explained to us

that in order to have a baby in Alaska, people had to get on a plane, and travel, and stay in a hotel, to be near a hospital. Val, tell me if I'm not remembering this correctly. Like, it really became -- it really helped us open our minds to the potential that expansion could have in these very specific circumstances.

MR. FIEDLER: So, you know, I think one of the things that came through, particularly through, in Val's remarks is, you know, expansion got over the finish line in Alaska, but the political obstacles were very real and not -- you know, some states that, you know, there just might not be a (inaudible) obstacles. You know, if the -- if Congress were to consider to come at this problem legislatively, what do you think the options look like there, and what should Congress be thinking about?

MS. WACHINO: Well, clearly, there's the option that Biden campaigned on, which is enrolling people in non-expansion states into a public option, so, that's option number one. In the past, there have been proposals to increase the matching rate for expansion. So, when ACA was first enacted, states received 100% federal match for the first three years, and then it slowly declined from there, and so, basically, the proposal, which was an Obama era proposal, was to extend that to newly expanding states. So, that's another option on the table, there may be others.

The one thing I'll say, I mean, when you think about legislation, you think, you know, well, it's -- they're divided, Congress, really narrow margins, which is true. Interestingly, Medicaid is very popular. I think we've seen that at the national level. If you look at the polling, three-quarters of people have a favorable view of the program. Most of the way expansion has moved forward in the past few years, despite opposition at the federal level, was through ballot initiatives, all of which have succeeded, and so, I think that whatever option Congress and the administration choose to pursue, there's a little bit of political wind at their backs, in moving it forward, even though we're in this kind of, you know, narrow margin legislative environment on the Hill.

MR. FIEDLER: Val, it seemed like you wanted to jump in there.

MS. NURR'ARAALUK DAVIDSON: No, I was just going to say Amen, sister. I think, you know, resetting that clock because -- and it's something that just really burned us in Alaska, is that, you know, that the three years was a date specific, and it -- those three years really should be tied to the date

that someone starts Medicaid expansion, and so, for those early -- and I know the reason was it was to incent early adopters, but we're at a different time now, and being able to do that, I think, would be really, really helpful.

But I also wanted to speak a little bit to Jen's comment about the importance of making sure that we're enrolling people who have historically been, and also Vikki's comment, enrolling people who are historically underserved, and I remember, it was my first Tribal Technical Advisory Group, to the CMS administrator, asking this question, at the time, which was, okay, I'm about to ask you a really, really critical question that will determine whether you and your entire family has access to healthcare through Medicaid, are you -- so, be ready, I'm going to ask you. And they were like, okay, we're ready, and I said, (speaking in Native language), and they stared blankly, and -- of course, because they didn't understand what I was saying, and I reverted back to English, and said, oh, gosh, unfortunately, based upon your non-response, I'm going to have to deny your application.

And we do -- even for people who don't speak -- who -- even for people for whom English is not their first language, we also have a lot of really grandiose language, sometimes, in making sure that that, when we're asking questions, that, you know, we shouldn't need -- you shouldn't have to bring your lawyer or bring your advocate with you to help you understand that paperwork. And what's the purpose of that? It really is -- you know, we should be thinking about how do we let people in, versus how do we keep people out, and a lot of times it just feels that way, and I think that's not very helpful.

MR. FIEDLER: Okay. So, I want to switch gears again, which is, you know, there's been a lot of, I think, policy discussions in D.C., and I think throughout the country, focused around the idea that, you know, healthcare is just sort of one determinant of health outcomes, and that's led to interests both in ensuring that Medicaid beneficiaries are connected to other programs and services they might be eligible for, and then potentially in using Medicaid to fund various types of sort of non-medical social services. So, I'm curious to hear a little more about what you all view as this -- promising options in this space and what -- where the pitfalls are, and how you think CMS should be approaching this policy area. You know, Jen, I know, on the cross-program integration space, this is something you've thought about.

So, I thought we might start with you, but I suspect all of other panelists are going to have thoughts on this question, too.

MS. WAGNER: Sure, I mean, the question of Medicaid funding non-medical services is complicated, but cross enrollment with other programs is back pocketed. These programs are out there, they're funded, you know, they're there for people. And how do we stop looking at things program by program and look at things from the perspective of a family who needs help and the burdens they face by having to contact multiple agencies, put the same information on multiple forms in order to get benefits to support their family, and so there are lots of opportunities, and I think the new administration can do a lot to send that message from the top down, and that could be specific directives to coordinate among agencies.

I know, under the Obama administration, FNS and CMS, you know, did talk and tried to talk more, but there was a whole lot going on at the time. So, what can be done to make sure that policies are consistent, both at a high level and at an operational level. I'm not talking about changing the law, as far as the definition of household and income, but policies about when renewals can be formed -- sent, and things like that can be aligned to really ease problems for states that are administering these programs, and also what is measured.

You know, if CMS were to direct states to measure cross enrollment, with SNAP, with LIHEAP, with WIC, that could expose a lot of things, ideally provide some incentives, some technical assistance, to help do that, and to even set, you know, broad goals and directives, that will trickle all the way down to the governor level, and to the agency of every child under 5 who is low income, should be enrolled in Medicaid, SNAP, and WIC. Let's make it happen. Let's highlight best practices. Let's identify opportunities that streamline policies.

The programs are there, and we can even use technology to help. States are siloed, that's tough, if we can change that, great, but there's a lot of complicated bureaucracy involved. So, how can we do things on the front end? By creating combined applications that provide that information to each program and that share data among the programs, so that, at least from the client perspective, it's a

relatively seamless experience.

MR. TSAI: I have two thoughts. One, Jen, is in response to your comment. I think from a state standpoint, so, those make a lot of policy sense. One of the things to think about very tactically, from the federal standpoint, and I'll speak to it because I'm sitting in a state seat, many of those pieces require either cost or operational -- have cost or operational implications, and states do have challenges with balanced budgets, and we kind of noted the broader context up front.

So, Massachusetts, like, we have the opposite issue, with -- we do referred eligibility for a bunch of sister agency programs, get them onto MassHealth, and what we typically find is the other way. We have a lot of folks on Medicaid, that we find are actually not on something like SNAP, and there are initiatives around that. But for a state that's not there, it hasn't historically been there, even if they wanted to do that, there's a lot of cost and operational stuff. So, to the extent there's a handful of very concrete priorities with, you know, enhanced FMAP for doing X, Y, Z, that clears a bubble of focus and kind of fiscal reality to doing some of those pieces.

Matt, to the broader point around the role of Medicaid in addressing some of the health equity and the racial disparity of other components that we have seen very substantially, I echo number one, Vikki's comment. The existence, the very existence of the Medicaid program, in a robust fashion, easily accessible to the population, is critical as a starting point. I think, at least from my perspective, bottom line, Medicaid has a goal in doing more, in experimenting with some of the other social services, and in Massachusetts, we call them health related social needs because our populations, even if you think of it from a fiscal standpoint, we have individuals who are going in and out of the ED 10-40 times, within a very short period of time.

Some of that is relating to -- related to housing instability, along with a range of other factors. It doesn't take a lot of brain power to quickly think, gee, if we -- if we figured out a different way of not only thinking about the range of other social supports around that, but interesting ways of managing housing, that you can actually probably reduce costs, overall. There are, as you noted, Jen, some complications with what Title 19 covered, but I do think the 1115 is another reason. Vikki, we had spent a

lot of time on that, as well, together, but there is opportunity for states, as long as there's a clear framework and expectation that, yes, how do you think about targeting some of these programs, etc., but I think there's a lot more that Medicaid programs could do, if offered flexibility, through waivers and such, by CMS, and I think that's an imperative, in this time, for Medicaid programs and others to be thinking about, beyond the standard cost, quality, and member experience profiles on that.

The last thing I'd say about that, a lot of this starts with data, as well. So, in many different states, it's really hard to even measure where you have inequities from across a range of different dimensions because some of those factors are not captured in eligibility systems, and if you don't know what some of those disparities are, it's very hard to target those in a very clear way, and so, again, a push, whether it's, you know, a description of leadership, of let's go in this direction, all the way to enhanced funding for states that are bringing those sorts of things up, I think are all pretty important to addressing this.

MR. FIEDLER: Val, it looks like you want to jump in.

MS. NURR'ARAALUK DAVIDSON: Sure. So, I think one of the things we can -- we haven't really spent a lot of time talking about yet is what about children who are in out of home placements, and there is a lot of disparity in our communities about who those children are. So, for example, in Alaska, right now, I think the latest statistic I saw is that Alaska Native children make up about 20-22% of our state's population, but 65% of the children in out of home placements are Alaska Native or American Indian, and that is an unacceptable disparity, and so, one of the challenges -- we have a traditional way of doing things, where, you know, which is what my family did, I had a niece and a nephew who came to spend a weekend, and stayed for four and a half years, and they're mine now, but we didn't go through the state system, ironically, and my family was very fortunate, we were in a financial position where we could do that, but there are other families and communities, who are way, way, way below the poverty level, who don't have the resources. They have the love, they have the interest, but they don't have the resources to be able to take kids in, and so -- but there are some things that we're doing as we're enrolling people, as we're ensuring that they have resources to help them on the child

welfare side, but it's simple things, like while they're waiting for that eligibility to happen, they have no food, and there's one store in the community, and a gallon of milk is $12. So, so, how do you cross over to those kinds of things that really allow us to be able to meet the needs of children and families that are beyond just straight Medicaid? And I think we could do a lot more there.

MS. WACHINO: I agree. This is such an interesting conversation because I think there are so many different ways to think about social determinants. You know, I think, to Val's point, there are systems that are holding us back from achieving health. I'm less familiar with the child welfare system than with the criminal justice system, but, you know, it is clear to me that one of the biggest social determinants of health is experiencing incarceration or experiencing law enforcement, which, you know, too often, particularly for people with mental health and substance use issues, ends in, you know, health issues and sometimes in death, and in -- you know, people leaving incarceration have very high rates of overdose and hospital use. So, I think part of social determinants is really drilling down on some specific populations and figuring out how to meet their needs better. I totally agree with Jen that thinking about cross program enrollment is pivotal because if you're able to get a low-income Medicaid beneficiary enrolled in SNAP, you're not just meeting their nutrition needs for a day or a week, you're helping them meet their nutritional needs on an ongoing basis, and that's when you really start to move the needle. There are a lot of tools available in the Medicaid program, now, that I think are potentially underexplored. I mean, Medicaid is rare in that it provides a transportation benefit. There's been a lot of innovation in the transportation space, and I think, you know, it's worth looking at, transportation as a social determinant, and how do we really make the most out of that benefit. Medicaid provides supported employment and housing transition services to subsets of beneficiaries, and a lot of that takes place through home and community-based waivers, or other home and community-based programs, where states haven't fully leveraged them yet. So, I think there's a role to play there, as well as, as Dan suggests, thinking more broadly, through 1115 waivers, about what we can do. I do think there are considerations there.

Matt, you asked about pitfalls, then I would reframe it as considerations, which are that -- you know, it's important to recognize that these -- there are -- many factors drive health, and to start

incorporating them as we meet the needs of complex populations. I wouldn't want that to come at the expense of looking at separate social systems. As you know, housing comes to mind, we have a lack of affordable housing in the country. There have been discriminatory practices in housing, and I think it's important to advance that ball forward and not just turn to health to solve some of those problems but making any changes to Medicaid operate in conjunction with some of the broader reforms that I think may actually be needed to help move the needle on the health and wellbeing and housing security of some very disadvantaged populations.

MR. FIEDLER: Okay. So, I wanted to switch gears once more, and then we're going to go to a couple of audience questions, but, so, you know, one thing that I think two of you have touched on is driven in part by the opioid epidemic, that there's been a lot of interest in finding ways to ensure the Medicaid program is meeting enrollees' behavioral healthcare needs, and I, you know, I was curious, maybe starting with you, Dan, so, what do you see as the sort of thing states are doing to address these gaps and (inaudible)?

MR. TSAI: I think it's one of the biggest questions, from a delivery system standpoint, that states are thinking about, not only because of the increase in mental health and behavioral health challenges we're seeing during the pandemic, but I think, you know, folks have spent -- we've all spent a lot of time talking about parity, and from a state standpoint, folks have all sorts of things and, you know, parity requirements, but when you really look at the system from a clinical delivery system standpoint, behavioral health has basically been, you know, neglected, generally relative to the fiscal healthcare system, both in terms of structure, in terms of coverage, in terms of levels of payment, and in terms of thinking about access, everything from if I show up at the emergency department with a broken arm, I will get taken care of there. If I show up at the emergency department with -- in crisis with some sort of mental health or other addiction crisis episode, I may or may not get taken there, I may be referred to many other things, I may be stuck in the emergency department, I may be lost to all sorts of things, with absolutely no resources, and no urgent or immediate or relatively timely access.

In addition, you've got a provider system. In Massachusetts, we have one of the highest

per capita rates of -- per behavioral health clinicians in the country, 50% take insurance, even less take Medicaid. So, that's the system that you're starting with, and on the Medicaid side, 75 to 80% of our spending is related to individuals with behavioral health needs, not that BH spending is 80% of spent, but the comorbid conditions fall in the results of that. So, I think there's a strong motivating piece that I think folks are increasingly rallying around as something that has to be addressed around that.

So, I won't get into a whole bunch of policy things we're thinking about, but some of those involve states being able to make investments and think about structure of the delivery system for behavioral health, everything from what the front door looks like to what more urgent and crisis care looks like, and leveling up on expectations for traditional medical physical healthcare providers, in a way that has not been the case today, and also thinking, frankly, about the role of other non-Medicaid payors on Medicaid, relative to behavioral health services, as well. We end up being the primary payor. Those are not all Medicaid, you know, only folks. Some of that includes individuals on Medicare and commercial insurance, where the behavioral health benefit is fundamentally quite different.

So, I think, from a policy standpoint, a lot of it involves actually strengthening the core underlying structures and access and models of behavioral healthcare, paired with investments tied to actually raising the expectations, and so, where we started the discussion at the beginning of this, with state budget challenges, those are really challenging things because we just rolled out a budget here, in Massachusetts, that invests a lot in new behavioral health services and supports, in the midst of a very challenging fiscal environment, those are really hard decisions to make, and you multiply that across many different states and territories, where folks might agree on a policy solution, but the fiscal piece becomes very challenging behind that.

MS. NURR'ARAALUK DAVIDSON: So, I would also say that, in terms of addressing not, you know, not just the opioid epidemic, but other -- a broad range of behavioral health services, is that we also can -- we have the opportunity to do things in a different way, and so, Alaska has had, for some time now, a Behavioral Health Aide Program, that is a federally certified position, they receive about two years of training, and they receive care -- they receive their training both in substance use disorders and also in

mental health, and so, they have an unlimited scope of practice, they provide care under other clinical supervision, but they are in our communities, and they are basically the eyes and ears of everything that's happening in a community.

And so, sometimes, I think it's being open to other different kinds of provider types, to be able to address those things, because our average village size, for example, in Alaska, is 350 people. A psychiatrist is not going to live in a community of 350 people, they should, but they're not, probably. And so, how do we make sure that the people who live in those communities have the training and have the tools to be able to do that, which does a couple of things. One is it makes sure that we can do -- provide culturally competent care in a cultural context and in the language of the people that we're trying to serve, and we also provide care closer to home, which we know have -- we have much better health outcomes.

But there are some other things that we can do that will help that. So, for example, in telehealth delivery, you know, how do we -- you know, we could continue to spend a lot of money on travel, or we could better align Medicaid telehealth policies to really align more with some of the Medicare flexible -- that some of the flexibilities that are enjoyed by Medicare. And one of the reasons I mentioned the Behavioral Health Aide Program is that program has actually been the Community Health Aide Program, which includes Community Health Aides, Behavioral Health Aides, and Dental Health Aide Therapists. That authorization has been expanded, nationally, and so, tribes and tribal health organizations may be extending those services, and so, we have to be open, sometimes, to doing things, different provider types and providing in a different delivery format, and, quite frankly, sometimes just getting out of the way, standing -- getting -- moving -- not standing in the way of progress.

MR. FIEDLER: Okay, so, I want to -- and I -- this is actually a, I think, a good segue from some of what we were just talking about, to one of the audience questions, which is that, how do we get every licensed physician to participate in the Medicaid program, and just to sort of broaden that question a bit, you know, what challenges do state Medicaid programs face in ensuring that they've got an adequate number of participating providers, to ensure that enrollees' healthcare needs are met, and where states are struggling, what are the solutions in state policy and in federal policy?

MR. TSAI: I guess I can start, since I kind of forgot that was one of your -- it's a real challenge, period. I don't have a really good answer to that because I think that the issue is much more stark on the behavioral health side than the physical healthcare side. On the long-term service and support side, interestingly, with some exceptions, Medicaid is often the predominant payor, including with the home and community-based service provider piece.

So, on the physical healthcare side, I mean, there are a range of policy numbers we've talked about. I would, from a federal standpoint, I would encourage, for every single lever possible, whether explicit or implicit, to really think about integration into the Medicaid spacebar, so, CMMI models, we talked about that at the beginning, of having much more of a Medicaid specific focus, as well. Things have generally encouraged that sort of expectation, or just, you know, conditions of participation for Medicare, things of that sort, but, at the end of the day, you know, when you talk to a bunch of providers, it does come down to rates and funding, and the challenge -- the glory and the challenge of being at the state level is you get to do a whole bunch of things, and work with folks on the ground, and do things you dream up together, as a community, and then you have to think about the fiscal reality, at the end of the day, and how to allocate investments across many, many different pieces, and so, I think it's no secret, kind of how generally Medicaid pays well to Medicare and commercial.

So, I don't have an easy solution. From a state standpoint, I could waive a nice, easy proposal and ask for more federal support around different things, that increases the rates in investments levels with strings attached to that, that's generally how we, in the states, approach those sorts of things. I'm very curious, Vikki, how you think about that, from a federal standpoint.

MS. WACHINO: Well, provider recruitment and provider payment is one of the responsibilities that is primarily state. I mean, states have a lot of flexibility around rates. You know, I think, at the federal level, just reflecting on my Obama era experience, we not just looked at, but put forward proposals around monitoring access, which were, you know, partially motivated by concerns that arose out of the 2009 financial crisis, when provider rates were being cut. We've been -- we also promulgated rules around network adequacy and managed care, which is, you know, sort of the parallel

to access and fee-for-service, wanting to make sure that, you know, pro -- that we have enough providers participating to serve the population.

All of those rules have been rolled back, and so, I think it's a good question, kind of how well the next set of folks at CMS approach access, and then I think you, you know, add to that, access challenges that may have emerged since the pandemic. I mean, Dan was absolutely right when he said earlier that there's been a, you know, a big impact on smaller providers who play a really big role in the Medicaid program, and I think we need to really look at how those changes in states and across the country -- whether and how that's changed provider participation and access to services in the program.

MS. NURR'ARAALUK DAVIDSON: So, I mentioned earlier looking at other provider types, and I'm going to just highlight one. So, so, I think a part of, you know, the quality of the answer that we provide is always dependent on the scope of the question that we're answering, and so, we're talking about physicians. It -- and you could do the same for dentists. I know that, in Alaska, we had almost no private dentists who were in Medi -- who were enrolling Medicaid patients, or who were seeing Medicaid beneficiaries, and so, we had lots of vacancies in our dental programs, and we could -- basically developed a new provider type, that was modeled after a program in New Zealand, it's also offered in Canada, and the United States, until we started our program, was the only industrialized nation that did not have a mid-level dental practice, and so, we created the Dental Health Aide Therapy Program in the Tribal Health System, and they can -- they provide -- within a limited scope of practice, they can do simple drillings and fillings, they can do uncomplicated extractions, most of their work is with kids.

And I'll tell you, we were sued by the Alaska Dental Society, we were sued by the American Dental Association, and, you know, we worked through all of that, but I'll tell you, once those -- when we made sure they were able to be enrolled in Medicaid, and that we worked with CMS to make sure that they could be reimbursed by Medicaid, but the other piece is -- I will tell you, there was no greater effort, there was no greater opportunity and rush to the door to get providers enrolled in Medicaid than creating the Dental Therapy Program because the dentists were -- they saw this as competition, and they wanted to make sure that they were seeing Medicaid beneficiaries, as well. So, sometimes, it's

beyond just, you know, are we looking at the right group of people, and for the first time since contact, we have cavity free kids in communities that don't -- that have dental therapists, and the other thing is we were talking -- I want to tie this back a little bit. The other thing that position provides is there's the dental therapist, who lives in the village, and also a dental assistant. Those are two jobs available now, in that community, that they didn't have before, and one of the greatest ways that you can increase somebody's -- a family's health status is to increase their economic status, so, a great opportunity for the entire community.

MR. TSAI: Okay, Matt, I think you're on mute.

MR. FIEDLER: Sorry about that. I've got about 100 more questions I wish I could ask this group, and I think the audience does, too, but we're almost at the end. So, I want to just quickly go around, if people have any brief final thoughts they want to share before we conclude, and we'll go, I guess, in reverse order we did the opening statements, so, Vikki, I'll start with you.

MS. WACHINO: I think that this conversation has been a great discourse between state leaders and a former official, and I don't think I have anything to add, but really appreciate the opportunity to join the conversation.

MR. FIEDLER: Jen?

MS. WAGNER: I echo in those, thanks for a great conversation, and just to express how refreshing it is that we are talking about these proactive measures about getting people connected to healthcare, rather than taking it away and limiting the access for people. So, it's wonderful to be in this new day.

MR. FIEDLER: Okay. Dan?

MR. TSAI: I'd say the role of strong leadership, from the federal standpoint, whether it's through explicit levers or just a policy description to things, I would not underestimate how powerful that is, in actually having things translate through to the state level, on any of the range of really important topics and direction we've talked about because states, the Medicaid directors, and administrations respond to that, in part because we're always trying to figure out what we can pitch to get approval for

things, and knowing a strategic direction that CMS is going, and you come with that, and I wouldn't underestimate how many times the Medicaid directors, across all colors of states, are there, trying to surmise what the heck CMS is thinking, what -- there's a real power to that, and across any one of the things we mentioned. So, it's exciting to see the leadership around that, and I encourage that continued pace.

MR. FIEDLER: Great. And, Val, you'll get the last word.

MS. NURR'ARAALUK DAVIDSON: I ditto what everyone said. In addition to that, I think that, you know, one of the things that we can do, as we're doing this work, and different people alluded to it, but I'm going to say it a little more Bethel-style, which is known as being really direct, sometimes, and so, I think when we're -- when we're grappling with these issues and when we're meeting with people, one of the things that we can do, very, very, very, very concretely is we ask the hard questions of ourselves, including are the people that we are working with, on our teams, are the people that we are meeting with, are the people that we are involving in the inner circles to have these kinds of conversations truly representative of the people that we serve, or does everyone have the same haircut? If everyone has the same haircut, we're doing it wrong, and I think we have the opportunity for more inclusion, including hearing from the people for whom all of these policies, you know, will -- they feel the -- they feel the implications, in a very real way, of the decisions that we are making at the policy level, and I think we -- we could do a little more of that. But --

MR. FIEDLER: Great.

MS. NURR'ARAALUK DAVIDSON: -- (speaking in Native language) for this incredible opportunity. I loved spending time with you all. I -- my mind is really turning in a -- such a great way, thank you.

MR. FIEDLER: Well, thank you, all, for joining the panel, and thank you to the audience for watching, and we look forward to seeing what happens in the Medicaid program over the coming years. So, thank you. Thanks, again.

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