PUBLIC MEETING

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Thursday, January 20, 2022
10:31 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:31 a.m.]

CHAIR BELLA: Welcome, everyone. Thank you for joining the January MACPAC meeting. We are excited to kick off today with a continued discussion of an approach to access monitoring and moving toward recommendations for our June report.

So welcome to Linn, Martha, and Ashley. I will turn it over to you all. Linn, I think you're going to start us off. Is that right?

[No response.]

CHAIR BELLA: Excellent.

PROPOSED APPROACH TO ACCESS MONITORING RECOMMENDATIONS FOR JUNE REPORT

* MX. JENNINGS: Well, good morning, Commissioners. Today we're back to continue our work and discussion on access monitoring and the considerations for designing and implementing a new access monitoring system. Today Martha and I are going to present the proposed access monitoring plan and possible recommendations.

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Today I will begin by giving an overview of what

we've discussed in this past meeting cycle, and then I'll provide an overview of the goals and key elements of an access monitoring system. Then I'll turn it over to Martha to present the possible policy recommendations and our next steps.

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In September, staff presented background on the current access monitoring systems in Medicaid and the challenges with monitoring access across states and delivery systems.

Then, in October, we invited an expert panel to discuss the data gaps and limitations and approaches to addressing these gaps.

In December, a second panel discussed the design and implementation considerations for a new monitoring system. We also had a second session in December where we presented the goals and key elements that the Commission had coalesced around in the prior meetings, and I'll provide a short overview of those goals and key elements.

Next slide.

So, to begin, as the Commission and others had previously noted, an effective access monitoring system

should prioritize these six goals. It should allow for actionable and meaningful comparisons across states and delivery systems, and the monitoring system should prioritize methods that are efficient, timely, and adaptable. For example, it should build on existing data collection methods and reporting wherever possible and allow for updating over time, which should help reduce some of the administrative burden associated with monitoring. As the Commission has discussed during this cycle, the monitoring system should also be focused on equity.

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Next, we have the key elements, and these should be discussed and considered in designing a new monitoring system. The first element of a monitoring system is the access measures. Access can be categorized into these three primary domains: the potential access, realized access, and beneficiary experience and perceptions. All three domains are necessary to fully measure and monitor access, and as was discussed in prior meetings, there are data gaps and limitations with collecting these measures.

The second element is the roles and responsibilities of CMS, states, and plans in designing and

implementing a new system, and these should include the role of stakeholder engagement throughout all of these processes, who is responsible for data collection, analysis, and reporting, and who is responsible for oversight of this monitoring system. In December, we heard from panelists and from the Commissioners that given the federal obligation to ensure access, CMS should take a primary role in the design and oversight of a new system. We also heard that CMS should engage stakeholders throughout the design and implementation processes. Additionally, in order to implement the system, another area for consideration will be determining who is responsible for these various implementation pieces: the data collection, reporting, and analysis.

Now I am going to turn it over to Martha who will present potential recommendations.

* MS. HEBERLEIN: Thanks, Linn.

Moving on to the draft recommendations, the recommendations for a new access monitoring system will be offered as a package, as there are multiple components that the Commission had suggested should be included. The recommendations on the next few slides are drafts and meant

to reflect the Commission's discussion of broad goals and design features over the last three meetings.

The first recommendation is shown here on the slide. This overarching recommendation directs CMS to develop a system that meets the broad goals identified by the Commission. Recommending a core set of standardized measures would allow for an assessment of access across states and delivery systems. In addition to being comparable, the measures should also strive to meet the other goals of the system that Linn just described. For example, the measures should provide timely and actionable data and promote efficiency by building on existing data collection efforts.

To reflect the role of the program in providing care to low-income and vulnerable populations, the measures should encompass both acute care and long-term services and supports. I will add here that measure development for long-term services and supports was an area of particular interest to the Commission and will be highlighted as such in the chapter.

This recommendation also directs the agency to issue public reports with state- and national-level data in

a consumer-friendly format. The Commission has noted that public reporting can help ensure accountability, identify problems, and guide program improvement.

Recommendation 2 calls on the new monitoring system to assess the full experience of Medicaid beneficiaries in accessing care, so the three domains that Linn laid out, which includes the availability of services, the use of services, and beneficiaries' perceptions and experiences with care.

Recommendation 3 goes on to further discuss the need to prioritize monitoring services for which Medicaid plays an outsized role and where there are known disparities or access concerns. In addition, it notes that a monitoring system should allow for modifications to account for changes in priorities, measurement, and care delivery. For example, as the COVID-19 pandemic has increased the demand for behavioral health services, monitoring access to counseling and other mental health services is particularly salient at this time.

As discussed in prior meetings, priorities will need to be established, given the constraints on federal and state capacity as well as data limitations. There are

a number of approaches the agency could take to establish priorities, and the recommendation language is written to capture the various priorities that the Commission has discussed. In the text of the chapter, the Commission could further highlight specific examples that have been raised in discussion. For example, the Commission has noted the important role that Medicaid plays in providing maternal health services. Services with known access barriers such as behavioral health and dental health also have been noted as priorities. Stakeholders also raised the importance of monitoring access for populations in which there are known disparities, so examining access by race and ethnicity, language, disability, sexual orientation, and gender identity.

Recommendation 4 would call on CMS to take the lead in developing a system but seek input from states, beneficiaries, and other stakeholders to design a system that is meaningful for them and to secure their support. Engaging stakeholders through multiple avenues such as comment periods, roundtables, and work groups throughout the process will help ensure an access monitoring system that is designed with input from multiple perspectives,

including those who benefit from the services.

This recommendation is fairly high level in describing the key roles and responsibilities of various players that Linn described. However, there are certain tasks where CMS, states, and plans may have particular advantages. For example, states are well positioned to collect and report service use data, and there are also places where CMS could reduce the burden on states; for example, by calculating specific measures. Your memo notes some of these roles and the possibilities for delegation, but we can further articulate those in the narrative of the chapter.

Recommendation 5 acknowledges that beneficiary perceptions and experiences are important components of monitoring access, yet existing data sources are not adequate to measure such things. Administrative data do not capture beneficiary perceptions of their care, and grievances and appeals information may not be aggregated, transparent, or representative of general experiences. Existing state-level beneficiary surveys are limited in the data they gather and the comparability across states, and while some federal household surveys can measure unmet need

and barriers to care on a national level, sample size limitations do not allow for state or subgroup comparisons. Panelists and interviewees suggested that a more standardized beneficiary survey could help monitor beneficiary experience consistently across states.

While a federal beneficiary survey has been raised at a number of meetings, the Commission did not settle on whether such a survey should be administered at the state or federal level and what, if any, amount of customization states should have. The Commission could either be more prescriptive in its recommendation about a beneficiary survey describing a preferred approach or discuss the pros and cons of various approaches in the text of the chapter.

A federal survey similar to the Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems, known as the NAM-CAHPS, would ensure comparability and may relieve state administrative burden. Several researchers, including two panelists, said that the NAM-CAHPS specifically could serve as the starting point for a federal Medicaid beneficiary survey.

Alternatively, a state-administered survey could

include a core set of questions to help with consistency but also allow for some customization. Such an approach is taken with other surveys, such as the Behavioral Risk Factor Surveillance System, or the BRFSS. Depending on the level of consistency in state methodology such as the sampling approach, a state-administered survey could introduce additional variation.

Recommendation 6 would direct CMS to further standardize T-MSIS data for the purposes of access monitoring. T-MSIS data are the best source of service use data across states, although quality concerns may make state- and population-level comparisons difficult. Additional consistency in variable definitions would allow for a more accurate and complete assessment of the services people are using, the providers they are seeing, and allow for comparisons across demographic groups of interest.

The final recommendation would direct CMS to provide additional analytic support and technical assistance to states. There are several areas where Commissioners, panelists, and stakeholders noted the need for state technical assistance. For example, several researchers said that states will likely need assistance to

improve the quality of data reported to T-MSIS. Several states also emphasized the need for more specific guidance from CMS and the importance of tools such as templates and data dictionaries.

Given the capacity concerns raised by states and researchers, the Commission may want to make a separate recommendation highlighting the need for additional technical resources and assistance for states. However, as has been noted in prior Commission comments, limited state capacity does not negate the obligation for states to collect and report data necessary to monitor and ensure access to Medicaid beneficiaries. As such, the Commission could discuss the need to support states in implementing a new system in the chapter and implications without making a formal recommendation on technical support.

So, if the Commission decides to move forward with this set of recommendations related to a new access monitoring system, staff will return with refined recommendation language and the draft report and chapter for the Commission to review and comment.

We're hoping to keep the discussion today focused on the concepts presented in the recommendations, whether

they're hitting the mark, and whether there's anything that's missing. If there are specific word changes on the recommendations, you can share those with staff in writing.

It would also be helpful to raise any specific points that you would like to have included in the rationale and text of the chapter in support of the recommendations so they can be incorporated prior to reviewing the chapter in April.

So, with that, I'm going to turn it back to the Chair for discussion. I'm going to leave up this last slide that provides a summary of the package of recommendations and can serve as a reference for discussion. I'm also happy to go back to specific recommendation language, if that's helpful.

Thank you, and we look forward to hearing your conversation.

CHAIR BELLA: Thank you very much. You all have done an amazing job of taking what we've discussed and putting it in a very comprehensive and understandable package.

I want to take the temperature of the Commission. My sense from prior discussions and from seeing all this

come back to us is we do want to move forward with a recommendation. I'm putting that on the table. If anyone disagrees, please raise your hand, and we'll have that discussion.

[No response.]

CHAIR BELLA: The presumption is we're moving forward then with the package of recommendations.

In prior conversations and as has been highlighted from the text, we pretty much reached consensus on Nos. 1, 2, and 6, so happy to have discussion on those but really would like to make sure that we get to a couple of areas where we might need more discussion. Also, keep in mind there is a difference between what we might want to elaborate in a chapter versus what has to be in a recommendation. So there's plenty of things we can discuss in the chapter. For example, on No. 3, we're not going to debate today which population or which services are more important today because those things also change, but we are going to discuss the importance of prioritization of populations and services, so kind of thinking about directionality for the chapter as we put forward a general recommendation about the need to prioritize and we give

some examples, I think, is important.

Let me stop talking and turn it over for Commissioner comment.

Heidi.

COMMISSIONER ALLEN: I've been looking forward to this conversation all week, so very excited to be talking about measuring access in the Medicaid population because I think this is a serious, serious problem that we have. We don't have a robust way to measure access, so I think these recommendations are really important and exciting.

I have just some notes that I wasn't sure if it was language or intention. We talk about measuring acute care and long-term care, and I'm not sure if what we meant by acute care is just hospital -- what I think of as acute care, which is emergency departments and hospitalizations, or if we're talking about outpatient and services, because I think that a lot of our barriers to care are actually in outpatient care. So I want to make sure that the language reflects our intention, which I believe is to understand and have a broad understanding of access to care.

The second thing is that I wanted to say overall across the recommendations, I would like to see an

amplification of researcher inclusion. I didn't see a lot of language about making datasets publicly available, and I think that that is really important because when I think of the years I've spent on the NIH study section for health and health care disparities and the cutting edge of research that's been done and measuring disparities, it's all been in Medicare because Medicare has public datasets.

Along with that, I'm wondering if there's any possibility to align with Medicare's data collection so that you could actually study people as they move from one source of coverage into the other. If there is some kind of compatibility across measures and the fact that a Medicare beneficiary survey can be merged with Medicare claims data is a really important way to triangulate some of these concerns. Do you see beneficiaries reporting difficulty accessing data? Does that match what we see in the clinical records when we compare Medicaid patients to other patients? So I'd like to think about that or talk about that a little bit.

Then in terms of who should administer the survey, I would just like to point out that there are things that -- you know, in our materials, there's a

discussion about the PRAMS survey, and the PRAMS survey is administered by states, and states are able to add additional questions, which I think is really great, but there's a lot of states that don't report their PRAMS data because they don't have a high enough response date. That's not a concern in the Medicare beneficiary survey. So I think that kind of speaks to the possibility that the federal government might be able to do this, have the resources and the consistency across states to get that full reporting. But when looking at PRAMS, we could consider the idea that states could come up with questions or modules that they want specific to their state.

I would also add that in terms of modes of delivery that I'm running a study right now with my colleague, Jamie Daw, and we're emailing surveys. The Medicaid population is younger in many respects than the Medicare population, obviously, and email has been a pretty successful way to get people to fill out surveys, so we could have even more modes.

So those are my initial thoughts. Thank you for letting me spill them all.

CHAIR BELLA: Thank you, Heidi. It's great to

see your excitement.

Tricia and then Fred.

COMMISSIONER BROOKS: Yeah. I just want to reiterate two points that Heidi made, and the first is acute care. Same conversation, but I also don't think acute care includes preventive care, and I think that's important.

Then the second piece is just to lift up this for datasets for researchers and to again talk about the high cost of accessing data through T-MSIS that's on our list of recommendations. I think we really have to bring that to the attention of Congress to potentially do something about it.

CHAIR BELLA: Thank you, Tricia.

Fred and then Martha.

COMMISSIONER CERISE: Thanks, and great chapter -- I mean memo. I thought it did a great job of laying out some recommendations that I agree with.

The acute care issue caught my eye as well, and I didn't know if "clinical care" or "medical care" or something more general that caught prevention and maintenance would be a better term there.

In terms of prioritization, I think you do a good job of stressing including the beneficiaries in there, and so assessing what matters to patients in terms of prioritization through surveys or whatever means, it aligns with the examples you're using around behavioral health and dental, the things that we hear, but I would kind of emphasize, as we prioritize, what are the things that matter to patients. Then perhaps another one is where we have good evidence for effectiveness would be something to consider in a prioritization scheme.

I know on the second recommendation, the inclusion of another group that has good insight is the primary care providers in terms of access, and I don't know how practical that is. I mean, it may end up being something that we survey regularly, but I know that as I talk to primary care pediatricians, they can tell you where access problems are, and no surprise, dental, behavioral health come up in all of those conversations as well, so just something on how practical it is but something to consider there as well.

In my last comment, I don't know if it's embedded in here and just not called out, but as we look at the sort

of measures of access, potential access, and realized access and things like that, one of the obvious measures of access is outcomes. And I don't know if that's sort of just an assumed issue or if that's something that we specifically need to call out. People are getting their vaccinations, if they're getting their preventive care. What are those outcomes? Because I think that will inform a lot in terms of access to services, where the other ones tend to do it a little bit more indirectly.

CHAIR BELLA: Thank you, Fred.

Martha, then Toby, then Brian.

COMMISSIONER CARTER: Just briefly, because it has already been addressed, the issue of calling acute care. I think maybe we could do something with that, even in an endnote, because the list is actually rather long. We don't want to think about preventive, obviously, acute, chronic, restorative, like happens in dental care, and rehabilitative, and then palliative. And there are probably more.

But I think we want to make sure that we are really looking at the whole spectrum of care, and we can't list that all in the recommendation. So there may be some

way that Linn, Martha, and Ashley can address that.

CHAIR BELLA: Thank you, Martha. Toby?

COMMISSIONER DOUGLAS: Yeah. First really great work, and this framework is going to be so important as we think of just how we advance overall the right access monitoring system.

The one point I want to make is just from the state administrative standpoint and just thinking about just how much work this is. And as we think about Recommendations 3 and 4, how it incorporates into Recommendation 7. And I don't know how we weave this in, but all of this takes a significant amount of work on the side of the state -- timelines, staff, the right type of competencies -- all again back for the right reason, but we just need to balance the priorities and the work with the limitations of states staffing and competencies.

CHAIR BELLA: Thank you, Toby. Brian, then Bob, then Darin, then Verlon.

COMMISSIONER BURWELL: I want to absolutely support what Toby just said about recognizing the limited capacity of states to take on this kind of work. There have been many federally led initiatives out of CMS that

have failed due to overreach, and I think this is an area where there is very large potential for overreach, and I would recommend highly, under 3 and 5, that we recommend that CMS take this in pieces and prioritize certain access issues, and also in terms of beneficiary surveys, focus on a small number of populations and get it right rather than too many populations.

CHAIR BELLA: Thank you, Brian. Bob, then Darin, then Verlon, then Laura.

COMMISSIONER DUNCAN: Again, thanks for the great work that's done, and I appreciate the comments that are made. The one thing that I would ask as we look at that, and Brian, to your point, some of the consistency that can come out of CMS, allowing states the flexibility but needing the consistency so that the data gathered is something that we can measure and use across different populations.

And the other thing I would like to call out is to make sure that all surveys or anything, it is inclusive of kids, not special populations in general but children as a whole, since it's the largest provider of care for kids.

CHAIR BELLA: Thank you, Bob. Darin?

COMMISSIONER GORDON: Just building on what Toby and Brian were saying about states, you know, I do think it is clear CMS has a role and responsibility to oversee what is going on with access, and I think that is where there has been the largest gap, their ability to appreciate and understand what's going on from an access perspective. I think many of the recommendations, you know, address building up some of that capacity and capability.

I also think about, from a state perspective in administering the program, you know, there is oversight but then there is administration of the program. And to the extent, as we talked about like in Recommendation 5 or in others, and some of the comments that have been made, that you look for consistency across states, as Bob was saying, and allowing them the ability to build into those surveys the things that they need to actually operate, react to the data, that the data is specific enough to be actionable for the state I think is vitally important.

So I don't think we can overemphasize having state involvement. When we talk about inviting stakeholder input, I don't think it should just be an invitation. It should be an expectation or a requirement that states who

are actually having to administer the program can give the feedback that they need about what is important to them and having information on access and operating the program from a day-to-day basis.

So I do think the state role is vitally important, and I think to the extent we can emphasize that through these recommendations, that their involvement be key, I think that's a necessary part of any recommendation.

CHAIR BELLA: Thanks, Darin. Verlon, then Laura.

COMMISSIONER JOHNSON: Darin, you said exactly what was on my mind, but I just will start off by saying this is really a great job and I really felt like the staff really captured the conversations we had and the research that you all did as well. Again, all very good comments from my fellow Commissioners.

I would just say, though, from previous conversations that we had around this, I think the issue that really struck out for me the most was really around beneficiary perceptions, and that is where I focused my energies when I thought about my comments. Again, you know, it does make sense to me that any survey that we are doing is handled at the federal level, just because it

provides greater consistency. I think it eases the burden on the states, which was already said very articulately by my fellow Commissioners, but also promotes that idea of greater consistency across the board.

But also I think they key thing I really want to stress again, as Toby said and Darin said and everyone else, is the state involvement, and making sure that anything that is designed we make sure that we have state involvement at every single level for that, and also, was stated before, making sure it is very inclusive for the beneficiary populations that Medicaid serves. So thank you.

CHAIR BELLA: Thank you, Verlon. Laura, and then Heidi.

COMMISSIONER HERRERA SCOTT: Yeah. Building off of what everyone else has said and thinking about specifically Recommendations 2 and 3, it may be obvious but I want to point out, you know, the geographic differences in access, thinking about rural, suburban, and urban, especially as I think about community hospitals and cutting off service lines because they are no longer financially viable. So I just wanted to make sure that was on the

table as we thought about assessing provider availability and beneficiary utilization in 2 and 3.

CHAIR BELLA: Thank you, Laura.

Actually, Heidi, before I go to you let me see if anyone who hasn't made a first comment.

COMMISSIONER HEAPHY: This is Dennis, and I thank all the Commissioners for all their comments. And I am wondering, when we would define access, and I think this goes to Laura's point as well, is we are looking at geographic diversity, we are looking at all kinds of diversity as well, and transparency and information being member-facing.

And this might be too much in the weeds but provider access, they may be on the roles of being available for taking folks on Medicaid but are they actually available to folks? Are they actually actively taking on new members who have Medicaid, or are they not taking on new members? And in terms of access, is it physically accessed both from a disability access point but also from a transportation access point. So how are we really defining access I think is really key.

And then in terms of just populations, I think as

Bob was saying about children, it is really key that we also look at folks with disabilities not just as a population but also within priority populations that utilize Medicaid, African Americans and other populations. Thanks.

CHAIR BELLA: Thank you, Dennis. Heidi.

COMMISSIONER ALLEN: To Dennis' point, I would like to call out the secret shopper methodology as being something. It is not named in our recommendations at this point as one of the data collection, modes of data collection that is really helpful, but it is very helpful.

And then I wanted to build on Tricia's comments around T-MSIS. We have already invested in T-MSIS. Like we put a lot of money into T-MSIS. So the idea that there is this little hill we need to go over to make it actually usable seems to me very penny wise, pound foolish not to just get us there where researchers are actually using it. So there are quality issues, whether it is state technical support, whatever, whether it is managed care reporting. I think that those seriously need to be resolved so that it is a good data source.

And then even if we could be explicit with our

recommendations, T-MSIS should not cost more per enrollee than Medicare publicly available data. I mean, just a principle like that, something that, because right now I think you pay per year, per state, which there are so many states that, you know, that is not how Medicare is. Medicare is paid for, I think, by the year, and you get the whole population.

So those are some things that, you know, there might be more information that we need to look at to see exactly how we could be more comparable to Medicare in how much it costs, but I think that would be worthy of having a strong recommendation.

CHAIR BELLA: Heidi, I think the direction we are headed now is to talk about it in the text but not necessarily to make the affordability of data a recommendation. Does that work for you?

COMMISSIONER ALLEN: I mean, I would prefer to have it be part of a recommendation, because I think it's huge. You know, we have data. We're not sure how good it is, and if it's really good you're not sure if people can afford to use it. So tying those two things together, that it needs to be high quality and it needs to be accessible

to researchers, I think is like part of having that realized evaluation that we're asking.

We want the health services research community to be doing this research, because much of what we know about access and disparities in Medicare does not come from the federal government. It comes from researchers. And we want that same high quality, rigorous, and volume of research for the Medicaid program. We serve more people than Medicare, and yet our ability to do research is just like, you know, a tenth of what it is for Medicare. So to me that really is key.

CHAIR BELLA: Does anyone else have comments on that issue? Tricia?

COMMISSIONER BROOKS: I'll just say I am in agreement with Heidi on that.

COMMISSIONER HEAPHY: This is Dennis. I totally agree.

CHAIR BELLA: Anne?

EXECUTIVE DIRECTOR SCHWARTZ: You know, as someone who did my dissertation using Medicare data because it was available, I understand where Heidi is coming from. I feel like we would need to do a little bit more work here

regarding some of these issues that you have talked about. I think we could maybe be a little bit more directional and explicit, and maybe come back to that later.

It feels awkward that we haven't done the legwork on it to make a full recommendation, although I think we could maybe finesse a little bit in the recommendations on including researchers and then talking in the text about the accessibility of the data.

COMMISSIONER ALLEN: May I respond to that?

CHAIR BELLA: Sure.

COMMISSIONER ALLEN: Yeah. So that totally makes sense about the T-MSIS part, because I think that, you know, really understanding how expensive it is, how hard it would be to do a comparable study to a Medicare sample, I think that would be really good information to have. But including researchers in all of these different areas where we talk about stakeholders, I really would like to see that amplified.

And then the idea that the data would become public, because right now in our recommendations we kind of talk about the government producing reports, but if it is public then states can use it and researchers can use it.

And so, you know, that is something I feel like we know that making data public is important for having a broad access research agenda around it, and do you feel like we need any more legwork in making that recommendation?

EXECUTIVE DIRECTOR SCHWARTZ: To me that seems like eminently doable. There are a couple of places where the words "researchers" could go in the recommendation and where we could talk about it in the text. So yes, I think that is totally doable.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: To that point, I think we need to make sure it's inclusive of other stakeholders. Right now I don't have the language in front of me on the draft materials, but I think there were four stakeholder groups that were identified. But it didn't say including these, so it sounds like it's only those four, and I would want to make sure that, you know, policy experts and consumer groups also could be represented in being part of whatever is developed and monitored on an ongoing basis.

CHAIR BELLA: Thank you, Tricia. Other comments?

[No response.]

CHAIR BELLA: So remind me, timing. Is this coming back in March or is this coming back in April?

EXECUTIVE DIRECTOR SCHWARTZ: I would say with the progress that we made today that we can come back in April with the chapter written out and with the recommendations revised, and take the vote then. Then the discussion in April would focus on whether we have adequately captured the various nuances that you mentioned to this point. So it doesn't seem like we need to do this in March as well.

Martha Heberlein?

MS. HEBERLEIN: Yeah, that is what I think. I would agree.

COMMISSIONER HEAPHY: This is Dennis. Going back to the idea of how do we seamlessly integrate and ensure that children are represented throughout the recommendations and folks with disabilities are seamlessly integrated as well. Like how do we make sure that this happens, because children are often just not included or explicitly included as a population. So is there a way to make that pop more in the recommendations?

CHAIR BELLA: I think that's something they can

take back, and then if you need any additional clarification or discussion it could come back to us in March. I'm going to leave it in the hands of the staff to take that back, Dennis, and accommodate it in the chapter. Does that work for you all, Martha, Linn, and Ashley?

[No response.]

CHAIR BELLA: Okay. Any other comments on this?

Anne, process question. We are a little ahead. We could take public comment now or we could move on into the vaccine session. What do you suggest?

EXECUTIVE DIRECTOR SCHWARTZ: Go ahead and see if anybody wants to share anything.

CHAIR BELLA: Okay. Great. We are going to open it up for public comments. If anyone would like to share thoughts on the discussion we just had on access monitoring as we move toward a package of recommendations this would be the opportunity. If you would like to make a comment please use your little comment icon. And I will remind folks to introduce themselves, the organization that they represent, and we ask that comments be no longer than three minutes.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. It does not appear we have anyone that wants to comment at this time. We may have someone right before lunch, but for now, Heidi, you opened it, and this is near and dear to your heart. Do you have any closing comments?

COMMISSIONER ALLEN: My only comment is that I didn't bring up, that I think we could continue to think about, is to make sure that our measuring accesses are robust to changes in administration and priorities so that we have populations that we are always looking at that we know are important to the Medicaid population. I am thinking about specifically because not every administration might care about LGBTQ folks, because that is something that sometimes is partisan, and yet I think that in our recommendations if we can make sure that there is a core set of different populations that we want there to be regular access information about, I think that might help.

CHAIR BELLA: Thank you, Heidi. Any other last thoughts from Commissioners?

[No response.]

CHAIR BELLA: Okay. Linn, Martha, Ashley, thank you very much. We will look forward to seeing this come back in April, it sounds like.

We are going to move into our session on improving vaccine access. We have Chris and Amy. I see them both. Welcome. You know we're always excited about this. It continues to be timely.

So I will turn it over to the two of you to take us through -- no, I will not. I will turn it over to Kisha, who is going to lead us through this session. My apologies, Kisha.

VICE CHAIR DAVIS: No, no worries, and I will turn it over to you guys, Amy and Chris, to get us started on vaccines.

IMPROVING VACCINE ACCESS: REVIEW DRAFT MARCH REPORT CHAPTER AND ADDITIONAL POLICY OPTIONS

* MS. ZETTLE: Great. Well, thank you, and good morning, Commissioners.

Today we're going to walk through our project on vaccine access for adults enrolled in Medicaid.

I'm going to begin with a brief overview of the draft chapter for the March report to Congress, and we've

included the draft chapter in your meeting materials. First, we will review the role of vaccines in advancing public health, and then we'll discuss the coverage requirements for vaccines under Medicaid. Then we'll review adult vaccination rates and discuss public policy options or considerations to improve vaccine access.

Following the chapter overview, I'll turn it over to Chris who is going to walk through specific policy options that the Commission may want to consider for the June report, and then we'll discuss next steps and hear from you all on whether you'd like to pursue recommendations for the June report.

The COVID-19 pandemic has highlighted the importance of vaccines in preventing illness, hospitalization, and death. Despite this important role, vaccination rates for routine vaccines are well below goals that have been set by public health officials. In 2019, influenza and pneumonia, both vaccine-preventable diseases, were the ninth leading cause of death in the United States.

These vaccine-preventable diseases also present economic costs. One study estimated that vaccine-preventable diseases cost the U.S. $9 billion annually.

Research also suggests that a number of vaccines are cost-saving while others are cost effective.

Next slide.

Coverage for adults in Medicaid is more restrictive than vaccine coverage for other sources of health insurance. Vaccines are not a mandatory benefit for all adults in Medicaid, but for those in the new adult group, preventative services are covered without cost sharing. This includes all vaccines that are recommended by Advisory Committee on Immunization Practices, or ACIP.

For all other adults in Medicaid, however, states can decide whether to cover recommended vaccines and whether to apply cost sharing. This group includes individuals with disabilities, pregnant women, and parents, and they account for about 38 percent of Medicaid-enrolled adults. About half of states cover all ACIP-recommended vaccines.

There is mandatory coverage of COVID-19 vaccines and their administration for about a year after the public health emergency ends, and since we last presented on this topic, the House of Representatives did pass the Build Back Better Act, which included a provision to require coverage

of all ACIP-recommended vaccines without cost sharing for all adults enrolled in Medicaid, so extending coverage to those who are not in the new adult group. This bill is currently in the Senate, but the path forward is still unclear at this time.

Next slide.

So, as we noted earlier, vaccination rates are well below the target levels that have been set by public health experts, and adults with Medicaid coverage tend to have lower vaccination rates than those with private coverage for nearly all vaccines.

Within Medicaid, the differences across racial and ethnic groups are mixed. People of color in Medicaid generally have lower vaccination rates for tetanus, Tdap, and pneumococcal vaccines, lower than White non-Hispanic enrollees, but people of color, many of them do tend to have higher vaccination rates for influenza. Vaccination rates are more similar between people of color enrolled in Medicaid and private insurance than they were for White, non-Hispanic adults.

For pregnant women, the difference in vaccination rates between those enrolled in private insurance and those

in Medicaid were substantial. For example, influenza vaccination rates were about 20 percentage points lower for pregnant women in Medicaid than for those with private insurance.

Throughout our work on this topic, we've discussed policy options to improve vaccination rates among Medicaid enrollees. The draft chapter expresses the view of the Commission that vaccine coverage is necessary as a necessary first step to ensuring access, but that coverage alone may not be sufficient to improve vaccination rates significantly. To improve access, steps could be taken to expand provider access and availability and to offer beneficiary support and education.

In our interviews, we heard concerns that low provider payment may hinder a provider's willingness to administer vaccinations, which can contribute to low vaccination rates in Medicaid. The research also supports this concern.

There are two components with inadequate payment that we looked at. First is that ensuring that providers are paid adequately for the purchase of the vaccine itself, and then secondly, ensuring that providers are paid

adequately for administering those vaccines. Shortly, Chris will walk through how those policy options could address one or both of those issues.

We also heard that to improve access, Medicaid enrollees need to be able to get vaccinated across a variety of settings, beyond just primary care. Unlike children who are likely to have a medical home, many adults may be more likely to access care for pharmacies, emergency rooms, or specialists.

Beneficiaries may also need greater support and education on vaccines. The vaccine schedule for adults is somewhat complex and is based on risk factors, age, vaccine history. So providers can play an important role in helping beneficiaries both understand the benefit of vaccines but also which vaccines are recommended for them specifically.

We also heard from experts that vaccine hesitancy may be growing, and education could play an important role.

Now I'll turn it over to Chris who will walk through some of the policy options.

* MR. PARK: Thanks, Amy.

Amy teed up some of the issues related to access

and beneficiary education and support, and I'll walk you through some of the potential policy options that we've identified. While we are presenting these options separately, keep in mind that many of these options could be paired together to create a multifaceted approach.

Here, we have a few options that could address payment adequacy and one that focuses on provider networks. The first option would be to increase the federal medical assistance percentage, or FMAP, on vaccine administration to encourage higher payment to providers. Most recently, the American Rescue Plan Act provided 100 percent FMAP on COVID vaccines and their administration through one year after the public health emergency ends and has resulted in most states paying the Medicare rate.

The second option is to allow Medicaid providers to purchase vaccines at the federally contracted price that CDC negotiates for other programs. This could help address issues on vaccine acquisition costs. Under this approach, providers would still have to purchase vaccines. However, the provider would likely get a chargeback, meaning that they would receive a payment directly or indirectly by the vaccine manufacturer that is equal to discount negotiated

under federal contract.

The third option is to implement regulations for vaccine payment. CMS could implement regulations for the payment of vaccines, similar to those in place for outpatient prescription drugs. Those regulations require states to pay for drugs at average acquisition cost plus a professional dispensing fee.

Vaccine access could also be improved by making vaccines available across a large range of settings and providers. Policy options could encourage states to expand the types of providers allowed to administer adults' vaccines under Medicaid.

This table provides a high-level assessment of policy options across a few dimensions. It is difficult to predict how strong these effects would be in absolute terms. So these assignments of low, medium, high are meant to be more of a relative assessment against the other policy options.

Option A is to increase the FMAP on vaccine administration. This would require a statutory change. Increasing the FMAP has the potential to improve vaccination rates moderately and could do so without

increasing state costs, although total Medicaid spending would still increase as it would shift spending to the federal government.

A big question is how large a FMAP increase would be needed to be effective in increasing payment rates. 100 percent FMAP would certainly support states in increasing payment rates to Medicare levels, as they did for COVID vaccines, but it's not clear if COVID is a unique situation or whether states would follow a similar approach for all other vaccines.

Any increase in the Federal match would likely need to be greater than the 1 percentage point increase provided by Section 4106 of the ACA. Many stakeholders did not think it created a strong enough incentive for states to cover all recommended vaccines without cost sharing.

Option B would allow providers to acquire vaccines at the discounted CDC price. Stakeholders in our interviews thought this option by itself would have little effect on vaccination rates. This option would also have the benefit of reducing state and federal spending on vaccine purchasing if the reduced cost resulted in lower state payment rates. A new payment system would likely

need to be implemented to allow providers to take advantage of these discounts. It could create a significant administrative burden for vaccine manufacturers and providers.

Some stakeholders had concerns that expanding the size of the population accessing the CDC-negotiated price could result in smaller discounts if manufacturers change their pricing strategy. A statutory change would be needed to require manufacturers to negotiate and to ensure that the price is available to all Medicaid states and for all vaccines.

Option C here implements payment regulations on vaccines, and it would go further to address both concerns related to vaccine and administration payments and can ensure that payment would at least cover most providers' costs. Like increasing FMAP for vaccine administration, this policy would have a more sizeable effect on vaccination rates than some of the other policies under consideration. However, this policy would increase Medicaid spending in many states, and federal spending would increase as well. This policy can increase the administrative burden on states if they have to do a survey

to determine the average acquisition cost for vaccines or a study to determine the average cost to administer vaccines. Similar to the prescription drug payment requirements, this policy could be accomplished through regulations.

This next option, Option D, would recommend that CMS release federal guidance encouraging the use of pharmacies and other providers in providing adult vaccinations under existing authorities. If states respond and expand the types of providers able to administer vaccines, it could have a fairly significant effect on vaccination rates in those states. However, guidance is optional, and some states may not act.

In particular, it could address racial disparities if the expanded provider network serves a greater share of people of color or underserved geographic areas. Similar to many of the other policy options offered, this approach would increase spending for both states and the federal government if more Medicaid enrollees get vaccinated.

This option would not be operationally complex, but some states may also need to change state law to allow for additional providers to administer vaccines.

This next set of policy options would be focused on providing education and support to beneficiaries. One option is around payment for vaccine counseling. Currently, most states only pay for vaccine administration but do not make a separate payment for counseling that does not result in a vaccination.

Another option is to improve immunization information systems, or IIS. IIS improvements would make it easier for providers to access their patient's vaccination history and identify which vaccines are still needed.

The last option category is to provide resources for beneficiary education and outreach. This could take many forms, such as public health outreach campaigns to address vaccine hesitancy or providing support in getting beneficiaries to the doctor or pharmacy for a vaccination.

In this table, Option E would pay for vaccination counseling to help encourage providers to offer additional support and counseling to vaccine-hesitant individuals. This policy option could be pursued through guidance on how states could provide coverage for vaccine counseling visits under existing authority, or Congress could go further and

add counseling as the part of the mandated benefit if they choose to do so through Build Back Better alongside vaccines and their administration.

This option could help address vaccine hesitancy in certain racial and ethnic groups. However, it's not clear to what extent counseling will ultimately lead to vaccinations.

In our interviews, there are some concerns that delinking payment from the actual administration of the vaccine would increase cost without actually leading to increase in vaccinations. Depending on how states manage utilization and the level of payment, this could result in a significant increase to state and federal spending.

Option F would help improve IIS. Currently, if the IIS is part of the state's Medicaid Management Information System, or MMIS, then they can receive 90 percent federal match for design and development and 75 percent match for its ongoing maintenance. If the IIS is operated by a non-Medicaid agency, match is only available at 50 percent. This option can be done under existing authority through CMS guidance on what activities are allowable and technical assistance on how to structure the

integration of the systems. Congress could go further and allocate additional funding for IIS and interoperability improvement, similar to what was done under HITECH in 2009.

This option by itself would likely have the limited effect on increasing vaccination rates. It would increase both state and federal spending, depending on if states need to make changes to their systems to integrate the two systems.

Over the long term, this could reduce state spending if the state can claim the 75 percent federal match for ongoing maintenance instead of the regular 50 percent match if the IIS were operated by non-Medicaid agency. This policy could be operationally complex to implement, depending on the systems change needed.

This last Policy Option G could take several forms. CMS can provide guidance and examples of how states could use existing Medicaid authorities to fund public health initiatives to increase beneficiary education and outreach, or Congress could establish a program similar to the CHIP health services initiatives under which states can use a limited amount of CHIP funding to implement initiatives focused on improving children's health.

Because there are a range of approaches, it's challenging to assess the potential effect on vaccination rates. We anticipate that education outreach programs would likely have a limited effect on increasing vaccinations. However, programs could have a greater effect in reducing racial disparities if the state focuses the additional resources on barriers that disproportionately effect people of color. State and federal spending would increase, but states may be able to offset some of that spending by getting federal match on some activities that were funded by state-only dollars previously or by leveraging MCOs to provide some of these programs through non-benefit spending or value-added services.

So for next steps, staff would appreciate Commissioner feedback on the draft chapter for the March report. We also hope to get your feedback on the policy options we've presented today to improve access and beneficiary education and support and whether the Commission would like to pursue recommendations for the June report.

If so, Commissioners should narrow which policy

options they would like to see brought back as potential recommendations. If the Commission would like to make specific recommendations in the June report, staff will present draft recommendations in March, and then we would return in April to present the draft chapter, and the Commission would vote on the recommendations then.

Also note that if Congress does not act to make vaccine coverage in Medicaid mandatory for all adults, we can make that recommendation in the June report as well.

This last slide just consolidates all of the previous assessment tables to help in your discussions, and with that, I'll turn it over to the Commission.

VICE CHAIR DAVIS: Thank you, Chris and Amy.

I think I will start to chomp away at this, looking first at the chapter, and I want to say that the chapter was just extremely well done. I was really happy with it. I mean, I could really see how you all had responded to many of the questions that we've brought up in previous conversations, the focus on disparity and equity, how things break down in terms of vaccinations for prevention versus certain specific diseases. So I just really appreciated the attention to detail there.

I want to hear from the Commissioners, any questions or concerns about the chapter, anything around the direction that it takes or themes that you think need to be emphasized more, emphasized less, and then we'll move into the policy options, but first, just any comments or questions on the chapter.

Yeah, Heidi and the Martha.

COMMISSIONER ALLEN: Sorry. It took me a second to find my cursor.

So, as I've been getting deeper into this every time I read the new materials, I found myself struggling a little bit with understanding the concept of increase or decrease in state spending, and the difficulty I'm having is that by virtue of more vaccines being used, which is the policy objective of all of this, prices go up. And I think it's useful to know who those prices go up for, but I think that because the objective is to increase vaccines, then it's more helpful for me to understand where prices go up because of the policy option itself and not because there's an increase in vaccines.

For example, one of the recommendations would require changes to the system that's used for monitoring,

and that is a different cost than just the states or federal government is paying more for what we want to have happen.

So I'm just wondering how difficult would it be to think about this decrease/increase in state and federal spending to be more -- you know, like one concept is who is bearing the brunt. If it's versus FMAP, then it's federal government versus the state -- and I think that's very useful to understand -- but teasing out how much it costs to do that is not specifically related to what we would want to have happen, which is more people get vaccines. I hope that was clear. I apologize if it wasn't.

COMMISSIONER DAVIS: Thanks, Heidi. Amy or Chris, any other clarification that you need on that point?

MR. PARK: I think that all makes sense, and for the most part in a lot of these places the increase that we are talking about could be coming from the increased utilization of vaccines and more people getting vaccinated. But, for example, there are other places where, like payments for vaccine counseling could increase costs for people who would have gotten vaccinated anyway. So I think as we move forward with any of these recommendations,

discussion for future meetings, we can try to make that a little bit more clear.

COMMISSIONER DAVIS: Thanks. Martha?

COMMISSIONER CARTER: Sorry, Kisha. I think that my comments are more about linking to these policy options. So if we are not ready for that I will hold until you are ready for that.

COMMISSIONER DAVIS: Okay. We will come back to you. Laura?

COMMISSIONER HERRERA SCOTT: Chris, thank you for that overview and capturing at least some of the comments that we made in the last call.

So a couple of things. Just thinking about access and given our prior discussion, I wonder how much of the low vaccination rates are related to access. And to the point that you made in the memo about increasing the types of providers administering the vaccine and what kind of lift you would get from that. You still have the increase in spending related to the increase in immunization but it would be because we created access for people who don't have access today.

And I know there was some expansion under the

public health emergency, but do we have more details on what states are doing and which states would have to go back to scope of practice or just scope-of-practice issues. But for sure an opportunity around increasing access to immunizations.

And also thinking about the benefit design. I don't know how many states include vaccines on their medical side or pharmacy benefit and how much of an impact that has. Arguably it is easier for a member or patient to be able to walk into a pharmacy and get vaccinated versus having to schedule a PCP appointment and maybe take time off from work to get the vaccine. So if there is any information on that and the impact of vaccinations.

And then, lastly, thinking about the spending, and I don't know if this is doable, but thinking about vaccine-preventable diseases and what states are spending today for those states that don't cover all the recommended vaccines, and whether that spending could be used to offset the increase in increased vaccinations and avoidable complications related to that condition.

COMMISSIONER DAVIS: Thank you, Laura.

COMMISSIONER HEAPHY: This is Dennis. I have

question, and I apologize if I should know this. But when I look at reduced racial disparities, that is central to what we are doing -- I am looking at E and G -- it says, "Low improvement of vaccination rates but medium in reducing racial disparities." And so I'm having a little bit of dissonance wondering if the improvement in vaccination rates is low but the impact on racial disparities is higher. How do those work together?

MS. ZETTLE: Yeah, so when we talked to stakeholders about this specific policy, and you will see the same thing, I think, for G, there was some concern that delinking payments for vaccinations and just paying for counseling may not actually increase vaccination rates. So there was some concern there.

But to the extent that there could be vaccine hesitancy among people of color or different ethnic groups, that potentially by paying for vaccine counseling more resources could be dedicated to addressing some of those concerns with certain populations.

So the same thing could be said for Medicaid resources of education and outreach, when we talk to stakeholders. You could really target some of those

efforts towards certain populations, and therefore address racial disparities, even though the overall impact on vaccination rates may end up being low.

I hope I answered your question, or Chris, if you have anything else to add.

MR. PARK: Nothing to add.

COMMISSIONER HEAPHY: Thanks. You answered somewhat, but I'm still a little confused. I guess how are you determining that there would be that reduction in disparities? Is it just based on educational factors that improve overall, reduction in racial disparities even if it doesn't improve vaccination rates?

MS. ZETTLE: So, to Chris' point, these are relative. So when we were looking across these policy options and trying to determine which of these would potentially have a greater effect on reducing racial disparities we identified these two policy options as potentially having the greatest potential to be targeted to results in a potential increase in vaccination rates among people of color. And so that's sort of where that comes from. But when you look at the total overall improvements of vaccination rates, we don't necessarily see a

significant change in rates.

COMMISSIONER HEAPHY: And then just one follow-up. Would it be possible to disaggregate some of that data a little bit to see which populations or subpopulations within racial and ethnic populations really need to have an increase in vaccination rates? Because folks with disabilities, they may be a higher rate but not in the broader population of African Americans or Hispanics or something like that.

COMMISSIONER DAVIS: Anne, did you want to jump in here?

EXECUTIVE DIRECTOR SCHWARTZ: Yes. I just wanted to maybe get Chris, in particular, to jump in on what we're able to do with the data we have, for both this question that Dennis just asked and some of the questions that Laura asked. Because I think there are some things we can definitely do and a bunch of things we would love to be able to do but can't, and I think it might be helpful to hear about that.

MR. PARK: Sure. And in previous meetings we had mentioned that we were looking at the T-MSIS data to try to see if we could identify differences in vaccination rates

across states and potentially different eligibility groups such as, Dennis, as you were saying, individuals eligible on the basis of disabilities versus other adults. And when we ran the data what we were finding are vaccination utilization that are significantly lower than what we had seen in the survey data, which, we don't know all the reasons for that.

We have some speculation but, otherwise, the differences weren't great enough and we thought that there might be some data discrepancies in the T-MSIS data and it would be confusing to present that information alongside the survey data, where we see like 30 percent Medicaid enrollees getting the flu vaccination, but in the T-MSIS data it was only like 10 to 15 percent.

So I think directionally we saw things that we were somewhat expecting in vaccination rates being higher for the new adult group than it was for other adults, but the differences were pretty small because the rates were so small that it was hard to discern what were meaningful differences at that point.

And so to your question, Dennis, about whether vaccination rates are different among minority groups,

people of color, among those with disabilities versus those without, that's something we could look at but the data seem to be somewhat unreliable so it is hard to kind of draw definitive conclusions from those data.

COMMISSIONER DAVIS: Thanks, Chris. Yeah, the data foils us again. Fred?

COMMISSIONER CERISE: Oh thanks, Kisha. Yeah, I was trying to get in just on the education and outreach piece. You know, with good data, like COVID you have a universal, everybody that was vaccinated was in a registry and you can tell where people are getting vaccinated and where they are not. And so you can target areas where you know you have disparities. In big systems we have done that, where you can go down to the block level and understand where you've got pockets of people who are not vaccinated and then use targeted education and outreach, using community influencers and people that the individuals trust to get very specific about raising rates in areas where you know you've got low utilization.

And so, I think there's something there. I do worry if it's general and not targeted like that of what the impact might be.

I did have one question and one comment on two other recommendations. One, Chris, maybe could you talk more about the federal contract pricing and some of the concerns there? Because it seems to me if we are going to make a recommendation that we want broad coverage that we would want to pair that with trying to take advantage of, if we are going to use more let's try to get better pricing universally. And so I would be interested in hearing some of the -- it sounded like there was some skepticism about that.

And then finally, on the payment for vaccine counseling, you know, particularly the example you used around pregnancy, that's an area where you've got kind of a defined package of things that you'd like to do, and I think anything that further fragments how we pay for care generally is not a great idea. You know, and moving that into kind of a bundle of these are the things you want in pregnancy and paying more globally is a better idea. And I would be concerned about creating another category of payment for people, you know, another code you can bill for as opposed to trying to group that into more like a bundled payment. And you could put incentives and things like that

in there if you want to drive vaccination rates that way.

Anyway, that's my comment on that one. Chris, can you talk about the federal contract pricing a little more?

MR. PARK: Sure. The federal contract price right now is something that CDC negotiates with manufacturers for purposes of the VFC program, the Vaccines for Children program, and also the Section 317 immunization program, which is a federally funded purchasing program, to provide vaccines for uninsured adults. And so, this is something that's done currently, so that's one reason why we're suggesting it, is because the process is in place already to negotiate the price.

But the participation is voluntary, for manufacturers, and there is no set formula like there is in the rebate program for what the discount would be. So some of the concern that we've heard is as a greater pool of people are trying to access these prices, manufacturers may rethink their pricing decisions and offer a smaller discount to kind of ensure a certain amount of revenue from vaccines.

And also not all vaccines are included in the

program. You know, the primary purpose was for vaccines for children, so there may be some adult vaccines that may not be included in the program right now. And as new vaccines come out it is not necessarily guaranteed that the manufacturer negotiate pricing there.

And so I think to guarantee all vaccines would be covered and all states could access the price, because, it is somewhat of a voluntary negotiation right now, there would need to be a statutory change.

We did hear from a couple of states who have a universal purchasing program for vaccines, and they are using the CDC price to negotiate the pricing for those programs in the state. However, as I said, this is kind of a voluntary negotiation and there is nothing that would require the manufacturer to offer those prices to the state. So I think this is a place where certain things can be done right now under existing statute and process, but to guarantee that you would need to make it statutory. And also if you wanted to guarantee a certain level of discount, that might have to be built into statute as well.

COMMISSIONER DAVIS: Thank you, Chris and Fred, and it is a good transition to talk more about the specific

policy options, if you have questions or concerns about those or suggestions on grouping them.

I know, Martha, we wanted to come back to you, and Melanie, did I see your hand as well?

Martha, we can go to you.

COMMISSIONER CARTER: Right. Thanks. I want to look at linking Option D and F. I want to speak in favor of increasing the types of providers administering vaccines, and in particular I think we should look at, I guess this would be a recommendation to the states that nurses be billable providers for the purpose of administering vaccines. And also pharmacists, because they really served a big role through the pandemic, and continuing their involvement in vaccine administration for adults.

I want to point out a couple of things. There is potentially a little bit of a tradeoff here when you add different types of providers to administer vaccines. As an example, when an adult goes into their primary care provider for their flu shot or they need a tetanus shot, that is an opportunity for the PCP to look at the broader preventive primary care needs. And so you lose some of

that by taking the vaccine administration out of that environment.

But all in all, I think it is really important to increase access to vaccines that we expand the types of providers. And I think it needs to be linked, though, with F, in addition to bolstering the immunization information systems that any provider type that becomes a billable provider for vaccine administration they are required to report to the, when, immunization information system.

I can't tell you how many times it has happened that, you know, people come in and you don't know whether they've had their vaccines. This happens more with children, but we are sort of expanding on the system. And they get the vaccines again sometimes. So we've got overuse, inappropriate overuse of vaccines.

And, of course, there are a lot of PCPs that their reimbursements and their bonuses are linked to some quality metrics around vaccines. So it is important that that whole body of knowledge is available to the people who need it, which means that everybody who administers vaccines has to report to the system. Thanks.

COMMISSIONER DAVIS: Thank you, Martha, and I

will put a second on much of what Martha said, especially around the linking D and F, if you are going to expand the folks who can give vaccines, making sure that there is a robust system in place to be able to monitor that, to prevent duplication and facilitate just folks knowing, and recognizing that that does take some of that ability for primary care to weigh in on a thing on the patient's overall health, if that patient is not getting that vaccine done in the primary care's office. But I think the greater good is really that the patient gets the vaccine, and I think if COVID has taught us anything, opening up the availability and access to be able to obtain those has been really significant.

Toby, and then Verlon.

COMMISSIONER DOUGLAS: First of all, great chapter. It really lays out the issues well.

In terms of the policy options, just stepping back, and I know we've talked about this and others, of where maybe there are times we just don't need recommendations and options, I look at these and I just wonder if the chapter should be including these as options for states. I mean, some I know do take federal

requirements, but is this really an area where we would have enough information to say this is truly a recommendation that we would want to take at this time, or rather that these are different levers that states can take, or the federal government can take.

So that's just where, when I look at this and see the implication.

COMMISSIONER DAVIS: Anne, do you want to address that? Because I think part of this is this kind of quandary we are in, in terms of what happens with Build Back Better, and how much of the vaccine mandate gets taken up by that and if that should pass, and what potentially happens to these set of policy options in the event that that starts to move.

EXECUTIVE DIRECTOR SCHWARTZ: Well, I mean, Chris and Amy are probably better to answer it, but I think really what we found is the coverage piece is the big precursor, but all of these pieces come after that as additional steps to be taken.

I guess to Toby's question about whether we have enough information or not, the question, I think, really is what other information would you need, and can we figure

out whether we can find that or not? That's where I would defer to Chris and Amy.

[Pause.]

EXECUTIVE DIRECTOR SCHWARTZ: So that was an invitation to you guys to say something.

MS. ZETTLE: I agree with you, Anne. I think that what we heard from our interviews and from experts is really that the coverage piece is foundational, and so we are sort of in this interesting position in that the House has already passed a bill that would address that component. And so we lay that out in the chapter.

Then what we heard from interviewees was that that coverage is foundational, but that alone isn't really going to get at the issue. There are also plenty of beneficiaries who have coverage of vaccines and are not able to access them for a number of reasons or maybe are hesitant to do so. So these policies would layer on top, and so the thinking was that whether Congress moves to include that in some sort of package going forward that would either address that, and then we could come back and lay out these recommendations for Congress, or maybe in June, a recommendation on coverage could be made and then

add on whichever additional access options you all think would be important for Congress or for states to consider.

If there are specific areas that you want more information, Chris and I can certainly go back and talk to states and follow up with folks that we've talked to and see if we can get more information, but we look to you all to see where you feel like we're missing or what areas we're missing.

VICE CHAIR DAVIS: To that end, Toby, is there specific information that you think would be helpful or just kind of more in a general sense?

COMMISSIONER DOUGLAS: It's more in a general sense that this is such an area that isn't -- I don't know what additional data, and I go back -- is it the Commission to -- you know, without really strong analytical framework for these, are we -- we're sending out -- I'm not saying these aren't good ideas, but is it really at the level of a recommendation versus these are approaches that could be taken that should be considered?

VICE CHAIR DAVIS: Thanks, Toby.

I'll just do a quick time check. We've got about eight minutes left in this conversation. We'll go to

Verlon and then Laura and then Heidi.

COMMISSIONER JOHNSON: All right. I'll be quick. I will just say that I really liked Martha's linkage in terms of D and F.

I would just also say that as we think about treating the whole person and empower beneficiaries, I'd like to see G, as well, in terms of making sure we're educating and providing outreach. I think that works, and in very different settings, I think it will really go hand in hand here as well.

Thank you.

VICE CHAIR DAVIS: Thanks, Verlon.

Laura?

COMMISSIONER HERRERA SCOTT: Amy, just to follow up on the coverage review you just quickly did. With the states that had more comprehensive immunization coverage, were their immunization rates higher than the states that didn't? Is there anything you could say at the state level?

MS. ZETTLE: Yes. So that's a great question, and with the survey analysis that we did, because of sample size, we were not able to break it down by state and

compare.

Our plan and our hope was that we'd be able to look at T-MSIS and then do a state-by-state comparison within Medicaid to see, okay, are states who aren't covering vaccines or are applying cost-sharing policies, is this influencing vaccination rates, but as Chris already laid out very well, we had some challenges using T-MSIS to estimate state-level vaccination rates. So we just don't have state comparisons at this point.

VICE CHAIR DAVIS: Thank you.

COMMISSIONER HEAPHY: This is Dennis. I'm sorry. I wanted to echo Verlon's recommendation of D, F, and G. And as someone who lives in a state where I can -- I love the idea -- I go and get my flu shot and my COVID vaccine at CVS, and so the idea that it's so -- at the departments a lot, and they're always telling folks to get your flu shot, to get your vaccine, yet I think it's really helpful. So I definitely support what Verlon was saying, building off of Martha's recommendation.

VICE CHAIR DAVIS: Thank you, Dennis.

Heidi.

COMMISSIONER ALLEN: So going back to Toby's

point, I feel like there's some of these that I have a hard time knowing what's best, just that more information kind of thing, and that's really the A, B, and C. But then there's one -- the D, E, F, and G seem like we have really good evidence, and that just seems easier for me to think about.

I'm just going to say as a parent -- I got my kids boostered yesterday -- it's very hard to get a pediatrician appointment after school hours, and it's really hard to take your kids out of school and take work off to get immunizations. I've had so many times where -- like, one time, I had to take my son in to get immunized on his birthday because the school wouldn't let him back in if he didn't have this immunization at this age, and it was just like you get into all these weird things. So, instead of being in school on his birthday, he was in the doctor's, in the office, getting a vaccination on his birthday. So it's kind of like -- like, it's just an access barrier, and that's an access barrier for people that are privileged. For folks that can't take time off work, for kids who really need to be in school, it's not easy to make these appointments. So having after hours, having the CVS, those

kind of things just make a huge difference.

And I also want to say that trying to keep track of vaccinations across providers, there may have been a time when you would see a doctor for 15 years or 20 years, but that is just not the way it works anymore. Clinics get sold and bought and move, and you end up with this fragmented record that -- for all of the people in my family, I have little pieces of paper with vaccines written around at different places, and trying to make sense of them as a whole is impossible. And you can't call anybody to say is this okay, and documentation for school, all of those kind of things, these recommendations, I think, would have a tremendous impact on making life easier for families.

VICE CHAIR DAVIS: Thank you, Heidi.

Tricia?

COMMISSIONER BROOKS: So I just want to be clear. I think we're talking about recommendations for adults here. Am I correct in that? And that these recommendations would not apply to kids because, with all due respect, Heidi, I think the pediatric community feels very strongly about the potential for problems with

children if their medical home isn't where they're getting their vaccine. I just think we have to have a different conversation and want to make sure that what we're talking about here is just limited to adults at this point.

VICE CHAIR DAVIS: I believe that's correct.

Amy, Chris, I saw you nodding that this is for the adult population.

MS. ZETTLE: Yes.

MR. PARK: It's primarily for adults, but some of these things could have broader influences to children such as the education and outreach. Things like that could also be applied to children depending on how states take up those options.

VICE CHAIR DAVIS: Thanks.

You know, as we wrap up, I'm hearing pretty strong consensus around D, F, and G, especially around F and the need for that kind of immunization information system just across the board for all of the reasons Heidi has mentioned. And I think any of us who have had to manage the care for little ones or big ones, how important that is, and even just as a primary care provider, not even knowing where my patients have gotten their vaccines done

is certainly a challenge.

I'm hearing strong support for D in terms of increasing the types of providers that are administering vaccinations.

I'm hearing strong support for G, as well, around resources for targeted education and outreach.

And I see you, Darin.

The idea that this really be targeted towards those communities that have lower vaccination rates, I think that that's something that we should be commenting on. It's not just Medicaid resources and education for everybody but something that is more targeted at getting at the disparate populations and those who may have been excluded.

I have a couple comments on the other policy options, but I will hold those and go to Darin first.

COMMISSIONER GORDON: Yeah. First, I just want to say I'm kind of where Toby is. None of these are bad options, but I do kind of feel like the determination on coverage is going to be the deciding factor.

Then I do think there are a couple of areas that I will -- I mean, these are options. These are levers, but

I saw questions about -- like, on G, for example, when you're bringing that up, I don't have a good appreciation of what all is happening on the public health side with regards to education and outreach resources. Obviously, to your point, some targeted education and outreach efforts would obviously be helpful. I'm trying to in my own mind -- I feel like I don't have a piece of the data to understand what kind of funding is going into public health regards to education and outreach resources. What areas are they focusing on? Where is the gap?

I'm sure if you looked back, you know, kind of pre-COVID, most people would agree that there's probably not enough resources on education and outreach at all on the public health side.

I just don't know if that's still the case. So there's a few of these that I feel like I would like a little bit more information, but again, I do think we have time if we're looking to see what plays out on the coverage determination.

VICE CHAIR DAVIS: Thank you, Darin. I see that conversation of what's covered by Medicaid and what is public health response and where that overlap happens.

Stacey.

COMMISSIONER LAMPKIN: Thanks. I'd just like to chime, a little bit of a twist on Toby and Darin's comments, where I think I would be more supportive of recommendation versus providing the information about the option, to the extent that it is removing a barrier for a state or helping a state execute on something.

If it's something a state already has the option to do, I don't really know what we're adding there by recommending it and just calling it out, but if it's helping a state execute which coverage is in place, then that feels more like value as a recommendation.

VICE CHAIR DAVIS: Thank you, Stacey.

Anybody else want to weigh in here? I know we're just about at time, but if anybody else wants to weigh in on this formal recommendation versus leaving it out there as policy options?

Yeah, Darin.

COMMISSIONER GORDON: And just to be clear, I may have a different feeling after we see how some things play out. So it's like whether it is now versus, you know, seeing if there does ultimately become a coverage

requirement.

VICE CHAIR DAVIS: Fair enough. Fair enough.

What I'm not hearing great consensus on are around the access parts in terms of adequate payment, the A, B, and C.

I'll just say from my view on those, I think the federal contract piece is important but not sufficient in terms of moving the needle, and it creates a level of administrative complexity for those providers to then bill, wait for the reimbursement and at the new rate. That doesn't necessarily leave the provider enthusiastic about wanting to then do vaccines in the office as opposed to something like C that, there's a requirement for payment at a certain level that you're going to be reimbursed as from a provider's standpoint in terms of ease of being able to see patients and provide vaccines. I think that's just a little bit of an easier hurdle to cross, especially because it's more of a regulatory change and statutory change.

But, again, I think I'm not seeing necessarily consensus in that with payment, and so I think fleshing that out a little bit more when we come back together in April, we may be able to get a little bit further on that.

Amy, Chris, additional information that would be helpful to hear from the Commissioners before we wrap up?

MR. PARK: Are there any options you would like to take off the table? We haven't heard much about -- and you kind of mentioned this, Kisha, about maybe the federal contract price doesn't move the needle enough. We didn't really hear anything, Commissioner comments on increasing the FMAP. So are there things that you think we should just take off the table when we come back in March for further discussion?

VICE CHAIR DAVIS: I'd love to hear from other folks.

I will say personally that the payment for vaccine counseling, for many of the reasons that Fred also mentioned, I am pretty hesitant on. I worry that that just pays providers to counsel for patients who they already were going to give a vaccine for, and does that just increase price in a way that's not targeted? And, you know, would I see more benefit in a targeted education and research campaign for those patients who are falling through the cracks rather than paying to counsel for folks who probably are already going to get it?

Yeah, Martha.

COMMISSIONER CARTER: I think that ensuring adequate payment for the cost of the vaccine and for vaccine administration is integral to all of these. I don't think we're going to move the needle at all if we don't make sure that happens.

I am unclear about the best mechanism for that, but as you said, Kisha, at the primary care level, it's very difficult to think about increasing your adult vaccine administration if you don't know whether you're going to get paid, how you're going to get paid, whether you have to buy the vaccines in advance and then wait to get reimbursed for six months or a year. It just doesn't move the needle enough without that piece of ensuring adequate reimbursement. I don't know the best mechanism to get us there.

VICE CHAIR DAVIS: Thank you, Martha.

COMMISSIONER HEAPHY: This is Dennis, Kisha.

I'm just wondering about D because I really like D a lot, and if there's strong opposition to that, or if there's more information that, Amy, you or Chris can provide us that might help us better understand the value

of having the potential providers administering vaccines? Do you think that there's any data out there on that? We do see barriers to access, and for me, that's a frontline opportunity.

MR. PARK: There was a study we mentioned in the paper about that they looked at which types of providers were able to bill Medicaid for vaccines, that we can highlight that a little bit more for you, though some states have been making -- you know, this was for the 2018-2019 time period. Some states had been tweaking some of their scope-of-practice laws recently with COVID, so that they're allowing pharmacies to do a little bit more on vaccinations, that we can try to look into a little bit to see if COVID has gotten states to expand the provider network any for Medicaid on other vaccines, but we're not sure if we can do a comprehensive 50-state review on that part, but we can certainly provide some examples of where states have done that.

VICE CHAIR DAVIS: Thanks, Chris.

We'll go to Toby to take us home.

COMMISSIONER DOUGLAS: Oh, that's a lot, if I'm to take it home.

VICE CHAIR DAVIS: You can do that.

COMMISSIONER DOUGLAS: I do want to say on C and D, as we assess it, remember just the bigger context of the role of states on how they decide the scope. If we're going to just focus on this, what are the implications on other provider types and rates where they do have flexibility? This is where states do. So I just want to make sure we're careful too, as much as this is an important area, but after where we talked about overall access is important in the previous discussion, what are we setting up here as implications if we start making recommendations around provider types and requirements?

But I hope that isn't the taking-home, so, Kisha, back to you.

VICE CHAIR DAVIS: No, I think it's a great point in thinking about better understanding the implications for states if we were to recommend that increasing provider types and how big a lift would it be. You know, are states having to change statutory guidance? And several states would have to do that in order to expand who can get vaccines.

So this has been a great conversation, more

animated than I thought it would be. So thank you everybody for your comments.

I will turn it back to you, Melanie, for any final comments from the floor.

CHAIR BELLA: Yeah. We actually need to go to public comments, so thank you, Kisha.

I'm going to invite anyone in the audience who would like to make a comment to raise their hand. I just remind folks, please identify your name, your organization, and keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I am not seeing any hands.

All right. Thank you, Kisha.

Chris and Amy, thank you. I know there's a lot to sort of digest from the comments. We have a lot of work and discussion to continue in this area, some of which is contingent on some big things happening, and so we will look forward to continuing this discussion for sure. Thank you both.

And thank you to the Commissioners. We are going to take a break now for lunch. We will be back at one

o'clock Eastern with a panel on restarting Medicaid eligibility redetermination, so encourage you all to be back here at one o'clock promptly and we'll get started. Thank you.

* [Whereupon, at 12:09 p.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: Okay. Welcome back, everybody. I want to start promptly, out of respect for our panelists' time and also because I know there's a lot we want to get through in this hour that we have with them.

Joanne, welcome. I think our panelists are here,

just maybe not on camera yet. We will let everybody get settled and then, Joanne, we will have you kick it off.

PANEL DISCUSSION: UPDATE ON RESTARTING MEDICAID ELIGIBILITY REDETERMINATIONS

* MS. JEE: Okay. So do we have everybody? Great. Okay. So we can go ahead and get started.

Sorry. I've already got the technology issues.

All right. So this panel serves as an update on where things are and considerations for the restarting of Medicaid eligibility determinations once the PHE ends. As a reminder for Commissioners, we had a similar panel in the fall of 2020, during which officials from Medicaid programs in California and Kentucky came and shared with you their views, as well as an individual from the Center of Budget and Policy Priorities. And so we are hopeful that this will be a useful update on what you heard back in the fall of 2020.

Before turning it over to the panelists I will spend just a couple of minutes with some background information and sharing some information on recent developments, just to help set the context for what our panelists will share with you this afternoon.

As a reminder, in March 2020, the Families First Coronavirus Response Act provided states with a 6.2 percentage point increase to the federal Medicaid match if they met certain requirements, including the continuous coverage requirement. That requirement prohibited states from disenrolling most individuals from Medicaid if they had been enrolled as of or after March 18, 2020.

I just want to note for you here that the time frames for these requirements differ from each other. The continuous coverage requirement ends in the month in which the PHE ends, whereas the FMAP increase ends in the quarter in which the PHE ends.

And as you probably know, the Administration just extended the public health emergency declaration, which will take us through April. However, it is not known precisely how long the PHE declaration will continue, and so that really leaves states with a little bit of uncertainty in terms of how long the continuous coverage requirement will be in place.

Due to a combination of that requirement, the continuous coverage requirement, and pandemic-related job and accompanying coverage losses, Medicaid enrollment has

grown substantially over the PHE. CMS, in its most recent enrollment snapshot, reported that Medicaid enrollment grew 19 percent from February 2020 to June 2021.

Despite uncertainty about the duration of the PHE and accompanying requirements, states and CMS have been planning for the eventual return to routine renewals for quite some time. And during this time, concerns have been raised about the potential for coverage losses among individuals who do not complete the renewal process or those who are determined to be ineligible but do not get connected to other forms of coverage. Concerns have also been raised about state capacity to address the renewals as there will be quite a large volume of renewals coming up, and other state resource constraints.

Just to touch base quickly on some recent developments, in August 2021, CMS issued revised guidance on the return to routine renewals -- it's like a little alliteration for you all -- and that revised guidance from December 2020 in two key ways. First, it extended the time frames for completing renewals pending verifications and redeterminations based on changes in circumstance from 6 to 12 months, and secondly, it requires states to conduct an

additional redetermination for individuals who are found ineligible for Medicaid during the PHE. And just as a reminder, previously states did not need to do this if individuals were found to be ineligible within 6 months of the end of the PHE.

Over the last year, CMS has issued a number of different tools and guidances to help states prepare for the unwinding of PHE flexibilities, including resuming renewals. In addition, they have provided guidance and technical assistance opportunities related to strategies and approaches for avoiding unnecessary loss of coverage.

Finally, Congress is working on the Build Back Better Act. The House-passed version of this bill decoupled the FMAP increase and the continuous coverage requirement from the PHE. It creates a glide path for the gradual reduction of the FMAP increase and establishes certain guardrails or requirements to help mitigate unnecessary coverage losses.

The Senate has not completed its work on the Build Back Better Act, and at this point the future of the legislation is somewhat unclear.

All right. So with that we can turn it over to

the panel. First we'll hear from Melissa McChesney of UnidosUS, and she will share with us some information about approaches states are taking, or can be taking, to help individuals complete their renewals and avoid unnecessary coverage loss.

Then we will hear from Jeff Nelson, from Utah's Medicaid program, and Jeremy Vandehey from Oregon's Medicaid program, who will share with us information about how their states are thinking about the renewals, any issues or concerns that they are anticipating.

So with that I'll turn it over to you, Melissa.

* MS. McCHESNEY: Thank you, Joanne.

So as was said, my name is Melissa McChesney, and I am a health policy advisor for UnidosUS, before working at Unidos, I worked for Every Texan as a senior policy advisor, and in both of those roles I have worked with a coalition of Texas advocates on the pandemic-related Medicaid provisions, including the continuous coverage requirement.

So I will be speaking today about the implications for beneficiaries of this requirement and strategies that may help mitigate loss of coverage for

eligible individuals.

Because of the requirement to maintain Medicaid for beneficiaries during the COVID-19 public health emergency, Medicaid is working as it should, as a bulwark that supports families, including during an unprecedented national emergency. Yet when Medicaid's enrollments resume, the millions of people who rely on Medicaid will become highly vulnerable to loss of coverage and care.

For this reason, state Medicaid agencies and CMS must take necessary steps to minimize the number of still-eligible people who will lose coverage for procedural reasons when states are allowed to restart Medicaid disenrollments, and ensure individuals who are truly no longer eligible are successfully transitioned to other coverage such as CHIP and the Affordable Care Act health insurance marketplace.

Given our scope today and our limited time, I will be focusing on the first goal, which is to minimize the loss of coverage for still-eligible people. The stakes for getting this right are high. Poor planning or execution by a state could trigger massive disenrollment of eligible individuals. We have seen this occur in other

states in the past. Therefore, state officials must make it their top priority to learn from those past instances to ensure eligible children are not denied.

Even small gaps in coverage can lead to interruptions in access to medications, therapies, and other medical treatments. Delayed or skipped treatment often leads to worsening conditions and greater use of high-cost care, meaning the stakes are not just high for low-income families and children, there also are important implications for the health care system as a whole.

In Texas, more than 40 percent of children rely on Medicaid or CHIP for their health care needs, and nearly two-thirds of Texans enrolled in the Medicaid program are from communities who have suffered disproportionate health and economic impacts from the pandemic. Fifteen percent of Texas Medicaid enrollees are Black, and 49 percent are Latino. Coverage losses would be devastating for low-income children and families who rely on Medicaid, and would only deepen existing racial and ethnic disparities.

So now I'll talk about some of the strategies that may help mitigate loss of coverage for eligible individuals.

Past experiences in other states like Tennessee and Missouri have shown the significant risks to coverage that can come from restarting renewals. But we can also learn from these same experiences to influence the planning of state Medicaid agencies to avoid large numbers of eligible individuals becoming uninsured because systems are unprepared for the onslaught of renewals.

Medicaid eligible and enrollment systems are complex, and each state will have its own unique circumstances to consider. I will focus on the best practices that Texas advocates have recommended to the state, but there are many more that could come into play, depending on a state's circumstance.

Specially, Texas advocates have focused on reducing administrative burdens on beneficiaries, avoiding overloading an already-stressed eligibility system, and requiring updated contact information from clients. I will speak to each of these three briefly.

First, states are required to reduce administrative burden on clients during renewals by attempting to renew coverage using third-party data sources and without requiring action from the clients. This

requirement is often referred to as an administrative renewal, or ex parte renewal, and was created by the Affordable Care Act.

Effective administrative renewals not only reduce burden on clients, they also relieve pressure on eligibility systems by reducing the number of renewals that must be processed manually by eligibility workers. Unfortunately, Texas has not made a good-faith effort to follow this law. Texas processes a mere 9 percent of Medicaid renewals without action from the client. This is one of the lowest administrative renewal rates in the country and represents a big missed opportunity for the state.

Advocates understand that system changes take time, but Texas advocates have been highlighting this concern for the Medicaid agency for years, and specifically related to the end of the public health emergency since the summer of 2020. At this point we feel better enforcement from CMS may be required to convince the state Medicaid agency to improve this process.

The second strategy I'd like to highlight, to mitigate coverage loss of eligible individuals from

Medicaid, is to spread out renewals over time to avoid further overloading an already-strained system. In Texas specifically, the eligibility enrollment system is already under a great deal of stress. Texas operates an integrated eligibility system, where SNAP, TANF, Medicaid and CHIP applications are all processed by the same workforce.

High turnover of eligibility staff and budget cuts that led to a hiring freeze of that same staff has meant that applications renewals are processed more slowly. In fact, in October, only two-thirds of SNAP applications and only 10 percent of SNAP renewals were processed within federal timeliness standards. This led to Texas taking the rare step of pushing SNAP renewals out by six months in order to catch up.

In addition to delayed application processing, we have received consistent reports from community-based organizations that the call center wait time has been long, with clients on the phone for 45 minutes to an hour. I highly think this speaks to the current state of the public benefit eligibility enrollment system in Texas.

We fear the end of COVID-19 continuous eligibility provision for Medicaid will further strain this

system. Therefore, we have encouraged the state to take steps that focus on increasing efficiencies and reducing administrative burden. Specifically, once states are allowed to restart determination of Medicaid they will need to do a new assessment of eligibility for each Medicaid beneficiary, and this work should be spread out over 12 months, as allowed under the updated the CMS guidance from August of 2021.

Finally, we know from past experiences that one of the main reasons clients lose coverage after their state pauses renewals is due to outdated addresses. States should begin massive outreach campaigns that are communicating to clients the need to update their contact information. These should include targeted, culturally competent messages that take into account the unique needs of racial and ethnic minorities, people with disabilities, non-English speakers, and families which include non-citizens. States should also be leveraging third-party data sources to find new addresses and the assistance of health plans and providers.

In addition to robust outreach campaigns and partnering with a variety of stakeholders, we have

encouraged Texas to ensure the technical process for clients to update their contact information is consumer friendly. As we have mentioned, wait times on the call center are not feasible for clients. Furthermore, the online application has not been effective because if clients in Texas forget their passwords they must call the call center to reset it, leading them right back to the 45-minute-plus wait times. Right now, enrollment assisters on the ground must rely on faxing paper forms to efficiently assist families in updating information about their case.

As you can tell, this is a complex, multifaceted issue, so I have attempted to highlight some of the biggest concerns and opportunities for Texans. I appreciate the Commission's time and attention to such an important issue for the new year, and I will be happy to answer questions or dive deeper on a topic during the Q&A, as needed.

Thanks, Joanne.

* MR. NELSON: Hi there. My name is Jeff Nelson with the great state of Utah, and good afternoon to all of you. It is a pleasure to be with you this morning to speak a little bit from the state perspective, and you are going to hear some repeating themes, I think, as we move along.

So I just want to take us back in time a little bit to 2020. In early 2020, we were trying to figure out what the heck was going on, right? We were all coming home, many of us in our homes today, trying to figure out how to do these meetings like this, figuring out what the mute button really was for and how to undo that. We are still working on that still sometimes.

But as all that was going on there was some good conversation, I think, happening at the federal level, which decided that the people that we serve, those in Medicaid, needed to have some continuous coverage, and that requirement came out very quickly and we were forced to implement that very fast. So we did. We were able to get that done in Utah, and we thought, you know, that was a pretty good idea. We liked that. We want to do that with our CHIP program as well.

We worked with CMS almost immediately to do the same thing that we were doing in Medicaid with our CHIP program. So we did the same idea. We call it forced eligibility in our state. We kept the eligibility open and running for those children on our CHIP program. And that was early 2020.

In late 2020, as the guidance started to change and allow this to be a little bit more flexible, we got better at these meetings, we got better at working from home, and there was some more flexibility that was added to the program as well, so we could move people from one program to another within Medicaid. And we thought, again, this is a great idea. We should do this in our CHIP program too.

So we sought a second state plan amendment, or SPA, with the CHIP authorities, and at that time we learned we did not have authority to keep CHIP open like we were doing with Medicaid. What that meant was we got to go through this unwinding process first, or one of the first states to do so.

And so in early 2021, it was April 2021, we began trying to figure out how to unwind what had just been a short period of time on the CHIP program. We did all that we could. We tried to reach out to folks. We tried to get updated addresses where it was appropriate. We set out a notification. We did everything that we thought would be appropriate to keep cases open and ongoing.

But in the end what we simply did, really, was

turn on the old rules inside of our eligibility system. So 15,207 is where we were on our CHIP program at that point in time. We are a smaller state. That is a lot of kids, though, for us. And that number quickly turned into 8,943, almost overnight, as we lost 41 percent of our CHIP program enrollees as we moved back and unwound what was happening in our CHIP program.

I am not going to forget 15,207 kids. It was also a news story, which helps me remember sometimes. So maybe, just maybe, we are a canary in the coal mine, or maybe, just maybe, we are a cautionary tale for some other states on what needs to happen.

We did learn a couple of things, and you have heard these before. Addresses are not up to date. We do not know where our people are. We lost that normal point of communication we have, so we have to do better. We, in our state, are now doing things like if you have a moment with a client, validate that information, try to make sure you get the email or the address, the phone number. Keep it up to date. We tried to communicate that to our folks as well.

The second thing we learned is that people do not

understand their eligibility or what the government is or is not doing, so we need better communication. Our communication in our state has been consistent. Keep your contact information up to date with us. Please complete your review, and in our state we are doing renewals still. Please complete those renewals. It keeps you out of whatever might happen once the public health emergency ends.

The third thing was we sure could have used more time. We are grateful for that August 2021 extension from 6 months to 12 months. That made sense to us. I am nervous about getting things done in 6 months, clearly, but I am still nervous about getting things done in the 12 months that we have been given.

So finally, four concerns. In Utah we have got some pretty conservative politics. I think we rival Texas on some issues, but we do what we can there. So my first concern is, will we really get the 12 months? We have a lot of pressures. First of all, legislative folks heard 6 months for a long time. They understand probably that we have 12 months, but they do want us to get our program back to normal, whatever normal is. So we have proposed a risk-

based approach in our state to really look at which cases we know are ineligible first or we know that we will be moving from one program to another program -- an example would be Medicaid children to the CHIP program -- and try to tackle those cases first.

We will then focus a list of the reviews that are left and try to tackle the programs that make the most sense to us on where we think those risks lie.

The second concern, enhanced funding. You already heard that those are running on separate tracks. That's a problem for us. This is a 12-month effort paid for at the best-case scenario. Maybe we get 60 days of enhanced funding to pay for that period of work. It's a lot of work that's coming our way.

Which brings me to my third concern, which is are skilled eligibility workforce that we've had for years has changed. At this point in time, 15 to 20 percent of our workforce have never -- they're new. They have never processed a Medicaid or CHIP renewal under the normal, what was the normal time frame. So they don't know what this even means. As we go to unwind, we've got a fifth of the workforce that potentially doesn't know what they're doing.

That's going to be a problem for us.

And the fourth thing I'd point out is uncertainty. The number one question I'm asked on every single day except for once every 90 days is when will this PHE end, and I can never answer that question. None of us know that answer. We're certainly watching the news like you all are too, but we still have a lot of uncertainty about what's going to happen.

Sixty days' notice is what we've been promised that we might know in advance. We could use more than that. If we had a certain date, that would help us as well, but some of the details are still missing.

Some of the other uncertainties we have are, for example, when can we start our renewals? If the PHE ended today, can I start doing renewals today for next month, or do I have to wait until next month to start that activity? Some of these little, tiny detailed questions do matter to us on how we're going to implement or not implement what's going to occur.

So, with that, I just wanted to let you know that we do not plan and do not want to have a repeat of that CHIP experience that we went through last year. We hope to

do better this next time.

I too look forward to your questions, and I'm going to hand the microphone over to Jeremy on Oregon.

* MR. VANDEHEY: Great. Thank you all for the invitation today. I'm Jeremy Vandehey. I'm the director of the Health Policy and Analytics Division for the Oregon Health Authority. Oregon's unique nationally or at least among a handful of states where we've consolidated most of the state's health care programs into one agency. We run the state's Medicaid and CHIP programs but also the marketplace, public employee programs, and my team's role is not just informing what's happening in Medicaid but also broadly of what we're doing in the state to try to expand coverage. So we'll take a bit of a broader lens as we're talking about this.

We in Oregon have grown Medicaid from about 1.1 million people before the pandemic to about 1.4 million. About 300,000 more folks have come on.

As the public health emergency ends and we get back into the redetermination process, our forecasting team is expecting about 300,000 people will roll off. For context, our health insurance marketplace only has about

140,000 people. So this is a really significant transition of folks coming off, and I'll go through a few stats here. Our expectation is a lot of these folks will end up back uninsured and will end up back at Medicaid at some point in the future.

What the public health emergency and pause on disenrollments has allowed is folks to self-attest to a lot of criteria to be able to have expanded presumptive eligibility and to adapt continuous enrollment. Several of these things are going to inform policy changes that we're expecting to try to put into place permanently in Oregon. We're going to look to expand postpartum coverage to 12 months, to be able to continue a more streamlined income verification process, and as I'll talk about at the end, several of these, we'll be asking for in an 1115 waiver, requests for more broad use of continuous eligibility.

I want to hit first on what this means for people in Oregon more so than I think on the process pieces. We do a health insurance survey every two years in Oregon. We just have, hot off the press last week, data from 2021, which is our first datapoint at what's happened with the uninsured rate before and after the pandemic.

In 2019, we had an uninsured rate of about 6 percent in the state, but what's really significant is inequities underneath that. We had about 12 percent uninsured rate for Hispanic, Latinx, 8 percent for Black, African American folks in the state.

In 2021, the uninsured rate dropped in Oregon to 4.6 percent, and this was largely due to the continuous enrollment for Medicaid. We saw a small drop in employer coverage, but we saw a much larger expansion of folks into Medicaid, and I think most importantly, we saw a huge drop in the uninsured rate for Black, African American folks in the state from 8 percent to 5 percent, so we saw a huge reduction in inequities.

We're concerned as we go to unwind the public health emergency, what this means in terms of 300,000 folks rolling off and potentially losing coverage. As the previous speaker said, this isn't just about insurance. This is about being insured so you can access the care you need and the importance of continuity of care.

One of the lessons we've learned through the pandemic is largely what this continuous eligibility process has done is stopped the churn population. We've

always known churn is a huge issue. We now have the data and information to realize how big of an issue it is.

Before the pandemic, about 43 percent of the applicants in a given month had enrolled at some point in the last two years and about 24 percent in the last six months. That has almost entirely gone away. Pretty much, the only applicants coming in have never been on Medicaid, and that stayed pretty consistent before and after the pandemic. Only about 14 percent of folks enrolling in a given month have been on in the last two years. So we've basically seen that this two-year mark is really important.

I mean, in our 1115 waiver renewal, we're going to be asking to basically be able to move from an annual to a two-year continuous eligibility process, and we think that will largely stop a lot of the churn that's happening within Medicaid.

We've also seen from our health insurance survey data that these gaps between Medicaid and the marketplace are real. I mean, every time we go through an eligibility redetermination process, we lose a lot of folks who are actually still eligible. From our most recent data of folks who were under 138 percent of federal poverty level,

about a fifth, 20 percent, say that they're uninsured because they lost Medicaid coverage. But they're telling us their income means that they're still actually eligible. So every time we send applications out, every time we try to renew folks, we know we lose a significant amount of folks just through the paperwork hassle.

We also know that -- I know this is a little out of scope for this group, but for folks between 138 percent and 400 percent of the federal poverty level, about a third of them say that they're uninsured because they lost Medicaid coverage. So they are losing Medicaid coverage, but they aren't picking up marketplace coverage. And we know that's in large part due to cost. We also think it's in large part just due to the struggles of trying to move from one system to another.

I've been kind of using the term lately that nobody would change their car insurance every year and the hassle that that would take. It's so much more cumbersome and such a huge disruption of people's life to change health insurance every year, and yet a lot of these folks are doing that once or twice a year, trying to navigate multiple systems, trying to change their primary care

provider and get the access to behavioral health services and other services that they need.

So our takeaway from the data is we know that breaks in coverage are hugely disruptive for continuity of care. We know the churn issue is real, and we know a lot of these folks will no matter -- despite our best efforts become uninsured, and they will come back in Medicaid at some point. And we will have created a disruption for really no reason other than trying to get back to a previous state of continuing to do redeterminations. For us, a big goal going forward is how do we really stabilize coverage for people for a longer period of time.

In terms of how we'll go about the redeterminations process in Oregon, we will leverage the full 12 months available. We really see outreach and enrollment as the most -- outreach and enrollment assistance and communication as our biggest issue, and really see this as being an all-hands-on-deck process.

We will do a lot of automatic redeterminations and reenrollment wherever we can, but that's largely on keeping people in or disenrolling them from Medicaid. Where we run into the bigger challenge is smoothing the

transition over to the marketplace. We're on Healthcare.gov, the federal platform. There's no way to do an easy data exchange or automatically enroll folks. So what that means is we can largely automatically determine whether they're going to be eligible for Medicaid or not, but then we have to do a data handoff to our marketplace team.

Then we'll have to do a manual outreach and enrollment, which they're planning to do, and we're gearing up for a lot of that. They're going to try to crosswalk folks to provider networks in the marketplace that provide continuity to lower cost-sharing plans, but that's going to need to be supplemented with substantial amounts of outreach and trying to get folks to go to Healthcare.gov and sign up and expect that they will have the financial resources to enroll, and I expect for a lot of folks who are bouncing in and out of Medicaid eligibility, a lot of them just won't enroll, and they'll wait for their income to come back down or until they need services and will come back into Medicaid, unfortunately, which from my perspective is a lot of sort of wasted effort.

I think a couple considerations going forward, I

would highlight similar comments folks made before. Predictability is really important. It's great that the public health emergency was extended. If it's going to be extended again, though, we really need to know what that looks like. We're planning right now and getting an extension of two days before is really disruptive. We would prefer to have as much time as possible, and the 12 months is great, but the more time the better. The longer we can stretch this out, the less likely we are to lose people just through a paperwork hassle instead of because they truly are no longer eligible.

Second is we are really looking at ways that we can stabilize coverage. We've been thinking about things like the basic health plan or other things in our 1115 or 1332 waiver that would keep people in their managed care organization above 138 percent for that churn population. If they're bouncing back and forth, forcing them to the marketplace and then back to Medicaid just doesn't make a lot of sense.

And then, finally, as I mentioned, we'll be asking through a renewal of our Medicaid waiver this year to be able to do continuous enrollment for kids from zero

to six and continuous enrollment for everybody else for two years, and we really think that will largely stop the churn and stabilize folks for people who are really teetering on the edges of eligibility.

I'm happy to take questions. Thank you.

CHAIR BELLA: Joanne, are you ready for questions, or do you have anything else to add?

MS. JEE: No. Thank you to the panelists. Commissioners, we turn it over to you.

CHAIR BELLA: Okay. Wonderful. I think I saw Tricia's hand to start.

And thank you to our panelists. You have no idea how invaluable it is to hear from you directly, so thank you very much.

Sorry, Tricia. Go ahead.

COMMISSIONER BROOKS: That's okay. It was truly an exceptional presentation by all three of you. I probably couldn't have done it better myself bringing up many of the issues that you raised.

I'll have more comments on transitions when we get to the Commissioner-only conversation, but I have two quick questions for Jeff. Jeff, great to see you again.

First of all, can you just speak to the 41 percent or the 6,000 or so kids that you lost? Approximately, how many do you estimate were truly ineligible?

And then a second piece, so I can turn off my mic, is a number of states have integrated eligibility systems that are administered by sister agencies and not by the Medicaid agency. So I'm hoping you might share some insight into the additional challenges that that presents to the Medicaid agency.

MR. NELSON: Sure. So let me take the second question first.

It's interesting as we talk about the systems. We are that state that works through a different agency that administers one large eligibility system. We've been competing for time. So, oddly, we have other things going on. Not only is all of this going on, we have combined our health and human services. There's some political stuff behind that too, but we're combining our agencies that control the Medicaid program. So that's happening.

We've got other laws and things that are changing with our food stamp and SNAP programs, and they have some

competing goals. And one of those is to take our entire platform and move it to the cloud. So that's happening this year as well, actually in April. So we have a lot of other things that are happening around the system.

That said, we would like to know how many people we are keeping or holding open that we think need to be looked at. We call that "flagging." We're about to start flagging those cases next month. So had the PHE ended this month, I couldn't even give you a really good count of how many people we're looking at. So that's one of the challenges.

And each time we have those conversations, of course, it's trying to network and make sure you greased the right wheels and the skids to make sure that you get your piece of the pie done and taken care of. So that's been an interesting process over the past 10 years for me to do.

Earlier, as we talked about the 41 percent of the children that left the program, we don't have a really good figure for how many truly were ineligible or not. What we can tell you is they have not come back to the CHIP program. We've not seen -- as a matter of fact, our CHIP

program continues to decrease slightly each and every month during the pandemic. The reason for that is that the number one driver for kids moving into the CHIP program, they come from our Medicaid program, and while that -- that can't occur right now. So we expect those floodgates to open quite a bit as the PHE ends and we're able to move kids from Medicaid to CHIP.

If you're looking for a guesstimate, I'd say at least half of those are probably still eligible in some capacity, whether that be at the exchange, whether that be on Medicaid, or even coming back to the CHIP program itself. And it probably is higher than that.

CHAIR BELLA: Thank you.

Other Commissioners?

Kisha.

COMMISSIONER BROOKS: Hi. Thanks, everyone. This was just a really excellent panel. I think we're all really interested to hear what's going on, on the ground, and I think one of the things that comes up so much is the churn.

In out last or the session before that, we talked about -- when you actually get into the data, folks are

not dropping off of Medicaid for long periods of time when they churn off, that they end up coming back on within six months. Jeff and Jeremy, you both alluded to that.

Some of the pushback that you hear is, well, you know, isn't there rampant, fraud -- or the cost of having folks on the program when they actually shouldn't be? I just want to hear how some of those conversations have gone in your states around, well, isn't it too expensive to keep these folks on the program, even if it is for six months, when they don't need it and how you're starting to think about navigating that.

We certainly, I think, have seen the benefit of folks being able to be on continuously certainly for the health of individual, but if those types of conversations are happening.

MR. VANDEHEY: I'd be happy to jump in, if you like.

I agree. Like I said, we've seen now the data of how many folks are churning off and churning right back on and also seen that -- we aren't seeing a drop in coverage nearly as high in other markets to offset the amount of folks with an Oregon health plan or Medicaid program. So

what that tells us is really this is a population that's going uninsured and then back on Medicaid and uninsured and back on to Medicaid.

Every time that's happening, they're largely doing that when they need services. So what we aren't doing in the intervening time is providing primary care, providing continuity to community behavioral health, those types of things.

And I would argue, although this data, we look everywhere for this data, it's very hard to find, but my hypothesis is we're paying for it one way or another. We're either paying for it at the time that somebody has an acute situation and we have provided the expensive service, and whether we're paying a capitated rate for six months of the year that's covering the time that folks need some acute services or we're spreading out coverage over the entire year -- and on average, that would sort of reduce the monthly cost -- we're paying for it one way or another.

But I think more importantly is the impact on individuals who are -- especially folks whose income is fluctuating slightly up and down, where they're needing to -- and I hear the same with literally folks needing to have

their hours reduced because they can't afford coverage in the commercial market or they can't afford the care that they need through their employer's coverage because they can't afford a $5,000 deductible.

So I think the more we can stop the churn and provide continuous coverage and keep folks who are mostly going to be -- who mostly are going to be on Medicaid over the course of a couple years in Medicaid and folks who are mostly going to be in the marketplace over a couple of years in the marketplace, keep them where they are.

For Oregon, we're a little unique in the sense that most providers provide both Medicaid and commercial coverage. We have about an 89 percent rate of folks and providers in Medicaid -- who provide Medicaid in the state, and our commercial insurance market is largely domestic and largely is the same overlap with our Medicaid managed care entity.

So what we're really talking about is the same set of providers and the same set of insurers. We're just moving people around from eligibility buckets, and each time we do that, they're receiving breaks in care.

MR. NELSON: And to that, I would add that

there's a cost each and every time that that occurs. Every time we have to take a phone call or that we reprocess a case, there is a cost. There's an administrative cost to that action. So I fully agree with everything that Jeremy just said.

MS. McCHESNEY: And the one thing I'd add here, just because everyone has touched on it, but I did touch on it in my presentation, so this pushback you mention about sort of program integrity and fraud, this is certainly what Texas Advocates have seen as we've been trying to improve the administrative renewal process here in Texas. Again, with less than 10 percent of the population being processed administratively, even though it's federally required, this has been of great concern to us, that we've been highlighting some of the major issues with how that system works. But the pushback we always get is, well, we have to consider program integrity.

So there certainly seems to be from -- you know, coming from a conservative state with conservative leadership, this large concern with maybe one child who might stay on the program longer than they were eligible with much less concern for the other hundred children who

churned off the program during the renewal process because the renewal process wasn't client friendly or efficient and they were unwilling to use third-party data sources in a way that could reduce that administrative burden on the clients. So this is -- you know, that's certainly that pushback that you were talking about. It's certainly what we're seeing as we try to improve that particular aspect of the renewals.

MR. VANDEHEY: Can I just add one more point? I think it is also important to remember that the federal government is paying for most of the care, whether somebody is in marketplace coverage or Medicaid coverage. And I would argue even more if they are in Marketplace coverage the states are picking up a share of the cost in Medicaid, and reimbursement rates are much higher in Marketplace coverage. So the cost of care is more expensive.

So to me, I'm sort of like we're just shuffling dollars around behind the scenes, but the state and federal government is paying for a large share of this, regardless of where folks are at.

COMMISSIONER DAVIS: Thanks so much. That's helpful.

CHAIR BELLA: Brian?

COMMISSIONER BURWELL: If you were sitting in our seats and could make recommendations to the federal government about how to manage this transition as smoothly and as efficiently as possible, and you knew that the PHE was going to end, I mean, you were notifying the states that in 60 days it would end, what guidance would you provide us to recommend about how to make this transition back to, quote, "normal" to work as efficiently as possible?

MR. NELSON: So I will jump in first, I guess. So I alluded to this a little bit in my remarks, but we appreciate the guidance we have gotten to this point in time. CMS has been very good about giving us information on a high-level, 30,000-foot view of what this should look like.

For us, we would like runway. The 60 days is fantastic. I might be able to get my people counted in 60 days; that's great. I would prefer 6 months. If you could tell me that that date's out there and it's something I can legitimately plan for, I can move other activities and schedule around that to take on this activity, and do the

pre-activities, what I call pre-activities, things we can do now to try and maybe soften as we get toward that larger view, I think we could do a much better job.

So for me, I need some of those details answered. In our state we have spend-down populations. We have the medically needy population, which means that some people pay each month to have Medicaid. So if the public health emergency ended today, would I start charging that fee today for next month, or could I start doing that for next month, or do I wait until next month? The answer is, we don't know.

There are a lot of pieces. We just don't have those pieces in place to really firm up what we would like to do and to make sure we have a smooth transition. So it adds some unnecessary stumbling points that maybe we could just fix if we could have that conversation.

MR. VANDEHEY: Yeah, I would add two things. I would echo what Jeff just said around runway and timelines. And I think sometimes folks forget, at the federal level, that we are on a different political and budget cycle. So in Oregon we have a short, 30-day legislative session coming up in February. If the public health emergency ends

we don't have another legislative session until next year. So I have one bite at the apple to get any budget issues resolved, any policy changes resolved, and I don't think we are going to be able to because things are too fluid. It's going to be very difficult to really land the plane on some really big conversations.

And so the ability to align this with times that the legislature is meeting and the times that budgets are happening -- we will get the work done in the 12 months. What I worry about is that doing so we are not going to have the adequate time for outreach and enrollment. And we are going to have a lot of folks that are going to come off and they are going to be right back, and we are going to be going sort of "Why? Why did we do that?"

I think the second piece that I alluded to is, you know, there is some flexibility within the Affordable Care Act that I don't think has fully been leveraged. The basic health plan was an idea, to try to create a different program for the churn population, and use marketplace dollars to be able to continue to provide coverage somewhere else.

I would love the opportunity to be able to take

those dollars and build smooth coverage for folks coming out of Medicaid, who are teetering on the cusp of disenrollment. It is not a cost to Medicaid. It is dollars that we are going to be paying for, for the marketplace anyway. Why not give folks the option of staying right where they are and not having to sort of force them off and to come back? That is not how the regs are written right now. There are some challenges with the ACA. But I think if we could be creative and figure out ways to give states some paths to, in a budget-neutral way, be able to keep folks where they are and enrolled, whether that's through a basic health plan or use of 1332 waivers, I think giving states some paths to be creative here, there is a time and space to do that and then not lose all these folks.

MS. McCHESNEY: The final thing I would add, and I can keep it at a high level, is there are some really great federal requirements and provisions that were created by the Affordable Care Act that the enforcement isn't really there. For a conservative state like Texas, this is a big issue for us. So for example, a lot of these efficiencies that we are talking about in keeping people on

can be approved by the use of third-party data sources, but the way that that was implemented, states can sort of pick and choose what they use, and in Texas we have seen arbitrary limits on the use of those data sources.

So more enforcement. We really appreciate all of the guidance that CMS has put out to states. We think there are a lot of great ideas in there. But it has all been done under the guise of look at all the great things you could do if you choose to do it, and we'd like to see something just a little bit stronger than that, especially given sort of the political nature of certain states.

COMMISSIONER BURWELL: Thank you for those responses. I appreciate it.

CHAIR BELLA: Laura.

COMMISSIONER HERRERA SCOTT: Thank you for this panel. It was outstanding. And Jeff, you highlighted something that I haven't thought about in all of this, is determining your own workforce and time that you have to manage all the cases.

So the question is really to Melissa and to Jeremy. Are you seeing the same workforce changes as well, and same kind of comment that Jeff made? One, will you

have that amount of time and will it be enough, same kind of concerns?

MS. McCHESNEY: I can speak quickly to Texas. Turnover rates were an issue even prior to the pandemic. In fact, Texas' timeliness standard for Medicaid dipped in the two months prior to the pandemic. In January and February of 2020, we saw some of the lowest timeliness rates in Texas in Medicaid for a long time, and they were even worse for SNAP, if you can imagine. So it certainly turned over a big issue. And in all of the workforce shortages that we have seen in other industries during the pandemic, that certainly hits eligibility workers are they are often a lower-paid job and it is a very complicated job.

So certainly those have been an additional constraint, just the pandemic-related workforce shortages. And then finally I will add that Governor Abbott asked for 5 percent across-the-board cuts at the end of 2020. One of the ways that our agency administered those was cuts to the eligibility workforce. And then even with the additional FMAP that was coming to the state, those cuts were still baked into the budget in the legislative session in early

2021, so they have been on a hiring freeze. So not only is there a lot of turnover, there was a hiring freeze. So this has created just an extreme strain on that workforce in Texas, absolutely.

MR. VANDEHEY: I don't know if turnover specifically has been an issue. Like Jeff, we are a state where we have readministered the Medicaid program with Oregon Health Authority. Our sister agency, Department of Human Services, runs the eligibility team. And certainly workforce is an issue broadly across the state enterprise, and we are struggling for workers. We are struggling to make hires. We are competing with the private market, like everybody is, and there is a shortage of workers.

And can't speak on behalf of whether they have seen a lot of exiting, but I know that hiring has been a massive issue. On top of that, it is the same eligibility teams that are doing other human services programs. So they are seeing caseloads or applications increase for TANF and SNAP and a variety of other programs that are just overall struggling to keep up with that.

So certainly hiring, broadly, is an issue. I don't know if they have seen turnover within their teams,

but certainly getting staff on and keeping staff on and getting through the recruitment process is a really significant challenge. And certainly trying to compete with other needs for human services is a significant challenge.

CHAIR BELLA: Toby, and then Heidi.

COMMISSIONER DOUGLAS: A lot of you have talked about communication and just updating addresses and contact information. Can you talk of the concerns or the experience in Utah as well as going forward around how you use plans, providers to both communicate, to update information in a way that the beneficiaries don't have go to directly to their eligibility worker and go to where they are receiving their services and have it updated and communicated?

MR. NELSON: So I can speak for our state. We have actually increased the ability, or broadened the ability for people to actually update those addresses. It was tied to just eligibility workers.

We have a unique thing, I think, in our state called health program representatives, that help you select the health plan you want to get, and they're state

employees. So we've added that ability for those folks as well. They take a lot of phone calls. They are able to at least have that touchpoint and directly add into the system.

As far as the health plans, we have actually been in quite a few conversations with them, and it's been interesting. They have a need and I have a need, so this is a good thing. They, of course, would like to make sure that they're selling the products as people move to the exchange, and that's fantastic. It's a free enterprise, right? But I need them to find the people that are not finishing their reviews, which may go, again, back to Medicaid and beyond their plan, or may go to the exchange, in which case they can sell them something. That is fantastic.

So we've tried to find a way to share both a closure list, which are those people that are going to close in the next 10 days, and we're starting that process actually as soon as now, this month, to try and make sure that can get into the regular system, I guess, or regular processing for them. And we work with them to give them a list of who is coming up for renewal, which predates all of

this. We've always given them a list of who is coming up for renewal this month so they can reach out.

The difficulty we have is that phone call has got to be funny. "Hi. I'm with the health plan. You haven't finished your review. Let me get you on the phone here with somebody else that is going to take your calls. It's about 45 minutes to get into them." So it's an odd conversation to have.

But as far as the addresses, yeah, they help us with that portion of is. They are certainly another contact to try and push that along. But you have to make sure your system itself can function and can handle that extra capacity from the health plans.

So it's an interesting thing, and I'm just laughing a little bit. I was asked recently, "Well, couldn't you just hire like 100 people that can help you out?" It's not that easy. The access alone, the timing it takes to train somebody to do this work is not simple. The health plans, of course, themselves, would love to do the eligibility, and that probably looks something like, "Hey, you're eligible, because you're here." It can't be that easy.

So we have to figure out how do you make the system itself work better and then how do you have those ancillary groups that can help you, help you. But this is one that, we are engaging in those conversations and trying to make it better now.

MR. VANDEHEY: The only thing I would add, we certainly get a lot of requests from our managed care entities to be able to go in and update addresses. I think we are going to be looking for ways to provide more flexibility than we ever have in the past, to be able to do it, and like I said earlier, really see this as needing to be sort of an all-hands-on-deck across providers, health plans, community partners.

One piece I would say, even when you get the address right we still lose a lot of folks. We've done polling in the past of Medicaid members and ways to try to engage with them on helping inform policy and things like future procurements or changes to the program, and what we consistently get back is the visceral negative response when they get a letter from us. When they get a letter from us their reaction is, "Something bad is about to happen to me." And so that is the life of folks within

Medicaid, is navigating a difficult bureaucratic process, and we keep trying to make that easier. But even when we get the address right we're just going to lose folks every time we send them a letter.

MS. McCHESNEY: I'd like to build on that a little bit. We've talked a lot about how the timeline, a more definitive timeline, is really helpful for the states so they can build to that timeline. But it's also really helpful in outreach to beneficiaries. We know from so much research on the ACA marketplace and other research areas that timelines and deadlines are what motivate people. And right now there's no timeline or deadline you can necessarily give a client. And so that's making outreach more difficult.

And then in Texas, again it sounds like a similar theme. There's been much more openness to the idea of taking information from health plans on updating addresses, but these are sometimes older systems and they just take a lot longer to program. So they're looking at much more sort of Excel spreadsheet manual workarounds to get some of that functionality in there, because there's just not time to rebuild the system to do automated updates from the

health plan of those addresses. So that's also a constraint that's built into this.

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: This has been a really helpful conversation. I want to thank everyone on the panel.

I kind of have two questions. One is related to the states that are doing eligibility for multiple programs at one time. I'm curious how that will work if it's not time for your redetermination for another benefit. Is it possible that you could qualify for one benefit and lose another benefit earlier than you would have if you could have waited until it was time for your determination?

And also because the timelines aren't going to match, that probably means extra work for a different reason than just the fact that we're doing the redeterminations. It will un-sync these programs.

So that's my first question. And my second question is what to do about the timelines that we give people to return things to us by a certain date. And I'm going to take us way back to 2003, when Oregon implemented cost-sharing in the Oregon Health Plan standard program.

And they said, okay, you know, your first copayment needs to be paid by February 1st. A bunch of people lost their enrollment, not because they hadn't mailed it by February 1st -- they had -- but because the state didn't open the mail and process the payment for weeks later because they couldn't handle that volume of mail.

So are you putting explicit policies in place that say if it has been mailed by the deadline, or on the date of the deadline, it will be processed and accepted, regardless of when we actually open it?

MR. VANDEHEY: I'll start. I think that's a great point on the influx, and it may be entirely possible our team's thought through that piece, but I think it's a really important point around backlogs of the incoming. We have seen this in other scenarios as well. When we launched the marketplace back in 2014 we had an influx of applications that were hard to keep up with. And so I think it's a good point around the received versus opened.

My concern is regardless of that, what are we doing for folks who actually need care during that time, whether that's covered or not?

But I think the point also I would add is, and

where I think I was trying to go with the address issue, is it's not just about addresses and the letters. It's around the outreach from trusted folks who can help people navigate the process. You know, it's not as simple as writing a letter and then responding to us. It's actually doing that outreach and find folks and have somebody who can help them navigate through the process, and I think it's a good point around the possible backlog on us.

MS. McCHESNEY: So I can speak to both, from Texas' perspective, because it is an integrated system, and there's a good history here. So before the Affordable Care Act, children's Medicaid certification periods were 6 months, and SNAP certification periods were 6 months, and the state actually did a lot to automate the renewals so that they would be happening at the same time.

With the Affordable Care Act pushing that out to 12 months, which was a good provision for beneficiaries of Medicaid, it did delink some of that. And so we did see this issue of families coming in at the 6-month mark to renew their SNAP and then potentially losing the children's Medicaid coverage because of what was reported under SNAP.

You know, this actually highlights the importance

of the guidance that CMS put out last August, making it where they have to do a new redetermination of eligibility for all Medicaid beneficiaries after the pandemic ends, that they can't use old data. Because our concern would be we still have people submitting new information for their SNAP application, and maybe when they submitted that application for SNAP or the renewal for SNAP they would have been above the Medicaid income limit, but that doesn't mean that 6 months from now that that's still where it will be. So doing this fresh determination of their current situation for Medicaid, that is an important piece of that guidance.

And then as far as the time to return, this is a big issue in Texas. They give a mere 10 days for verification. Now for a renewal, technically, you're given 30 days, but if I turn in my renewal packet and then I didn't submit income stubs with it and I need my income stubs, then they request that information, that additional verification, and only give that 10-day clock. We regularly see people who receive the mail after the 10 days has gone, and certainly don't have time to get it back to the state agency in that time period.

There was good guidance put out by CMS at the end of 2020, that recommended a 30-day time period as a reasonable time period, but again, this goes to my point about enforcement. That was a recommendation. It was very clear to our agency that that was not something that they felt like they had to follow, that it was just a recommendation.

So again, we're looking to that enforcement, because we really do think it would be a minimum 30 days. Those 10-day time frames are just too short for the mail to go to and back from the client in time.

MR. NELSON: Your questions are very good. I think that if there's a belief out there that a family is doing one review per year to get all the programs taken care of, that should be just quickly wiped away. I would expect that most families that have multiple programs are doing two to three or four reviews each and every year. And it's funny because Medicaid has its own rules and other programs have their rules, but some Medicaid cases cannot be reviewed more than once every 12 months, and some need to be done each and every 12 months, and those run-on different cycles. The babies aren't born on the Medicaid

review cycle. It just doesn't happen that way.

So you get these funny moments where people are either reviewing all the time, and my partnering agency would love to do a renewal, do a full renewal on everything, every single time something comes up. Then you would be doing 10 reviews a year. It doesn't make sense.

So it is very difficult, I think, for families to understand which benefit is up, which one is not. The analogy is doing your auto insurance is correct. It's just that you're taking a car on and off. You know, you have five cars and they're all coming on and off at different times. It's not one renewal. So it is a very interesting process.

As far asking for verification, we too have a 10-day limit, but what we have found from our experience is if we can make it 12 days, the information will come back on the 12th day. If we make it 15 days, it comes on the 15th day. So for us to keep the wheels moving, to keep the system churning as it needs to move, we do give the 10 days, understanding, though, and we are very careful about making sure that if the information comes in on time, and we have it appropriately, that the case does not close and

that we keep the case -- in some cases we extend for another month if we need to, to make sure that we can give proper notice, at least a 10-day notice, that their case is going to be closing, if that would be in effect.

But it is a difficult situation. It's a funny battle. We've tried many of these things, Melissa. I appreciate what you are saying very much, because we have tried this multiple times. You do 30 days. You do 20 days. What is that right number? And what we find is whatever that number is, most of that comes back on the last or shortly after the last day.

CHAIR BELLA: I know we're at time. I don't know if you have time for one more question. If not, feel free to drop.

I actually have a question for you all. One is to Jeff and Jeremy. Are the states -- are you all talking to each other? Are you all sharing concerns? Are you sharing best practices? Does that forum exist?

Brian asked you the magic wand question, which is what would you do if you were asked? I would ask you a sort of similar question. Is there anything we didn't ask

you that you want us to be thinking about with regard to this topic?

So I would throw those out there, and if you have to hang up on us, we'll say thank you in advance. If you have time to answer, that's wonderful.

MR. NELSON: I'd be remiss if I did not again capitalize on this moment to say, look, the funding is a problem for us. I've got people, the prognosticators of the world. They're trying to figure out each and every month where are we going to be. Are we going to make the budget? Are we not going to make the budget?

The fact that this doesn't line up and that we're not really going to be paid for the time -- it's going to take us 12 months to figure out who shouldn't be there and where should they really be. It's going to take the full 12 months, but the payment goes away almost within 60 days. So that's hard for us to understand, and it does put additional pressure on a state like mine to say, "So can you do it in six months? How about three?"

And we've had those bills proposed as recently as last year. I have not seen anything this year. We're currently in our session, and fingers crossed, we won't.

So I'm hopeful that we'll get that full 12 months.

But the point is not lost on us that we aren't getting paid for that period of time, so that's hard.

And I've lost your first question, just in talking about that. Sorry.

CHAIR BELLA: No, I was just asking about the states. Are you all talking to each other? Is anybody feeling good about the timing?

MR. NELSON: I can mention that we're part of an ETAG group, which is a technical advisory group that exists you've probably heard of. We hear from other states routinely in those types of larger forums, and I feel like Utah fits in well. We're hearing the same complaints or the same issues from other states. It seems to be that we're in the mix with somebody else at least, and that's helpful to at least have someone commiserate with you. But it doesn't mean that the problems are being solved necessarily.

We do communicate. I think one place we lack is we -- all of us, I'm sure all of us have a plan in place. I've got one, pen to paper. It has happened. I've got one. But we're not broadly releasing those plans to each

other, and maybe that would be something that we could do.

I know CMS can ask for them at any time, and they have not done so at this point in time. But maybe sharing some of our plans and ideas in advance would be beneficial. Just a thought.

MR. VANDEHEY: Yeah. I think there are some new conversations happening through NAMD and other places. I think folks are trying to stay connected. I do think there's a level of state-specific issues, whether it's politics or legislative cycle or budget cycle that creates its own set of circumstances for each state. I do think folks are talking. I think we're all extremely appreciative for the additional time and the extension of the public health emergency and then immediately trying to figure out is that the real point or is there another one after that, and that's a question none of us can answer.

So I think the flexibility both in terms of timing and process is really important. I do think I'll hit it again. I really do think thinking about some other tools under a waiver or under the ACA or basic health plan and thinking about those policy goals that were part of that of how do states take dollars that are available and

use them in a flexible way, those are reasons those mechanisms were built into the ACA. Now it feels like the time that we should be leveraging them and figuring out how to allow states some flexibility over the course of the next year to be creative and how they're using available federal dollars to maintain coverage.

I guess the last piece I would add -- and maybe it wasn't highlighted -- we talked a lot about the importance of outreach and enrollment, but I don't know that there's ever been a sort of state-federal campaign needed of this size, potentially and thinking about how do we actually inject the resources into the community to go out and do this outreach. I think the normal 50-50 admin match is not a great tool for states to say, okay, let's just find a bunch of money and go get a 50-50 match. I think thinking about this as a partnership would be huge.

Then I didn't hit Heidi's first question. So I just quickly do want to say we are trying to align SNAP and Medicaid both in terms of timeline as well as trying to move to a single income verification that would apply for both.

CHAIR BELLA: Thank you very much.

Melissa?

MS. McCHESNEY: So, obviously, I don't work for the state. So I can't speak to your first question.

But I think the one thing -- and I mentioned it in my discussion, but it didn't necessarily come up in this discussion was this idea of the call center wait times. This is just something that comes up every time we've seen systems not work well. Part of that is these really long call center wait times. We've talked about workforce constraints and shortages. Those apply to these call centers as well, and during a pandemic, this is where a lot of this clientele -- that's where they go to get their questions answered to figure out what's going on with their applications. Right now, they're just not working.

I work in several different states, and I'm hearing this from every state that I work, in Arizona, Texas, Florida. Of course, states with high Latino populations is where Unidos targets.

So this is something that we really need to think through. We have online applications. They don't always work for this population, and so many of them end up back in that call center. I don't have solutions there, but I

just wanted to highlight it as a real concern because it's just such an essential piece of the eligibility and enrollment system, and right now, they're just really overloaded.

You guys probably even in your own experience at home have tried -- you have ended up waiting on longer hold times than usual. That's especially true for eligibility and enrollment systems.

CHAIR BELLA: We could ask you to stay forever talking with us, but we will respect your time. This is an area that is very important to us. If things come up that you would like to share, please feel free, and if we can be of support in what you're doing, please also reach out. And I'm sure we may have a few follow-up questions for you as well, so really appreciate you spending time with us today. Thank you very much.

MS. McCHESNEY: Thank you for the invitation.

MR. VANDEHEY: Thank you.

FURTHER DISCUSSION AMONG COMMISSIONERS

* CHAIR BELLA: Okay. We have a little bit of time for us to talk. I just have to say I just -- everyone knows this, but I really love it when we have panels. It

just really makes it real. So, Joanne, thank you for putting that one together.

Let's open it up to Commissioners. I see Tricia first and then Darin.

COMMISSIONER BROOKS: So this is all I've been living and breathing for the past year. So I could probably take the whole time, but I'm going to focus on two pieces.

Melissa brought up issues with the call center before. I will tell you that when Missouri had restarted renewals after a very long period of time of not being -- they had wait times of two and a half hours on their call center lines. So this is going to be a huge, significant problem.

There have been published performance indicators that states are supposed to submit to CMS, and since 2014, there's a very long list of them. We've seen very few of those have seen the light of day. We've seen application volume enrollment, but none of the other data. And the data we need to monitor this is data that states should have been reporting for the past seven years, including call center statistics, which would be call volume, call

wait times, and abandonment rates.

Then the second piece of information is understanding the share of people who are losing coverage due to procedural reasons, non-eligibility reasons. They didn't get the mail; they didn't return the documentation that was required. Those two pieces of information can help us set an early alarm system here when things are going badly for beneficiaries, and yet I don't have a lot of confidence that even though CMS is going to -- it says that they're collecting these data. They've got other data that they're going to collect from the state. They'll be monitoring it, but I do not think there is any plan for transparency on the data. And this is going to happen so quickly in some states that by the time we realize the impact on enrollment, it will be too late to stop the train.

The data is one piece that is needed, and I wish we could get it out of CMS. Even in Build Back Better, there were specific requirements on reporting data but no public reporting requirement.

The second piece I want to lift up are the transitions, and here's what's really concerning to me. I

spend a lot of time in meetings with CMS or others, and there's a huge focus right now on smoothing transitions from Medicaid to the marketplace. In fact, what we have learned is that the account transfers in that direction do not work well. They don't have all of the information that's needed, even if CMS were to launch some kind of a chase campaign to really reach out and try to help people.

So it's going to be a problem, no matter what, but I'm very concerned that we are talking about kids in this equation because kids should not be moving from Medicaid to the marketplace. They should be moving from Medicaid to CHIP, and there's not a lot of focus on that. Premiums are going to be a barrier. Thirty states still charge some kind of premium or enrollment fee, and so I think we have to make sure that we are thinking about these populations very differently and tracking the data very differently because, honestly, there are very few reasons why kids should be falling off when the unwinding starts.

So I will stop there. I'm always happy to say more about this particular topic, though.

CHAIR BELLA: Thank you, Tricia.

Darin?

COMMISSIONER GORDON: You know, I think the thing that we heard -- we heard a lot of different things from the panelists, but one of the things that we heard that we've discussed previously and I think is still probably the most critical aspect of it all is the timing of notification when the PHE is going to end but also the timing of when that additional match expires as well.

As we heard from the panelists, there becomes pressures when that funding goes away that they have to contend with, and it's all going to be hitting at a time also when they do need to ramp up staffing. That was the second thing that we heard. So this is something we haven't really discussed on this topic previously, but having the lead time to get staffed up to deal with moving through this process is going to be critically important because it's not quick to be able to bring someone on and train them adequately. So, as time is short, training isn't probably as robust and thorough as you would like it to be, and therefore, mistakes can be made.

I would raise this other issue that is something we had seen back when I was at the state, but there was this requirement that a determination has to be made by a

state employee, and it made it really complicated for us to bring on or leverage contracting, which is something states do. It's maybe, quite frankly, even faster in some cases than going through hiring for this kind of seasonal or episodic increase in activity. But there's only so much a contractor can do as part of the eligibility process too. So that takes one of the solution pathways, I think, from states and makes that even more complicated as well.

I appreciate everyone's comments, but everything I heard, it does come down to as much advanced notice as possible, sufficient time to get through the backlog, and funding that coincides with that time period to be working through that backlog as well.

COMMISSIONER HEAPHY: This is Dennis.

I've been thinking race, ethnicity, and language and wondering what kind of barriers there were -- or to different populations, and is data actually being tracked? So that was foremost in my mind as we're talking, but the other was just workforce capacity in general.

CHAIR BELLA: I can't figure out how to get off mute.

Okay. In the process of doing that, I've missed

that there are other hands.

Brian.

COMMISSIONER BURWELL: Two things. I'm quite sort of confused about what is the current fiscal situation of states in regard to their budgets. I've been working with a state now that has an $8 billion budget surplus for FY 2022, and I think there are a number of others. Certainly, we've heard about California, et cetera.

But other states still have deficits. I don't have a good sense of where states are. So they're asking for more federal money, extension of FMAP increase, et cetera. I don't have a good context for evaluating that, those requests. So that's one thing.

Second thing is the whole thing with addresses. You see differences in the private sector. Is it a technology problem? Is it a money problem? I keep trying to escape from AARP. I've moved twice in the last year, and I swear the mail gets there before I move.

There's technology out there that can do this stuff much more efficiently. I mean, Social Security obviously knows when you move almost immediately. I understand it's a low population, and there's a lot of

transitions, et cetera, but I just wonder how much of it could be solved by using advanced technologies.

CHAIR BELLA: So I'm not sure they do know when you move immediately, Brian. When I was at CMS and we tried to use SSA data, it wasn't -- because people had gone to direct deposit for most of their checks, we didn't have good addresses that we could leverage anymore. So I hear you on --

COMMISSIONER BURWELL: Even when SSA was available as a potential data match?

COMMISSIONER GORDON: Yeah.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: Can I add? I mean, just on that point alone, we saw where SSA was overriding our corrected address with bad addresses and had -- actually, one individual who was patient and kind with us, who pointed out this happened not once but twice. They had their child who had never been out of the state with a Florida address, and so it's not nearly as perfect as I think you're giving it credit. There's challenges there in what overrides what when you're pulling in from multiple data sources.

CHAIR BELLA: Hold on. I don't want to go down a rabbit hole with that.

COMMISSIONER BURWELL: Okay.

CHAIR BELLA: Darin, you wanted to respond to state budget.

COMMISSIONER GORDON: Yeah.

CHAIR BELLA: Tricia wanted to respond to something, and I think I may have cut Dennis off. So I want to make sure we get to all of that. So Darin on budget, please.

COMMISSIONER GORDON: On the budget point, I do think it's, to be clear, states have been told don't remove anyone from the rolls, and so you have rolls that are swelled quite considerably in everything. The way that the federal government helped mitigate that was saying here's additional funding to support that.

The issue of states saying that we're funding -- assessing more funding is needed is give me time to get back to normal from the thing you made me do and fund me to allow me time to do that, and I think their request, I think, is a reasonable request because, in the absence of that, I think it's going to put states in a position to

accelerate a process to get back to normal quickly because they do not have that support to allow it to transition back to normal.

So I just want to raise that point. I don't think they're asking for more money. I think it's having the money aligned with the requirement.

CHAIR BELLA: Tricia, did you have a comment on Brian? And then I'm going to go to Dennis, and then I'm going to go to Martha.

COMMISSIONER BROOKS: Yeah. Well, just the national -- the Post Office National Change of Address database is a good source for updating addresses.

Back to this budget issue, I think states were ahead of the game in the early months of the pandemic, and now they're not so much anymore, the 6.2 percent. But, arguably, because they were getting that surplus in the beginning, that should be covering some additional time.

But what we are generally hearing about state budgets is that there are more states that do not have deficits than there are that have deficits, although we're just starting to see budgets being filed by state governors. But I think Brian's point is well taken about

budgets as well.

CHAIR BELLA: Dennis, did I cut you off earlier? So I apologize, and the floor is yours.

COMMISSIONER HEAPHY: That's okay. I think there's something wrong with my mic as well.

I've been sitting here first thinking about ethnic and minority populations and disparities and language access and how that's impacting, to help people being impacted that have language accesses.

But I'm also wondering -- I don't see this as just a state problem -- are other states working with hospitals and other large entities in the state to figure out how they can work together on these issues? Because it seems that if the state is going to take it all by itself, it's going to take forever, and people are going to be harmed.

Back to the point when you were asking folks are you talking to each other, is there a way to bring the states together in a formal manner, even if it's quick now, and see if there are any themes that arise that can be addressed across states in terms of best practices? I'm just thinking everyone is silent and so focused on

themselves. They're not looking to see what resources might be available across states but also within their state to run the health care system itself, having the health care system help, because they're the ones that are going to be most adversely affected as providers when folks come in and don't have any insurance.

CHAIR BELLA: Yeah. I mean, it wasn't surprising to hear them say that NAMD is kind of facilitating those conversations. I don't know how often we're talking with them, but it would be helpful just to hear and sporadically be checking with NAMD too on state readiness and sharing their best practices and if there's any information we can glean from them.

EXECUTIVE DIRECTOR SCHWARTZ: CMS is doing that as well.

CHAIR BELLA: Great.

Martha and then Heidi.

COMMISSIONER CARTER: Just an observation. I was really struck by the -- I think it was Jeremy's observation about the business case for reducing churn and just the cost in the system when a person is disenrolled and then reenrolled, and I wonder if we can highlight that a little

more.

I suppose it's not available to us, but if a comparison of the cost of leaving somebody where they are until an additional coverage is found rather than disenrolling them, that's probably a bigger analysis than we can do. But I was, like I said, really struck by the business case of this whole endeavor of churn.

CHAIR BELLA: Thank you, Martha.

Heidi?

COMMISSIONER ALLEN: So I have two thoughts. One, just reflecting on how confusing this is going to be to consumers, because they don't follow Medicaid policy so closely that they understand why suddenly all this stuff is happening and why there's a two-and-a-half-hour wait when they call on the phone. I think even just communicating that it might be hard to reach us, please be patient, it's important that we talk to you, that that might be helpful because I think if I were an enrollee and I had no idea that there had been some change to the public health emergency and now they're going to disenroll me and if I tried to call and I was on hold for an hour, I'd be very confused about what's happening.

And the second thing is for the very few states that have state-based marketplace exchanges, are there any efforts to auto-enroll folks that are marketplace-eligible into the marketplace plans rather than making them reapply?

COMMISSIONER BROOKS: I know that California is looking at that, but I'm not sure that other states -- there's a paper coming out with researchers at Urban and our sister center at Georgetown, the Center for Health Insurance Reform, and that talks a little bit about that. But that may be the only one. But they're planning to auto-enroll them in the lowest-cost silver plan or maybe it was the silver plan with a zero premium and then give them the opportunity to opt out, but it sounds like a very novel approach.

COMMISSIONER ALLEN: And there's other states that might be able to do that. So that would be where the idea of states connecting with each other, that understanding what California is doing could help a state like Colorado.

CHAIR BELLA: Other comments?

COMMISSIONER BROOKS: And just to Heidi's comment there, these states do get together very frequently, the

state-based marketplaces, and a lot of them are supported by work going on at Princeton under the State Health and Value Strategies project. So I do think they are sharing that information.

CHAIR BELLA: Yeah. I'm quiet because I'm thinking about just the -- I'm thinking about how hard it is to be in their seats and not have more notice, and 60 days' notice is better than nothing, but it's still hard when they're going to turn all this on and thinking about how difficult it must be to be the states and trying to answer those budget questions from people who want some certainty. I don't think a letter from MACPAC or anything in that regard is going to do anything this time around.

So, Anne, I put this in the bucket of the Commissioners are interested in keeping an eye on this, continuing to talk about this, hearing from people on the ground, and would suggest that you and Joanne sort of -- you obviously are cataloging the things that are of interest to us, and we continue to bring this back when it makes sense for us to talk about it or hear from others again. For now, I appreciate sort of keeping it top of mind for us but don't see any direct action coming out of

this particular session. But, obviously, it's a big point of engagement for all of us.

I am going to turn now to see if we have any public comment. So, if anybody in the audience would like to comment, please use your hand icon, and we'll open that up now.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: I feel like we're at the in-person meeting again. Nobody wants to comment.

All right. We'll give it just a few more seconds.

For the new Commissioners, it used to be sort of hold your breath and see if anybody in the audience walked up to the mic and wanted to actually say something. When we've been online, we've actually had a few more, few more participants.

Okay. I don't see anyone.

Do any Commissioners have any last comments?

Joanne, any parting words?

MS. JEE: No. Just appreciate your engagement and conversation.

CHAIR BELLA: Yeah.

COMMISSIONER BURWELL: That was a nice panel.

CHAIR BELLA: What did you say, Brian?

COMMISSIONER BURWELL: I was just saying that was an excellent panel.

CHAIR BELLA: Yeah, it really was. It really was.

Okey doke. It's 2:30 already. We are going to take a 15-minute break. Please be back at 2:45. We'll finish the day with two sessions on duals and integrated care. Thank you, everybody. See you shortly.

* [Recess.]

CHAIR BELLA: Okay. Let's go ahead and get started so we can keep moving. Welcome Kirstin and Ashley. Heidi's been waiting for the access monitoring thing all week. I've been waiting for these sessions all month or all year or something. So welcome. I'm excited to have this discussion, and I will turn it over to you to get started with our duals-related session.

REQUIRING STATES TO DEVELOP A FORMAL STRATEGY FOR INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES

* MS. SEMANSKEE: Thank you, Melanie, and good afternoon, Commissioners. We have a couple of sessions on policy issues related to dually eligible beneficiaries today. We are starting with a discussion on our draft recommendations on raising the bar on integrated care, and later Kirstin will walk through a notice of proposed rulemaking that CMS published last week.

Today I'll start with a quick update on the Duals Data Book. Then we'll recap our discussion from October as context for our potential policy recommendations, and we'll spend most of our time today discussing the draft recommendations, the first of which would require each state to develop a strategy for integrated care and the second would provide additional federal funding to support states in doing so. And finally we'll discuss our next steps as we prepare to include any recommendations in the June report to Congress.

Some of you may remember, we published a Duals Data Book with information on dually eligible beneficiaries as a joint effort with MedPAC. We are updating the Data Book this year with 2019 data from T-MSIS. Our prior version used data from 2013. And we hadn't updated the

Data Book in a while because of challenges with the transition from T-MSIS, which has now been resolved.

The updated Data Book will be posted on our website, and the book includes Medicaid and Medicare data on dually eligible beneficiaries in several areas, including their enrollment and spending, demographics and other health characteristics, their eligibility pathways into Medicaid and Medicare, managed care use, continuity of care, and spending on long-term services and support. Most of the exhibits in the book are limited to the fee-for-service population, and I'll note that some exhibits that showed trends over time have not been updated in this version, just given the data gap from 2013 to 2019.

As you know, integrating coverage for Medicare and Medicaid for dually eligible beneficiaries has been an area of focus for the Commission for the past two years. Around 12 million individuals are eligible for both Medicaid and Medicare, with the majority eligible for full Medicaid benefits. These individuals could greatly benefit from an integrated care model, yet only 1 in 10 were enrolled as of 2019.

In October, staff presented findings from a

roundtable with states about the barriers to integration and how federal support could help states move towards further integration. It was clear from the discussion that states are in different places, and some states with low levels of integration may need some guidance on where to begin.

The Commission also weighed in, in October, on several policy options, and some expressed interest in requiring states to develop an integrated care strategy. Stakeholders that staff has spoken with since the discussion, including states, a plan association, and beneficiary advocate were supportive of this incremental approach. It was because they recognized that states are at different places and gives low-integration states a place to start.

We are also proposing today that federal funding be provided to support states in developing the strategies given the effort and specialized Medicare expertise needed to successfully implement an integrated care model.

The long-term vision is that the strategy would outline a path toward full integration in each state. For our purposes, full integration would include a single set

of benefits provided by a single entity and a single set of marketing materials and enrollment cards. Full integration would also involve care coordination, aligned financing and would ensure consumer protections such as an ombudsman program and a unified appeals and grievance process.

This slide has the draft text of our first recommendation, which would require states to develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within a certain time frame and with a plan to update the strategy periodically. It also highlights some key areas that we see as important to a strategy.

Although a strategy does not need to achieve full integration at the outset, it should have full integration as an eventual goal, where a majority of full-benefit dually eligible beneficiaries are enrolled in a fully integrated plan. A fully integrated plan is one in which all Medicaid and Medicare benefits are covered under the same entity and it may take the form of a fully integrated dual-eligible special needs plan, known as a FIDE SNP, or a managed fee-for-service model.

We envision that states would have around two

years to develop their strategy and would be required to review and update the strategy as needed or until they have reached a high level of integration. We expect that CMS would ultimately determine the timeline for developing and updating the strategy.

This slide lists a few key components of such a strategy. We view these components as an important part of the strategy, but we expect ultimately that CMS would determine actual requirements. And we can highlight these components in a chapter that would accompany our recommendation.

First, we believe the strategy should lay out the state's integration approach and whether this is through managed care or fee-for-service. For example, some states may choose to leverage their contract with dual-eligible special needs plans, D-SNPs, in order to further integration, and other states may prefer to use a managed fee-for-service approach similar to that used by Washington State. We think that CMS could provide examples of potential approaches to integration, which would help states who may be uncertain of how to proceed.

The strategy should also specify who is eligible

to enroll in integrated coverage and how coverage will be tailored to the unique needs of different subpopulations of dually eligible beneficiaries. The strategy could also specify which Medicaid benefits are covered and which might be carved out, and should also consider whether D-SNPs will be required to provide certain Medicare Advantage supplemental benefits.

The strategy should also describe the state's approach to enrollments, which may include whether to use any automated enrollment processes. States can also discuss whether they plan to use exclusively aligned enrollment, which is when a D-SNP enrollment is limited to full-benefits dually eligible beneficiaries who receive their Medicaid benefits from the D-SNP, or through an aligned Medicaid managed care plan owned by the same parent company, and this ensures that the same entity is responsible for all Medicare and Medicaid benefits for all of its members.

It should also describe a plan for outreach to beneficiaries, providers, and other stakeholders in order to improve awareness of the benefits of integrated care and promote provider participation.

The strategy should also ensure key beneficiary protections, including an ombudsman program, a unified appeals and grievance process, care coordination, and a beneficiary advisory mechanism, which would provide input into the design and ongoing operation of the program.

The data strategy should also describe how the states will use Medicare data and identify any data-sharing agreements that the state will need to have in place in order to use certain contracting strategies with D-SNPs, such as default enrollment. The data strategy should also consider ways to improve collection of demographic data in order to inform quality.

Finally, the strategy should include a plan for how states will measure quality in integrated care. For example, this could be based on the models of care that are required for every special needs plan.

This slide has the draft text for our second recommendation on additional federal funding. The funding would support states in developing the strategy we discussed, to integrate care for full-benefit dually eligible beneficiaries.

This recommendation would reinforce our June 2020

recommendation and specifically link the funding to the development of an integrated care strategy. This recognizes the need to build capacity at the state level, particularly Medicare expertise, in order to successfully implement an integrated model.

In our 2020 recommendation, we did not specify the form of the funding, but we discussed that funding could be provided either through a grant program modeled after the start-up grants that were available to states in the Financial Alignment Initiative or funding could also take the form of an enhanced federal medical assistance percentage.

We look forward today to Commissioner feedback on these draft recommendations, including whether we have captured all components of an integrated care strategy that we would like to highlight. If Commissioners decide to move forward we can begin drafting a chapter. The staff would present a draft chapter in the spring with a vote on any potential recommendations at that time.

And here again is the draft text of our recommendations for Commissioner comments, and I will now turn it back to the Commission for further discussion.

CHAIR BELLA: Thank you, Ashley and Kirstin. Just a couple of sort of context and level-setting and then we'll turn it over to our discussion.

So for the new Commissioners, as was mentioned we did make a recommendation in June of 2020, for support for states. We are bringing that back now to support kind of this requirement that we would be recommending that Congress put on the states. But also because over the past two years we have just continued to hear that the states need help. They need to be able to build capacity. And so we don't feel that it is -- unfortunately, the need still remains, and so it's nice to be able to pair it with this other recommendation, though.

So let me first ask, does anyone have concerns broadly with going down this path of recommending a strategy and then honing our recommendation to support states in doing so? Before we get into this I would just like to understand if there are any broad concerns with that, and then we can discuss some of the more details around what the strategy might contain.

Just because I love duals doesn't mean you guys can't speak up if you have any concerns here with this path

we're on. I'm taking the silence to mean we're comfortable moving down the recommendation path to recommend these two things. Is that a fair assumption? I am seeing heads nodding. If it's not, please raise your hand. Darin?

COMMISSIONER GORDON: No, I think it makes sense. I mean, we're asking for a strategy to lay out your thoughts in these various areas for integration but also provide the funding. So I think it makes sense. If we were just saying let's do the strategy without giving some support, I would have some concerns, but I think it's a good direction.

CHAIR BELLA: Okay. We talked about this at least once and we gave feedback on the types of things we would like to see in the strategy. We're not going to like micromanage every single word, and we're not going to uncover every single rock probably. But the staff has done quite a bit of thinking since we last discussed this, to bring back with us some more specificity around what might be required in this strategy.

We'll open it up for feedback on those elements, starting with Martha.

COMMISSIONER CARTER: I basically agree with this

recommendation. I am questioning whether there should be something in here about reimbursement levels or payment strategy. In particular, we heard that some providers were not in support of dual plans, and it may be linked to timely reimbursement or reimbursement levels. So I want to throw that out as maybe something to think about, that the plan should actually include something about reimbursement levels and timely reimbursement.

And specifically, of course in my area of concern, is how do we involve the FQHCs, because a combined PPS rate would have to be developed in order to pay them according to regulations.

So I think it's a broader question but then also a specific one to the health centers, and I'd like to hear what the other folks think about that, because I don't remember talking about that, but it just struck me here.

CHAIR BELLA: Does anyone want to respond to Martha? Darin?

COMMISSIONER GORDON: Not a response, but it just sparks questions for me. When we talk about reimbursement, are we talking about -- I mean, obviously we're not opining on like if it's in a managed model like a health plan

model. We're getting into weighing in on how MA plans reimburse for Medicare services, are we? That's not what you're suggesting, is it?

COMMISSIONER CARTER: I think I was really remembering the question of timely payment. I think that came up in one of our previous meetings. And just the whole issue of providers not supporting their patients going into integrated plans.

And so I didn't see anything in here that was going to help move that forward. So reimbursement is obviously a huge concern, but maybe there were other things that we need to be looking at there.

COMMISSIONER GORDON: Yeah. I don't recall that. I mean, that's just me. I don't recall exactly what was said with regards to reimbursement there. But I do think we're obviously limited to what we can opine on the Medicare side of the payment. On the Medicaid side of the payment, obviously, that's a whole different story. But I didn't recall that, because obviously payments vary state to state, and there are time limits and requirements that are out there.

On the FQHC front, could you just give us a

little more information? I mean, you're talking about a blended PPS. I mean, PPS only exists on Medicaid and I don't know of Medicare paying a PPS, or do they? Okay. Can you expound on that a little bit?

COMMISSIONER CARTER: I'm afraid I'm not the expert, but yes, Medicare pays on the PPS. Medicaid pays on the PPS. And so how would the health center get reimbursed in these models? A lot of states don't really include health centers in these plans, and it's complicated. So I think a strategy to include the health centers is important.

CHAIR BELLA: So I would just say a couple of things. One, Darin, I think the broad comment was for providers that believe they get paid better in Medicare fee-for-service they might be telling their members not to -- not that they won't be seeing them if the person chooses to join an integrated product. I think it's that broad issue.

I guess, Martha, what I would say is I think part of this recommendation is to give a little nudge to the states to actually be thinking about what they are going to do in integrated care. For many states, they are not doing

anything today, and so the first step is do I want to work with a D-SNP? Do I want to think about capitating behavioral health and long-term care?

So I think we need to strike that balance of some states certainly, their strategy, could answer how they are thinking about reimbursement of FQHCs, but for some states, you know, we're trying to get them at a base level of even being able to devote time to thinking about this product.

And so I asked Kirstin and Ashley to kind of think about where financing and reimbursements needs to fit, because it is an important bucket, and then let's work on what the right level of detail is, recognizing that states are going to be in different places, and the broad recommendation is meant to speak to all states, even though that's difficult, particular for ones that are a little bit more advanced.

Okay, I see Brian.

COMMISSIONER BURWELL: I don't know if we want to say anything about what assumptions we can provide states around what they can do on the Medicare side of the equation. So we're requiring states to develop a strategy. What can the states say about making changes to Medicare

policy in the development of the strategy? And obviously what expectations would the federal government have about Medicare payment levels? Do they have expectations of savings? Does it have to be budget neutral? Does it have to project savings over a certain period?

I think the state strategy depends, to some degree at least, on what they can say about changes to Medicare.

CHAIR BELLA: Yeah. I want to remind us one more time. The number one, kind of first step on this is to get all states thinking about integrated care and to devote brain space and resources to thinking about that. There are other organizations that, Brian, provide technical assistance around Medicare and how Medicare works, and there's a whole host. Like that's not our job, I don't think. Like our job is to get Congress paying attention or appreciate the fact that they are paying attention, and to continue to shine a light on the fact that there are too many states where these products are not available to dual eligible beneficiaries and so what can we do to push that?

So I want to be careful that this is not going to solve an issue of telling states how to think about

Medicare payment policy or medical necessity or Medicaid integration. Maybe we'll get there, but this is a very first step, both symbolic to Congress and also for states for whom this is discretionary at this point, and it keeps getting bumped by things like COVID and eligibility redeterminations, trying to get this higher on their list.

So I say that to just like keep us at a certain set of expectations for what we're trying to drive here with this particular strategy. We have a whole host of other strategies that go in the weeds, with D-SNPs and Medicare and all those things. This is not that. I just want to be clear on that. It doesn't mean we can't do those other things.

Kisha.

VICE CHAIR DAVIS: Thanks, Melanie, for clarifying.

And I -- both of these recommendations in general, I will say the one thing, as we think about the strategy, having an eye towards equity, when you think about the dual population, they are the marginalized of the marginalized, and making sure that we are -- that there is an eye to who is getting included and who isn't and that

it's not worsening any disparity within certain populations as these types of plans are rolled out and that states should be including that as part of the plan and program as they develop them.

CHAIR BELLA: Bill?

COMMISSIONER SCANLON: Yes. I think about sort of payment differentials a lot and sort of what the impacts of them are.

The reality is, as I understand it, that there is a very significant number of states that for duals, 80 percent of the Medicare-allowed amount is going to be the payment to the provider because that is more than what the state would pay under the Medicaid program. So, in terms of a population that's this damaged, it's the fully Medicaid-eligible, not Medicare-eligible, that's going to have more of an access issue because they're going to be paid even less than what a dual is going to be paid sort of for a physician.

Now, in terms of dealing with plans, I just googled something and saw that there was a 2017 study that showed that Medicare Advantage plans were averaging about 97 percent of traditional Medicare, Medicare fee-for-

service rates. So those rates are relatively comparable.

I'm not sure the coordination when we're thinking about it. It's thinking about getting discounts for care as much as the coordination is meant, in fact, the utilization of care in a positive way. That's the coordination issue.

The payment issue, I do worry about differentials within Medicaid, among Medicaid beneficiaries, and Medicaid and Medicare versus the commercially insured individuals.

CHAIR BELLA: Thank you, Bill.

Dennis, I'm going to guess you have some comments. I'm going to preemptively call on you.

COMMISSIONER HEAPHY: Thanks. First, I want to agree with Kisha. I don't think we can overemphasize that if states are going to enter into this process that equity has to be a priority or the priority and develop ways to actually achieving that.

Also, I think an emphasis on rebalancing spending and ensuring that we're looking at care integration and not reducing access to services through real integration.

And I guess we've been through this -- I don't know how many years. It's very challenging. It's a really

challenging process, and so I have too many comments to actually add today. I think it's going to take me time, and I think I'd rather comment later because it is -- I don't want to go down some rabbit hole here. The idea of it is excellent. I think there needs to be opportunity. There needs to be integration, and the way we're achieving health equity and improving health outcomes for folks, but at the same time, we can make sure that this does not become a system where people get ghettoized into managed care systems with only a very small pool of providers that can -- they can see a small pool of hospitals they can go to, and so I think we need to think really expansively about what the implications are within this in terms of access to care.

CHAIR BELLA: Thank you, Dennis.

Other comments?

Brian.

COMMISSIONER BURWELL: I wonder why we wouldn't want to say -- be a little more specific about when the initial strategy is due from the states; for example, two years from the effective date of the legislation rather than keeping it ambiguous. I mean, then it would be tied

to the funding. So states would be funded for two years or something.

CHAIR BELLA: Okay. Kirstin and Ashley, can you think about that when you bring this back to us, kind of think about lining up timing for support and for a deadline?

Anne.

EXECUTIVE DIRECTOR SCHWARTZ: Yes. I guess I have a question about those kinds of things, whether they need to be in the recommendation or they should be discussed in the text. You see in the recommendation here, there's a bracket around "every three to five years." You know, every three to five years is not a great recommendation. It should be either three or five, but we could excise it entirely and just say update the strategy on a periodic basis and then talk in more detail in the text. So I'm just wondering about whether that might be a better way to deal with whether there is enough time for states to do it but not so much time that it never happens.

CHAIR BELLA: Well, first, I think it would be nice to have a timing there for the first time, right? It should be no later than X so that there is an expectation

that it's done and the funding is there, and it seems that we could be a little looser and have the Secretary opine on how often they're updated. But it does seem like we -- if we want everybody to do this and we're sending a signal that this is important, I would prefer not to leave that open-ended.

Does anybody disagree with that? So that's echoing Brian's comment.

[No response.]

CHAIR BELLA: Okay. Other comments?

[No response.]

CHAIR BELLA: Okay. This is the only time we will have -- where we're asking for a pretty high-level recommendation on a very complicated subject. So I'm chuckling inside that we wanted to go more complicated on this. You will have a chance to go more complicated on this subject in a few minutes when we talk about the C and D rule.

But this, though, I appreciate the Commission's support of moving forward in a way that we're sending a signal about the importance of all states having a plan, thinking about a plan for the beneficiaries, dual-eligible

beneficiaries in their respective states and funding to support that.

COMMISSIONER HEAPHY: Melanie?

CHAIR BELLA: It will be a big win.

Sorry, Dennis.

Just one thing. It will be a big win if all states become fluent in HIDE, FIDE, MMP, like all of those things. That's going to be a huge step forward.

Dennis?

COMMISSIONER HEAPHY: I was going to say I would love to see in the recommendations the words and how they're going to advance health equity, so just state it explicitly in No. 1.

CHAIR BELLA: Okay. Thank you, Dennis.

All right. We are going to -- well, Ashley and Kirstin, do you need any more on this?

MS. SEMANSKEE: No. I think we have all we need. Thank you.

CHAIR BELLA: Okay. We are rounding up for our last session, which is the Medicare payment rule; in particular, the portions of the Medicare rule that pertained to dual eligibles. For someone that follows this

closely, I think this is the most space that dual eligibles have ever gotten in a regulation. So that's exciting and also overwhelming.

Kirstin and Ashley are going to walk us through some of the provisions. We're going to remind ourselves that in this body of work, there are sort of three themes that we look at. So we'll try to think about our comments in those three buckets, which we can come back to once they walk us through the major changes and the slides. After we finish that discussion, we'll take public comment on both of these two sessions related to duals.

So I will hand it over. Kristin, I think you're going to lead us through this. Is that right?

REVIEW OF NOTICE OF PROPOSED RULEMAKING AFFECTING DUAL-ELIGIBLE SPECIAL NEEDS PLANS

* MS. BLOM: Yeah, that's right.

CHAIR BELLA: Perfect. Thank you.

MS. BLOM: Thanks, Melanie.

So we'll walk through this Notice of Proposed Rulemaking, or NPRM, that CMS released last week.

Next slide, please. Thank you.

So the proposed rule would make changes to the

federal regulations that govern the Medicare Advantage program and the dual eligible special needs plans, or D-SNPs that MA operates.

I'll be speaking throughout about D-SNPs, but then you'll remember that there are two subsets of D-SNPs, which are FIDE and HIDE SNPs. HIDE SNPs are highly integrated. FIDE SNPs are fully integrated. So you can think about it as D-SNPs first, and then within that, there's sort of a higher level, which is HIDE, the highest level which is FIDE.

Because D-SNPs provide coverage to duals, the proposed rule includes a number of provisions that are of interest to the Commission. You know this as MA rule. In fact, CMS explicitly sets out in the rule to improve integration of Medicaid and Medicare for people who are enrolled in D-SNPs.

Next slide, please.

Medicare-Medicaid plans, or MMPs, the plans that were established as part of the demonstrations under the Financial Alignment Initiative and which are operating in nine states today are prominent in this rule. Many of the changes that CMS is proposing would apply features of the

MMPs to D-SNPs. For example, there's a list here. CMS is proposing to require that D-SNPs set up an enrollee advisory committee to obtain input from beneficiaries about what it's like to be enrolled in a D-SNP.

Next slide, please.

And another way that MMPs are prominent is that if the rule is finalized, CMS suggests that MMPs might be converted to D-SNPs. It does stop short of making this a requirement or of specifying a timeline or anything like that. It simply notes that this is one approach that could be taken, again, if the rule is to be finalized.

CMS notes in the rule that since the Financial Alignment Initiative began, the program that set up the MMPs, the integrated care landscape has changed a lot, and there are opportunities now to implement integrated care on a larger scale.

Other proposed changes in the rule are largely consistent with MACPAC's work and with Commissioner discussions on these topics but may not necessarily result in significant changes in the three areas that we focused our work on. Those are increasing enrollment in integrated care, making integrated products available to more people,

and promoting greater integration in existing products.

CMS is asking for public comment through March 7th. I'll spend the remainder of the presentation walking through areas that we have identified for potential comment for the Commissioners.

Next slide, please.

I'll walk through these areas for potential comment at a pretty high level because I want to reserve the time today to hear from you guys about sort of the key messages you would be interested in including in a letter.

As Melanie mentioned, this rule had a lot of provisions related to dually eligibles, and it's fairly detailed and complex. So I'll go through at a high level and then will be happy to take your questions.

So the proposed rule includes a requirement, as I mentioned a couple seconds ago, about establishing an enrollee advisory committee. This is a feature of the MMPs. Currently, all MMPs have this, and the rule would require that all D-SNPs establish such a committee so that they can hear directly from beneficiaries.

The details, of course, are yet to be worked out, but as an example, in the MMPs, these committees meet

quarterly and include enrollees, family members, and other caregivers that reflect the diversity of the enrolled population.

Also, in the rule, CMS would modify health risk assessments, or HRAs, that SNPs are required to conduct to add questions on social determinants of health. Because many dually eligibles have multiple social risk factors, CMS is proposing adding questions on things like housing stability, food security, and access to transportation.

Specific questions will be included in sub-regulatory guidance if the rule is to be finalized.

Then CMS states that unified appeals and grievances -- that unifying appeals and grievance processes, these are the separate processes in Medicaid and Medicare that people who are dually eligible have to navigate, is feasible in additional plans over what's happening under current law, and so the proposed rule would expand the universe of D-SNPs that are required to have the unified process. This is, again, a feature of MMPs. Currently, MMPs have an integrated process so that it's more straightforward for the dually eligible population to navigate.

Next slide, please.

The propose rule would require exclusively aligned enrollment for all FIDE SNPs, and as Ashley noted earlier, this occurs when the same entity is responsible for all Medicare and Medicaid benefits for all of its members. Several states have FIDE SNPs currently that do not have exclusively aligned enrollments, including Arizona, Pennsylvania, and Virginia, and they would need to make some changes to their programs if the rule is finalized.

Also, under the rule, FIDE SNPs would be required to cover Medicare cost sharing for qualified Medicare beneficiaries and other full-benefit duals. This would include all cost sharing, so that's coinsurance, copayments, and deductibles. Premiums are not included, and this change is meant to streamline the claims processing and reduce burden on providers by keeping them from having to submit multiple claims.

This is something that actually all existing FIDE SNPs are already doing. It's part of their capitated contract. So this would not have an immediate effect.

A number of states, as you know, carve out

certain Medicaid benefits from Medicaid managed care contracts. Most commonly, that is LTSS and behavioral health services, and the proposed rule would codify the current CMS policy of allowing certain limited carveouts for integrated plans that are FIDE SNPs and HIDE SNPs. These carveouts would only be allowed if they apply to a small number of eligible beneficiaries or if the carveout constitutes a small part of the total scope of services.

The proposed rule would also require service area alignment for FIDE SNPs and HIDE SNPs with the Medicaid service area because integration is possible where service areas overlap. According to CMS, the proposed change would primarily affect HIDE SNPs because all FIDE SNPs in 2021 met the requirement as it's stated in the proposed rule.

Next slide, please.

So, in the proposed rule, CMS suggests that states might want to consider converting their MMPs to D-SNPs if the provisions in the rule are finalized. As I said, CMS notes that in the last 10 years, things have changed. The integrated care landscape is different, and there are opportunities in MA for benefit flexibility and to implement integrated care on a larger scale than was

previously possible.

CMS is not proposing this as a requirement and is not even proposing it as a change. It is simply noting that it would be interested in feedback on this considered approach. It offers that it would work with states, of course, to develop a transition plan. There are nine states that are participating in this model that would have to do this conversion.

CMS also acknowledges in the rule that there would be disadvantages to this approach, and some of those are listed here on this slide, things that wouldn't transfer necessarily from an MMP into a D-SNP such as passive enrollment.

CMS also notes that there would, of course, be challenges related to the transition itself of moving the over-400,000 beneficiaries who are in MMPs currently into D-SNPs. There could be disruptions to beneficiaries and complexities for states. So this is something that CMS is considering, but again, just to reiterate, this is not proposed as a change currently. It would all hinge on whether the rule becomes finalized or not.

Next slide, please.

CMS also proposes to allow states with exclusively aligned enrollment to require an MA organization to establish a contract that only includes one or more D-SNPs within the state, and this is being done in order for states and others to get an accurate picture of the D-SNP's performance.

Certain quality measures, including things like star ratings, are reported at the contract level, and so anyone reviewing that information can't distinguish between D-SNPs and regular MA plans that are all subsumed under that contract. According to CMS, the majority of D-SNPs are in contracts that include regular MA plans.

CMS is also proposing in the rule to codify the ability of states that have exclusively aligned enrollment to use their contracts with D-SNPs to require integrated member materials. This would include things like summaries of benefits.

We talked with CMS about why this provision would only apply to D-SNPs with exclusively aligned enrollments, and their view is that those plans are particularly well suited to making this change, and it's difficult to integrate these materials fully outside of exclusively

aligned enrollment, an arrangement where a single entity is responsible for both sets of benefits.

And then in the proposed rule, CMS would streamline plan oversight. MA organizations that receive capitated payments from both Medicare and Medicaid have to follow, of course, requirements, both federally and at the state level related to plan oversight.

CMS identifies drawbacks to having two sets of requirements in the rule. For example, states might not be aware of the requirements at the federal level, and CMS might not be aware of state requirements. So the rule would give states access to CMS's health plan management system, or HPMS, where states could do things like review marketing materials, models of care, plan benefits, et cetera. This would allow states to view D-SNP information without having to request it from the D-SNP itself and would in theory provide a better way of communicating between states and CMS on D-SNP performance.

And then, finally, on this list is the maximum out-of-pocket limit. Under current law, CMS requires that all SNPs establish limits on enrollee out-of-pocket cost sharing for Medicare Parts A and B. This is called a

maximum out-of-pocket limit, or the MOOP. In setting that limit, though, MA plans only count the amounts the enrollee actually pays. They don't include state responsibility or exemption from cost sharing, which can lead to situations where state Medicaid programs might be covering Medicare cost sharing that's otherwise covered by the plan.

So the proposed rule would include third-party payments in setting that limit, and that means that the limit would be met earlier. CMS estimates that this change would result in less spending for states and payments to providers would increase.

Next slide, please.

So there are a number of other provisions in the rule that affect dually eligible beneficiaries, but we have not suggested any comments for these. They are listed here. We're just including them for completeness. We just discussed these a little bit in the memo that you got. The Commission has talked about some of these in the past and has not spoken about others, but basically, if you are interested in comments or in giving us feedback on any of these, we're happy to take that relative to the letter. But in the interest of time and complexity, we're kind of

leaving these off.

Next slide, please.

So our next steps are to obtain input from you guys during your discussion, and then depending on your interest in commenting on the rule, we would be preparing a draft letter for your review.

Next slide, please.

We wanted to just leave this slide up for you during your discussion. These are the areas we've identified as potential areas for comment, but again, of course, totally up to your level of interest. We're happy to answer any questions on any of these, or if there's anything that's not on this list
that you'd like to talk about, we're happy to do that.

I'll turn it back to you, Melanie.

CHAIR BELLA: Thank you, Kirstin.

I'm actually going to kind of kick off and try to set some context for how we might think about responding. Our presumption is that we are going to respond. So, if anybody does not agree with that, you should raise your hand. Also, we're not expected to respond to everything that's in here, and we should keep our comments, which are

in line with the themes of our work. Those themes are increasing enrollment in integrated products, making integrated products more widely available, and promoting greater integration.

When I look at these, first, CMS -- we need to applaud CMS. They have done a tremendous amount of work here. It is not easy, and it is not -- this is a population that often gets overlooked. So kudos to CMS for doing so much. When I put this against our buckets, it seems to -- they seem to fall in the "promote greater integration." There's not much in here I see that increases enrollment in integrated products or makes integrated products more widely available. Again, I applaud them for -- there are things about addressing carveouts and bringing over flexibilities that exist today. Integrating materials, integrating oversight, I would like to see us ask if there's a way to make that available to more rather than less states -- and beneficiary protection, some really important beneficiary protections they would pull over, like the enrollee advisory committee, like the integrated grievances and appeals.

But I do think we should think about is this --

are the things in here solving some of the problems about helping states get to HIDE and FIDE status and breaking down barriers to having HIDE and FIDE, and is it time to remove the MMP product? Are we sure that there's not more to learn from that model? And what are states who are doing that? Are they interested in continuing that model? Because in some of these cases, we're going to end up with fewer of the FIDE SNPs, and you could also see the MMPs going away. So trying to think about how we reconcile the policy intent and line it up with our goals, I think, is really important.

We are not going to get into the weeds of the MOOP and the unified grievances and appeals. We don't expect you all to do that.

What would be helpful is to get a sense of is there anything on this list of -- the list that we're looking at right now that folks are not interested in commenting on? If so, why don't you flag that if there's something on here that you don't think is within our purview to comment on. And then if there are particular things that are of interest to you, please use your comment time to reflect that, those areas of interest, and anything

that you would like to see the staff expand upon based on what has been provided to you in the summary comments or that you read yourself.

So, with that, I will open it up. I'm going to actually start with Darin and then go to Toby.

COMMISSIONER GORDON: Thanks, I think. I'm trying to think if there's areas that I would want to comment on. I think your opening comments were kind of where my head is at. I'm just curious if some of this is going to actually result in less integration, not obviously the intent, but I just think the practical application of some of this could.

You know, I think the areas -- I'm curious. Like, on the maximum out-of-pocket limit, is that maximum out-of-pocket limit on the FIDE or HIDE SNP side? I didn't read that section of that, of the proposal, or was that in total? Kirstin?

MS. BLOM: That is in total. I'm just checking my -- because all of these provisions, of course are super complex, and I don't know how I was -- you know, MMCO did a great job of keeping this stuff straight. Yeah, I'm pretty sure that's all of them.

COMMISSIONER GORDON: Okay. The only thing that when I look at this, I don't have any kind of reaction. Like the enrollee advisory committee, it feels a little bit like it's duplicating with the medical advisory committee that Medicaid has, but I don't know if there's really anything to add. I mean, I don't think there's really any issue there.

I do wonder about unified appeals and grievance. I know we're not getting in the weeds, but, I mean, if there's the ability -- and I'd say this really applies to not just that example, but that's one that stands out to me that's pretty complicated. Is there the ability for this being like the aspirational goal where they want folks to get in the proposal in giving time to start moving in this direction? And the reason I just bring that up, I think if we start to flip this too quickly, we're going to go the other direction, and I think some of this stuff after dealing with some of it personally is incredibly complicated.

And there's one thing I want to say, Kirstin, on the comment on the cost sharing, capitation for Medicare cost sharing. Not all FIDE SNPs are doing that,

unfortunately, because I know we're -- our FIDE SNPs in Tennessee are not. So while the overall majority -- probably, it may very well be everyone but Tennessee. It's not everyone quite yet, and that in and of itself is complicated as well.

Just as a general comment, I don't know if we want to get -- I don't think it's really particularly helpful getting into each individual item, but I'm more concerned about how we can think about this transition being done in a way that doesn't undermine our intended purpose of promoting more integration.

MS. BLOM: Melanie, if I could just make one comment, I think one thing I probably should have said is a lot of these are basically applying to states and plans that have exclusively aligned enrollment. So, if they don't already have that, they're not necessarily subject to some of these. So that's just to clarify, and thanks for the note about Tennessee.

COMMISSIONER GORDON: Yeah. Thanks for clarifying that, but I think that my issue or concern is still the same, MMPs being unraveled and not knowing in those states if they would actually have the wherewithal or

the ability to transition to this new model. But those states that are already in some kind of integrated model taking this very, very huge step, is that equitable, and how realistic is that? It would be good, although timing doesn't allow for it to get some state perspective, but I think, directionally, I think it's good. I'm just a little concerned that it may be that it's a huge lift that moves us in the wrong direction.

CHAIR BELLA: Thank you, Darin.

Toby and then Dennis. I'll go to you next after Toby.

COMMISSIONER DOUGLAS: Yeah. First, I definitely align with what Melanie and Darin have said. I want to make sure that we are highlighting is this truly moving in the right direction and promoting and incentivizing integration.

One area clearly on the benefit, No. 6 on the Medicaid benefit carveouts, clearly, we want as much integration, but we have to also recognize how challenging it is for some states to be able to carve in certain benefits, and so how do we still incentivize integration. Maybe it's okay that they're not as a HIDE, but are we

figuring out different ways to ensure integration and that they're still advancing it? Even if a state like California will not be able to integrate in, it's personal care services or it's especially mental health, as one example. What does that mean for still trying to advance integrated care?

CHAIR BELLA: Well, Toby, you tell us. What would it take to get California to fully integrate the long-term care and behavioral health services for dual eligibles?

COMMISSIONER DOUGLAS: I don't know if that would ever happen, to be honest. I don't know what it could be. It's just so embedded in so many different parts. So then the question is are there other ways to financially align, which does get to question around the MMPs.

CHAIR BELLA: Thank you, Toby.

Dennis?

COMMISSIONER HEAPHY: I guess a couple of things I'm missing from this and I think is really critical, I don't see anything about care integration in these 12 boxes. I think what's missing is care planning, care coordinating, and quality measures, because if there's no

definition of what a care plan looks like or what a care coordination looks like, then we can't really get to what does that mean to integrating services.

I think it's also important to look at carveouts. A lot of those carveouts are really waivers, populations that don't want to be in a managed care because they're really concerned about reductions in their access to LTSS services, and so that's something that's really key to better -- to examine.

Then in terms of the MMPs, I agree with -- I think it was Darin was talking about this, maybe Toby as well, but Darin was talking about unraveling the MMPs right now, because right now, we have MMPs in Massachusetts, and I'm looking at -- I think that's why I had such difficulty with the last presentation is we're trying to bring states up to a certain level and build their capacity to do things, and yet even with the MMPs, we haven't reached a level yet where we feel comfortable with necessarily letting go of that three-way contract between CMS, the state, and the plans.

So I think there's a lot of opportunity here to not -- I guess we as a state, as advocates, and even

nationally, I just received this information, and we're trying to figure out what our thoughts are on it. I think for me, the big takeaway is what's not here, and that's the care planning, care coordination, and what does that mean to be fully integrated, BH and LTSS with the medical care?

CHAIR BELLA: Thank you, Dennis.

Other comments?

[No response.]

CHAIR BELLA: I mean, I think it is important to be clear that trying to address carveouts, a laudable goal, right? That is a very important thing. It just hits reality in states like California, and you hear from Toby saying we're never going to change this county carveout system. So how do we think about that?

There's some other things in here that people have been asking for, for a long time. For example, without getting too technical, this would allow for you to look at star ratings for just duals in a plan, duals against duals. People have been asking for those, that ability and those tools from a quality improvement side for a long time. So some of these things might go really far toward advancing our goal of promoting greater integration.

We might just want to be clamoring for how are we also ensuring that we're not displacing any plans or beneficiaries in the process, as we continue to kind of support where CMS is and also support as Congress keeps trying to raise the bar for integration as well, kind of reconciling all those things.

So is there anything on the 12 that people do not want to see fleshed out in our comments?

[No response.]

CHAIR BELLA: I can't believe you haven't all read this rule. I know you've read the summary, so this is good validation.

How about, Dennis, your point on some things that are missing? Did you have a comment, Dennis? And then, Brian, I see your hand.

COMMISSIONER HEAPHY: I was going to say I did read the materials. I'm literally just processing everything, and that's why I'm not commenting as much as I might otherwise. For me, I always think about care integration as care coordination, care planning, and there being an end goal as person-centric care. So, if we don't have that, then I'm wondering what is the purpose of

putting everybody under a managed care umbrella with the two funding streams if they're not going to be integrated? Will they be integrated in this? Will they not be integrated in this? What will integration look like, and who is going to oversee that? Will it be state by state? I guess it will just look -- I just have a lot of questions.

CHAIR BELLA: Thank you, Dennis.

Brian and then Toby.

COMMISSIONER BURWELL: So, like many others, I was kind of overwhelmed by the amount of information in the NPRM and don't feel certainly prepared to comment on it at this point.

I guess this is for both Anne and Melanie. Will we have any opportunity to submit further comment, you know, additional comments after we've had a chance to think this over in a way that doesn't -- isn't disconnected with the policies of not having any conversations in between meetings? Because the next meeting is March 4th. The letter is due March 7th. We don't have any opportunity to talk about this between now and then.

CHAIR BELLA: Yeah. That's why, I mean, the

first pass -- so the preparatory materials have given summary information that ties to prior conversations that we've had or tries to tie the prior conversations that we've had, and so first pass is to say is there anything on this list that makes anybody uncomfortable in the direction it's going. Totally understand. I mean, it's a big reg, and we're not meeting again until right before the comments are due, and so we're sort of in a rock and a hard place there.

That's why you should flag anything that you're concerned about, and if there's a feeling that it's too complicated or it's too risky to comment on based on what we've talked about in the past or what we talk about here, you should flag that now, and we'll take that into account as we're drafting the comments.

And, Anne, you're welcome to say -- I mean, I don't think they're going to get more time on the comment letter because this is part of the Medicare circle.

EXECUTIVE DIRECTOR SCHWARTZ: No, they're not. I mean, I'll be completely honest and say that my guess is that even if most of you had more time to sit with us and digest it in terms of what the Commission has done so far

on this, I don't think we're likely to come up with newer comments on it.

I guess what I would say --we can always draw on our past record. So, if there's something that comes up for you, say over the next two weeks, you could email me and Kirstin, and we can figure out if there's a way to address that, for example if that relates to something that we've already done and a way that doesn't get in the way of our general practice of doing everything in the sunshine.

COMMISSIONER BURWELL: There's certainly nothing on this list that I would take off. I mean, I have just initial thoughts about maybe additional comments around the capitation, No. 5, particularly from states that don't pay cost sharing now under the lesser policy, and also how the whole rule deals with partial duals, which we've discussed a lot in previous conversations. But I'm not sure how partial duals and what options are available to D-SNPs and how they treat partials.

CHAIR BELLA: Kirstin, did you want to say anything on partials?

MS. BLOM: Yeah. Because the rule is really focused on full-benefit duals and plans that have

exclusively aligned enrollment, which would mean they are enrolling full-benefit duals only, there is not a lot in here about partials. But that's a good question.

CHAIR BELLA: I know --

COMMISSIONER BURWELL: So the rule about partials. You know, they can just stay where they are, you know. It doesn't take a policy position either way on partial duals.

MS. BLOM: I would just say it's focused on the plan that it thinks has the most ability to make the kind of changes they're looking at, which are not even all D-SNPs. They're the ones that have exclusively aligned enrollment. So, yeah. Most of the provisions that are on this list or that are in the memo just really didn't about partial duals.

CHAIR BELLA: I'm going to let you all--

COMMISSIONER HEAPHY: Just one more thing to say enrollee advisory committees, those can be meaningless unless there's language that -- in the instances as far as these committees actually have teeth and can impact policy and that the folks that are on the committee actually reflect the voice of the populations that are impacted or

part of the D-SNP world. And so for me that's really important that it be an authentic committee, that they actually be able to effect change and that they be representative of the population.

CHAIR BELLA: Thank you, Dennis.

I'm going to turn to public comment to see if we have any comment. I'm going to give you all a chance to kind of digest this a little bit more and identify any additional comments you might like to make.

So we're going to open it up. What's that?

COMMISSIONER DOUGLAS: I was going to say something. Can I quickly say something?

CHAIR BELLA: Sure.

COMMISSIONER DOUGLAS: Yeah. So one just wrapping back to a previous item, since they are so related. Are we planning on putting anything in around just even what our recommendations are around advancing integration? Because it kind of gets to, in many ways, our comments in these areas as to just what the overall view we have and how states are going to need resources to do it.

CHAIR BELLA: I think certainly, we'll bucket in our three areas, and many of these, like some of them can

be direct examples perhaps of promoting integration. I think we take every opportunity we have to reinforce prior recommendations to support states, and so I would presume that we would take this opportunity as well.

COMMISSIONER DOUGLAS: Great.

CHAIR BELLA: Okay. We're going to take public comment. I would remind folks to please introduce yourself and limit your comments to three minutes or less.

MS. HUGHES: Pamela Parker, you have been unmuted to make your comment.

PUBLIC COMMENT

* MS. PARKER: Thank you all. I'm Pam Parker with the SNP Alliance and also a long history of working on integrated programs in the state of Minnesota and nationally. And I want to just make a few comments here quickly on some of the questions that you've had.

First of all, I think it's important to see this as CMS is trying to fill in areas where there is misalignment currently. I don't think we see this as a whole new -- I mean, there are some new directions here but I don't see it as a whole new program that they are trying to develop. And so I see them filling in places where it's

been just infuriating to have misalignments, like in service areas and people in two different plans still and they're yet being able to be called FIDE SNPs and things like that. So they're trying to clean up, I think, a lot.

Second of all, you've been concerned about where is the care coordination piece of this. It's not addressed here but there is a huge care coordination piece in D-SNPs. There is a tremendously intricate model of care with integrated delivery teams, you know, all of the care management team kinds of things, interdisciplinary teams, and requirements for, you know, training providers in the model of care. It's extremely deep and it's all overseen by NCQA. So you don't see it here but it's a huge portion of what goes on in D-SNPs in order to coordinate care for duals, and I would encourage you to become more familiar all those pieces, because it's an immense undertaking.

And what they're doing in this rule is allowing states to add some things in to align that model of care further with state MLTSS requirements, which has been done in Minnesota and has worked really well. So it's a complicated process but it's not that it's not there.

And then people were concerned about partial

duals, and I just want to say there is provision here for partial duals to continue in D-SNPs. They wouldn't be in the fully integrated D-SNPs because they kind of tend to mess up the single member materials and the communication processes because they have a different set of benefits. But there are pathways that CMS has included in this rule for them to continue to be in a D-SNP and have access to those supplemental benefits and care coordination, even though they wouldn't be in the same exact measurement cohort as the full benefit duals.

And then lastly I would just mention that as I read the rule -- and I've spent, you know, the better part of the last couple of weeks just really focused on this -- is I don't read it as completely getting rid of MMPs, and I think it's wise for them not to do that. I think there may still be some opportunities for states that feel the MMP is the right move for them or that it's an important piece.

And I see CMS more asking about that. And I think they've set a direction where they're interested in going further with D-SNPs, which we find to be great, but MMPs have also played a good role, and an important role, and maybe still can, in some instances.

So I don't see them as completely ruling that out, so they're signaling a direction.

Thank you for the opportunity to talk.

CHAIR BELLA: Thank you, Pam.

MS. HUGHES: Camille Dobson, you have been unmuted. You can unmute your line to make your comment.

MS. DOBSON: Thank you. Good afternoon, Commission. I wanted to comment first around the integration strategy recommendation. You know, I think anything that's going to drive states forward on integration I think would be really helpful. I would just caution, you know, this is what happens. A requirement goes in and the money doesn't come. So I would recommend that you make it very clear that CMS needs to make funding available before they make the strategy mandatory.

I think you hit all of the right pieces. I think I would just -- yeah, I always caution drawing too much on the D-SNP model of care, because it is so clinical, and if you're going to talk about quality that you definitely highlight the need to add LTSS quality measures as a way to address the experience of consumers who are getting HCBS in an integrated care program.

And then, secondly, I wanted to applaud Kirstin for the analysis of the rule. I'm barely slogging my way through it still. I will tell you, initially, so far I have heard some concerns, primarily from the states that have engaged in an MMP. They were taken by surprise, I think, about this language. They had been hinted at but they were not told, I think, directly, that CMS was going to signal the move. So far the concern has been removing the opportunity to secure savings from Medicare. While I think the states would tell you that some of the savings appear illusory to them in the rate-setting process, nonetheless it still exists, and that's a route that's not available in a D-SNP integration approach. And so I think that's problematic.

Those states who are using the MMP approach really like it, and one of the things they like the best about it, actually, is the direct access to MMCO staff to help negotiate and buffer the conversations with their Medicare colleagues. So I would hate for them -- a couple of the states have mentioned so far that that would be something they would really hate to lose, and really that the states need time to be able to transition to an

integrated D-SNP model.

We'll be obviously writing comments, probably not on all the things that the Commission has identified as areas for comment, but certainly we'll share our concerns that, you know, state flexibility continues to be an option for states, even though it is disappointing that not as many have moved forward on the ball. Hopefully they continue to take your recommendations, not just for the quality strategy but overall funding to build Medicare capacity under consideration when they're adding new requirements for integrated care programs.

Thank you for the opportunity.

CHAIR BELLA: Thank you, Camille.

We have certainly talked in the past about the need to align incentives for states, and so this is an important part of MMPs that actually CMS called out in the rule, so that can be part of our comment, presumably.

Other thoughts from Commissioners?

COMMISSIONER HEAPHY: This is Dennis. I think Camille raised an important point about the need to look at the clinical emphasis of the care coordination model within SNPs and how do we make sure that, is it through NCD or a

combination of NCD and CAHPS, HEDIS measures, that there be some level of accountability to a care model that actually reflects the HCBS and recovery emphasis and not just a medical one.

CHAIR BELLA: Thank you, Dennis.

Can we go back to the slide with the 12 on it, please, just so we're looking at that as we wrap up the conversation?

So again, I know this is a lot to digest. It came up fast. The good thing is it came out before this meeting. Even if it feels like it's coming on you quickly at least it didn't come out next week, when we wouldn't have a chance to be together at all, to sort of talk about general themes and areas that we might comment.

Any last thoughts on any of the things on this paper? Martha.

COMMISSIONER CARTER: Thanks. I appreciated the comment on the care planning component that's already in the D-SNP model. But to get to Dennis' point, I wonder if we might want to highlight and comment on that we agree with the health risk assessment with questions on social determinants of health, number 2, but we didn't actually

say that those then get addressed in a care plan. And I think there was something -- I went back and read our memo here, and there's something about using particular questions from the Accountable Health Communities Model.

So there's that level of specificity in sort of what questions they're going to ask, but it really didn't say that they're actually going to do anything with that assessment once it's there. So we could be explicit, that those responses, that that assessment gets rolled into a care plan.

CHAIR BELLA: I think they probably didn't because that's already the requirement, Martha, for the assessment to feed the ICP, the integrated care plan, and this is, I think, a reflection that they're giving more direction about having additional, more non-medical questions in the HRA that don't exist today. But that set of requirements around what's in the HRA into the innovative care plan already exists for this special needs plan.

It doesn't mean we can't speak to Dennis' comment, and I appreciate you raising that.

Laura?

COMMISSIONER HERRERA SCOTT: No, I was just -- you answered the question, the response. It's part of the model of care so it's there. It's just maybe not in this rule that just came out.

COMMISSIONER CARTER: Can I ask one more question? If adding questions about social determinants of health is added, is there also a requirement to address those in the existing model?

CHAIR BELLA: There's a requirement to have the health risk assessment drive the care plan. That's part of the overall model of care.

COMMISSIONER CARTER: Okay.

CHAIR BELLA: Yeah. Laura, did you have another comment?

COMMISSIONER HERRERA SCOTT: The only thing I would add, and, you know, this is really important, social drivers, and I think a lot of health risk assessments are inclusive of social drivers and activities of daily living and other social factors that impact care. The longer you make a health risk assessment the less likely it will be completed. So as we add on different questions to cover different themes, it just lengthens the HRA, and it becomes

very time-consuming and then completion rates go down. So that's the caveat to adding more questions.

CHAIR BELLA: Thank you, Laura. Darin?

COMMISSIONER GORDON: Yeah. I think the challenge here like we said in the very beginning. Each of these areas that are listed, or the majority of the areas that are listed, I should say, simplify the complexity of the two systems, for either the member or for providers. And I think that's good. That's a good direction for us to be going.

I think the only concern I have, from a comment perspective, again, it is the bridge from here to there and how long is that bridge, and is there the ability for states to be able to get there in a reasonable amount of time without undermining or sacrificing some of the steps they've already taken toward integration.

I think that's my challenge, was it's not so much that each individual thing, is there some special comment and/or concern, because I think directionally it's right. It's how we get there, and concerns about if we move too fast, if we end up unraveling some things, some of the progress that's been made, in some cases.

CHAIR BELLA: Yeah. It's hard to be CMS, because on the one hand we're always saying like you've got to move faster, get rid of these carve-outs, raise the bar, and on the other hand today we're saying, wait a minute, you might displace things.

So I think we need to be careful. Our themes have been increase integrated products, increase enrollment in integrated products, and increase integration. And along the way we've recognized the core theme of that is supporting states, because states, if they don't do this or they can't do this, you have HIDEs or FIDEs or MMPs. You can't have any of that, and that's holding back a lot of integration. And the plans suffer. The beneficiaries mostly suffer. The providers suffer. All of that.

So we have a careful line to balance here, but I think we've done enough work in this area, in core themes, that we can address those things that advance and call attention to those things that we want to keep an eye on, or if we want to be worried about guardrails and transitions and all those things, so that we don't reverse progress.

COMMISSIONER GORDON: I don't think we're sending

the message that, you know, hey, we're saying we want you to move forward on integration and now we're saying no. I think it always comes down to, you know, when you think of policy you always have to connect that back to the ability to operationalize the policy.

And so as you said at the beginning, applaud the big step forward of trying to make integration really, truly integration and not just in name only. I think it's consistent with other things we've said about making sure that there is an ability for folks to transition in a way that doesn't have unintended consequences. I think that's my only point.

CHAIR BELLA: You're going to get the last word today, Darin. Congratulations.

All right. Having said that, does anyone have any other questions? Or Kirstin and Ashley, do you have what you need?

MS. BLOM: Yeah. I think this was a good discussion. We will go back and be in touch with a comment letter.

CHAIR BELLA: Okay. Thank you, everybody, for staying so engaged today. We will be back tomorrow

morning, and I need to refresh my memory on what we're kicking off with. We are kicking off with money follows the person. So we will see you all back here at 10:30 a.m. Eastern tomorrow.

Enjoy your evenings. Thank you very much.

* [Whereupon, at 4:02 p.m., the meeting was recessed, to reconvene at 10:30 a.m. on Friday, January 21, 2022.]

PUBLIC MEETING

Via GoToWebinar

Friday, January 21, 2022
10:31 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
KISHA DAVIS, MD, MPH, Vice Chair
HEIDI L. ALLEN, PHD, MSW
TRICIA BROOKS, MBA
BRIAN BURWELL
MARTHA CARTER, DHSC, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
TOBY DOUGLAS, MPP, MPH
ROBERT DUNCAN, MBA
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
VERLON JOHNSON, MPA
WILLIAM SCANLON, PHD
LAURA HERRERA SCOTT, MD, MPH
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:31 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome back to our Day 2 of our January MACPAC meeting.

We are going to jump right in starting off the morning with our report on Money Follows the Person. Welcome, Kristal, and we'll turn it over to you to get us started.

MANDATED REPORT ON MONEY FOLLOWS THE PERSON QUALIFIED RESIDENCE CRITERIA: REVIEW OF DRAFT CHAPTER FOR MARCH REPORT

* DR. VARDAMAN: Great. Thank you, Melanie. Good morning, Commissioners.

Today I'm going to go over our draft chapter on MFP qualified residence criteria. I'm going to start off with some background on the mandated study and review some of our past meeting discussions. I'll then move on to reviewing the draft chapter and discussing next steps.

As you all know, the Money Follows the Person program, or MFP, helps people in institutions return to the community. The qualified residence criteria differ from the HCBS settings rule, which is currently underway in its

implementation, and Congress has asked MACPAC to do a study identifying the settings that are qualified under MFP and those that qualify under the rule, and over the past several months, you all have had discussions about the pros and cons of aligning the MFP criteria with the settings rule.

To fulfill the mandate, we are planning to publish this report as a chapter in the March report to Congress. So, over the past few months, we've had a number of discussions on this topic.

In September, I brought to you all some background on both MFP and the settings rule. In October, we reviewed the results of analytic work that included reviewing data on MFP transitions, a survey of program directors that we conducted, and themes from our stakeholder interviews.

Then last month, we brought you all some policy options which you discussed. You had a robust discussion and ultimately decided the Commission was not going to include a recommendation in this report but would rather weigh the pros and cons and tradeoffs of the current criteria.

So I'll go on now to review the draft chapter, and we begin with some context for MFP, which we discussed some of this last month. Deinstitutionalization, the shift to serving people with disabilities in the community rather than institutions, really began in the '50s, and over the past several decades in Medicaid, we've seen increased focus on what we call rebalancing, which is shifting the balance of Medicaid spending on long-term services and supports, or LTSS, from institutional services to home- and community-based services. This shift really follows several decades of, again, movement to serve more people with disabilities in the community, also coming from the enactment of the Americans with Disabilities Act and the Olmstead decision, and so Medicaid, through both federal and state efforts, has been supporting rebalancing a number of ways, including MFP.

So MFP was first authorized by the Deficit Reduction Act of 2005 and has been most recently extended by the Consolidated Appropriations Act of 2021. It's helped over 100,000 people transition back to the community, and the draft chapter reviews a number of MFP program elements, which I've listed here on the slide.

This provides some background on the program and its accomplishments.

Of course, related to the mandate, it also reviews the qualified residence criteria, which has been the core of our discussion these past few months. MFP-qualified residences must fit into one of these criteria listed on the slide, so a home owned or leased by the beneficiary or their family member, an apartment with an individual lease, or a community-based setting in which no more than four unrelated individuals reside.

The settings rule sets a different set of standards for any HCBS setting that receives Medicaid HCBS payment. So this includes both residential and nonresidential settings, and the criteria under the settings rule, the standards are defined by the nature and quality of people's experiences in those settings rather than solely by their physical location. So what this means is that some of these standards are a bit more abstract and really have to undergo close examination by states and CMS to understand whether or not the settings will meet those thresholds.

But, generally speaking, the settings rule is

broader than MFP qualified residence criteria. It doesn't include things like the strict four-person limit, and so overall, the settings are more broad than under MFP.

There are really no data to specifically assess the tradeoffs of changing the MFP criteria. So, for example, we can't easily compare the experiences of people who transition to the community through MFP versus through other authorities that states may use to transition people, and so our assessment is largely informed by stakeholder perspectives.

So, as we discussed in October, one of the things that we did over the summer was to conduct a survey of MFP program directors. Just over half did say that there were some barriers to transitions imposed by the qualified resident criteria. Assisted living, transitions to assisted living, was the issue that was most commonly a concern, and about 70 percent of program directors thought the criteria should be aligned with the settings rule.

We also conducted a number of stakeholder interviews with federal and state officials, beneficiary advocates, provider organizations, and other experts, and here, we really heard mixed views. Stakeholders didn't fit

neatly into boxes. So not all beneficiary advocates, for example, felt one way versus all provider organizations feeling another way, so it was a variety of perspectives.

Those in favor of the qualified residence criteria overall preferred the criteria's clear, enforceable requirements. They appreciated that MFP settings have a higher bar to meet than other settings, and they thought that was something that was important. They said part of that was because they felt that the quality of life may be better in smaller settings.

In contrast, stakeholders that were in favor of alignment said that a single definition would avoid confusion and operational challenges. They thought alignment would maximize transition opportunities, expanding the number of available residences for MFP, and they said the settings rule allows for more choices for beneficiaries.

So, again, over the past several months, you discussed the advantages and disadvantages of the existing criteria and implications of potential changes. Overall, following last month's discussion, the consensus seemed to be that there was not sufficient evidence at this time to

support aligning MFP resident criteria with the settings rule. Ultimately, the decision reflects values in terms of what people's views are on the most appropriate use of MFP funds, and so, with that, the draft chapter outlines the arguments for and against changes drawing from your discussion as well as the stakeholder perspectives.

So, first, we reviewed the rationale for retaining the existing criteria. First, that it focuses on small and highly integrated community settings. The MFP settings may promote greater autonomy for beneficiaries in terms of choices over their everyday lives. Also, we heard from stakeholders that there is a lot of uncertainty right now about implementation of the settings rule, and there were some concerns about implementation that led them to prefer maintaining the status quo.

We also know that other authorities outside of MFP may be used to help beneficiaries transition to the community. Transition services can be provided under existing waivers, for example, and so those don't have the same restrictions that MFP has in terms of where individuals can live in terms of receiving those funds.

Then, finally, that MFP incentivizes states to

promote HCBS infrastructure development, and that pushing the systems towards these smaller settings was valued by many.

In terms of the rationale for changing the criteria, of course, we also heard that broadening the criteria could open up more settings to be eligible for MFP transitions, and also that it could be simpler for states to have one set of rules. So having all settings treated similarly may reduce any operational challenges, and also in terms of claiming federal funds for transition services, it would be simpler because there wouldn't be a need to differentiate different settings.

We end the chapter discussing some other concerns about MFP, things we heard through our stakeholder interviews; for example, other challenges to transitions. We heard a lot about housing availability and workforce capacity. Stakeholders discussed sort of the lack of affordable and assessable housing as being a major challenge and the workforce capacity as well. Those are themes that we hear throughout work related to rebalancing and expanding access to HCBS. So we weren't surprised to hear it but wanted to make sure that we highlighted that

here as well.

We also heard quite a bit about funding uncertainty. In recent years, there were a number of short-term extensions to MFP, and during that time period, some states found that they had to let go of staff, as they weren't sure whether the funding would be extended. In some cases, it was, but it was difficult for states to plan ahead.

Currently, MFP funding is authorized through fiscal year 2023. States have some flexibility to continue to spend those funds for additional years if they don't exhaust them in the first year of award. However, we had stakeholders bring up the fact that it's still only a few years away and they're starting to have to think about what they're going to do in terms of the future of the program.

Finally, we also wanted to highlight a lack of recent evaluation data as being something that has hindered our understanding of MFP in recent years, and additional data could help assess issues like the qualified residence criteria standards in the future.

So, in terms of next steps today, we welcome any feedback you have on the draft chapter, and we'll go back

and make some revisions and plan to publish this in the March report to Congress.

With that, I will turn it back to the Chair. Thank you.

CHAIR BELLA: Thank you, Kristal.

As you all know, we've had a lot of discussion and debate on this and have gone -- this is a topic where we have spent some time and I think really are trying to convey that in the report and help explain the tradeoffs. So, Kristal, I appreciate you gathering all of that and putting it into the chapter.

From Commissioners, it would be helpful to know if you have feedback to ensure that it captured our discussion and also if there's anything substantive you have comment-wise. If there any sort of edits, those can be handled offline. So this is really for substantive comments, not for edits.

Toby, I'm going to start with you.

COMMISSIONER DOUGLAS: Okay. Thanks, Melanie.

First, Kristal, I've been on the Commission a long time, and you've done such a wonderful job on all the HCBS, and this is a great chapter. Again, good job.

I read the chapter and really feel the chapter embodies a lot of the discussions and all the interviews and information.

The one feedback that I'd ask when you go back and look at the chapter, just the summary of it. Given that there were such different perspectives, I'm a little concerned that the summary is so succinct that it doesn't capture the diverse opinions and where we really landed on why and if it was as definitive on that, so some nuancing on how you do it. Again, I'm not going to wordsmith, but just make sure that it's clear the Commission had different perspectives.

Thank you.

CHAIR BELLA: Thank you, Toby.

I'm looking for other hands. Brian.

COMMISSIONER BURWELL: I echo Toby's praise of the chapter.

Kristal, I really think you did a great job on an extremely difficult chapter with difficult concepts about living in community-based settings and standards for these populations.

I think it was well framed. The topic was well

framed, and I think you did reflect the feelings of the Commission in presenting both the advantages and disadvantages of each option.

I only have kind of two substantive comments. I mean, one doesn't really relate to the chapter itself. I think MFP is a great example of how demonstration programs can be used to influence Medicaid policy and the fact that these demonstrations often end up with unintended consequences. MFP has really evolved into a program in and of itself rather than a demonstration, though that's how it's often referred to as.

I think that this is a topic -- you know, we have only a half an hour -- that we should return to or the Commission should return to. We've had other discussions of this type around 1115, both research and demonstration waivers, and I think it's something -- MFP is a good example of how demonstrations do evolve into something else and develop their own constituencies, et cetera, rather than something that we learn from and then adopt into mainstream policy. That's really an aside.

The only comment I really have on the chapter is really more of a tone one. I wish that we could be more

explicit around the sentiment of the Commission in our language. I noticed that you often use the term just "we" rather than the "Commission," and I don't see any reason why we can't be very up front with saying, you know, the Commissioners had very mixed views on this issue and could not come to any consensus about alignment versus nonalignment, and therefore, we're not making a recommendation on this. I don't think there's anything wrong with being up front about differences of opinion within the Commission.

CHAIR BELLA: Thank you, Brian. I think along the lines of what Toby was suggesting too, take another look at making sure that conveys the differences in the discussions.

COMMISSIONER BURWELL: Mm-hmm.

CHAIR BELLA: Dennis, do you have a comment?

[No response.]

COMMISSIONER BURWELL: I think you're on mute, Dennis.

COMMISSIONER HEAPHY: Yes, I was. Thanks.

I was the most outspoken person in supporting remaining -- of maintaining the guidelines, and I think I

appreciate everyone's perspectives on wanting to align the HCBS and the MFP requirements. I think, contextually, though, what's missing from the conversation is that the disability community itself has been pushing for maintaining ongoing funding of MFP and preserving the current standards so that we don't end up with the minimization of those opportunities to actually live and engage in community settings.

I had actually sent a lot of recommendations to Kristal, but for me, what is critically important is the idea of someone being able to lock the door. That may seem like something that's small, and yet being able to lock your door or having your lease give you a lot of control over your environment. I've got a lease to my apartment. That's my place, my home, as opposed to I'm living in a setting where someone outside myself has control over when I come and go, whether or not I can actually stay in that apartment, and so if it's a group home setting or something, so that someone outside myself with external authority can actually determine my rights based on my behavior within the scope of that program as opposed to living in the community where I actually have the

opportunity to be staying like within that context. I don't know if I'm expressing that clearly enough, but I think that's a big difference.

When I've lived in different settings, I appreciate the need for different opportunities, but MFP is unique and I think sets a bar for what the ideals that Olmstead puts forward, and so I think we have to look at this in a broader context that, all of a sudden, it's not just about relieving a cost burden but really about maximizing opportunity for folks to realize their civil rights in the community. And MFP sets that bar.

I appreciate from the state's perspective of folks that implement this, how challenging it can be, particularly within the context of our environment, but at the same time, I think we need to have some sense of the initial purpose of Olmstead, at least from the perspective of the disability community.

Was that helpful?

CHAIR BELLA: Thank you, Dennis.

COMMISSIONER HEAPHY: With all that said, I really appreciate all the effort that Kristal put into the chapter, and I look forward to reading it.

CHAIR BELLA: Thank you.

Other comments from Commissioners?

[No response.]

CHAIR BELLA: Kristal, do you have what you need?

DR. VARDAMAN: Yes. Thank you all. I appreciate your comments, and we'll go back and make some revisions, including fleshing out some more on the Commission's discussions that you all have had over the past couple months, so thanks.

CHAIR BELLA: Okay. Hang with us for just a minute. We have a little bit of time before the panel. So I'll go ahead and see if we have any public comment here. So I'll open it up to see if we have anyone in the public who would like to comment on our work on this chapter. If you do, please indicate by using your hand icon. I am not seeing anything. I'll give it just a minute.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. I don't see any public comment.

Kristal, thank you very much. I appreciate your work and look forward to this being released publicly.

Thank you.

DR. VARDAMAN: Thank you.

CHAIR BELLA: All right. Anne, we are a little ahead of schedule. If our panelists are here, we can start or --

EXECUTIVE DIRECTOR SCHWARTZ: I see two of our panelists are here. We chased away someone and told her to come back at 11:00. So you might want to wait a few minutes here.

CHAIR BELLA: Okay. We'll just give everybody five minutes. So, if you want to turn your cameras off, feel free. Please come back in five minutes, and we'll get started with this panel. Thank you.

* [Recess.]

PANEL DISCUSSION: BENEFICIARY ENGAGEMENT AND ELEVATING CONSUMER VOICES IN MEDICAID POLICYMAKING

* MS. FORBES: All right. Well, let's get going. Good morning, everyone, and "welcome" to our panelists.

At the December meeting, the Commission heard from two expert panels -- one about how we can design, implement, and improve a system for monitoring

beneficiaries' access to care and the other about what it means to apply a health equity lens. Part of both of those discussions was the issue of how to better engage Medicaid beneficiaries in policymaking and in our work on reducing racial and ethnic disparities.

Given how much focus the Commission has had on beneficiary engagement within those topics and throughout many of its discussions, we thought we should bring in some experts to talk with you specifically about how Medicaid and CHIP can more consistently and effectively work with and hear from the people served by the programs.

So we've asked three people to join us this morning who will share a couple of different perspectives on this issue, and I'll introduce them in a minute. But, first, to explain the plan for this session, I will start with a couple of questions for the panelists to get the ball rolling, and then I will turn it over to the Commissioners, as I'm sure you have lots of questions of your own. And there will also be an opportunity for Commissioners to have a discussion among yourselves after the panel concludes.

So our three experts today include Kate McEvoy,

who is currently a program officer at the Milbank Memorial Fund. She is also the former Connecticut Medicaid and CHIP director and former president of the Board of Directors at the National Association of Medicaid Directors. In all of those capacities, she has worked to elevate the consumer voice.

We also have Cara Stewart, director of policy advocacy at Kentucky Voices of Health. We have reached out to her many times before at the staff level. She'll share her experiences working to connect local community-based organizations and the state Medicaid agency on a variety of issues.

And we have Cathy Simone, a Massachusetts Medicaid member who is enrolled in the Commonwealth Care Alliance Health Plan and is a member of its Member Voices Program, and she'll provide her firsthand perspective.

Their full bios are in your meeting materials, so I'll leave it at that. I do again want to thank them for being with us today and offering their perspectives.

And the last thing I want to say is there's nothing -- there's no specific actions for the Commission to take at this time. We thought it would just be helpful

to have a dedicated conversation about this and give you the opportunity to hear about what's going on at the state and the plan level and what some of the challenges and opportunities are, particularly as you're thinking about future work and how to do more to incorporate the beneficiary perspective.

So, with that, I'd like to start -- sorry, Cathy, I'll put you on the spot -- by asking you about your experience as a member of a health plan that has a robust member engagement function. You know, Commonwealth Care has Consumer Advisory Councils and something called "Member Voices" that identifies members who can provide input on different issues. So can you start by telling us more about how you as a member participate in that or maybe give us an example of how you've gotten involved in a specific issue?

* MS. SIMONE: Sure, I can do that. Can everybody hear me?

MS. FORBES: Yes, thank you.

MS. SIMONE: Good. Probably about three years ago, I had lived in Florida but I had moved back to Massachusetts. I'm originally from here. But, anyways, I

came back for the support of my family because I was dealing with some mental health issues. And so when I came up, I took care of all that, and then the next thing I did was I got on MassHealth, which is in Massachusetts we have -- you basically can't live in Massachusetts without insurance. So if you have no insurance, they will put you on an insurance called "MassHealth," and that's where I started, which is Medicaid for Massachusetts.

And then I proceeded to, a couple of years later, I had heard about someone at a medical center that I was attending for mental health behavioral services. They had suggested that I look into the One Care program, and the One Care program is the Commonwealth Care Alliance, which is part of Medicare and Medicaid. And so that's what I did. And so since then, probably about three years ago, I've been attending this. And a couple of years ago, they asked me to come on board with some focus groups and then the Advisory Committee through the Voices program.

There's been ups and downs with it, but the majority I have found that I've been very happy with what they do here because, because of this all-encompassing program, it helps me in a lot of ways. And I guess it's --

for this program, the MassHealth part was different than what I'm in now, and the Medicaid one was -- I guess it was a little bit different because of the fact that it just focused on just Medicaid, and now it has to do with everything that I -- Medicare and Medicaid, which is really good.

My experience with them, like I said, has been a little bit up and down, but I have had very good experiences when I, I guess, advocate for myself, which is really good. The only drawback is sometimes I get concerned that some people might not be able to navigate some of the services, and that's probably one of my biggest issues, not knowing which services are available out there and what programs could benefit me and other people.

So that's about it.

MS. FORBES: Okay. That's helpful. I'm sure that's something the Commissioners will probably follow up on. But I did want to follow up with the other panelists. Cara is not at a health plan or the state, but works with consumers and community-based organizations. Can you share some examples of what has been done in Kentucky to promote beneficiary engagement?

* MS. STEWART: Sure. You know, sort of how Cathy started, there's sort of a mixed bag. We had had some approaches from our state to engage enrollees in Medicaid that have been really wonderful and some that have not. And I've been thinking quite a bit about what the difference is in the ones where it feels adversarial rather than collaborative and kind of what works. It's very easy for it to be very alienating if you're having someone who doesn't sit in a bureaucratic meeting all day and who doesn't speak sort of that language in the same kind of policy way come into a meeting and feeling like their voice is the most important voice, because it is, but it's hard to get that feeling across, even with people that we work with directly a lot and provide technical assistance to. Something they often say before a meeting during prep is, "Well, I don't really understand enough about that." And, of course, the reality is, no, you understand the most because you understand your experience and you are an expert in your own experience, which is what matters.

And so the meetings where that can be communicated are the most successful -- the meetings where there is technical assistance provided for enrollees and

professional support. You know, so when they know that there's someone who's got their back, to answer their questions- before or after. I feel like that's kind of the best thing that we've done in Kentucky, is work with community groups, with the state and consumers, and kind of have a three-level, three-layer approach to engaging consumers with the government directly.

MS. FORBES: I'm sorry. Can you just elaborate on that a little more, the three-level --

MS. STEWART: So, in most states, in most laws, when you're going to have a panel or an advisory board -- in Kentucky we have some formal structures for engagement with Medicaid. We have our Medicaid Advisory Council. We have a Consumer TAC, a Technical Advisory Council, which has consumers on it. And those are very formal and don't feel as productive for changes to policy or in the consumer experience for me and the people that I've watched participate and seen participate and listened to.

The ones that feel more productive is our state-based marketplace, kynect. We have an advisory board there, and on that advisory board there are some consumer advocates, but then advocate groups support some members,

you know, some people with current lived experience. They have got someone like me or another advocate who does that professionally with the policy piece supports that person -- you know, answers their questions before or after.

And there's really two pieces to make it work, in my opinion. There is having that technical support and that professional assistance, and then there's also having a closed loop, because nobody likes to feel like they've made themselves vulnerable, put themselves out there about their experience, and nothing happens. If you feel like you're throwing yourself into a bureaucratic dark hole, you are not likely to want to share that experience again.

Something that we've done in Kentucky with the kynect Advisory Board has been to keep the agenda recycling so that every month or so, there's the same issues back on there again, and that way -- in early days, in our first version of kynect, this was really empowering, and it was also -- it made improvements. And when -- that's kind of the ultimate end goal. It's a win-win when people see their participation leading to changes. And if somebody's had a bad experience, seeing it change will make them a lifelong engaged consumer, lifelong engaged enrollee, which

is what I'm always looking for, is raising people's voices in that way.

So having that follow-up of, "okay, we heard you, this is what happens" -- even if the answer is "we're not able to change that or fix that," just the follow-up, you know, having a response, can really make a huge difference in the way I've seen people interact.

MS. FORBES: I think that's a really good segue because I think that Kate has some ideas, sort of going back to your state experience, on how states can facilitate standing means of beneficiary engagement to ensure that sort of continuous feedback loop.

* MS. McEVOY: Thanks so much for the opportunity to wrap around those comments, and I just first want to say I'm really honored to join Cathy and Cara. Cathy, it's not a small thing to share your experiences personally. And, Cara, I'm really compelled by especially the frank conversation around the failure points of the traditional mechanisms that we've relied on.

I do want to reflect back. I really hear you on some of those aspects. States have typically channeled most of the attention and energy in these areas, even where

there's a lot of good will and urgency on the part of state officials. And I know that is the case, and it has been nothing but enhanced by the urgency especially of communities of color during the pandemic.

That said, as you pointed to, Cara, it tends to take the form of the static opportunities through, you know, highly structured Medicaid Advisory Councils. The state plan amendment comment process can often feel, as you said, really impenetrable. It's as though it's a process that's hard to navigate, of uncertain value and intimidating. And I think all the observations that you made -- and Kentucky was an amazing exemplar of consumer-led work on really putting in place an exchange that worked for people. So I really congratulate you on that.

So many of the aspects that you talked about lead me to say that, you know, state officials can do much more to start from a posture of humility and be asking big foundational questions of people around how the programs can improve their lives and not rely on these mechanisms that I just described that tend to be very issue-specific and static in time, as I said. Also, really only allow members to penetrate when policy proposals have already

been kind of prioritized in the hierarchy of needs and also, you know, framed pretty comprehensively.

As you said, you know, forums can tend to also have an antagonistic dynamic and not be engendered in a way around mutual interest, around the questions of improvement, and that's not often demonstrated. So to Moira's question, in Connecticut there were several examples where we really tried to engender something different with intentionality, and it's a hard process for us all constantly bringing that attention and energy into doing something different and more meaningful.

One of those -- you know, going back to Cathy's comments, she described that process of her own navigation, from entering Medicaid and becoming part of the duals plan. I mean, your last point, Cathy, around that being difficult for many people, you exemplified that in terms of how you kind of found that pathway and you've had learning that is valuable to everyone among your peers.

We had a similar set of circumstances with a number of members who received behavioral health services in Connecticut. We have a very comprehensive BH benefit in Connecticut, a recovery model, a lot of attention to

evidence-based interventions and the like, but historically really fell down on a lot of the aspects of saying to people, you know, what can we do better and differently. Members really took the initiative, this small group, a kind of nucleus, to come together and say, you know, we have really strong, experiential evidence of some of the gaps and the failure points; we'd like to not just come and give comments on actions that the Medicaid agency has taken, but we'd like to form our own entity, self-actualize. They became part of the consumer and family group that really stands as a partner to the state in advising not just on the sort of aftereffect of the decision about policies, but really generating new ideas and, as you talked about, Cara, that feedback loop.

This group is also extraordinary in that it sponsors an annual conference called "iCAN." The entire conference is member-led, -originated, all the curriculum, all the speakers, and it's a focal point for development of legislative priorities and specific feedback not just for the Medicaid agency but for all the domains of human services. And they own that whole process, it's self-perpetuating, and so that's an example -- you know, I think

Cara and Cathy are talking about opportunities that feel like they are member-led, member-originated, and kind of go back to that disability-informed perspective of it arising out of the lived experience as opposed to perceptions of state officials.

So I just offer that as something that has been really meaningful to me.

MS. FORBES: Thanks, Kate.

So to go back to Cathy, you're someone who has given your time; you've participated in these things; you've offered up your perspectives on things at the health plan level. But you also sort of noted in your opening remarks that you also have -- you know, it isn't always clear, like what -- how to navigate and what the benefits are and things like that, especially in a duals plan. So do you have any thoughts, from where you're sitting, on things that states or health plans could be doing to make it worthwhile for consumers to be providing their time and expertise and so it's not just a one-way street? What makes someone feel like their input is valuable and has an effect or shows that it has value?

MS. SIMONE: Well, one of the things that this

program provides is called a care partner. It's basically a case manager type thing. And that person on that end, when they are attentive to me, I feel like, I don't know, I just feel like this is great. I'm getting the services I need. I feel like someone has compassion and cares about me, like cares about me individually and about my health care. And that makes a really huge difference -- that connection.

The other thing is, like what Kate was saying, about this members-led environment I think would also be really good because when I got to the Voices program with these other members, you know, we talk about things but we also have this bond or this collaboration that goes on, and I think that helps a lot. Because I learn so much from other members, and it's only a small group. I mean, in the past, because of the pandemic, it's gotten really small, but in the past it's probably been up to like 10 to 12 members. And some of the things that go on there I didn't know.

So it's great that you have this interaction with the members, because then I learn things as well, which is members-led, if that's what I'm kind of understanding.

Maybe that's something that she's thinking about. But that's how I see it.

Just for example, there was only four of us in the last meeting, or something like that, but there was a gentleman there -- I think he said he just broke up with his partner that he had for seven years -- and he didn't know that the program had 24-hour/7 clinical behavioral services, because he was waiting for an appointment with a therapist through another program -- well, through this program but through the service line he contacted somebody. And I said, "Oh, you know, there's a program right here that you can all right now and schedule something immediately," because he was having a really hard time that he just ended up in this breakup.

So it's stuff like that that I feel that, you know, it falls through the cracks type thing. And the other thing, when these people were talking, is the stigma that is attached to Medicaid. It's unbelievable when I go into a doctor's office or see a nurse or whatever, I sometimes don't reveal my insurance or my background and stuff because of the way I feel that I am treated. I know that you talk about racism, but I don't know if people know

about the stigma that's attached to it whether it's mental health or just being on Medicaid.

So I just wanted to point that out now, because that's also something that seems to happen in the system. I don't know if any policy can change that. It's more probably something cultural. But I just wanted to bring that up. I think that's a tough thing for people that are on Medicaid also struggle with.

Thank you. I hope I answered your question.

MS. FORBES: You did, and thank you for raising that. I mean, it's exactly why it's helpful for you to be here today, so I appreciate you raising that important point.

Another question I guess that I could sort of throw out to all of you is, and Kate sort of touched on this a little bit, is that there are some federal requirements now where states do have to put some things out officially for public comment, and those mostly revolve around either provider payment changes, and of course the providers speak up, and waivers. I mean, there's a couple of things where there's a federal requirement. MACPAC's job is to make recommendations mainly about federal policy.

Are there areas, --Cathy, I don't know if there's things where you feel like beneficiaries have had more of an effect when you've weighed in at the plan level, or Kate or Cara? Are there things where there should be more requirements that like, yes, states should always have to go out and really get more public input before they make changes in this area or that area? Not that we have all-compassing power at MACPAC, but in theory. I'll just throw that one out.

MS. STEWART: You don't? I misunderstood.

I'll say that in Kentucky we had tremendous success at engaging both with that public comment period. You know, when we had an 1115 waiver proposed in here Kentucky we had like 12,000 comments, from almost 10,000 unique individuals, and the majority of those were people that did have direct experiences. So having that opportunity did make it easier to engage with folks and show the path. Sometimes people are like, "Where's the door? How do I engage somehow with this sort of giant structure?" And when you have those specific pathways where you can give people specific instructions of how they can do it and ask specific questions, people are willing to

share.

But a lot of times if you're giving somebody sort of a blank box or a general right to your person, who is going to do it, right? I mean, it's hard to get started. But whenever there are specific changes, yeah, I think it's the right way to engage folks in what that would look like in their lives.

MS. McEVOY: Yeah, I think that's beautifully said. I just would like to see; I feel very compelled to comment as a former state official. We need to back way up from that point in time, you know, to a much earlier junction point.

I would use as an example, because I know you've been discussing, Money Follows the Person this morning: Connecticut has had, for 20 years, since the first progenitors of MFP demonstration grants, a body that is composed of a majority of individuals with disabilities, with lived experience in what doesn't work around our landscape for people, from an accessibility standpoint, experiential. And as the state first embarked on Money Follows the Person, one of the reform goals around systems change was to say we need to operate differently, that this

body, the rebalancing advisory group, would be a thought partner in developing the operating plan for MFP.

This was a very kind of radical thing for a Medicaid agency to do, in that I think there's a lot that we tend to keep behind the curtain, in terms of the formal processes, especially of framing the policy implementation that we do on that kind of day-to-day basis.

You know, thinking about how to engender enough technical expertise in the Medicaid nuts and bolts, while capitalizing on, like I said, the lived experience and expertise of the people who are on that body, was the sort of central question of how to leap off that, and that has informed that work in Connecticut ever since. There's not a sort of sequential aspect of how Connecticut approaches this. It's always concurrently advised. You know, Cara talked about the need for a feedback loop. It's actually a kind of corollary process where that body is advising.

And that body then naturally morphed as the state elected to do a Community-First Choice state plan amendment into co-writing that state plan amendment. That's also kind of an unusual exercise. State officials don't often let folks in on that process, and they were also, some of

them, sitting in on the calls with CMS to negotiate that state plan amendment.

So I'd really like to urge, you know, yes that public comment process can be made much more meaningful, but really thinking about opportunities to go back further upstream in the decisional process, because it had incredible value for us in terms of coming to a more meaningful benefit.

MS. FORBES: Thank you. That's super helpful, Kate. Thank you.

And then I guess my last question before I turn it over to the Commissioners, and this comes back to, you've given a lot of specific things I think that we can all take back. Obviously, a lot of this work, I mean, sort of the envelope of a lot of this work is to remove barriers so that people can be their healthiest selves. Do you have any sort of final thoughts on any other changes that we can make to help, I mean specifically to this issue of engagement?

MS. STEWART: Well, I would love to follow up on what Kate just said about making the process more meaningful. So in Kentucky, even in very recent years,

we've had the opportunity to engage with state agencies that intended to have meaningful engagement and a state where the 1115 comment, public responses were completely ignored. We had to use the Judicial branch to enforce the law requiring the state to consider those comments, and the state agency even sued Medicaid members for having comments and complaints, which is a very scary sort of situation to be in when you're asking somebody to put their name out there, knowing that in the past somebody did that and the state sued them. You know, they sent sheriffs to their home, knocking on their door.

And so anything that you all can do to put guidance in around that meaningful response and exchange, knowing that at some point, in some states, like Kentucky included and some of our neighbors, will have very hostile state agencies. And even if the individual workers aren't -- because usually they aren't, because usually they're people that understand the programs and the benefits, but their boss, you know, gets turned over with elections, and that is a very real risk that needs safeguards.

MS. FORBES: Cathy or Kate, any --

MS. STEWART: Sorry to be a downer.

MS. SIMONE: Can you hear me?

MS. FORBES: Yes.

MS. SIMONE: Okay. I just wanted to bring something up that happened to me this week, and this is probably, again, nothing. I don't know if policy can change this or whatever. But one of the things that happened is I finally found a dentist near me. So services can be sometimes very difficult to find, a doctor or somebody, a specialist, that will provide services because of the insurance that I'm under, whether it's Medicaid or Medicare now.

So I just got a phone call from them, and I was looking so forward because it's been six months. I was going to go for my cleaning and I knew I had some dental work I needed done. And what happened was is whoever, somebody at the office, called and said, "We no longer take your insurance." And I was so disappointed because it took me so long to find somebody there. They were a great service. And now I have to go back into the program and find out where I can find somebody. And like I said, it took a long time to find somebody that took the Medicaid or MassHealth.

And the other thing was, because there's a lot of things that are around here that don't take it, and so now I have to go back to the drawing board, which I'm not looking forward to.

So I just wanted to share that, as well as there was another thing that was going on that the company said that they did take it, but then when I called to see if I could make an appointment they said that doctor doesn't take it. And that was another frustrating thing.

So I just wanted to kind of -- you know, you talk about safeguards. I don't know. It's so disappointing to have such a limited amount of services to not be able to go to anybody, to be perfectly honest with you, that I have to, again, navigate to find out where I can go and who I can see. And it's not easy. I mean, they have a directory and everything, but it doesn't always -- like I said, I could go on the directory. One day I had like ten people, and I called them all and they said they didn't take it, even though it was listed on the directory that they did.

So I just wanted to kind of point that out, because that can be not fun to do.

MS. FORBES: Understood. Understood. And

managed care oversight is on the Commission's agenda.

Kate, did you have any final thoughts before we go to the Commission?

MS. McEVOY: I just want to leap off where Cathy said. You know, Cathy, what you said was extremely powerful, and I just want to reflect back. You know, at the federal and state level we often tend to look at things as systemically. You know, as a Medicaid director I would have had a lot of data on access, you know, the number of providers and the timeliness of getting someone into services. I have data on experience of care surveys we do, like on an annual basis. We use mystery shopper calls to try to call a practice as if we are a Medicaid member and see how we're treated.

That said, those things tend to describe things very globally and they are not occurring on a very regular basis. Like I said, it's often annually. And what you just said about your experience, you know, there is a directory, Massachusetts is a state with broad coverage, a lot of providers, good provider reimbursement, but you still ran into a complete obstacle in getting the service you needed, which has an impact on lots of aspects of your

life, I'm sure, in terms of how you can fit that in with your employment and everything.

So what you said is, I know, incredibly helpful to the Commission in terms of examining how we do that on a kind of more rolling person-informed basis so that we can translate. We may think the program is operating very well in some of those aspects but on an individual level that's not the case.

And I'd just go back to that comment around kind of member-originating groups. An example in Connecticut, there was a self-advocacy group based in New Haven called the Kitchen Table Cabinet, affiliated with a local community organization, Christian Community Action. They had met for years, primarily around self-advocacy and training around the legislative session, but they, like you, could say, "You know, you may be saying this is how the program operates but that's not what I see on a day-to-day basis." And that's what Medicaid directors need to hear more about.

So thank you very much for offering that experience.

MS. FORBES: Well thank you, Kate and Cara and

Cathy. That was all the questions I had so I wanted to turn it back to the Commissioners. And I think Kisha is facilitating the discussion?

CHAIR BELLA: She is, yes.

COMMISSIONER DAVIS: Yes. Thank you, Moira, and thank you to our panel. We have lots of questions already in the queue, but again, we just love having a panel, and I think the insights that you brought already has been so helpful. And we'll start with Bob.

COMMISSIONER DUNCAN: Thank you, Kisha. First of all, I'd like to thank the Commission for putting together this panel. Cara, Kate, thank you for your leadership and what you have been doing to engage the stakeholders. Cathy, I appreciate the reality that you bring to the Commission, because this is one of the big roles of the Commission. So thank you for your honesty and your experience. I appreciate it greatly.

Cara, a question I have is, and again, I appreciate your honesty in how elections can impact in the real world of state government. You mentioned some things that could help set standards in place so that regardless of what happens in an election there is that continuity and

consistency there to take care of the members. What would be some things that you would recommend around that?

MS. STEWART: Well, I mean, how many do I get to choose? So I would say you could put in some payments. You could do all kinds of things that would put in guardrails to guarantee easier use or easier engagement and protections, because all you have to do is look at what -- you can look at what Kentucky tried to do a few years ago. Just go look and see exactly what Kentucky tried to do to Medicaid and then say, "Okay, none of this is allowable because we know it creates terrible health outcomes that is bad for the program and not the intention of Medicaid."

So, you know, the playbook is out there as to what the risks are. You know, the risks are an over-burdensome preventions of fraud and the over-proving of information that the state has access to. So I'm also a connector, which when Cathy was talking about having a person, that is a real person that works with you. In Kentucky sometimes that's been the most successful -- our connectors, in having real people in in communities that they can text and call and see in person to answer their questions about getting enrolled, but also throughout the

year.

You know, I have people call me with questions about prescriptions. They get a prescription and they're like, "What do I do now?" And having somebody that they know knows them and cares about them to answer that phone, that's not calling an 800 number where you're on hold forever and don't know who you're going to get.

But, you know, during that time we had attacks on Medicaid members and just ways that could be prevented. You could say you're not allowed to. You know, you're not allowed to ask for birth certificates if the state already has it and it has already been submitted once. Right? You are only allowed to do that however so often. I mean, people are only born once; why do they have to prove it multiple times a year?

So simple things like that. Or requiring the state to use their own resources to verify information before putting the burden on the consumer. It doesn't make any sense why the consumer is supposed to go to that particular building to get a piece of paper, to give to somebody in that same building. But yet we require that of folks.

And in states that are looking to overburden their residents, those are the kinds of things they are going to do. So to say you can't, and it's on the state to do those things, then that would put in some protections.

But if you would like some very specific recommendations I will happily get you a laundry list.

COMMISSIONER DUNCAN: Thank you. I appreciate that.

COMMISSIONER DAVIS: Thank you. Tricia and then Martha.

COMMISSIONER BROOKS: Thank you, guys. This has been a great panel.

Cara, good to see you. I wonder if you would lift up a little bit more the breadth of the relationship that connectors have with both Medicaid and marketplace enrollees. It is fairly unusual, or uncommon, that basically you are their eligibility case manager, if you will, that you know everything about them, you can see their notices, you know when their renewal is due.

How did that come about, because I'm frustrated that more states don't provide that breadth of consumer assistance, which I think would be extremely helpful.

MS. STEWART: Oh. Well, you know, I'm the choir on that one, Tricia.

So it came about through consumer engagement and consumer advocate engagement in the early days of our state-based marketplace. That kynect advisory council, when we had that sort of monthly feedback about what would be helpful and what would work and let's try this, and, I mean, we had live testing where, hey, let's try this out, hey let's try this out, and let's bring people in and have real folks try this out and see how it works and if it's actually understandable. Having those focus groups was what we found to be incredibly helpful.

Right now, we're trying to replicate that by having Dr. Jamila Michener do a study in Kentucky of interviewing lots of people who are currently enrolled in Medicaid, child care assistance, SNAP, and WIC, and also some staff to figure out what's working on both sides because if people aren't able to do their jobs, even if they're very well intended, it doesn't matter.

But, in the early days when we were having those sort of feedback sessions with the advisory committee and going back and forth, something that we created and the

state supported was this dashboard. So, like Tricia is talking about having -- I know if somebody that I have enrolled, if they get an RFI at any point in the year or if they have a change, I get that notification too, and I have a case management dashboard built into our state-based marketplace that allows me to prevent people from calling through cracks, to do that sort of emotional labor of the check-in and the follow-up, and I can calendar things and use the fact that I am paid to do that and put it on my calendar. Whereas, you know, that person is not. So I can make it easier, and I can let them just text it to me, which is easier for a lot of folks, or I know I'm going to run into them here, there, or yond. I know where they work. You know, I'm going to go see my hairdresser today, and I do her enrollment, and I'm going to do something while I'm getting my hair done and update that because that's the normal sort of part of the work.

But integrating it into your daily life, kind of in that way, is a more honest approach, and I think having kynect with that dashboard, I suffered whenever we had Healthcare.gov and I did not have my dashboard. I mean, how do you -- what do you even do? Like, how are you

really helping people? You're just kind of sitting beside them by a computer and reading to them? Like, that isn't really helping, and so if you're going to have helpers out there, give them the power to help. If you're going to have people -- and there are people in every state who are willing to help, and there are people with deep policy knowledge and deep procedural knowledge who are willing. You know, there's legal aid lawyers everywhere, but if they don't have the tools to do it, then it's not meaningful. And, luckily, in Kentucky, we do have those tools, and I'm very, very appreciative for it.

VICE CHAIR DAVIS: Thank you, Cara.

Kate or Catherine, did you want to weigh in on this point at all before we go to Martha?

MS. McEVOY: Cathy, do you have thoughts?

MS. SIMONE: Well, I have a -- you know, something came to me when you all were talking. Someone brought up fraud is a huge thing, I guess, in the system.

I was just wondering if anybody knows who checks that. I don't know if you know the answer to this. I was just curious. Who checks into that? Are they self-responsible for that, you know, whoever is submitting this,

the information? Because I know that the organization that I belong to, this CCA, they're huge. They're a really big organization, and I was just kind of wondering who checks to make sure that I did see this person. Does anybody know the answer to that? Do you understand my question?

VICE CHAIR DAVIS: Yeah. I think there's the perception of fraud and then the reality that it may not be as big an issue as it may be perceived to be.

Cara, you look like you're chomping to respond to that.

MS. STEWART: Oh. No, I was just going to say, like, Cathy, there is no real consumer Medicaid fraud. You can't like go to Walmart and use your Medicaid card if it's not a thing. It's a perception, like Kisha was just saying, but there's a gazillion checks and balances --

MS. SIMONE: Okay.

MS. STEWART: -- and for providers to make sure. Yeah. Whatever is happening is happening on the provider side, and I think we're doing a fine job of catching it.

MS. SIMONE: Okay. I was just curious about that because, you know -- and I'm kind of wondering, is that also something out there culturally to -- you know, like

what you were just saying. It's not maybe as big as the public is hearing that it is because the way that I hear it, if I do hear it, it comes out that way that there's a lot of fraud going on in Medicaid and Medicare.

So, you know, again, here we are listening to things that aren't really happening in the reality world, I guess. So thank you for answering my question about checks and balances.

MS. McEVOY: And I think what Cathy said really did illustrate the linkage between the two questions that were posed by Commissioners, you know, how to set critical mass of demonstrated achievement in the program to help insulate it against major policy changes that can occur with transitions and the question around how to kind of engender participation in a comprehensive way with a relationship of a lot of Medicaid programs and the exchanges.

Connecticut is another example of a state-based exchange.

And I think Cathy is getting in an important point, and that is, she also talked previously about kind of public perception of Medicaid. What can we do in terms

of translating messages around the rigorous existing processes that accompany documentation confirm through both the federal and the state-based marketplaces, to the extent there's a few left, you know, to counter what can often be, you know, a pernicious and difficult set of messages that is broadly held and can tend to have a race-based component of perceptions of people who are using public insurance? How do we engender that through publication of data and our practices, but how do we also achieve that critical mass of people who are sharing their lived experience through grassroots advocacy of the type that was, you know, so prevalent in Kentucky to counter, to level set the misperceptions that I think perpetuate, especially the stigma, the perceptions around a fraud to which Cathy was referring?

And I think the reality is there, you know, can be hopefully, you know, address this especially through member effort that can be enduring, even if specific state structures are interested in transparency or direct member engagement, even if that changes over time.

VICE CHAIR DAVIS: Got it. Thank you so much.

Cathy, I think it speaks just to the importance

of folks like you being here on these panels, and when we talk about reducing the stigma that surrounds Medicaid, the way to do that is to hear from folks who are on Medicaid and their lived experience and ensuring that we're getting diverse voices and a variety of voices in the room and in that conversation. So, again, I just want to thank you for being here and bringing that perspective.

We'll go to you, Martha.

COMMISSIONER CARTER: First, again, thank you, Cathy, Kate, and Cara. That was a nice alliteration for sharing your knowledge and experiences with us.

I've got a question for Cara. I want to check out something that I think I heard, but I want to go back to it.

I kind of understand that your role is direct service and also support and advocacy. I thought you talked about technical assistance for people who are serving as a consumer voice.

MS. STEWART: Yes.

COMMISSIONER CARTER: And I think that's really powerful. Having had consumers on the board of directors of my organization, I realize how much support they needed

to feel comfortable and empowered to speak up.

I want to just have you flesh out a little bit more how that system works, how it got started. I'm curious whether that exists in other states and whether that model could be spread because I think it's really a very strong and powerful tool.

MS. STEWART: Thanks, Martha.

I feel very strongly about if you're going to ask someone to share their experience that they be well prepared and it be meaningful for everyone involved and it not be exploitive and it not be -- there's a lot of risk involved in that. When you're asking somebody to testify in front of a committee, well, somebody may be very, very mean to them, and you need to tell them that in advance and what that could be like. It takes a lot of reframing where the power is.

So, yeah, the way that we do that is we do pre-meeting preparations, and we do ongoing education. But I have no interest in taking Medicaid enrollees and turn them into policy experts because, first off, who's got time for that? I don't want people to do that. They're already experts, and it's more about reminding folks that what they

need to bring is their expertise. And sometimes it's about just setting the stage and telling folks what it's going to be like, what it's going to look like, what might happen.

And that can really -- also, I did that when I had cases at legal aid. Well, I am an attorney, but, you know, that can really change the way someone's experience goes when they have their expectations. Even in taking your kid to the grocery store, setting expectations of what they're going to be allowed to pick is very important before you go in. So it's the same thing with anyone. Whenever you go and you don't know what's going to happen, it's risky.

So we have actually sort of a semi-formalized structure of kind of our regulars that we go to. We call it our "health justice network," "health justice advocates," and a couple of other states, I know, do have that. North Carolina has something like that where you create that community that Cathy was talking about. So that way, you've got members who are talking to each other and build sort of a shared experience that way. Also, you build power because when people feel a part of something in a meaningful way, they feel more power because they already

have the power, but it's a matter of feeling it and being confident in that, especially when you're going into a very formal setting.

And the same is true for boards. Any of you all for any of your boards, make sure that you've got meaningful board training because otherwise that person is just there, and the ability to contribute and be heard is less.

So, yeah, that's something that we work really hard on, and I feel strongly that it should be a little bit more formal. So, like, the state, when they ask Kentucky Voices for Health for a consumer or for an enrollee, they don't also say to us, "And could you please invest 20 hours a month or 20 hours a month in making sure that this person's experience is meaningful?" Now, we do that because that's a part of what Kentucky Voices for Health does, but I would like for it to be either a trained part of it or an expectation of state agencies, that if you're going to have someone share their experience, that they get technical support, they get technical assistance to go along with it.

COMMISSIONER CARTER: That's great. Thank you.

Very helpful.

VICE CHAIR DAVIS: Thank you.

Dennis, I'm going to bring you into the conversation here.

I have a question first, though, just around thinking about the diversity within Medicaid and how you all think about making sure that we are getting diverse folks to the table in terms of minorities, in terms of language, in terms of disability, how you're making sure that you're getting a comprehensive set of voices and not only the one or two folks who are ready to raise their hand.

MS. McEVOY: I'm happy to start off on that.

I think we've all acknowledged this requires much more intention, especially by the majority White culture, standing bodies that have more historically been the kind of fulcrum point of public comment. I think it starts with humility on behalf of largely White leadership to say that there is a range of experiences that may be outside the lived information, data, evidence that typically inform programs, and that enlisting folks who bring that to advise on engendering a climate that is going to feel radically

welcoming, feel a value, not gratuitous, and then identifying a range of viewpoints that have not been historically well represented, notably starting with people of color.

But I will just say another experience in Connecticut that I had is, you know, the tremendous marginalization of people with disabilities in every aspect of informing health care policy tends to be a marginalization to regard them as only informing LTSS and also, speaking as a lesbian, people in LGBTQIA community who aren't even captured in data. So there's big gaps even of kind of addressing the comprehensiveness of the voices that need to be enlisted.

Starting there, I think, is critical because if you aren't kind of acknowledging the realities there, none of the enabling strategies that we talk about that I think are evident but poorly performed on are going to be less likely to be successful.

So I defer to Cara and Cathy on their own experience with that, but I think for me, that's been a really important part of where you start.

MS. SIMONE: Yeah. I think I found it

interesting when you were talking about feeling welcome. I think that that's not something that I feel in being in the program a lot of times.

I don't know. You were talking about race, but there is something to do also with being a woman, that I think there's also inequality there as well still that goes on.

You know, being disabled, a disabled woman, even in my own family, when I decided to apply for Social Security because of my disability -- and it wasn't that long ago, but the way that I was treated was almost like what is -- you know, there is something wrong with you because you're doing this.

And I want to feel more empowered when I sign up for this thing and people don't treat me like there's something wrong with me, and all I'm trying to do is feel better and get better. And to feel like I'm in an environment that makes me feel worse, why do I want to subject myself to that?

I don't know. So that's kind of where I'm coming from, and I appreciate what you say, Kate, about I want to -- I want to feel like I am not some sort of burden to

society and taking their taxes away from them. I don't know how to change all that, but I wish we could change, somehow change what Medicare is doing. I don't know how to do that, but I sure would like to see something like that. I'm not taking their taxes, and I'm not -- you know, I paid my tax as best as I could, and, you know, I don't know. It can be quite frustrating.

Sorry. I get a little passionate there.

VICE CHAIR DAVIS: Passion is appreciated.

MS. SIMONE: And thank you, everybody, for doing this. I really appreciate it.

VICE CHAIR DAVIS: Dennis, I'll turn to you for the last question for our panel.

COMMISSIONER HEAPHY: Sure. I guess I'd love to connect with each of you after today, but, Cathy, in particular, I really appreciate everything you shared. I'm actually a member of Commonwealth Care Alliance myself, and it's hard to hear -- I raised it yesterday -- meeting the importance of care coordination and how it's so difficult to find a dentist, and yet care coordination should be helping you with that.

But I'd like to hear a little bit about how you

think you're being part of the Voices committee on CCA impacts how CCA functions because they also have the CAC, which is a Consumer Advisory Committee, which is required by MassHealth and CMS as part of the contract. I want hear a little bit more about as a person with Voices, in Voices, how do you feel empowered and how you're changing or influencing how CCA works, or do you think you are?

MS. SIMONE: No. You know, there are good things about the program and I'm very grateful for Massachusetts for having MassHealth. I look at it as a universal health care in Massachusetts. That's how I see it.

I've been to the Voices program a few times, the meetings, and they're very helpful because of the fact that they want to hear our experiences as far as what we think about certain programs. There was something that came up that we all looked into, and they did change it. They did change it. They went back, because it was a transportation issue and the ones they went to improve it was worse than the ones that they had before.

But I think that type of thing does empower me. It gives me a voice, literally. I am glad it's called the Voices program. It gives me a voice to talk about some of

the experiences that I've had, good and bad. And I have used what you're talking about the care coordinator, my care partner. She will be able to help me find a dentist.

But at the same time, it's only a list, that's just a list of things. It's not like they're helping me individually. I'm going to be going through the list to see who I want to choose.

But the Voices program I think is great. I think it gives me some empowerment. It gives me a voice. I get to share the good and the bad of the program. And there's a lot of good that comes out of it, because like I said, I find out things when I go to these programs that I didn't know provided these type of services, which is so beneficial for me. I mean, I can't tell you, almost every time I go to a meeting I will hear somebody say, "Oh, I didn't know they did that."

I am so grateful that I live in a state that provides, like I said, universal health care. I am very, very grateful for that. As limited as some of the services might be here and there, I'm glad that I have something. I used to live in another state, and this just tops that state one hundred-fold, seriously.

I don't know if I answered your question. I hope I did.

COMMISSIONER HEAPHY: That was great. That was great. If you want to give us advice on what is, if we were going to make a recommendation to Congress or something that said every state should have an advisory committee, what makes an advisory committee actually be authentic and have impact as opposed to just being a checkoff box that states do.

MS. SIMONE: I just think it's about the members. It just goes back to the members. And I think that if you get more members who want to educate you on their experiences, I think you'll find out a lot of what goes on. They're the people you should go to. I always felt this way when I worked. I used to be a licensed clinical social worker, and I remember it was always about the client that I felt knew what was best and what their needs are.

And so if I had to make a recommendation I would just say, maybe you should look at an advisory committee of members that are in some of these Medicaid programs.

COMMISSIONER DAVIS: I recognize it's the top of the hour and I want to be respectful of your time. But

Kate and Cara, before you go, if you do have this flexibility to stay on and answer that question from Dennis we would love to hear from you on it, in terms of recommendations that MACPAC should be making around what makes a meaningful advisory board.

MS. STEWART: I mean, I'll repeat what I said, that the folks have meaningful technical assistance to support them, and have their costs covered. Obviously, it takes money to go to a meeting in person. That also is the thing that happens in Kentucky is the folks that show up are the folks that are within 30 minutes. In Frankfort it requires an overnight stay to participate, because of the long drive.

So those sort of logistic pieces are also equally important for meaningful participation.

MS. McEVOY: Yeah. I think what's said has been so powerful. I pretty much like to stand on Cathy's comment on just going back to people. I really feel like there's nothing more important than that. I can talk about the things that I suggested earlier about Medicaid agencies going much further back in the process, engendering collaboration with standing groups that are member-led.

You know, to an early point of framing a policy, I'd love to see more of that.

But at the core, if you're asking yourself that question, are we, at every available interval, interacting in a way that honors the lived experience of the range of folks who are relying on Medicaid, you can't go wrong with that. And I feel like that's where we most frequently fail. So I just want to honor Cathy again for that, because I think that's an amazing end to the discussion.

COMMISSIONER DAVIS: Thank you all so much for being here. We appreciate your time. We love panels. Cathy, we thank you so much for bringing your perspectives, and we just appreciate the time that you all have spent with us this morning.

FURTHER DISCUSSION AMONG COMMISSIONERS

* COMMISSIONER DAVIS: And so at this point we will transition to just the Commissioners and comments that you might have on this session as we continue the discussion.

I see Martha and then Heidi.

COMMISSIONER CARTER: I didn't have my hand raised. I was applauding.

COMMISSIONER DAVIS: Sorry. You were waving.

Heidi.

COMMISSIONER ALLEN: Well, thank you. I see that we still have a couple of people here. Thank you so much for this panel. I really, really appreciate it.

I just want to reflect a couple of things. One, even as a Medicaid expert I rely so heavily on the technical assistance and the policy support that the MACPAC staff provides for me before every meeting. I don't think I'd be prepared to come in here and have any conversations about what should be done with Medicaid without having their expertise, and I think that the idea that we would put people on a commission and not give them the information they need to weigh in, with their expertise that they bring, I thought that was really powerful.

I also want to talk about these community advisory councils, and I know there are different names in different states. But there is a statutory requirement that they have consumers on them. It's not clear to me how they're recruited, and it's not even clear to me that they are actually even there. And I think that the language is ambiguous enough that advocacy organizations sometimes serve as proxies. And I think that that's great. I think

that, you know, we had a great example of what an advocate who works directly with consumers can bring to this panel that we just heard. But then we also saw that Cathy brought an entirely different dimension that was of so much value.

And so it is clear to me that just having advocates serve as a proxy is not sufficient for voices. One of the things I heard Cathy say is, is this about Medicaid stigma and it's about Medicaid access, and it's about how confusing the program is for people who are trying to navigate it. And, you know, for us on MACPAC those should be our top three things that we're constantly thinking about. This is the stuff that causes disparities. And you have a consumer here who may be able to speak to us for 10 minutes, and that message became so clear.

And so the value added of consumers seems to me to be something we should be thinking about our policy avenues for, for strengthening that, and even just thinking of Dennis' role here on our Commission, even though he's a policy expert in his own right, you know, his lived experience and his connection to people who have lived experience changed how I thought about Money Follows the

Person and aligning those regulations.

So I don't know. Those are just my reflections I wanted to put out, after having listened to this panel.

COMMISSIONER DAVIS: Thank you, Heidi. Tricia?

COMMISSIONER BROOKS: Yeah. So a gazillion thoughts going on. One, going back to the stigma issue, because every time I hear that word I just cringe, that it's so pervasive. It is interesting, though. I actually think there's more of that cultural orientation toward Medicaid beneficiaries by not rank-and-file physicians or the direct health care providers but more so by the staff that do the intake and talk with people. And I don't know if there's more that we could do about that, to really better understand how prevalent that is and what we might do about it.

On the medical care advisory committees, I do think that's worth further study to identify where it's working well and what the differences are. We, in working with the advocacy community, we hear a lot about their MCACs. In fact, recently had a session where folks from Connecticut talked about how their MCAC actually reports to the legislature and not to Medicaid agency, which works in

a state like Connecticut because the legislators are very receptive to making sure that Medicaid works well. It might not work so well in conservative states, but looking at some of those differences in lifting up the best models.

And then going back to Cara and the discussion on kynect, it's phenomenal to me what the kynectors are able to do and see in terms of helping people get enrolled and stay enrolled, and I think it's very unusual. You know, a lot of states have portals through which assisters can help facilitate applications. They may be able to actually see, you know, what happens to those applications.

But in terms of following that person's eligibility, Cara used the acronym RFI. That's a request for information. So if a state is doing, for example, periodic income checks, and they think someone is over income, they send a request for information. Cara sees that and she can reach out to the beneficiary and say, "Hey, we've got to do something here or you might risk losing your coverage." So there's just a ton of work that can be done in this. And then just one last point, and that goes back -- Cara talked a lot about focus groups. One of the things that we've been hearing from the kinds of

organizations that do focus groups around Medicaid coverage is that it's become a lot easier to recruit people and hold focus groups virtually in this world, and it is another way that we could look at encouraging more ways to get people involved.

So I'll stop there.

COMMISSIONER DAVIS: That's great. Thank you, Tricia. Dennis, did you have a comment? I saw you came off mute.

COMMISSIONER HEAPHY: I didn't realize I was off mute. I wasn't sure if Fred had a question or wanted to say something.

COMMISSIONER CERISE: You go ahead, Dennis. I'll go after you.

COMMISSIONER HEAPHY: Thanks. A lot of things are going through my head right now, but I think we also need to look at -- this is something disability advocates are doing nationally, is how do we engage more with African Americans, Latinos, and other populations so it's not just white folks who are doing the advocating in the disability world. And the cultural differences are so many. So I think we really need to better explore and understand what

that means.

There are groups that are doing really well. There's the Camden Coalition and the National Center for Complex Care Needs, and I'm part of both those organizations. And I love being in the minority, as a white person, in these groups, because I learn so much. I just learn a tremendous amount, because others' experiences are so radically different. So how do we actually do that.

And I think something that was not mentioned is how important outcomes are. I think -- I forget her name, but the woman from Connecticut, McEvoy, spoke to going upstream, so that people with disabilities are part of that policymaking process at the start, and not brought in afterwards. So it's not like a focus group afterwards, like this is what we're going to be presenting to you. But it has to be upstream and have the outcomes that people actually see that change is going to occur from their input. And something that we've done. I'm going to speak again to minority populations, that I spent a lot of time recently working with a group that works with mainly Latino populations in Massachusetts. And I was told, frankly, "Dennis, people are afraid of repercussions and they don't

think it matters. They say no change is going to occur."

And so I think we need to better understand and realize that there are folks who are fearful of what might happen if they do speak up, and then that idea that my voice doesn't matter anyway why should I bring it forward.

And so those are some of the things I was thinking when the conversation was occurring.

Fred, sorry about that.

COMMISSIONER CERISE: No. No worries.

First off, Moira, thank you. That was just a phenomenal panel, I thought, and thank you for putting that group together. I don't know how you planned those three but they were just a perfect mix of perspectives and just so eloquent, so thank you.

You know, Tricia's comment about doing more work with the CACs, I think that's important. I'm sure there's great variability across states in that work. Just some see it as extra work that they have to check a box, and others, like some of the ones we heard, just have such meaningful input in how they nurture that and use the information. And so, you know, maybe some work understanding what different states are doing there would

be important.

I thought Cathy brought up an interesting point. I don't know how many states are doing this, and it sounds like it was happening by accident with her, but this idea of kind of these facilitated networks where people in similar situations have space for a conversation about their experiences. You know, with some expert or somebody from the program to be able to facilitate that and learn from each other, which is a different thing that the CACs but it could be an effective way for information sharing and networking among recipients. But the CAC work, I think, could be something meaningful.

And then, finally, as I listened to Cathy and her experience, I don't think anybody was surprised by some of that. But I wonder if, in our access monitoring recommendations or in that piece of work there is room for talking about enforcement and what we're measuring in terms of what people are doing with the information that they have. Because, you know, if there's anybody from Massachusetts Medicaid listening today, I mean, I don't think that's an adequate dental network that that person has right there, and she just described it to you why it's

not.

You know, it's an n of 1, but it doesn't surprise anybody on this panel, and I just wonder, we're putting a lot of effort into measuring and monitoring, and then there are some areas where, you know, that we've already talked about, behavioral health, dental, things like that, where we know quite well we've got problems. And so how much do we know about what we're doing to enforce the standards that we have right now?

COMMISSIONER HEAPHY: Fred, if I could just speak to what you were saying in terms Massachusetts and what Cathy said, that we have a coalition called Disability Advocates Advancing Our Healthcare Rights, and they have forums. And this forum brings stories like Cathy's forward, and that's why I was saying yesterday about the need for -- to look at care coordination planning because that's what we hear over and over again in these forums.

And then we have the One Care Implementation Council, which is the duals demo council, and we actually had a town hall meeting in December, and similar stories like that were coming forward in that.

So we're working with the state in how do we

actually take all this information and turn it into contract requirements and not just contract requirements but actually oversight of contracts to ensure that people are getting the support that they actually need so that stories like Cathy's are not so common, and that people aren't just getting a list of names in the mail, but they're actually getting the support that they're required.

I think Cara was saying that she does that, and I'm saying, my God, if they can do that, why can't we do that with these health plans? They should be doing this.

So I just wanted to say that we definitely do that in many ways in the advocacy community here.

VICE CHAIR DAVIS: Thank you, Fred and Dennis, both.

Going to you, Bill.

COMMISSIONER SCANLON: This follows on both Dennis and Fred.

Cathy's stories or experience sort of just underscore, I think, sort of the challenge that we face in terms of assuring that limited networks, which are important from a coordination perspective, they're important from an efficiency perspective -- so we're not

going to go to an any-willing-provider world, but at the same time, there's an obligation to make sure that there is sufficient information out there for the beneficiaries to be able to access services.

And I recognize this as a -- I mean, the idea of sort of what is efficient information, just setting up a framework that is appropriate for assessing sufficient -- a sufficient network is a challenge. Even when you identify a framework that's idea, you have to fill it in. You have to gather the information, and the minute you finish gathering the information, it probably starts to deteriorate.

There are decisions made by countless providers on a daily basis as to whether or not they're going to continue to what they said they were going to do yesterday, and so that becomes an issue for beneficiaries when they're actually seeking service. And I don't know how you overcome the problem there in terms of making sure beneficiaries have adequate, timely information, but it's something that we really need to consider.

And going back to some of yesterday's discussion about access measures, the most popular measure in policy

is probably the average, and the average is not good enough. It's the experience of the people that are at the extremes of the distribution that are really the critical tests of whether or not sort of policies are working and a program is working.

So I think we don't want to fall into the trap of saying, you know, 90 percent of people said everything is fine and that's a B plus, as opposed to the 10 percent. When we look at them carefully, then we understand sort of the failures that have occurred, so thank you.

VICE CHAIR DAVIS: Thank you, Bill.

Heidi, to this point?

COMMISSIONER ALLEN: I just wanted to follow up on what Bill said, and I know this is probably an entirely different conversation. But the technology is obviously there to know who live is seeing Medicaid patients and who isn't. I mean, managed care plans know their encounter data. If you have a provider who's listed as a Medicaid provider, but they have on claims, they have no encountered, then they are not a Medicaid provider, and they should be taken off the list. They can be sent a notice saying, "You haven't had any claims in 30 days.

Please let us know if this is incorrect, but we believe that you're no longer a Medicaid provider."

I think we should be pursuing those things because I think those are the things that consumers would want us to pursue, and again, when the consumer voice comes up, they say very clear where the direction is that we need to go. And I just think that that's so valuable.

VICE CHAIR DAVIS: Thank you so much, Heidi.

Moira, again, as we wrap up, any final comments? I think we got to everybody.

You know, I'll just that I think --

COMMISSIONER HEAPHY: I'm sorry. I just want to add one more thing to what Heidi just said and then what Bill said. Why is the vendor network not there? Is it because of the rates, because of the timeliness of paying bills? Because if the vendor -- I think we really need to understand and, again, go upstream and say not only what is an adequate vendor network, but why is it that, let's say, Cathy was able to get an appointment with the dentist one year, but then the next year, why did the contract fall through? What's changed in that contract and what's changed in that relationship is the result of the reduced

vendor network adequacy. So I think we really do need to look upstream at that as opposed to just explaining to folks that these are your choices. What's happening as a result that's causing that? Sorry.

VICE CHAIR DAVIS: No, that's great. Thank you, Dennis.

You know, one of the things I reflected on, on this panel, and how important the consumer voice is -- and, we are thankful that we have -- that there is a dedicated member on the Commission and that we have folks like Dennis and Leanna before him to be that voice of the Medicaid beneficiary.

But I will say it's also a lot to put that all on one person, and we as the Commission don't get to decide who is amongst our ranks and who gets to be here. But I would encourage the powers-to-be to think about can we have more of those voices amongst our Commission and bringing that kind of differential perspective to be able to just make us better.

I mean, I think as Heidi mentioned earlier and I think we've all experienced, we have learned from, you know, Dennis, the comments that you have brought and

Leanna's comments before you on -- it's changed our perspective. It's changed the direction of things that we take and how important having that direct experience is. So I just wanted to bring that forward as we close.

Again, Moira, thank you for putting this panel together. We enjoyed it. Always great to have panels, and especially bringing Cathy's voice into the mix was really great.

And I think with that, we'll turn it back to you, Melanie, for our closing and public comment.

CHAIR BELLA: Thank you, Kisha. Thank you, everyone, for engaging in that discussion. Certainly, we can keep talking about this and keep talking about the most effective way to bring it into our work while still respecting the folks whose voices we are trying to hear.

I'm going to turn it to public comment now. If there's anyone joining us form the public who would like to speak on this session or the one earlier, if you missed the public comment opportunity earlier, please raise your hand, and we will recognize you.

[No response.]

CHAIR BELLA: We have a quiet public today.

Everybody has brain-freeze from the cold, maybe. All right. I don't see anyone who would like to speak.

I'll go back to the Commissioners. Any last thoughts on any of our discussions today or yesterday, for that matter?

MS. HUGHES: We do have one hand up, Melanie.

CHAIR BELLA: Oh, wonderful. Sorry about that. Great.

Would you please identify yourself and your organization, and we ask that you limit your comments to three minutes, please.

MS. HUGHES: Sarah Potter, you've been unmuted.

PUBLIC COMMENT

* MS. POTTER: Hi. Yes, I'm Sarah Potter, and I'm from North Carolina. And I'm with Consumer and Family Advisories with different MCOs and a statewide advocate and have a son, 35-year-old son with cerebral palsy.

I just want to say I really appreciate the conversation and discussion you had today and want to thank all the panel members for bringing such insight.

I want to say in North Carolina, they do have their favorite list of advocates and what we like to refer

to as "tokens." My son happens to be one of them, and I really think we need to look hard at how we go about recruiting those very voices because we could spare ourselves so many mistakes and just misconceptions and misguidance, and when we go to make policy, because we tend to be asked after the fact, and then, of course, we know nothing happens.

And I fully understand having guardrails for the legislature because things can change drastically in a moment's notice after an election day.

So I just think this was a very valuable discussion and just wish there were more members of the public that heard it so that they could see their voices are really valuable and need to be heard.

I think the connector is wonderful. I think we call them "navigators" here, but families tell us that a navigator is more important almost than a care coordinator because it's somebody with lived experience. They trust them, and they tend to -- you know, advocates tend to dig and dig until they find the answer to a problem.

So I wanted to thank you all for this discussion today. I love hearing what Dennis has to say, and I just

want to thank all of you.

CHAIR BELLA: Sarah, thank you for taking the time to join today and for commenting, and whatever you can do to help us get the word out, don't be shy about sharing your view certainly outside of meetings as well. Thank you for taking the time.

I don't see any other hands. We'll turn back to the Commissioners. Any last words of wisdom, parting thoughts, questions?

Heidi.

COMMISSIONER ALLEN: I was just going to say that one thing that came to mind when I was listening today is all of the people who man the lines, the phone lines where they hear what's not working for people. Those are, I assume, state employees, and they might be a really phenomenal source of participation in some of these policy-advising bodies because they are paid by the state. They can be paid to come. We can recruit them and find people who would be great, and I think that they would bring a lot to every policy discussion because they see -- you know, they're like the canary in the coal mine. They're like the emergency department for the health care system. They see

immediately when a policy is causing harm.

CHAIR BELLA: Thank you, Heidi.

Anyone else?

COMMISSIONER HEAPHY: I'm just going to echo the point that was made by the caller that the importance of recruitment and who's recruited so they're not just a token or someone who's going to speak to whatever the organization wants them to say, but they really have to reflect a more authentic voice of the community. And it's kind of tough to be done. If you get endorsement from several -- or a couple of community-based organizations that are run by and for folks with disabilities or more generally organizations that serve -- let's say, justice organizations for ethnic and minority populations, that there needs to be some sense that people actually trust those folks that are being chosen for these committees, and that they're going to provide some support to those folks so they're not just there by themselves because it can be overwhelming for some people.

CHAIR BELLA: Thank you, Dennis.

Martha?

COMMISSIONER CARTER: If we wind up doing a

chapter on this, I would like to highlight that component that Cara talked about, providing support for consumers as they speak their experiences. A little descriptive section on that, I think, would be great.

CHAIR BELLA: Thank you, Martha.

Anne, any closing comments?

EXECUTIVE DIRECTOR SCHWARTZ: Nope. Thanks. Thanks, everyone, for their attention today.

CHAIR BELLA: Okay. Well, time flies, guys. We're done. We're done for January. Our next meeting is March 3rd and 4th, to be precise, so look forward to seeing you all then.

Thank you very much to Anne and Jim and the staff and everyone who joined remotely with us today. Have a great rest of the day.

* [Whereupon, at 12:30 p.m., the meeting was adjourned.]