PUBLIC MEETING

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

Thursday, January 26, 2023
9:30 a.m.

COMMISSIONERS PRESENT:

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P R O C E D I N G S

[9:30 a.m.]

CHAIR BELLA: Good morning. Welcome to the January MACPAC meeting. And I think everybody just do a quick mic check. Welcome.

All right. I'm going to turn it over to Kisha to get us started this morning.

VICE CHAIR DAVIS: Good morning, everybody. We are excited to have our race and ethnicity data session, and I will turn it over to Linn and Jerry to get us started.

IMPROVING MEDICAID RACE AND ETHNICITY DATA COLLECTION AND REPORTING: REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR MARCH REPORT

* MR. MI: Thank you. Good morning. The Commission has committed to prioritizing health equity across all of its work. During this work cycle we have been examining opportunities to improve the completeness and quality of Medicaid race and ethnicity data.

In September, we provided background on race and ethnicity data collection and reporting standards and an

overview of the challenges with these processes. In October, we continued our discussion with findings from a literature review and federal, state, and stakeholder interviews. In December, we described the state Medicaid data collection and reporting process, opportunities for improvement, and two draft recommendations and rationale.

Today Linn and I will present an overview of the draft chapter and the recommendations and rationale. The Commission will take a vote on these tomorrow.

Our March chapter will cover the importance of high-quality race and ethnicity data, the Medicaid data collection and reporting processes, challenges and approaches to improving Medicaid data quality, and finally, the recommendations and rationale.

Racial and ethnic disparities persist throughout the U.S. health care system, including in Medicaid and CHIP. Over 60 percent of Medicaid and CHIP beneficiaries identify as American Indian and Alaska Native, Asian American and Pacific Islander, Black, Hispanic, or multiracial, making measuring and addressing disparities in these programs particularly important. While gaps in Medicaid race and ethnicity data quality should not

necessarily prevent their use or efforts to address disparities, without high-quality data across all states, CMS, states, researchers, and other stakeholders are limited in their ability to measure disparities.

One of the administration's priorities has been to advance health equity, partly through increasing the usability of federally collected race and ethnicity data.

State Medicaid programs are also prioritizing health equity within their work, including working to improve the disaggregation of race and ethnicity data to assess health disparities, support outreach to beneficiaries, and develop targeted state policies.

State Medicaid programs collect race and ethnicity information on applications and have the flexibility to determine which race and ethnicity categories to collect. These questions are optional, as race and ethnicity information is not a requirement of Medicaid eligibility. Self-reported data is considered the gold standard and the best method for collecting information that reflects an individual's identity.

There are multiple factors in state design of race and ethnicity questions on the Medicaid application.

These include relevant HHS and CMS guidance, the HHS model application, state requirements and population priorities, and other benefit program requirements in states with integrated applications. When individuals are completing the applications, they may receive assistance from state and county eligibility workers, application assisters, and navigators, who can help explain the purpose of race and ethnicity questions to the applicant.

After applicants submit their application, their data is stored in the state eligibility system. State Medicaid programs then transfer data to the Medicaid Management Information Systems, or MMIS, where the data are processed for submission to the Transformed Medicaid Statistical Information System, or T-MSIS. In some states, they may require aggregating or reformatting the data. CMS then cleans and repackages the raw submitted data into the research-ready T-MSIS analytic files, or TAF. At MACPAC, we primarily use the raw T-MSIS data for our analyses, while many external researchers have access to the TAF.

I want to quickly note that states may supplement their application data with other state data sources, such as managed care organization data, for internal analyses.

However, these data never update or change the state eligibility system's MMIS or data submitted to T-MSIS.

There are many challenges with collecting and reporting race and ethnicity data which may limit their completeness and accuracy. States may have difficulty gathering these data from applicants due to individual concerns about how the collected information may be used. For example, one application assister organizations shared that some applicants who had previously been denied coverage were worried that providing additional optional information could lead to another denial.

Applicants may also not understand how to respond to the questions, especially when categories do not align with how they self-identify. For example, one organization that serves primarily Middle Eastern and North African populations share that many individuals will check Other and write in their country of origin rather than select one of the provided categories.

States may also have difficulty reporting data because of misalignment between how state eligibility systems, MMIS, and T-MSIS store and format race and ethnicity data. While many states have systems that

facilitate simple one-to-one mapping with the T-MSIS categories, some state systems require more complex reformatting and aggregation of data, which can sometimes affect the quality of the submitted data.

CMS has provided states with technical specifications and guidance on formatting and submitting race and ethnicity data to T-MSIS. CMS is also providing targeted technical assistance to identify and help states address data reporting issues through their new data quality tracking tool, the Outcomes-Based Assessments, or OBA.

During our research, two potential approaches to improving the collection of complete and accurate Medicaid race and ethnicity data emerged. One approach focused on providing states with an updated model application with race and ethnicity questions based on evidence-based approaches shown to improve applicant response rates. The second approach focused on providing state and county eligibility workers, application assisters, and navigators with model training materials that include information to share with applicants that could improve applicant trust in sharing their race and ethnicity.

Now I'll turn it over to Linn to walk through the recommendations and rationale.

* MX. JENNINGS: Thanks, Jerry. The two recommendations we are presenting today are essentially the same as we presented in December and reflect the Commission's discussion on approaches in addressing challenges with collecting complete and accurate Medicaid race and ethnicity data. The one change we did make is to the wording in the second recommendation where we updated the language to say "training materials" rather than only "training."

Although there were challenges with reporting, CMS has begun to work with states to provide TA to address the concerns with race and ethnicity, and so our recommendations only focus on the data collection. However, this is something we'll continue to pay attention to.

Regarding our recommendation implications, analysts at CBO have told us that these recommendations would not have a direct effect on spending, and so the implications instead reflect consequences of these recommendations rather than a cost estimate.

Our first recommendation would direct the Secretary of HHS to update the model single streamlined application and HHS should also direct CMS to update guidance on how to implement these changes on the Secretary-approved application.

Updating the model application race and ethnicity questions would help address some of the challenges with collecting complete and accurate data. There are evidence-based approaches for improving applicant understanding and comfort with providing this sensitive information. For example, including text about why these questions are asked and how the data may be used could improve applicant willingness to answer these questions.

CMS should also update the guidance provided to states about changes to the race and ethnicity questions. The majority of states have developed alternative applications or modified the model applications so guidance about how to implement these changes would also support states in updating their questions on their specific applications.

Further, the updates should also be coordinated with other administration-wide efforts, including the

anticipated revisions to the OMB minimum standards and other possible demographic data collection efforts. HHS should also consider implications of any of these changes on the federal health insurance exchange, which also uses the HHS model application, and on other benefit programs.

For federal spending there is the potential for an increase in short-term costs to develop the application and guidance, including matching costs to states for any associated systems changes. However, to the extent that these efforts would align with existing work in priorities, long-term federal costs could be minimal.

For states' updates that align with ongoing improvement would require minimal changes or additional effort. However, system upgrades may be necessary to implement certain changes, and this may lead to additional costs.

For enrollees with improved understanding and trust in responding to these questions, there is potential for program improvements due to the improved data quality and the ability to assess and address disparities.

Plans and providers are unlikely to be directly affected by this recommendation.

The second recommendation would direct the Secretary of HHS and CMS to develop model training materials to be sure that the state and county eligibility workers, application assisters, and navigators to ensure applicants receive consistent information about the purpose of these questions.

Assisters are vital to the application process and Commissioners and stakeholders agreed that providing them with training materials on how to ask these questions for the race and ethnicity information is an important component in improving applicant response rates, and training materials would improve assister knowledge about why these questions are included and how the information may be used. Further, it provides the assisters with language to explain the purpose of these questions to the applicants.

Currently, assisters don't consistently receive training from states on asking the race and ethnicity questions, and for states and assisters that rely on the CMS-provided federal facilitated marketplace assister training, these materials also don't include information on how to ask these questions. So to address this gap CMS

should develop training materials that specifically address the race and ethnicity questions, and then when developing these materials they should consider developing a customizable training module and materials drawing on evidence-based approaches and provide states with TA to update the training for their state-specific needs.

For federal spending there is a potential for an increase in short-term costs to develop and implement the new training materials, and for states the development and implementation of these materials would be optional. So for states that don't currently provide training materials and choose to develop them there could be short-term costs for states, but for those who have developed training materials the additional effort to update them could be minimal.

For enrollees, the potential improved education from application assisters may also help improve the enrollee experience when working with assisters and improve their understanding of these questions and how their data may be used. And for providers, this update could lead to improved training materials and the ability for providers to assist individuals in applying for Medicaid.

So this is the summary of the two recommendations, and we'd appreciate any feedback you have on the draft chapter, including on the tone and clarity. And if you have more specific edits, you can share those with us in writing. As a reminder, you will vote on the package of recommendations tomorrow morning, and so if you have any tweaks to the recommendation language, please let us know now so that we can have those ready for tomorrow's vote.

With that we will turn it back to the Commissioners.

VICE CHAIR DAVIS: Thank you both. You know, this is work that we've been working on for several cycles, and so I really appreciate being able to see this come to fruition. You know, one comment I'll make is that -- and I think this could come out a little bit more in the chapter -- is just a reminder that health equity data is part of the process. It's not the destination. It's really beginning the first step to really be able to examine health disparities and making sure that that is not the end of the work, that it's really just the beginning of the work.

I have some other comments and I'll save those for the end. Other comments from Commissioners? Tricia and then Martha and then Rhonda.

COMMISSIONER BROOKS: So mine is more of a question on Draft Recommendation 1, where you indicate that plans and providers are unlikely to be directly affected.

I guess I question that because if we are doing quality measurement at the plan level the plan should have the data that the state has in the same format and not have to require you to merge the data sets in order to do that kind of analysis. So I was just curious why we are stating that we don't think that the plans would be directly affected.

MX. JENNINGS: So I appreciate that comment and that's helpful to think about. I think the intention, which saying that would be unlikely to be affected, is that since the data are coming from the application and going into T-MSIS, that those data may not be going to the plans. Or if they are being used by the plans -- I guess as you are saying there is maybe some back-and-forth with those data, but I think the intention behind this was that it would be going to T-MSIS, and that would be the more direct

effect.

COMMISSIONER BROOKS: So I guess I think about states that might impose quality improvement requirements on plans specific to race and ethnicity, and to that extent expect the plan to report back in the same way. So even if they are taking that information from the state, they may have system changes to make in order to collect those data.

VICE CHAIR DAVIS: Thank you, Tricia. Martha, then Rhonda, then Sonja.

COMMISSIONER CARTER: Thank you. I'm generally in favor of these recommendations, and I think I'm good with the wording. I wanted to point out that there is a designation called a "certified application assister designated organization," a CDO, and a lot of the health centers are CDOs. And so they are responsible for their assisters. And so to the extent that their training materials, they need to also go to the organizations that oversee their staff that are doing this assisting.

So I'm not sure that we need to change the language but make the point somewhere in our materials.

VICE CHAIR DAVIS: Thank you, Martha. Rhonda, then Sonja, then Dennis.

COMMISSIONER MEDOWS: I want to speak in favor of both recommendations. I think they are well written out. And I also wanted to say how much I appreciate Kisha's opening remarks about this particular topic. I have a concern sometimes that we want to focus on the data and not get to what the data needs to do, which is to inform action, intervention, to both reduce, resolve, and prevent new disparities. So if we can make sure that we are committed to following this through and not stopping at that initial step that's fantastic.

I had a similar question about Recommendation 1 and the impacts on plans and providers, but it may be a little bit of a different nuance to it, is that multiple regulatory agencies are requiring both providers, including ambulatory hospitals and plans, to report on health equity. And so they have to actually figure out a way to do the self-reported information as well.

And it may not be that it is directly tied to the eligibility and enrollment costs that you were assessing, but trying to figure out the impact, but they actually have to do it for other reasons other than what we are talking about. It may be that additional cost is how do you

integrate the information in and make a decision about what is going to be the source of truth. If the doctors, hospitals, health plans, pharmacies are all sending in their information about what they believe the person is reporting for their race and ethnicity, somewhere there's got to be a single source of truth that's up to date and actually reflects what the patient says, and that may be a cost to managing that.

But I think this is really well done. Thank you.

VICE CHAIR DAVIS: Thank you, Rhonda. Sonja, and then Dennis.

COMMISSIONER BJORK: I want to echo the comments of what a great chapter and good, clear recommendations, and I support both of them.

In the chapter, on page 4, under state priorities, you mention that some states are requiring a health equity officer be appointed. And I just wanted to add that some states are additionally requiring that their managed care plans identify a health equity officer. In addition, some are using NCQA, or are requiring that health plans be NCQA accredited, and NCQA has a special accreditation for health equity, and a new one that's

called "Health Equity Plus." So that is just another thing that's happening and can be used as a tool.

And then finally, under implications in the chapter, I just want to echo what folks are saying, that there is a lot of value to the health plans and providers to having accurate information so they can plan their outreach activities. That's where we get to the action that Kisha was talking about. It will be much more efficient if they have accurate information on who they are trying to reach, how, what languages, and what ethnicities. So I think there will be a positive impact. Thank you.

VICE CHAIR DAVIS: Thank you, Sonja. Dennis?

COMMISSIONER HEAPHY: I support both recommendations and all of the comments, I think they are really great.

I would love to see a strengthening of language around collection of data on disability status and SOGI as a next step, because muddying the water now for the SOGI and disability I think would not be helpful. But including something in the document saying that in order to fully address inequities impacting folks, information about the minority populations, that we will have to collect this

data at some point and address those inequities.

I got information this past week on inequities impacting African Americans who have substance use disorder. And so how do we make sure down the line that we are collecting the data on the intersection of race, disability, and SOGI data. So again, not to impact the recommendations but to really maybe strengthen some of the language in the chapter itself.

VICE CHAIR DAVIS: Thank you, Dennis. That's a really important point, as we think about next steps for the data. And I am also in agreement with the recommendations. A couple other points to highlight. I think it's important to say something, or strengthen our comments in the beginning about why we are doing this. Medicaid serves the population that's highly vulnerable, many Black and Brown, and many folks with multiple languages. So it is inherent in the Medicaid program to be looking at health equity, and the first step to that is health equity data. And so pulling a little bit more on the why this is so important for this program to be looking at that right at the beginning.

I think, also getting to Rhonda's point around

what is the single source of truth and pulling out that self-reported data is the gold standard. And so I appreciate that you brought in some information about data imputation and different ways that groups are doing that, but putting some guidelines around that, that it should be used for analytical purposes, and what is the process, or that there should be a process, and not necessarily outlining what that is, but that there should be a process for really organizations getting better on getting that self-reported data.

And then you highlight this as well, but gathering data from additional sources, the importance of being able to do that, to have crosswalk within different, you know, whether it comes from Social Security Administration, that is helpful for beneficiaries to not have to duplicate and fill this out multiple times then also decreases the chance that there are going to be different answers, because they are filling out multiple applications. So as much as we can encourage this streamlining of that data collection process.

But overall this was just a wonderful chapter and I think a really good reflection of the conversations that

we have had around this table.

Other comments or questions from folks? Linn and Jerry, do you have what you need from us?

MX. JENNINGS: Yeah, we do. Thank you so much.

VICE CHAIR DAVIS: Thank you. We will look forward to seeing it back tomorrow for a vote.

All right. I will turn it back to you, Melanie, for our next topic.

CHAIR BELLA: Thank you both. We are moving into nursing facility payment principles. We also are continuing this work, bringing it back today to talk about recommendations that we would then vote on tomorrow.

So I will welcome Drew and Rob to lead us through this session.

NURSING FACILITY PROVIDER PAYMENT PRINCIPLES: REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR MARCH REPORT

* MR. GERBER: Good morning, Commissioners. Rob and I are returning today to present an overview of a draft chapter for the March report to Congress on nursing facility provider payment principles before reviewing two proposed recommendations that the Commission will vote on

tomorrow.

In this presentation, I'll walk through the main sections of the chapter at a high level, detailing relevant background, Medicaid's payment policies, how Medicaid payments can be used to improve nursing facility quality, and the interaction between Medicare and Medicaid for nursing facility residents.

Then I'll hand it over to Rob to review the payment principles that we first discussed in December before he presents our proposed recommendations.

The chapter begins with background on nursing facility industry and Medicaid's role as the primary payer for most residents. It describes how Medicaid payments relate to those of other payers and why Medicare payment rates, which typically exceed the costs of a facility, are not a good benchmark for Medicaid payments.

We describe several of the challenges that the nursing facility sector faces, most of which precede the COVID-19 pandemic, which has nonetheless exacerbated them. These include the fact that most nursing facilities are for-profit, and a growing share of facilities are part of chains, which can have complex ownership models, making it

difficult to assess facility costs.

Additionally, some stakeholders have expressed concerns about facility closures, particularly for those in rural areas where facility closures may mean loved ones need to travel much farther away from their community to visit residents.

In the chapter, we'll also note some opportunities in the industry, such as new models of smaller home-like settings, like Green Houses, which have shown some promise in providing high-quality patient-centered care.

We also discuss our prior findings that facilities that serve a high share of Medicaid-covered residents generally have worse quality ratings than other types of facilities. Given that these facilities also serve a greater share of racial and ethnic minorities, these differences in quality can contribute to and compound racial and ethnic health disparities. However, there are a number of such facilities that receive five-star ratings, showing that high-quality care for Medicaid residents is possible.

Next, the chapter discusses Medicaid payment

policies describing how Medicaid historically paid facilities and the types of payments it makes today. Since the Boren Amendment, which required rates to be adequate to meet the costs of efficient and economically operated facilities, was repealed in 1996, states have had considerable flexibility to set nursing facility payment rates. Most payments are base payment rates and fee-for-service. However, use of managed care is growing as well as use of supplemental payments, which states often finance with provider taxes or intergovernmental transfers and certified public expenditures from publicly owned facilities.

The chapter includes our findings that base payments vary widely by state and for facilities within states, noting that determining the net payment for these facilities is difficult as complete data is missing on supplemental payments, resident contributions to their share of costs, and provider contributions to the non-federal share of spending.

After describing Medicaid payment policies, the chapter overviews how Medicaid payments can be used to improve quality. In our work, we've studied staffing

rates, which have been a key measure of quality for states due to its association with positive outcomes for residents. The chapter outlines how there's considerable variation in staffing rates by state as well as disparities by Medicaid payer mix, suggesting that Medicaid payment policy has the potential to improve staffing rates. However, while other research has found that higher Medicaid payment rates can increase staffing, we found no clear relationship in our own research.

We also know that there are other state policies that may affect the extent to which nursing facilities spend the revenue they receive on direct care staff. For example, payment methods can incentivize certain behavior by tying it to payment, and state minimum staffing standards in excess of the federal standard can also require facilities provide a certain number of hours per resident day on direct care for residents.

This section also incorporates interviews we conducted in 2020 about the barriers that states described to changing Medicaid payment policies, such as limited state capacity.

And finally in the chapter, we highlight the

importance of the interaction between the Medicare and Medicaid programs in providing care to nursing facility residents, as most Medicaid-covered residents are dually eligible for both programs.

This includes the challenges states faced in applying Medicare's new acuity adjustment system to Medicaid, which was not designed for the long-stay residents primarily covered by the program.

Additionally, we describe how misaligned payment incentives from the two programs make it difficult to reduce avoidable hospitalizations for these patients. About one-quarter of nursing facility residents are hospitalized each year, and avoidable hospital use is estimated to cost Medicare and Medicaid $1.9 billion a year. Savings from preventing avoidable hospitalizations for dually eligible residents accrue to Medicare, and while long-stay residents are primarily covered by Medicaid, after a hospitalization, they return to the facility to begin a new Medicare-covered stay at a higher payment rate.

The chapter notes that prior demonstrations from the Centers for Medicare and Medicaid Services designed to address these misaligned incentives have produced mixed

results. However, during the COVID-19 public health emergency, CMS waived the hospitalization requirement to begin a new Medicare skilled nursing stay. This flexibility was widely used and has the potential to reduce avoidable hospitalizations, but it's unclear what will happen following the end of the public health emergency.

I'll now pass it over to Rob to walk through the payment principles that arose from this work.

* MR. NELB: Thanks, Drew.

So the chapter culminates with a summary of payment principles for states to consider when setting nursing facility rates and methods. These principles aren't formal recommendations that the Commission is going to vote on, but we tried to develop these policy statements to reflect the views expressed by Commissioners at prior meetings.

So the first principle is that payment rates should cover the costs of economic and efficiently operated facilities, similar to the old Boren Amendment standard. In doing so, it is important for states to consider whether costs are too low because of insufficient staffing and also whether reported costs are too high because of related

party transactions.

It's also important for states to consider all types of Medicaid payments that providers receive, including supplemental payments.

The second principle is that payment methods should incentivize quality and reductions in health disparities. Although nursing facilities face a number of challenges which may be outside of Medicaid's control, the chapter highlights the importance of using Medicaid policy to at least help Medicaid-covered residents access the same quality of care available to the general population, which is consistent with Medicaid's statutory requirements and would help reduce disparities by payer mix.

The chapter also notes the need for more evaluation to help policymakers identify the best strategies for improving quality and reducing disparities.

And finally, the third principle is that payments should be efficient, meaning that states get the maximum value for the amount that they are spending. The chapter notes the importance across state comparisons to identify those states with relatively high payment rates and poor quality outcomes, which likely have the best opportunities

to improve efficiency.

In our work so far, we've identified potential opportunities to improve efficiency related to staffing policies and supplemental payments, but more work is needed to identify the best approach for each state.

The chapter also notes the importance of better alignment between Medicare and Medicaid payment policies to promote efficiency. For example, we reiterate a view that's shared by MedPAC that it's inefficient to use high Medicare payment rates to offset low Medicaid payment rates. And we also highlight the need for further testing of new models to reduce avoidable hospital use to address some of those misaligned incentives that Drew was talking about.

All right. So then to improve the availability of data to assess whether payments are consistent with these principles, the chapter includes two proposed recommendations that you'll vote on tomorrow. So the first relates to transparency of data on Medicaid payments and costs. It's pretty long. So I'm not going to read it all, but I want to point out that based on the Commission's feedback at the last meeting, we added a third bullet here

related to data on nursing facility finances and ownership.

Also, we made a few stylistic edits to the version in your previous meeting materials, and so, hopefully, this new version is a bit easier to read.

The main rationale for this recommendation is transparency, which has been a longstanding Commission goal and is foundational for future analysis of Medicaid payments.

As Drew noted, in our review of available payment data, we found a number of gaps which this recommendation would help address.

I want to point out that the new part that we added related to transparency of data on facility finances and ownership is similar to a prior recommendation made by the National Academies, and it would help provide more information about related party transactions and real estate ownership models that may inflate the costs reported on facility-specific cost reports.

Overall, CBO does not estimate that the recommendation will have an increase in federal spending, but there may be some increased administrative effort needed to collect these data if they're not already

available. Of course, over time, though, the hope is that the better data will enable more stakeholders to participate in the rate development process and hopefully lead to changes in payment policies that benefit enrollees.

The second proposed recommendation would update existing requirements that states conduct regular analyses of nursing facility payments relative to costs and quality outcomes. Based on your feedback at the last meeting, we tried to add more explicit mentions of the importance of quality in these analyses.

The state-level analysis proposed in this recommendation are needed in part because the federal data available is incomplete. In addition, state-specific analysis can also help by better considering state-specific differences and allowable costs and other nuances of state payment policies that might be more difficult to account for in a national analysis.

This recommendation would update an existing regulation that has been largely unenforced since the Boren Amendment. But in our view, these rate studies are still needed to help inform the public rate-setting process, which replaced the Boren requirements, and also ensure

compliance with other Medicaid statutory requirements such as 1902(a)(30)(A).

In the rationale, we also discussed some of the additional changes to the rules that CMS can make when updating this regulation. So, for example, CMS could add more requirements for states to include considerations of quality and health disparities, and when updating the regulation, they could consider whether to expand this to also include managed care rates.

Finally, the recommendation notes the importance of providing more guidance and technical assistance to states to help them complete these rate studies.

So the implications of this recommendation are very similar to the first one, no increase in federal spending but likely some increase in administrative effort. It's unclear how states may change their policies in response to this requirement, but hopefully, over time, it will enable more public engagement in the rate development process and changes that ultimately benefit enrollees.

So that concludes our presentation for today. As noted, we're planning to vote on the recommendation tomorrow. So if you have any changes or comments, now is

the time to make them.

I also want to note that although this chapter sort of wraps up a lot of our nursing facility payment work for the time being, we still plan to continue monitoring state nursing facility payment policies, including the effects of any future regulatory changes such as changes to federal minimum staffing standards, which are expected later this spring.

To help guide your conversation today, here are the two recommendations, and we welcome your feedback.

CHAIR BELLA: Thank you, Drew and Rob.

I'm going to let Bill get us started and then go to Bob.

COMMISSIONER SCANLON: Okay. I have to say that you've done an incredible job here. I mean, this is a topic that has been hanging around for ages with very little information, and you, over the course probably of the last couple of years, engaged in a lot of pain in assembling all that information that was available, discovering how scant it was, and helping us think about where we need to be in the future.

Okay. I am fully supportive of the

recommendations, but I think that even more important are the principles that you've laid out. And I think that, hopefully, readers are going to not skip to the big bold print for recommendations and ignore those principles, because they are the heart of what we really need to be thinking about doing and asking ourselves how far are we getting in terms of trying to accomplish that.

Now, having said that, these are not easy principles. Translating them into action, in policy direction is going to be a very challenging task for a long sort of period of time, and we need to keep focusing on that. But the principles are critical in terms -- and you've summarized them beautifully.

The recommendations are a first step. We really do need this transparency. It's absolutely essential. We cannot be having these discussions in general terms, reaching sort of erroneous conclusions and then having policy actions follow the result of those erroneous conclusions. It's too important for residents. It's too important for states in terms of what they are doing, playing their appropriate role in terms of protecting residents, and whether they're spending their dollars

wisely. Those things are all going to flow sort of from this.

Now, there's no question this is going to be a big step if we were to have this transparency, and you do highlight that this is going to involve administrative costs up front, but we have to recognize what the long-term benefits of that is going to be. Rather than have each state try to struggle with this problem, the standardization that may come from CMS sort of assisting the states in coming up with the right approach will hopefully have some economies over time. And it will ultimately lead, I hope, to a much better use of our nursing home dollars as well as much better care for our nursing home residents.

Thank you very much for what you've done.

CHAIR BELLA: Well, thank you for being the Commissioner champion on these issues, so really happy with that feedback, and thank you for kicking us off.

Bob, then Rhonda, then Heidi.

COMMISSIONER DUNCAN: All I can say is wow. Bill, you've said everything I wanted to say but much more eloquently. But I did want to say again thank you for the

work, and I really appreciated you hearing us in our conversations around that third bullet about not only transparency, but that of the fuzziness of ownership and where that's coming from into our last conversation we were having about data and looking at quality and health disparities, calling that out in here, including that as incentives. So well done on the work.

Thank you.

CHAIR BELLA: Rhonda? Sorry.

COMMISSIONER MEDOWS: I speak in support of both recommendations as well. Well done.

I have one question, and I think maybe you discussed it last time. When you did your research, were you already finding that facilities were already sharing with states ownership updates like JVs, venture capitalists, et cetera, that kind of thing, or is this something that's going to be new that the facilities are now going to have to report in?

MR. NELB: Sure. So with the ownership data, what we're really trying to better understand is some of these sort of complex real estate ownership models. For example we have data on the cost reports about how the

facilities identify, whether they're public or privately owned or whatever. But for example, one of the states looked at a number of the facilities that are listed as privately owned, but then they're receiving supplemental payments that are intended for public nursing facilities. And better understanding that there are these arrangements where sort of one entity owns the real estate, another entity operates the facility, and so it's relevant for understanding, you know, the public-private issues for the supplemental payments but then also in terms of just general costs and quality. When you have these different parties sort of paying rent to different entities, it's tough to sort of figure out what the actual costs are, and so that piece will be helpful to understand as well.

COMMISSIONER MEDOWS: So it's going to be -- it's information that needs to come from the facilities afresh, fresh information, to some extent.

MR. NELB: Yeah. And the idea is the sort of comprehensive data. So right now we just sort of have one field maybe to say who the owner is, but understanding if these owner -- if there are multiple owners, sort of how they relate to each other, and so it might require more

than one field, I guess, to sort of answer that question.

COMMISSIONER MEDOWS: Thank you.

MR. NELB: And maybe Bill could add more.

COMMISSIONER SCANLON: Yeah. My sense is that we need better data. It's not that we don't have any data at all there. We certainly have had data on some ownership data, and there's been some analysis of that ownership data. But we need to again -- and it's almost similar to our prior discussion. We need to put it in a standard format to be able to look at it sort of across the country in the same way.

CHAIR BELLA: Thank you.

Heidi?

COMMISSIONER ALLEN: Thank you so much for this work.

My question was actually right in this area, which is I don't understand if our recommendations explicitly call for specific ownership --

[Pause.]

CHAIR BELLA: Heidi, we lost you. We have just enough of her question. I think maybe we could kind of interpret, but, Heidi, can you hear? If you can hear us,

we need you to repeat your question, please.

COMMISSIONER ALLEN: I can hear you, but my internet --

CHAIR BELLA: Can you type your question in the chat, maybe?

MR. NELB: And I can maybe -- it seemed like the germ of the question was whether we should be more specific on the real estate ownership data that we're recommending. This is where, in this case, we kind of deferred to the language that was used in the National Academies report which has a lot more detail in there about some of the type of information we thought sort of alignment here would be useful.

As Bill noted, it would sort of be further work needed to sort of maybe standardize the type of data that's collected, but I don't think we've done the work so far to sort of say exactly what that format should be. So we're trying to outline what the goal should be, and hopefully, as it gets implemented, there can be some more standardization.

CHAIR BELLA: So, specifically, she was saying, I'm wondering if ownership data will include private equity

beyond real estate. So I think what you're saying is we're laying out the principles. We're talking about the universe of things that could be collected as we sort of drill down on more specificity around the concept of starting to collect ownership data? Is that kind of what you're saying?

MR. NELB: Yes. Yep. And -- yeah. Some of the private equity may come up in more of the related party transactions piece, but we can explore in the rationale maybe to make that more explicit of the type of information that would be helpful.

CHAIR BELLA: Okay.

Heidi's comment is I would like to see us be explicit in asking for detailed ownership data that includes private equity. So I think, Rob, that's consistent with what you're saying for the chapter. Thank you, Heidi.

Dennis?

COMMISSIONER HEAPHY: Thanks for including under and over 65 information in the memo. I think it would be helpful to break it down more of the data on folks over and under 65 because these populations may be different. When

we look at recommendations like Green Houses and where people are going to be living, I think that there may be differences between under and over 65. Thanks.

CHAIR BELLA: Thank you, Dennis.

COMMISSIONER HEAPHY: Do you guys have thoughts on that?

MR. NELB: Let's see. So we have data now on the number of residents by age and things. So we can add a little more in the background of the chapter.

You're right that a lot of those, some of these new models, are more for the over 65 population, and so maybe we can highlight a little more again in the background about some of the challenges here.

In terms of rates, state have set like a general rate, regardless of the resident's age, but certainly, as we think about efforts to improve quality and reduce disparities, it's important to consider different subpopulations as well.

CHAIR BELLA: Okay. That would be great if we can detail that a little bit more in the chapter.

Fred and then Darin.

Thank you, Dennis.

COMMISSIONER CERISE: Thanks. I agree it's a great report, and, Rob, I can't help but just think that now that you've sorted out hospital financing, you're going to take on nursing home financing. So it will be good to get this one cleared up.

In the second recommendation that talks about assessing our payments related to quality outcomes, do you expect that to capture now in these supplemental payments that are tied to certain conditions? You know, that happens -- and so there's one piece of actually following through on whatever that condition might be, you know, a staffing ratio or something like that, and then there's the outcome. So I'm wondering if you could just elaborate a little bit on what you imagine we could collect under that section of tying whatever the payment methodology is to the outcome.

MR. NELB: Yeah. So I think the second recommendation about the rate studies begins at least setting the baseline of where states are at, so understanding this issue of what your payment rates are, the cost, and then what are your quality outcomes that you're getting. And so to the extent that you find a state

that is paying pretty high and maybe making these large supplemental payments but not getting great quality outcomes, the next step for the state is to -- and for other stakeholders in the state is to use that data and think about how to get more value for the money that you're putting in. Tying more pay-for-performance incentives to the supplemental payment is one strategy. But I think, as we note, the payment principles, it's important to evaluate how well those are working. And a lot of the pay-for-performance programs we studied haven't had the best results. We're not necessarily saying that's the -- there might be some other strategies that's worth considering as well, and so we're not -- we hope that the analysis in this recommendation too will help jumpstart those conversations, but we're not going into it sort of assuming what the answer is going to be.

CHAIR BELLA: Thanks, Fred.

Darin?

COMMISSIONER GORDON: Yeah. Thank you. Thank you for the report, but thank you for those comments.

Kind of where I was going was -- you know, I always get concerned when we say how does it compare to

cost because, as you noted, cost -- you can go down a really, really long rabbit trail there trying to figure out what is appropriate costs or not. But I was thinking about this in the context that as we see and hope that more states will be moving toward value-based payment arrangements in this area that our analysis just takes that into consideration, and like you said, some of the pay for performance, you know, there's mixed results, but I still feel we're in an experimental state at this point with some of that stuff, and that doesn't mean it's bad. It just means we're learning and moving in that direction. So that's one thing, so thanks for keeping that front of mind, and I have no doubt that you will.

The second thing, when it comes to ownership disclosures, I'm just curious. Is the information that's collected as part of provider enrollment captured more on ownership than what's being captured on the cost reports?

MR. NELB: A little bit. As part of the provider enrollment there's this -- what's called a NPPES system that does have some information on -- you know, in which ASPE, for example, has recently been using to identify recent data on changes in ownership and in some cases where

there are multiple owners. The NPPES system, which is a national -- it's sort of CMS, sort of federal provider enrollment. But presumably, a lot of states follow that or use similar methods. So that I think that's a source that could be used.

To Heidi's point, sometimes it doesn't identify, you know, private equity, or sometimes there are multiple -- you know, these entities are sort of part of a larger corporation or sort of arrangement that's, you know, sort of the next level that's maybe not as covered, so trying to capture some of that, and then -- yeah. And then the NPPES part doesn't get into the sort of the public-private issue, which is more of a Medicaid-type issue, I guess, in terms of how the financing works.

So there's opportunities to build on these processes, but the challenges now, you know, when we look at the data, it's sort of we have a lot of different data, but it doesn't match up. So trying to understand what the source of truth is a challenge, and so hopefully as the data improve, we'll be able to better understand what the arrangements are.

COMMISSIONER GORDON: That's helpful. Thank you.

CHAIR BELLA: So I just have a couple comments. First to echo the thanks and going back to what Bill said about continuing to hammer home on our principles, and as we look at our last discussion and we think about what we've done on provider payment and hospital payment, this transparency theme, I feel like we need an uber recommendation that is about, like, Congress and CMS should make sure everything is transparent and fully reported and all of these things. And so I just -- I know these recommendations are to HHS and to CMS, but I want to make sure that we're fully briefing our congressional colleagues as well about the importance of these things and really in our chapters tying together these themes, because the work really is -- all of it is coming together in our themes of improving access and disparities and outcomes and payment efficiency and all those things. And I think it's just really important to keep tying those themes together.

So thank you very much for this work.

Are there any additional comments from Commissioners?

[No response.]

CHAIR BELLA: Are you guys all set for tomorrow?

Okay. Thank you very much.

We'll transition into our next panel now, and we will welcome Chris.

[Pause.]

CHAIR BELLA: Chris, you are a panel of one. I guess I should say our next session, but as Kisha said, you're like three people combined in one. So welcome. I appreciate the work you've done on this, and we'll turn it to you to lead us through this session.

MEDICAID COVERAGE BASED ON MEDICARE NATIONAL COVERAGE DETERMINATION (NCD): REVIEW OF RECOMMENDATIONS AND DRAFT CHAPTER FOR MARCH REPORT

* MR. PARK: Great. Thank you. Today I'll provide a brief overview of the chapter and the draft recommendations.

At the December meeting, some Commissioners had comments on the scope of the recommendations and whether it should include all NCDs or be limited to those with CED requirements. Additionally, some Commissioners asked for more information as to whether the decision to follow a Medicare NCD would only be extended to the state or if

Medicaid managed care organizations, MCOs, could make their own decision separate from the state. I'll provide some additional information to help clarify the scope of Medicare NCDs and how states can control the decision to follow a Medicare NCD. Then I'll go over the options for recommendations. Commissioners are asked to select one of the options to proceed with a vote tomorrow. Finally, I'll go through the rationale and implications for the recommendations.

As we have discussed before, under the Medicaid Drug Rebate Program (MDRP), drug manufacturers must provide rebates in order for their products to be recognized for federal match. In exchange, states must cover all of a participating manufacturers' products for a medically accepted indication once a drug's approved by the FDA. States may limit use of particular drugs through utilization management tools such as prior authorization or preferred drug lists. But at the end of the day, a state cannot outright exclude coverage of a drug.

Medicare Part B covers physician-administered drugs. Part B must cover services that are reasonable and necessary. For drugs, this means that Part B generally

covers FDA-approved drugs for on-label indications and other uses supported in CMS-approved compendia. CMS can develop coverage determinations for items and services that apply nationwide through a national coverage determination, or NCD, process. Coverage with evidence development, or CED, is an option under an NCD. Under a CED, CMS can link coverage of an item or service to participation in an approved clinical trial or the collection of additional clinical data. And the CED was most recently applied to the antiamyloid monoclonal antibodies for the treatment of Alzheimer's disease.

At the December meeting, some Commissioners suggested narrowing the scope of the recommendation to allow states to just implement CED requirements but would not extend to NCDs without CED requirements. This would allow states to require the collection of additional data but not allow states to apply other coverage criteria that may be implemented for a Medicare population.

Commissioners asked for additional information on how often NCDs have been used for drugs and the types of coverage policies implemented. Based on our analysis of the Medicare coverage database, NCDs have been issued fewer

than 20 times on drugs. These NCD decisions have not been very detailed in terms of coverage criteria that would be specific to a 65-and-older population. The NCDs have largely confirmed that coverage is allowed for FDA-approved label indications or in some cases clarified off-label indications and types of providers or routes of administration that Medicare Part B would cover.

Based on the historical use and construction of Medicare NCDs, the NCD coverage criteria without CED requirements are generally in line with what states may already be using to define medical necessity or other prior authorization requirements. Allowing states to follow an NCD without CED requirements will not likely lead to a substantial change in coverage policies over what states may already accomplish under existing prior authorization authority.

As mentioned in prior meetings, CED requirements have only been applied to drugs three times, including the recent application to the Alzheimer's drugs. The CED requirements are the key feature of a Medicare NCD that states do not explicitly have the authority to implement under current law.

Additionally, some Commissioners asked for clarification on whether the authority to follow a Medicare NCD would extend to Medicaid managed care plans. All covered outpatient drugs are subject to the terms of the Medicaid Drug Rebate Program requirements whether dispensed under managed care or fee-for-service. States do not make individual coverage decisions on drugs at the state plan level because they essentially have to cover all drugs through the MDRP. They make individual coverage decisions on drugs through the process used to develop prior authorization requirements or preferred drug lists.

In the 2016 Medicaid covered outpatient drug rule, CMS noted that the terms of the rebate program do not require that Medicaid plans modify their formularies to mirror a state's fee-for-service drug coverage policies. This means that plans have the flexibility to establish their own coverage requirements that meet the statutory provisions of the rebate program. Because the recommendation would amend the rebate program to allow coverage according to a Medicare NCD, then this option would also extend to the Medicaid plans. The plans would not be statutorily required to mirror the state's coverage

criteria. However, states do have authority to require plans to follow specific coverage policies through the terms of the contract, including the authority to determine how a drug subject to a Medicare NCD is covered. States can require plans to follow the state's drug coverage criteria for some or all drugs covered under the contract. Conversely, a state could also choose to carve out certain drugs from the contract and provide them through fee-for-service.

So states ultimate do have the authority to make the coverage decision on a drug by requiring MCOs to follow their coverage criteria in the contract or through a carve-out. But states must proactively act on these options. The Commission could make a recommendation that would make this type of contract provision mandatory.

Today we are presenting two options to consider for the first recommendation. As a reminder, the recommendation would apply to the Medicaid-only population. Dually eligible beneficiaries are already subject to the NCD coverage policy because coverage of these drugs would be provided under Medicare.

Option 1 is the original recommendation that we

presented in December. This reads: Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on a Medicare national coverage determination, including any coverage with evidence development requirements.

Option 2 is very similar, but it limits the ability of states to only follow the coverage with evidence development requirements implemented under a Medicare national coverage determination.

So as I said, this option would just narrow the scope to just the CED requirements, and states could not follow an NCD that does not require a CED.

The primary difference between these two options is that Option 1 would add a marker for reasonable and necessary coverage into statute. It could provide some additional clarity as to what level of coverage is reasonable when it does not require evidence development, which may be helpful to some states by providing a federal standard by which they can benchmark their own coverage decision. However, many states may already be implementing similar coverage policies when assessing medical necessity

or establishing other prior authorization criteria. Both options would allow states to implement the CED requirements established under Medicare. As mentioned before, this is the key feature that states do not currently have the authority to implement. The net effect of either option is likely to be similar.

Draft Recommendation 2 is a new recommendation that was not presented in December, but builds on the question as to whether managed care plans should have the authority or whether they should conform to the state's policy with respect to coverage of a drug based on a Medicare NCD. And so draft recommendation Option 1 here is: Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on a Medicare national coverage determination, including any coverage with evidence development requirements.

Option 2 is just tweaking the language to say that it would only be the coverage with evidence development requirements implemented under a Medicare NCD.

The recommendations here, these options are

drafted to match the options in Recommendation 1, so if you chose Option 1 on Recommendation 1, we would choose Option 1 on this recommendation.

For the rationale, the NCD process is similar to the process states use to make coverage decisions currently, such as prior authorization. However, there are not well-defined standards as to what types of protocols are acceptable under the rebate program. Option 1 would establish into law the Medicare NCD as a benchmark for acceptable coverage requirements. Currently, Medicaid is not allowed to link drug coverage to the collection of additional clinical data. The recommendation would provide a statutory authority for states at their option to implement CED requirements that haven't been established under Medicare.

In its prior work, the Commission has highlighted states' concerns about paying for products that do not have a verified clinical benefit and the need to verify a drug's clinical benefit in a timely manner. Allowing states to link coverage of a particular drug to the collection of additional clinical data would help ensure that evidence of the clinical benefit can be developed in a timely manner.

Because Medicaid coverage could be tied to data collection, the recommendation could also encourage recruitment of a more diverse Medicaid population such as individuals with disabilities into clinical trials and prospective studies. That would help provide data on the clinical benefits of a drug specific to the Medicaid population, which may reflect a different mix of health status, demographic, and other socioeconomic characteristics than found in either the original clinical trial or the Medicare population.

Furthermore, a CED option could spur the negotiation of outcomes-based contracts. CED requirements would give states additional leverage to negotiate an outcomes-based contract that provides larger rebates when the drug does not provide the expected clinical outcomes.

It is important to note that this recommendation would not automatically apply current or future Medicare NCDs to the Medicaid program. States could decide to follow the Medicare requirements, but nothing in the recommendation would prohibit a state from providing broader coverage than allowed under Medicare.

States should also apply a consistent coverage

policy for any drug subject to Medicare NCD or CED requirements across all beneficiaries whether they receive services through fee-for-service or managed care. Aligning the policy would provide equal coverage across all plans and beneficiaries in the state. A consistent coverage product would also reduce the administrative complexity for providers who may be required to collect and submit data.

Furthermore, states should periodically review the clinical evidence that is developed and revise their coverage policies to provide access to effective clinically appropriate treatments. The Medicare NCD process does include formal periods for public comments and past NCD decisions. CMS has demonstrated a willingness to alter its proposed criteria in response to stakeholder concerns over beneficiary access. For example, CMS initially proposed CED requirements for the CAR T-cell therapies to treat cancer but removed those requirements in response to public comments.

CMS has also indicated that it would engage stakeholders and review data on the effectiveness of LEQEMBI, which is the second antiamyloid monoclonal antibody for the treatment of Alzheimer's disease that was

just approved earlier this month to determine if it should reconsider the existing NCD.

On implications, the recommendations are unlikely to affect many drugs but could still alleviate some budget pressure for states. Allowing states to follow a Medicare NCD would likely reduce federal spending for those drugs. In particular, the CED requirements would likely reduce utilization for those drugs and, thus, spending for drugs would decrease.

The CBO has provided a score of less than $5 billion in federal savings over 10 years. The score is the same for either option. In a similar manner, state spending would also decrease as utilization of drugs decreased. The recommendations would give states another tool to gather evidence of the clinical benefit of a drug in the Medicaid population. CED requirements could also help states negotiate outcomes-based contracts.

Drug manufacturers have been opposed to the CED requirements proposed under Medicare and have commented that Medicaid coverage should not be restricted further than currently allowed under the rebate program. They have argued than randomized, controlled trial requirements can

significantly reduce access. They have also stated while prospective studies provide broader coverage, they could still delay or restrict access due to the effort it takes to set up a registry and report the data.

CED requirements could change some manufacturers' decisions about the pathway under which they seek FDA approval, or it could provide an incentive for manufacturers to complete the confirmatory trial and get traditional approval quickly.

For example, the CED requirements applied to the Alzheimer's disease drugs can provide an incentive to seek traditional approval because the prospective study requirement allows for broader coverage than the randomized controlled requirement under accelerated approval.

Beneficiaries have generally been opposed to the CED requirements proposed under Medicare because these policies could delay or reduce access to the drug, which could result in beneficiaries not receiving a potentially beneficial treatment. In particular, participation in a randomized, controlled trial can introduce additional burdens such as travel that disproportionately affect low-income populations.

A CED requirement could provide some benefits to beneficiaries by providing important information about the benefits of treatments in specific subpopulations prevalent in Medicaid and whether there are potentially harmful side effects such as brain swelling that need to be monitored and managed. Providers could face an administrative burden in the collection and reporting of data required under a Medicare CED policy, but to the extent that these providers also serve Medicare beneficiaries, then they already need to have procedures in place to collect and report data, so including Medicaid in the data collection may not be a substantial burden.

For next steps, the Commissioners are asked to decide on which recommendation option to bring back for a vote on Friday. Please let us know if you have any edits to the recommendation language so that those can be made before the voting session tomorrow. And, finally, Commissioners should provide any feedback on the draft chapter.

And, with that, I'll turn it back over to the Commissioners for discussion.

CHAIR BELLA: Thank you, Chris.

I want to make an introductory comment, which is, unlike many of our recommendations, this one has really strong opinions on both sides of the issue, and so it's very important to hear from Commissioners and to get input from around the table. I also want to remind ourselves that we're all here because we care deeply about this population, so when we have differing opinions that come out during this session, please remember that about your fellow Commissioners. I think that's really important.

I'm going to ask Chris first to make sure -- first, I'm going to ask everyone around the table, do we fully understand the distinction with NCD and CED? Or raise your hand if you would like any additional factual information about those two things before I turn it over for general comments. Rhonda.

COMMISSIONER MEDOWS: Just a clarification. The population that would be most impacted would be adults and adults with disabilities or adolescents; so the children and pregnant women would not be impacted by this. Is that correct?

MR. PARK: Children could be affected to the extent that a particular drug is indicated for both

children and adults. So maybe like a cancer therapy, you know, could have indications for both children and adults. So potentially there could be some overlap. But if it's a drug specific to like a pediatric population, it is very unlikely that Medicare would --

COMMISSIONER MEDOWS: Would have a promising --

MR. PARK: -- make a decision on that drug. So, you know, it's more likely than not that a drug specific to the pediatric population would not get a Medicare NCD.

COMMISSIONER MEDOWS: That's what I'm thinking about, and some OB/GYN type issues as well for younger women, right?

MR. PARK: Correct.

COMMISSIONER MEDOWS: I just wanted to make sure that we know what population we're talking about for focus.

MR. PARK: Correct.

COMMISSIONER MEDOWS: Okay. Thank you.

CHAIR BELLA: Bob, a question? Thank you, Rhonda.

COMMISSIONER DUNCAN: Rhonda asked my question, but to go a little deeper on that, so use that cancer drug as an example, if through EPSDT it was determined that that

drug was medically necessary, would that trump that decision?

MR. PARK: That is a very good question that I think -- I'm not sure there has been a complete, fully standard process as to, like, the interaction between EPSDT and the drug rebate program, because there are some restrictions on drugs for pediatric populations that are currently in place, and it's not clear, you know, to what extent EPSDT could potentially trump those. And so I think that's still an open question.

COMMISSIONER DUNCAN: Yeah, that was my reading. First of all, you did a great job on digesting -- helping us digest that information in what you wrote. But my concern is anytime we talk about Medicare, that excludes the pediatric population, and then particularly when we talk about pharmaceuticals, clinical trials and studies for the pediatric population are nowhere near as in-depth as on the adult population. So there's a lot of trial and error there, and I just want to make sure kids are taken care of.

CHAIR BELLA: Is it a clarifying question before -- okay, Fred.

COMMISSIONER CERISE: Yeah, a clarifying

question. I'll come back with an opinion later. On Slide 6, where you talk about NCD, without the CED requirements being similar to states' medical necessity criteria, can you talk more about, like, what that component of the recommendation would add to help states with some sort of federal standards?

MR. PARK: Sure. Because the MDRP essentially requires coverage of medically accepted indications, that criteria is very, very similar to the reasonable and necessary criteria that Medicare uses for Part B in that FDA-approved label indications and -- or if it's been entered into some of these drug compendias that people use that clarify, you know, what common use might be. And so -- but there's still not clear standards as to what are acceptable prior authorization requirements.

So to the extent that Medicare has said we think this particular off-label use, for example, may not be reasonable and necessary, that could provide a marker for states to also say we agree, we don't think this off-label use is reasonable and necessary. So that could just be -- provide them a little bit of support in case there would be like a legal challenge to their decision. But for the most

part, I think where they end up with their current prior authorization/PDL process right now may be very similar to what Medicare decides if it does not require those CED requirements.

CHAIR BELLA: That's an important distinction, an important thing to understand. Did all the Commissioners understand that? Any other questions on that component? Bill?

COMMISSIONER SCANLON: My question, in some respects, relates to this, and it's the idea of if we have an NCD without CED the question would be why, or what the basis is for CMS to have that. And you just gave an example of saying that we do not believe that this is appropriate for some off-label uses.

And that triggers a question in my mind, which is you talked about states having the authority to do prior authorization. Within prior authorization would a state have the authority to say this off-label use is not something that we will approve?

MR. PARK: Yes, to the extent that it's not an FDA-approved label indication or it's not in one of those drug compendia, then states do not have to cover it because

it doesn't meet the definition of medical necessity at that point.

COMMISSIONER SCANLON: Okay. So that then brings me back to what was my original question, which would be an example of an NCD where the state would not have the authority to essentially do what Medicare is doing.

MR. PARK: Yeah. I mean, it's a gray area because you never know exactly if there was a legal challenge to a particular prior authorization requirement, what that result would be. But based on the historical decisions that Medicare has made under NCDs, without that CED requirement, my gut feeling is that those would be very similar to what states could do under their existing authority, so there would not necessarily be like a brand-new tool that would really allow states to do more.

So I think based on how it's been used historically, which again, may not be a predictor of the future, but based on how it's been used historically the NCDs without CED requirements are probably fairly similar to what states can already do.

CHAIR BELLA: Thank you, Chris.

All right. We are going to move into comments.

Dennis has a comment, I think. Dennis, is yours a comment or a question, because if it is a comment I have you in the comment line.

COMMISSIONER HEAPHY: Comment.

CHAIR BELLA: Okay. Perfect. I'm going to go to Kisha, Angelo, Dennis, Heidi, and then Fred, do you have a comment? Bill, do you have another comment or is it a question? Comment, Bill. I feel like I'm running an auction. Martha or Rhonda, did I see your hand? No? Okay. Kisha.

VICE CHAIR DAVIS: Okay. Thank you, Chris. Thank you for taking a very complex topic and trying to break it down and making it a little bit more clear, a lot more clear actually. You know, I'm in support of the recommendations, for the main reason of giving states the ability to have the same flexibility that CMS has for Medicare, for states to be able to have that flexibility in Medicaid, and really thinking about how these programs align, and trying to really create that alignment between the two programs in an equitable way. So that's where I stand on that.

You know, when I think about this issue around

the clinical trials piece -- and you do mention it in the chapter and maybe there's a way to draw it out a little bit more -- but that the clinical trials really need to be reflective of the population that is going to be served by that medication. And so that means that those clinical trials need to be inclusive in who they are bringing in. They need to be thinking about if this medication is going to be serving folks with disabilities or more vulnerable populations, how that is included in the trials. Because I certainly understand the comment of are we excluding folks because of trouble participating with clinical trials, and I think the onus is really on the clinical trial for making sure that the population that it is researching is inclusive.

CHAIR BELLA: Thank you, Kisha. Angelo?

COMMISSIONER GIARDINO: Thank you. I wanted to speak in support of Option 2, the coverage with evidence development.

Just a couple of comments. To me the key issue here is that we are talking about medications that have potential benefit, but we don't actually know if it's an actual benefit yet. And I don't think it's a virtue giving

people access to potential benefits unless we are going to make sure that we actually show that it's actual.

And I will just give you an example from my residency. When I was a resident -- this was in the 1980s -- we had a program called Mr. Yuck, and I gave thousands of patients sheets of stickers, and their moms and dads went home and they put these little neon stickers on all the poisons in the house. And these were neon-colored stickers, and everybody said, "Well, this is great. We are going to prevent poisonings."

When we did the research, and after three years of me giving thousands of parents these stickers, it turns out putting that fluorescent neon stick on the bottle made it intriguing to the child, and there were more poisonings. So as much as I wanted that potential to be right, as much as I wanted everybody to have that, we actually were harming people. That was not a virtue.

So if we are talking about a CED it means that there are professionals who say that there is still a potential and it is not shown to be actionable, and we should be promoting all of our programs to develop the evidence to know whether or not it's beneficial. We are

not talking about penicillin for strep throat. We are not limiting that. We are talking about something really serious that may have tremendous harm. And it's not exciting to me to give everybody access to that unless we are going to commit to determining if it is actual.

So that is why I really feel strongly that we should support Option 2. Thank you.

CHAIR BELLA: Angelo, thank you. So you would carry with number 2 for Recommendation 2. Great.

As you all are making your comments, please indicate which of these, if either, you are supportive of.

Dennis, then Heidi, then Bill, then Fred.

COMMISSIONER HEAPHY: I'm going to defer to Heidi first, if that's okay with Heidi.

COMMISSIONER ALLEN: Sure. That's fine with me. Is that okay?

CHAIR BELLA: That's great, yeah.

COMMISSIONER ALLEN: Sure. Thank you, Chris, for all of this, and I really want to especially thank you for answering all of the questions that have come at you. There have been a lot of them and I'm really grateful.

I have a lot of concerns with Recommendation 1,

which I think, from my understanding, the distinction are drugs that have been demonstrated to have benefit. I'm concerned that the national coverage determinations do not take into account the full Medicaid population outside of the dual eligibles. And I do believe, and I think that you've said this in your information to us today, that if the drug is efficacious but expensive, states do have mechanisms in place to prioritize and manage costs, and that states have actually been very creative, as we saw with the hepatitis C drugs, in figuring out how to do that.

I have a little more ambivalence around Recommendation 2, which is focused on CEDs. I just want to say that personally I believe it's FDA's role to address if the drug is efficacious, safe, and if the cost benefit of the drug warrants FDA approval. It does concern me that this would be made by a panel of people for whom this is not necessarily their expertise rather than the FDA.

And I am very concerned about the barriers for participation in these trials for Medicaid enrollees, which you did talk about. And I know that manufacturers have a responsibility to recruit and try to bring in as many people as possible, but I don't know that they actually

have requirements that they have to recruit by payer type or that they have to recruit by income. And we do know that people of color and low-income people are much less likely to be included in these programs because it is hard to find time to get off work or to travel or to get childcare. And that many of these trials exclude people simply because they have comorbidities, which is very significant for the Medicaid population, and then they are just not eligible for that.

So I feel like there is this loophole for the Medicare population that is a narrower loophole for Medicare, and that maybe, you know, some of these drugs may end up having benefit, and then we will have had years of a period of time where Medicaid enrollees were less likely to have access to them.

But I can see the points about that this would encourage manufacturers to have more endpoints and produce more evidence, and I am all in favor of evidence. I am just very concerned about access. Thank you.

CHAIR BELLA: Thank you, Heidi. Dennis, and then Bill.

COMMISSIONER HEAPHY: I really appreciated the

comments by Heidi and Angelo. I'm weighing them both in my head. Mr. Yuck, I think, is a really good example, Angelo, but then Heidi's points, I think, are also important.

And for me, I think, because the Medicaid population is so different from the Medicare population, might we be exacerbating disparities or inequities in outcomes for this population because the Medicare population is so different from the Medicaid population? I think that folks with really complex care needs, folks that intellectual disabilities, developmental disabilities, folks who have substance use disorders or folks with psychiatric conditions, schizophrenia, so how will this impact access to potentially beneficial medications for these populations who are just so different from the Medicare population?

CHAIR BELLA: Thank you, Dennis. Bill, and then Fred.

COMMISSIONER SCANLON: Yeah. I think this is a difficult subject because there is a lot of latitude in all kinds of different aspects of this. And as you pointed out, in terms of the NCDs as well as the CEDs, we have precedence to draw upon as examples. We can say sort of

that under these circumstances this would be fine. But those precedents are examples. They are not principles. They are not rules that are necessarily going to be followed, so we have to think about that to some extent.

At the same time, I think we need to be concerned about the process that brought us here. We have talked about the FDA as the source of approval for drugs. We need to remember that what CMS did here is dealing with a drug that the FDA signaled there is a need for more evidence. This wasn't an ordinary FDA approval. This was a drug where the FDA itself said that there was a need for more evidence.

Moreover, when we say the FDA is the ultimate decision-maker, but in terms of the ultimate expertise the FDA has an advisory panel that recommended against the drug that brought us to this discussion.

So I think we need to take that into our thoughts as well as we think about what are the policies or procedures that one needs in going forward.

I'm in support of Option 2, sort of in terms of limiting this to CEDs, because I think opening it up to the NCDs opens up a broader array of unknowns, and therefore, I

think we are safer if we focus on the CEDs.

In terms of the concerns about clinical trials being difficult and disproportionately affecting the Medicaid population, I have no quibble with that in terms of that this may be a very unfortunate reality. And we should be thinking about how do we address that.

One of the things if you look at drugs that have been withdrawn over the years, it's because of inadequacies in the clinical trials. The clinical trials were too focused on populations where there was more likely to be a benefit. And they got approved, and then when they were used by a wider population the side effects, the negative consequences suddenly started to crop up, and then the drugs were ultimately withdrawn.

So thinking about clinical trials should be a part of this. You know, how is it that we test? And is CED actually a good mechanism? Because we are taking, to some extent, the financial incentives of a manufacturer to get a drug on the market as quickly as possible out of the equation and we are actually adding some federal dollars to supporting this trial.

And so I think that taking this into a broader

context is important, but for the moment I think it is also important, for me at least, to support Option 2, in the two recommendations.

So thank you again, Chris, for the excellent summaries that you have done on this topic.

CHAIR BELLA: Thank you Bill. Fred, then Martha, then Darin.

COMMISSIONER CERISE: Yeah. My preference would be Option 1 but I could live with Option 2, and Option 1 because of the explanation that Chris gave earlier, where it would help give states some guidance. It doesn't sound like it would add a lot, or anything perhaps, to the authority they already have. But if it would provide some additional guidance that would be beneficial to states, I would be supportive of that.

You know, the issue of whether to do a recommendation at all, I do think it's important that we weigh in on that.

The FDA is going to make a recommendation based on the efficacy, the quality, or the safety considerations, and there is going to be a balancing act. And they have got to weigh the concerns of people with these serious

diseases that want access to drugs, and part of their job is to protect the public. And I think with all of these drugs there is a tradeoff. What we are seeing here is there is more uncertainty than we know, which is why we have got this requirement that CMS has put forward that they want additional evidence.

I think for us to dismiss or to minimize the role of CMS and the states here, or to discount their ability to make serious considerations is doing an injustice to those entities. I mean, CMS, they have thoughtful people that are looking at this. States have thoughtful people that look at these drug determinations. And to say that they can't have some consideration in these policy decisions I think is taking some authority away from them that they should.

Remember, states have an option to have a drug program or not, right? And so what we are saying is, well, if you have a drug program then it is an all-or-none thing. And for the most part it is, but in some of these very high cost, still in early phases of evidence drugs, I think it's reasonable to separate the FDA efficacy and safety decisions from programmatic decisions, people who have to

run programs and have to have consideration for broader things than a single drug.

So for that reason I think we ought to give that consideration to CMS and to the states, to give them some flexibility with this.

You know, I understand the argument on equity and for people to have access, but the truth is we are so far from equity and access to drugs in this country, with 30 million uninsured people, if we are going to make that argument let's put everybody in the bucket and let's look at negotiating prices to make these drugs available to everybody. We are not there, and so I think the programs need to have some ability to manage their programs, including these high-cost new drugs.

CHAIR BELLA: Thank you, Fred, and you emphasized states have the option to do the pharmacy coverage, period. I do want to remind us, because we haven't talked about this, this is an option. This recommendation would be an option for states. So it would not be requiring all states to take that up.

Martha, and then Darin.

COMMISSIONER CARTER: Thank you. I think I'm

good. Bill and Fred have said very well what I was thinking. I'm in support of, I think, Option 1, just to allow the states, just to sort of trigger that they may have some additional consideration there.

CHAIR BELLA: Darin. Thank you, Martha.

COMMISSIONER GORDON: Yeah, thank you, and Angelo and Bill and Fred, I think, articulated a lot of thoughts and considerations that I had.

The one thing I want to bring up in addition to that, like some of the material you all provided around where we did have the examples of how many times they have done this, which has been very limited, so let's keep in that context. But looking at one of the examples around CED, I want to read -- and I'm sure you all saw this but I think it's pertinent to some of the discussion. And this was Medicare writing this.

"We recognize that waiting for published results of an RCT may limit access. However, it is appropriate access that matters, and we have a real concern about potential harms to" in that case Medicare patients. So they are balancing these issues. And they say, "It is important to first demonstrate that the benefits outweigh

the harms with the patient protections in controlled settings of more evidence."

I think that is what we are saying here, and I don't know when you read that how you could say, but for Medicare it's okay. How could you have a different standard when you put it in that context of saying that we are not as concerned about the protections or the potential harms in this situation?

So I do think having that standard -- again, very limited situations that we have seen historically -- having that available to states that when they look at the evidence they too have this level of concern, only first and foremost when Medicare has made that decision, I think is something that it is hard to argue not giving them that ability.

And I appreciate Fred's comments too. I mean there was not a decision we made on benefits or drugs that was taken lightly. And I know a lot of the clinicians that are involved, including an extensive level of additional outside experts looking at it as well, then ultimately a decision is made here.

And I would assume -- and I don't know this,

Chris, and I don't know if you would have an answer for this -- but this type of decision, whether or not a state were to opt to follow Medicare's determination its CED, would, if I recall correctly, the requirements of a P&T committee, this would have to be at least discussed with a P&T committee before a state would take an action with regard to coverage.

MR. PARK: That is correct. The requirement is that the P&T committee be open to the public and that there are opportunities for public comments. So a state would at least have the period of public comment available for their decision.

COMMISSIONER GORDON: As well as these P&T committees are external and folks involved, clinicians that are involved as well, bringing their perspective also. So there's multiple levels of protections, limited times in which we've seen this historically. We're talking about situations where there is little evidence, and it's the hope that more evidence will someday happen.

I think for those reasons, I support giving states the ability. I could do Recommendation 1. I think Recommendation 2 is easier to support, but I could easily

support Recommendation 1 if there was more interest there.

Thank you.

CHAIR BELLA: Thank you, Darin.

Heidi. And then we're moving our way to public comment.

COMMISSIONER ALLEN: So I'm just trying to understand what the role of the FDA is for safety and efficacy in determining whether or not there's enough evidence for a drug to be covered if we're saying that we think states should be able to make that decision for Medicaid enrollees.

I understand that there was an FDA decision that many, many medical providers disagreed with, but creating a bunch of policy to circumvent the authority of the FDA and the expertise of the FDA and linking Medicaid, you know, amending the Social Security Act, which is not, you know -- I mean, that's an important thing to do, but to amend it to link ourselves to a Medicare population, which is distinct from the Medicaid population, except for where they are shared with dual eligibles, rather than trying to create a special mechanism for Medicaid to be able to make those decisions, I think it has equity in access implications.

And it's hard for us to look into the future to say what those would be.

But in the future, if they were, we would not be in a position to be able to do anything about it, other than to encourage states to do -- you know, to cover it. But they would still have the option, particularly if it impacted their budget, to not do, which would lead to increased state variation in health disparity.

So I just want to really articulate that concern.

CHAIR BELLA: Thank you, Heidi.

Bill and then Rhonda.

COMMISSIONER SCANLON: I think that we've heard a number of times about the differences between the Medicare and the Medicaid population, and no doubt, there are some very significant differences. But at the same time, I would remind us all that there is a very substantial population of Medicare eligibles that are there because of their disabilities. There are persons under 65, and we're talking about millions of people with very serious disabilities. And what we've seen before is that that population, very similar to people that have higher incomes but with similar conditions, they both end up needing the

same kinds of services and having some of the same tragic consequences.

CHAIR BELLA: Thank you, Bill.

Rhonda?

COMMISSIONER MEDOWS: I just wanted to add that I don't see these options as replacing or negating the work of the FDA. I see this as additive, and if I think about the Medicaid population in particular, I think that the clinicians, the pharmacists, the pharmaceutical folks that are on the local P&T committees, I honestly respect what they're doing when they come in to do their oversight, as they should.

CHAIR BELLA: Thank you, Rhonda. You kind of read my thought cloud, which is this does not also -- this still goes through a P&T committee, just as the states use today with public comment, which is, as you and Darin are both indicating, an important additional step. So I too see this as additive. Thank you.

Okay. I do want to get a sense. I thought we were leaning toward Recommendation 2. We had a couple of late entrants on Recommendation 1. Can I get a sense of the group on Recommendation 1 versus 2?

COMMISSIONER CERISE: I'm very comfortable with 2 as well.

CHAIR BELLA: How about Recommendation 2?

Okay. Chris, I'm going to ask that you bring back Recommendation 2, but let's also hear public comment because that may have some impact on how we think about those recommendations. Recommendation 2 with two, so the two 2's.

MR. PARK: Okay. Yep.

CHAIR BELLA: The two 2's.

All right. I'm going to turn it over -- what's that? Sonja, did you have a comment? I'm sorry.

COMMISSIONER BJORK: I had a question. Neither of the options are to not cover a drug. Is that correct? It's just to allow --

CHAIR BELLA: To allow the studies to do this.

COMMISSIONER BJORK: To allow studies to require clinical studies.

MR. PARK: Potentially, Option 1, there are some cases where Medicare NCD may say it is not covered for X, Y, and Z situations, and so there, there could be an area where it's not covered.

Historically, what we've seen, it looked like it was only done four times where it was not covered. Two of those cases were more about a route of administration that they did not think was effective, but like a different -- the drug delivered in a different way would be still covered. And then the other two, I think were for indications that were not approved by the FDA.

So, historically, coverage is usually provided for FDA-covered indications, but Option 1 potentially would give states the opportunity to exclude coverage if Medicare said they would exclude coverage in certain situations.

COMMISSIONER BJORK: Thank you for clarifying.

CHAIR BELLA: All right. So we're going to open it up to public comments. If you would like to make a comment, please use your hand icon. I would remind folks to please introduce yourself, the organization you represent, and limit your comments to three minutes. And I actually am going to have to be a three-minute clock enforcer today so that we can keep moving.

I see Allison Taylor had our hand up first. Welcome.

PUBLIC COMMENT

* MS. TAYLOR: Good morning. Thank you so much. Allison Taylor. I am presenting testimony on behalf of the National Association of Medicaid Directors. I am the Medicaid Director in Indiana currently, and I'm also serving in the role as president of the association.

I provided comment in September when the Commissioners were discussing this issue. I am going to revisit a bit of my testimony with some emphasis added for your consideration, given where we are in conversation today.

I just want to start by saying we really appreciate hearing these recommendations and the rationale that was presented earlier, do think they align with what ultimately I'll describe as our hopes to see more tools in the toolbox for states in this space.

So just to start again, a really quick level set, I think everyone knows, but Medicaid programs live in this space where they have to manage tensions between, of course, stewarding federal and state dollars and providing and ensuring access to services, support therapies, to really help individuals meet -- or help us meet the well-being needs of the folks that we serve.

So we have to operate on a balanced budget in states, and I can attest we are in the middle of our biannual budget process. And unanticipated Medicaid costs can present challenges to managing the program. I think I shared this with MACPAC in September, and at that time, I said, hey, you know, increasing -- we're facing increasing challenges, and I can attest a few months later, and that future is already here. It's becoming more challenging as states face increasing budgetary pressures and economic uncertainty in the coming years.

And certainly managing pharmaceutical costs can pose big challenges for Medicaid. When I was here in September, we talked Aduhelm and how it was kind of that perfect example of the type of drug that presents challenges to Medicaid.

At the time, there was some question of as to whether Medicare would cover it. We know that Medicare's decision would have major implications for Medicaid. So if it declined coverage, Medicaid would have become primary payer for duals, in essence, forcing states to pick up federal costs.

Fortunately, we know Medicare chose to use its

coverage with evidence development authority in that case, but Aduhelm is not the only example of the persistent challenges that states face. Drugs that are approved by the FDA with limited real-world evidence force states, us, into difficult situations regarding cost and coverage.

A recent OIG study, for example, found that Medicaid spent $3.6 billion from 2018 to 2021 for accelerated approval drugs with incomplete confirmatory trials past their original plan completion date, and this is especially true if the drugs are covered. Outpatient drugs with mandatory coverage under Medicaid drug rebate program, in those circumstances, states have to cover the drug, even if post-market trials indicate they do not in fact work. No other payers were required to do this, only Medicaid. I've heard this discussed in discussions earlier. So, effectively, Medicare and commercial payers are allowed to limit coverage until evidence of efficacy improves, while Medicaid programs have to cover the drugs with uncertain clinical benefits.

CHAIR BELLA: Allison, I'm sorry. Can you wrap up your comments?

MS. TAYLOR: That's fine.

CHAIR BELLA: I hate to do that. I'm sorry.

MS. TAYLOR: No, no worries. I have one bullet point left. So the key here is states really need to have tools to manage these situations. We really appreciate hearing discussion about, again, looking for some equity and parity and giving states the flexibility that other Medicare and other plans have.

So we appreciate the opportunity. Thank you.

CHAIR BELLA: Thank you for taking time to join us and provide this comment. Very much appreciated.

Milena? And I'm sorry if I mispronounced your name.

MS. BERHANE: Yes. Hello. Hi. My name is Milena Berhane, and I'm a policy manager with the Children's Hospital Association. Thank you for the opportunity to speak before the Commission today.

The Commission has considered the possibility of applying the Medicare NCD process to Medicaid coverage with the draft recommendation to Congress to make the statutory change to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on a Medicare NCD determination, including any coverage with evidence

development requirements.

We are concerned with the impact that this will have on the millions of children who are reliant on Medicaid coverage to receive their necessary drugs, and we ask the Commission not to put forward a recommendation until the potential impact on children is examined closely and the recommendation includes mitigation of the impact on children who need access to often lifesaving drugs.

Children rely heavily on off-label drugs, which make up over 50 percent of the medications utilized in pediatric care. With the NCD process, the requirements for coverage on the off-label uses of a drug are burdensome and often result in beneficiaries being unable to access medically appropriate drugs. If applied to Medicaid, children will face delays and restrictions in accessing the medications they need.

And children covered by Medicaid lack the supplemental or secondary coverage that often bridges the gap for Medicare beneficiaries. If subjected to the NCD process, children covered under Medicaid would not have that same supplemental coverage option to cover impacted prescriptions, and this would be detrimental to children,

further restricting access to critical medications and increasing burden for families.

Related to access, there is a concern with the delayed coverage approval process related to the NCD used in Medicare determinations. The NCD process can take between 90 and 180 days to be approved for coverage after the FDA has approved it and the drug has entered the market, compared to Medicaid, which covers a participating manufacturer's drug as soon as it is approved and becomes available on the market.

A delay in coverage approval would be harmful for children covered by Medicaid, especially those who have complex medical conditions and cannot wait 90 to 180 days to see if they will be covered for a potentially lifesaving drug.

In addition to our concerns, we pose the following questions to the Commission. Who would be determining which pediatric drugs are reasonable and medically necessary under Medicaid? Pediatric care has different considerations when compared to that of adults and applying the same determination process as Medicare may leave out important considerations that need to be included

for children. We implore you to consider these potentially harmful impacts that the Medicare NCD process would have on children covered by Medicaid before moving forward with the proposed recommendations.

Thank you for your time.

CHAIR BELLA: Thank you very much for your comments and taking time to join us.

Okay. I will say I may have skipped a step and made the assumption that I said we'll do 2 and 2. I thought everybody was leaning toward making sure there was clarity that this would be the state and not the state and the plans. I just want to validate that that's correct.

Okay, okay. I see a lot of nodding heads for the record.

Chris, you've gotten a lot of feedback. Generally, we hear support, but none of us are unconcerned about some of the broader issues, as Bill raised, around clinical trial representation and the underrepresentation of Medicaid beneficiaries as a whole. So I do want to make sure that we do justice to that in the chapter, and so I know that all of us will go back and take another look at the chapter based on the discussion we've heard today and

make sure that the intent and our commitment to access does come through alongside the tool that we're giving states and the point that Darin made about if we're worried about this for Medicare, it is appropriate to think about it for Medicaid as well. But I do want to make sure, particularly Heidi and Dennis's points -- and there were -- Bob started us off with points about children, which we just heard in the public comment as well.

Martha?

COMMISSIONER CARTER Something just came out recently, just in the last little bit of conversation, that I want clarification on, please. So it's about what the states can do regarding off-label usage, and did you say that there was off-label usage that wasn't FDA approved, but the states were able to take some action on that?

MR. PARK: Sure. There are some drugs that are off-label use but are widely accepted as common practice, and those are recorded into these drug compendia as to what situations those are, you know, commonly accepted by the medical community. And so if it's in one of those three compendia that are listed in statute, then that also falls under medical necessity requirements, and states should

cover those drugs for those uses.

COMMISSIONER CARTER: Are states required to cover those drugs, or is what we're talking about in Draft Recommendation 1 to allow states to make that determination themselves?

MR. PARK: Sure. So there, I think, are two compendia, and I think there's basically overlap between the two in Medicare statute and the three in Medicaid statute for medical necessity. So the reasonable and necessary criteria, as Medicare has laid out, is very similar to what Medicaid has laid out on statute for medical necessity. So it's on-label indications that the FDA has approved or inclusion in one of these compendia. So there should be a lot of overlap between what Medicare considers reasonable and necessary and what Medicaid says is medical necessity.

If a particular use is not in one of those compendia or not approved by the FDA, states would have the ability to exclude coverage currently under the statutory definition.

COMMISSIONER CARTER: Okay. Thank you.

CHAIR BELLA: That's impressive, Chris. Thank

you. Thank you for that.

Do you need anything else from us? I hesitate to ask.

MR. PARK: No. We'll bring back Option 2 for both recommendations tomorrow for the vote.

CHAIR BELLA: Okay. Thank you very much. Thank you to all the Commissioners for engagement. And, Chris, thank you for your extensive knowledge in this area, among others.

All right. We'll have our last session before we go into lunch, and switching gears, we're going to talk about home- and community-based services.

So, Tamara and Asmaa, welcome.

[Pause.]

CHAIR BELLA: Kisha.

VICE CHAIR DAVIS: All right. Thank you. Asmaa and Tamara, we will turn it over to you to get us started.

INTERVIEWS WITH EXPERTS ON CHALLENGES FOR STATES ADMINISTERING MEDICAID HOME- AND COMMUNITY-BASED SERVICES AND ACCESS BARRIERS FOR BENEFICIARIES

* MS. HUSON: Alright. Hello, Commissioners. So Asmaa and I are here today to share with you the interview

findings from a recent contract that sought to understand what the challenges are for states administering home- and community-based services, or HCBS, as well as the access barriers that beneficiaries may face.

As you know, MACPAC has developed a body of work on various HCBS-related topics. For example, in December 2021, MACPAC convened a roundtable of federal and state officials and national experts to consider the design of the Medicaid HCBS benefit. We presented the results of that roundtable discussion at our March 2022 public meeting, and this past October, we had a panel that also discussed various access barriers to HCBS as well as ways to streamline the delivery of HCBS.

This is just an overview of our presentation, and I'm going to start with a quick refresher on HCBS.

So Medicaid HCBS are designed to support people with a long-term services and supports (LTSS) need to live in their home or a home-like setting and to be meaningfully integrated into their community. HCBS encompasses a wide range of services such as personal care services, supported employment, non-medical transportation, home-delivered meals, caregiver support, and more.

Medicaid beneficiaries who use LTSS are a diverse group, spanning a range of ages with different types of conditions, including physical and cognitive disabilities. Some people receive services and supports for many years, or even decades. The types and intensity of services that people require varies, both within and across LTSS subgroups. And according to a recent report that included data from 48 states, over 7.5 million people used Medicaid HCBS in 2019. And eligibility for Medicaid LTSS depends upon both financial and functional eligibility criteria, which varies across states and across populations. And once an individual is determined eligible for Medicaid, they are entitled to the full range of covered mandatory services that the state has chosen to provide.

HCBS are optional services, but all states choose to provide HCBS to individuals who are financially and functionally eligible through one or more statutory authorities, as you can see laid out on this slide. Some states provide HCBS under their state plan, but most HCBS are provided via Section 1915(c) and 1115 waivers. Waivers give states flexibility to limit the number of beneficiaries receiving HCBS, they can target services to

particular populations, and they can also limit the availability of services to certain parts of the state.

HCBS that are covered under the state plan must be offered to all eligible beneficiaries, and state plan HCBS are typically more limited in scope than those provided under waivers. States are frequently managing several programs and benefit packages, each with its own set of eligibility criteria. This variation and the availability of HCBS across populations and across states as well as the complexity of managing the range of HCBS authorities can lead to access barriers for beneficiaries.

So to better improve our understanding of the challenges that beneficiaries and states are facing, we contracted with the Center for Health Care Strategies (CHCS) to conduct interviews with experts. CHCS, with the support of its subcontractor RTI, conducted 18 stakeholder interviews between September and November of last year, with federal and state officials, beneficiary advocates representing a range of HCBS populations, and national experts. And now I'll turn it over to Asmaa, who will talk through the interview findings.

* MS. ALBAROUDI: Thanks, Tamara. Good morning,

Commissioners. Today I'd like to spend the remainder of our time reviewing the interview findings.

So, first, we'll begin with barriers for beneficiaries in accessing home- and community-based services. Several interviewees noted that information about HCBS options and how to access such services is lacking for potential beneficiaries. Although states have worked on establishing no-wrong-door systems in which state and local agencies coordinate to create a simplified process for people to access information, determine their eligibility, and provide one-on-one counseling on LTSS options, people often do not know where to find information on HCBS.

One issue is the lack of training for and high turnover rates among information counselors. This is similar to other HCBS workforce shortages, both of which are partly driven by low wages.

We heard from one state that they're experiencing high turnover rates among their Area Agencies on Aging (AAA) counselors, which they depend on to serve as an HCBS resource for their residents. The state officials shared that these workforce challenges are not unique to this

particular state or AAAs.

Interviewees also expressed that information provided on state websites varies in terms of the level of detail and can be difficult to navigate; further, that a lack of accessible information, such as information for those who are visually impaired, creates access barriers when individuals are seeking information.

Some states have used funding from the American Rescue Plan Act of 2021 to improve the availability of HCBS information by allocating funding toward their no-wrong-door system. MACPAC is monitoring state ARPA spending plans to track the ongoing outcome of this and other HCBS efforts.

The next area raised by interviewees is the complex eligibility requirements that beneficiaries have to navigate. We heard that the range of waivers with varying eligibility pathways can result in confusion among beneficiaries relating to which waivers they qualify for, leading them to possibly apply for multiple waivers to increase their chance of being determined eligible and enrolling in a waiver.

National experts as well as federal officials

also shared that some income and resource eligibility criteria can deter individuals from applying for HCBS despite needing the services for fear of becoming impoverished. For example, to qualify for Medicaid coverage through the medically needy pathway, individuals have to spend down their income to their state's medically needy income limit. The median income limit was $478.50 per month for an individual in 2020.

And, lastly, state and federal officials raised issues related to the lengthy eligibility determination process given that individuals have to navigate both functional and financial assessment processes. For example, one state official noted that waiver applicants with intellectual and developmental disabilities, or ID/DD, in that state have to be determined medically eligible twice -- a state developmental disability system determination as well as an HCBS medical eligibility determination to apply for waiver services.

Interviewees suggested that states can enhance their eligibility and application systems by allowing for the medical eligibility determination process to occur concurrently with the financial eligibility determination

process.

Federal officials, national experts, as well as beneficiary advocates noted the enrollment caps and waiting lists allow states to manage spending by limiting enrollment, but these same levers also create barriers to access for beneficiaries. In some cases, waiting lists may be so long that beneficiaries never receive the services that they need. For example, a beneficiary advocate told us that persons with traumatic brain injury who were placed on waiting lists often pass away prior to receiving the HCBS waiver services that they need.

In our prior work, we found wide variation in wait times to enroll in a waiver, with estimates ranging from less than one year to 14 years. Wait times also differed within states among their various waivers, often by more than five years. Some states have changed their approach to waiting lists to try and ensure access to HCBS for those most at need while still managing enrollment. In Louisiana, we heard that the state transitioned from a first-come, first-served basis to a priority-based system for its waiting list management. In that state, individuals with ID/DD who are on waiver waiting lists are

assessed for a level of need and categorized into five different groups. Those at highest risk for institutionalization are prioritized for HCBS access.

In our previous work on waiting lists, state funding was cited as the most important factor in many states for increasing waiver capacity. In some states, explicit support from the governor or the state legislature led to funding increases that helped reduce waiting lists.

Next, we explored disparities in HCBS access. Several interviewees shared the challenges of identifying the extent to which these disparities occur given the lack of available data. Despite these data challenges, several examples shared by interviewees are worth noting.

Two interviews emphasized that racial and ethnic disparities may exist in how communities respond to nursing facility closures. They pointed to developments of community-based spaces such as assisted living facilities in predominantly white neighborhoods while communities of color simply experienced the reduction in services brought on by the nursing facility closure.

Interviewees also identified geographic disparities. For example, in rural areas it can be more

difficult to find HCBS providers or direct care workers.

We also heard about age-related disparities. One interviewee shared that individuals supporting care plan development, such as social workers, may not engage in person-centered planning for older adults, assuming they know their needs rather than asking about their preferences and needs.

HCBS access can be particularly difficult for individuals with multiple disabilities. For example, an individual with ID/DD and behavioral health needs may qualify for multiple waivers but may have difficulty determining which waiver is most appropriate for their needs.

And, finally, assessment tools. One beneficiary advocate noted that functional assessment tools are primarily focused on physical disabilities which can be exclusionary for individuals with cognitive or developmental disabilities.

Next, I will discuss what we heard about the challenges states experience administering HCBS programs. States may provide HCBS via state plan authority as well as waiver authorities, each associated with varying reporting

and renewal requirements. We heard from one national expert that HCBS waiver reporting requirements relative to state plan options are often more extensive.

One state official shared that states are burdened with growing quality and reporting requirements. We heard that technological investments that states must implement in order to comply with the requirements can be challenging. Interviewees also pointed to other factors that increase complexity. For example, in some states that have multiple HCBS waivers, they are managed by different state agencies.

Separate from challenges managing the range of authorities, budgetary constraints were cited as a limitation in state efforts to enhance HCBS access. Multiple interviewees indicated that state budget pressures may limit HCBS offerings.

Interviewees suggested several potential areas to consider when thinking about administrative complexities. They had various suggestions on how to streamline HCBS state plan and waiver authorities. They included consolidating HCBS authorities and aligning reporting requirements and renewal processes to decrease

administrative requirements. One state official suggested allowing for tiered benefit packages within one Section 1915(c) waiver program rather than separate waivers for each tier, essentially a redesign within existing authorities. This would be to address scenarios in which some states use multiple waivers to serve the same population but offer varying types and intensities of services.

For example, in some states they might have a tiered benefit system that targets individuals with ID/DD through use of several Section 1915(c) waivers.

The next was around increasing HCBS access for individuals with behavioral health conditions. One national expert we interviewed shared that only select states use Section 1915(c) to provide behavioral health services because of the institutions for mental diseases exclusion, or the IMD exclusion, which makes meeting federal cost neutrality requirements difficult.

One consideration is to revisit how the IMD exclusion could create a barrier to increasing access to Section 1915(c) waivers for beneficiaries with behavioral health needs who would benefit from HCBS.

One key takeaway we heard across the board was workforce challenges at the state and provider level. State staffing shortages can hinder efforts to establish more robust HCBS systems. Both national experts and beneficiary advocates noted the need for improved education related to HCBS options as well as the needs of particular subpopulations. Separately, interviewees cited the importance of states engaging stakeholders in any efforts to streamline HCBS options. For example, Florida actively worked with stakeholders to improve HCBS access for the ID/DD population in their state.

State officials mentioned limitations related to HCBS provider expertise and capacity and, in particular, when serving persons with ID/DD and behavioral health needs. Interviewees also shared that states should consider the direct care workforce shortage when attempting to increase HCBS access. A number of interviewees underscored that direct care workforce compensation is lacking, and turnover and lack of direct care workers leads to challenges delivering person-centered services.

One state official shared that, despite efforts to increase wages twice in their state, the new wages were

not competitive with other employment opportunities. One way that some states are looking to fill in the gaps of the direct care workforce is through the support of natural caregivers.

Finally, we asked interviewees for feedback at a conceptual level on the idea of a core benefit, including design elements and implications for the current HCBS delivery system. Again, the core benefit was an idea that was discussed at the December 2021 roundtable as a way to potentially increase access to HCBS and streamline services by providing a limited benefit to all HCBS beneficiaries in all states.

Overall, we found that most interviewees expressed general support for the concept of a core benefit. Beneficiary advocates and national experts were more likely to express support for the idea of a core benefit than federal and state officials who expressed uncertainty towards the idea.

Interviewees who expressed general support mostly agreed that it could potentially address the institutional bias and increase access to HCBS. However, many cautioned that the ability of a core benefit to increase access

depends on the design and implementation of the benefit. They also noted that increases in access could vary across states given existing state policies and systems for HCBS eligibility, enrollment, and coverage.

One state official predicted that the state would probably have to consider updating its payment rate structure to make the provider network viable in order to implement a core benefit, and that same state official also shared apprehensions related to state staff capacity to implement a new and innovative HCBS benefit given that some states are experiencing high vacancy rates.

The remaining interviewees were more ambivalent towards the concept of a core benefit. They raised concerns related to design and implementation and if such a benefit would add more complexity to the system. When asked if a core benefit should be mandatory or optional for states, almost all interviewees agreed that for a core benefit to have an effect on streamlining and increasing access to HCBS, it would need to be a mandatory Medicaid benefit.

To draw on interviewees' broad range of perspectives, we asked about possible design elements of a

core benefit that were raised during the roundtable. Generally, they supported a standard core benefit across states, with one set of services for all HCBS populations, and any additional services layered on top as tiers.

Most expressed support did so because they believed that it could help deter or address some inequities in HCBS access between states. On the other hand, we heard from state officials that they value flexibility to design a benefit that best meets the unique needs of their population.

The majority of interviewees indicated greater support for one standard package as opposed to multiple population-based core benefits, given some concern that a population-specific benefit would not accommodate the needs of individuals with multiple disabilities.

Interviewees provided insight on how services may be assessed when contemplating their inclusion in a core benefit. Specifically, stakeholders suggested that services should promote person-centeredness, increase community integration, and focus on outcomes. Interviewees were also asked to provide insight on the design of a core HCBS benefit as a tiered service-based or budget-based

model. In a tiered design, the first tier would serve as the core benefit, and subsequent tiers above that would provide additional services or intensity of services, so a service-based model, or additional dollar amounts allocated for the individual, or a budget-based model.

Generally, we heard support for a budget-based model and interviewees noted that states can better predict estimated spending under a budget-based model and provide choice and flexibility to consumers.

Interviewees also raised several considerations for operationalizing a core benefit. The first was around workforce availability. We heard that a primary concern of states in expanding access to HCBS is the workforce shortage and state staff capacity. Many of the interviewees also noted that states would need additional federal financial support to implement a core benefit, particularly if it was mandatory. A couple of interviewees pointed to low state take-up of the Section 1915(k) program, which is associated with an enhanced 6 percent match. This may suggest that states require greater support than previously estimated.

One state official noted that states may struggle

to invest in the infrastructure that would be needed to implement a new core HCBS benefit, such as updating state information technology systems, as well as developing more user-friendly systems that people can use to apply and track their application.

Several interviewees mentioned that states would need time to implement a core benefit, for example, to engage stakeholders in implementation, as well as secure funding from state legislators.

And, finally, and just as important, are beneficiary supports. We were told that implementation of the core benefit should also include beneficiary supports such as options counseling. Interviewees noted that while a core benefit could allow individuals to more easily access HCBS, it could also exacerbate disparities in access if it does not account for the different levels of support needs.

Our interview findings further substantiated that barriers to HCBS persist. Our findings clearly point to challenges that beneficiaries encounter in attempting to access HCBS, such as lack of information and complex eligibility requirements. Further, interviewees shared

that states experience challenges administering HCBS programs, primarily related to limited state staff capacity and worker shortages. Reactions to the concept of a core benefit were mixed, with over half of interviewees expressing general support for the core benefit, and most interviewees agreed that such a benefit would have to be mandatory in order to be effective, and that states would need additional federal financial support to initiate the associated and widespread programmatic changes that would be required.

Further, they agreed that states have limited capacity to implement new initiatives and that even if access were to be expanded through additional services, there is not a sufficient HCBS workforce to meet the current demand.

As states prepare for the unwinding of the continuous coverage requirement and are implementing their ARPA spending plans, we propose to revisit the concept of a core HCBS benefit at a later time.

In terms of next steps, the interviews underscored the challenges beneficiaries and states are facing, and we plan to focus our work in this area. We

plan to use feedback from interviewees along with the information we've gathered this past year through the roundtable and through our research to inform a descriptive chapter for the June report. The chapter will focus on barriers to access for beneficiaries and the complexity of administering these programs for states, taking into account the landscape of HCBS programs across states.

For our future work, we are planning to continue our research and analysis towards the development of policy options to address the complexities of the HCBS system. We welcome Commissioner feedback on areas of focus for the chapter as well as areas of interest for our future work.

Thank you.

VICE CHAIR DAVIS: Thank you both. What I hear you saying is it's complicated.

MS. ALBAROUDI: To say the least.

VICE CHAIR DAVIS: Which I think is a great area for the Commission to weigh in on. I think there are a lot of diverse topics that are in this memo, and one, I'm really appreciative of the feedback that we heard from the different stakeholders. I think hearing the voice of folks at different levels and how they interact with the program

is really helpful. I think we heard support from beneficiaries, and I think we heard from the states, "Yeah, maybe, but it's complicated." And I think that there is certainly an opportunity for the Commission to weigh in and help understand where those pieces are, what makes it complicated and what that ideal program might look like.

I want to hear from Commissioners. I think there are a lot of different places to weigh in here. Do we want to go down the road of exploring what a core benefit might look like? There is a road of, you know, do we want to explore a core benefit being mandatory or not? And then even within HCBS there are certainly a lot of areas that we can explore around workforce and different factors.

I see Angelo and Bob. Yeah, go ahead, Melanie.

CHAIR BELLA: Sorry. Just a quick comment. We are then going to have the panel that's going to talk about ARPA, and some of what they are going to talk about inevitably will address some of these challenges and barriers and opportunities. And there is another 30-minute period for us to talk after that panel.

So I just want folks to know, as Kisha said, there's a lot here, and so this is not the one shot in the

next 10 minutes to get everything that you are interested in. We will have time to ruminate after we hear from the panel folks too.

COMMISSIONER GIARDINO: Thank you. This was really informative.

Because of these long waitlists could you comment on highly mobile populations like military families? How does this impact -- let's say they have children that they want to be receiving this benefit. If they keep moving, I assume every time they go to another state they end up at the bottom of the list. So are there any accommodations made for populations like that?

MS. ALBAROUDI: So you are right that once they move from state to state they do have to reapply for the waiver services in that state. I am not aware of accommodations for that population but I can look into that, specifically for military families. Correct?

COMMISSIONER GIARDINO: Just because that's such a special population and we should honor their service. If we could at least see if there is any approach. Maybe the core benefit would help because then they would be applying for the same thing.

MS. ALBAROUDI: Sure.

CHAIR BELLA: Not all states are first come, first served also. So I would just put that out there.

VICE CHAIR DAVIS: Thanks, Angelo. Bob?

COMMISSIONER DUNCAN: I'll echo Kisha's comments. I really appreciate the feedback you got from the various stakeholders. I don't know how we address the workforce staffing or capacity issues. I think we are all facing that in all our industries.

I do like the concept of analyzing what a core benefit may look like, and particularly the comments you made around behavioral health and the conflict that lies there, because I think as we look our jails and prisons are filling up, as in their own home- and community-based services, with complex mental health issues and behavioral health. So I would like to also explore how we work through that conflict to make sure they have access to services close to home.

VICE CHAIR DAVIS: Thank you, Bob. Tricia, then Bill, then Darin, then Melanie.

COMMISSIONER BROOKS: I'm good.

VICE CHAIR DAVIS: Okay. Thank you. Bill.

COMMISSIONER SCANLON: Yeah. You did a remarkable job in terms of identifying some of the complexities, or many of the complexities that are involved with HCBS.

I am -- and this is a function of partly being around a long time -- I am really amazed at where we are with HCBS today compared to, in 1981, when the waiver authority was passed, there was none essentially. I mean, New York State was the only place that you could get an equivalent of an HCBS service.

And I think that the diversity, though, that exists today in terms of the kinds of problems that you identified, there are important lessons in there when we think about some kind of a core benefit. And your idea of a tiered core benefit makes a lot of sense in terms of that it will be potentially budget-driven to a certain extent.

But I think we need to look at it carefully and ask ourselves, okay, here is the existing situation in terms of what states are doing, and if it is, is there going to be this sort of base tier or lowest tier that is budget determined, what is that going to mean and what will it be like, sort of across the country. And if it becomes

too small relative to the benefits that are going to be added in the future to other tiers, then there is the question of is this worth pursuing that task?

We often talk about states' ability to pay for services, but having looked at state spending it is clearly a function not only of ability but it's also a function of preferences or choice, that states are putting different efforts into what they are providing to Medicare beneficiaries. They spend different proportions of their own money as well as their federal match.

So that needs to be taken into account when we think about the idea of a core benefit, because those variations in ability and in preferences are going to persist. Thank you.

VICE CHAIR DAVIS: Thank you, Bill. Darin and then Melanie.

COMMISSIONER GORDON: This wasn't my original comment but I echo what Bill said also is how those things are funded I think comes into play as well and difficulty and some of the choices that you are making. So if it is supported by provider taxes, you know, that money has probably less flexibility than if it was supported by a

general fund. But it is going to be a factor.

I appreciate the comments about the difficulty in managing multiple waivers. We lived that, we experienced it, and I could add more color there. They were always on different time periods, different reporting cycles, different conversations with CMS. So you may be talking about a portion of services an individual receives in a call over here, and then a separate call may even be going on at the same time with different people in CMS talking about the same people and different services, which is not a great use of resources but it's also not a great way to be thinking about the beneficiary, you know, from a complete perspective, very person-centered. So I do think there is a lot of work to be done there.

I think when you look at that it would be good to know what avenues states have today to simplify some of that. We did that by rolling more things into the 1115 in trying to deliver some of those services, but I don't know to what degree that pathway is available to others. But just trying to understand what constraints states may have, or pathways that states have to be able to simplify the complexity of having so many different waivers to manage.

Thank you.

VICE CHAIR DAVIS: Thank you, Darin. Melanie?

CHAIR BELLA: Yeah. I want to first thank you. I am very supportive of going deep on this work and figuring out how this carries into the next cycle.

I wanted to put a plus-one next to Darin's comments about simplification, for users of waivers and also for states. That seems like a very concrete area that we can really drill down on.

And I also want to say, I mean, I'd like to talk to more people. If we could figure out a way to continue to get more input, to continue to do what CHCS and RTI have done, that is very valuable, but the more we can get I think the more important it is.

And along those lines, just for Commissioners who weren't around when the core benefit sort of came up, there has been an interest that is very clear that there is an imbalance in the institutional services in the home- and community-based services in Medicaid. And I think some folks would like to see us recommend that nursing facility no longer be a mandatory benefit. Rather than taking that on we said, well, let's see what we can do to improve

access on the home- and community-based services side, and that brought us to this core benefit concept.

It's interesting to get feedback that sounds like the majority of people are somewhat lukewarm or had more questions than they did excitement. So our goal, as the Commission, has been to improve access, allow people who want to stay home or in the community to be able to do so to receive their care.

If core benefit is not the way to do that, that's really important, but that, to me, is our anchor. So if the other things that we are uncovering, if those are better vehicles to allow people to get the services to keep them home or in the community, that's helpful.

I think, though, for the Commission, as we think about the core benefit, states can provide these services today. So if our goal is to try to put home- and community-based services on par with institutional services, it already is voluntary for them to do that today, and we are not really going to move the needle on access if we are continuing to allow this to all be voluntary. And we have had hesitancy in the past to require more mandatory services, for a number of reasons.

So I think we have to hit that head on. If we really want to improve access we have to be talking about the voluntary-mandatory issue or we need to be looking for different pathways. It's an and-or. But that is sort of the elephant in the room. But at the end of the day what we have been trying to do is get more people the ability to receive those services, and the feedback we are hearing is that that is not the best way. That's important feedback but I would like to have more feedback. Thank you.

VICE CHAIR DAVIS: Thank you, Melanie. Bill, to that?

COMMISSIONER SCANLON: I have been on a different side on this mandatory, optional discussion, and I've decided maybe the question we should be asking is, if nursing facilities was not a mandatory benefit, what policies would you change? And if we had that list, it could be a mandatory benefit as long as we gave the states the authority to change those policies. And I don't know what they would be, because I think the assumption is that the nursing facilities are absorbing the budget and there aren't dollars left for the home- and community-based services.

And I think we are moving to a point where that's not necessarily the case, to the great extent that it was before. I mean, because we now sort of have much lower nursing home use than we did historically, and we have, coming out of COVID, even lower use in terms of reduced occupancy in nursing homes.

So I think we really need to know what we are going to do if we were to take away the mandatory designation for nursing facilities in terms of other policies that are going to enable home- and community-based services.

VICE CHAIR DAVIS: Thank you, Bill. That's an interesting spin on it.

Other comments or questions?

[No response.]

VICE CHAIR DAVIS: Yeah, Asmaa and Tamara, and I think this is really important work, and I think what you are hearing, for the chapter for June, certainly sharing, summarizing, you know, descriptive chapter of what we've found from those interviews and really, as we are laying out the work plan for the upcoming plan, how we really dive into the core benefit. I think I saw heads nodding when

Melanie was talking about how do we really start to better understand. Is this the direction to go and if so, what additional things need to be put in place to make that stronger?

MS. HUSON: Thank you for the feedback.

VICE CHAIR DAVIS: And we'll go to public comments.

CHAIR BELLA: Thanks, Kisha. Thank you both.

We'll open it up to public comment. If you'd like to make a comment, please raise your hand. Identify yourself and your organization, and I'll remind you to please keep comments to three minutes or less.

Henry, welcome.

PUBLIC COMMENT

* MR. CLAYPOOL: Hi. Thanks for the opportunity to share. I'm Henry Claypool. I work as an independent consultant but also have an affiliation with Brandeis University through the Community Living Policy Center. I just want to applaud and urge on the work of the Commission here. I think you are off to a good start.

There is one dimension that I didn't hear any discussion of that I thought might be important to try and

dig into as well, and that is the role that home- and community-based services play in helping our beneficiaries, particularly those with the most complex needs, access other types of services, so the other health care services that they might rely on to stay healthy and well in the community.

And I think that dimension is important because oftentimes these services are just viewed as a way to live in the community, but they play a far more important role, and it allows people to have access to a certain set of services that also facilitates their access to timely care. And that dimension, I think, would be interesting to explore. Thank you very much.

CHAIR BELLA: Thank you, Henry. I appreciate you taking time to make comments.

Anyone else like to make a public comment? Hannah?

MS. DIAMOND: Hi. Can you hear me?

CHAIR BELLA: Yes.

MS. DIAMOND: Okay. Hi. Thanks so much for allowing me to comment. My name is Hannah Diamond. I'm a policy advocate at Justice and Aging, and we really

appreciate this panel's focus on home- and community-based services and specifically the beneficiary perspective.

A few things that I want to underscore if I could. First, we are very interested in HCBS core benefit, but just want to say that it needs to be designed from the consumer perspective and maintain sufficient flexibilities to meet the needs of beneficiaries. And I heard you mention the person-centered component and community integration, and I also want to underscore the importance there of addressing health disparities.

And a key piece of that is really the data needs that you discussed throughout your presentation. Especially as we have moved more and more into the managed care space, it has become more difficult for us to understand really who is using these services and the quality of these services and where there are barriers to access.

So we need -- and it kind of goes back to the presentation at the start of the day -- we need to be collecting data beyond just race and ethnicity and including other demographic characteristics such as sexual orientation, gender identity, disability status, geographic

location, and age, and really examining the compounding effects of those identities on access, and really stratifying LTSS expenditure data by these demographic characteristics and by delivery system, so we can understand where there are disparities in access. And I think that will help in identifying and kind of moving this work forward.

Another example of a policy that we have identified that really speaks to the institutional bias is lack of prompt coverage to access to HCBS. Because of a discrepancy in how CMS interprets Medicaid's three-month retroactive coverage policy, CMS says that services cannot be paid for in the community until a plan of care is in place. But this is routinely done for care in a nursing facility. And as a result, an individual needing Medicaid LTSS has limited options as to where they receive care.

So we just want to point this out. We think that there are legislative and administrative fixes here, and again, as an example of the institutional bias.

And then I think another point that I would just like to end on, you know, this topic, HCBS, I think also can be interwoven into discussions for care for people who

are dually eligible for Medicare and Medicaid. And there has been a lot of focus recently on integration models. There was a recent RFI from six members of the Senate.

And we really think that integration models are only as successful as the program benefits that are offered within the two programs. And so given that, if the HCBS offerings are insufficient to meet the needs of people because of underfunding of HCBS or because of the variation across states, then the integration models are not going to be as successful.

So I just wanted to end on that note and really put in a plug for HCBS in the lens of integration. Thank you so much.

CHAIR BELLA: Thank you, Hannah. We appreciate your comments.

We don't have any other public comments, but Dennis, a comment?

COMMISSIONER HEAPHY: I think we need to look at HCBS in the context of the Americans with Disabilities Act, because without HCBS millions of people in the United States don't have access to rights available under the Americans with Disabilities Act. So if people are in

institutional settings and they don't have access to the services they need living in the community, they really don't have access to what's available under the ADA, the rights available under the ADA.

As a person who actually relies on HCBS services, something that needs to be looked at too is the ability that HCBS services provide to people that actually work in the community and have meaningful lives in the community. Not just meaningful lives but longer lives in the community. There's a lot more I would like to say but I'm looking at the time. I think it's important to look at this in context of people's rights and under the Constitution, in the context of the Americans with Disabilities Act, because without HCBS we are denying people their rights to the Americans with Disabilities Act.

CHAIR BELLA: Thank you, Dennis. I think that is an important and really good note to end on, and you will have plenty of opportunity to help us shape this, including after lunch, and then in our future work.

Thank you for this information. You've teed it up very well. We are going to take a break for lunch. We are going to come back and hear a panel on ARPA

implementation and issues and other things arising from states' point of view primarily, and then we will have another opportunity after the panel to have some Commission discussion.

Thank you, and we will reconvene at 12:45.

* [Whereupon, at 12:05 p.m., the meeting was recessed, to reconvene at 12:45 p.m. this same day.]

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AFTERNOON SESSION

[12:46 p.m.]

CHAIR BELLA: Hello, everyone. We are thrilled to continue the discussion of home- and community-based services-related issues. We have a fantastic panel with us here today. Tamara, I'm going to turn it over to you to kick us off.

PANEL ON THE AMERICAN RESCUE PLAN ACT (ARPA): STATES' EARLY EXPERIENCES WITH IMPLEMENTATION

* MS. HUSON: Great. Thank you, and good afternoon, Commissioners. I am just going to start with a brief background before we jump into our panel.

The American Rescue Plan Act of 2021, or ARPA, provided a temporary increase in the federal medical assistance percentage for state Medicaid programs to support the HCBS infrastructure. It increased the FMAP by 10 percent for the one-year period between April 1, 2021, and March 31, 2022. States have until March 31, 2025, to spend the increased FMAP earned during this one-year funding period.

This funding is the largest federal investment in HCBS that states have received in the past few decades, and

CMS guidance emphasizes that states should use ARPA funds on activities that enhance, expand, or strengthen HCBS, such as providing new or additional HCBS services, building No Wrong Door systems, streamlining application and enrollment processes, and expanding provider capacity.

States had to submit spending plans to CMS for approval on how they would spend this new money. All 50 states and D.C. have received approval from CMS and have begun implementation of the initiatives includes in their spending plans. States are required to submit quarterly spending reports and semiannual narratives to CMS on their progress. MACPAC staff are actively monitoring states' ARPA spending plans and implementation efforts, and we will continue to do so through the end of the implementation period in 2025.

So to better understand some state experiences and further the Commission's work on access barriers to HCBS, we have invited state Medicaid officials as well as a national expert to join our moderated panel today. Following the discussion, Commissioners will have time to discuss what they heard from panelists. Staff would appreciate Commissioner feedback on particular areas of

interest as we begin building out our framework for monitoring state efforts and how they may be impacting access to HCBS for beneficiaries.

Now I would like to introduce our panelists. Commissioners, you can find their full bios in your materials.

We are joined today by Liz Matney, the state Medicaid Director from Iowa; Kevin Bagley, the state Medicaid Director from Nebraska; Heidi Hamilton, the Director of the Disability Services Division from Minnesota; and Camille Dobson, the Deputy Executive Director at ADvancing States.

My first question for the panelists goes to our state representatives. Can you please briefly describe the initiatives in your state's ARPA spending plan, why you chose those initiatives, and then describe a little bit about how initial implementation is going? And Liz, since you are sitting to my right, would you mind going first?

* MS. MATNEY: Sure. In Iowa, the 10 percent generated over the course of that year created about $126 million of state funds that we could leverage towards our American Rescue Plan project. Through planning our focus

was primarily directed at creating real, durable change. We didn't want to just throw investments in that would last a short amount of time and create a cliff.

Within that, we are focusing primarily on three aspects: workforce, quality, and access. Our biggest investment that really was aimed at durable change was our community-based service evaluation. We contracted with an external entity, Mathematica, to do a full 360 view of our community-based services, including services for individuals with disabilities, individuals who are aging, and individuals with a serious mental illness. That includes not just Medicaid. Although Medicaid is certainly a backbone of that system, it brings in an evaluation of how other state systems touch the Medicaid program, intersecting, creating duplication or tension.

Our first report is coming out January 31st. We are very excited. Out of that report we have an additional $30 million that is dedicated towards actually implementing the recommendations found within that report.

The biggest investment that we made in terms of stopping the bleed -- we found ourselves in a situation where we were extremely grateful for the money that we

received through the American Rescue Plan. We were dropping workforce daily, experiencing significant access challenges, members were facing stress in their homes and communities because they didn't have caregivers. We invested $117 million in recruiting and retention bonuses. We created real, meaningful money in pockets for our direct care workers to help incent them to join the workforce pool as well as stay there, almost $4,000 per direct care professional.

That really did show incredible results. We need to back that up with sustainable rates, however, and that is another thing that we are working on.

After some hemming and hawing and conversations with our legislature we really didn't want to invest in something like rate adjustments, because, again, we didn't want to create a cliff. However, we did see a need to increase our home- and community-based services rates. So after months of negotiations with our legislature we agreed to leverage our American Rescue Plan dollars for rate increases through the duration of our American Rescue Plan tenure. So they agreed to, after -- we are running our plan through the end of March 2024 -- after that point

fully funding that rate increase plus some.

We have 11 different initiatives within our American Rescue Plan, and the total sum of dollars that we will be spending and investing into our home- and community-based services is almost $301 million.

MS. HUSON: Thank you. Maybe we could just work down the line. Heidi, would you like to go next?

* MS. HAMILTON: Sure. In Minnesota our plan is quite large. We have 54 projects that are in the plan, and we are projected to spend just over $600 million by March 31, 2024. The plan spans several populations. It covers people receiving behavioral health services, people with disabilities, people who are older adults, as well as our housing program.

So it was a lot of work to put the plan together across all of those different population areas. We really were focusing on increasing access for diverse populations of people, increasing our provider rates to enhance access to services, expanding HCBS services that are available to people, as well as supporting and strengthening our HCBS infrastructure.

We received partial approval of the plan on

September 22, 2021, and were able to move forward with quite a few of our initiatives, and then continued conversations with CMS and responding to questions that they had, and received conditional approval for most of the plan on January 24, 2022. So then we were able to move forward with implementing most of the plans.

In conversations with CMS, many of the projects that we had identified weren't directly tied to HCBS. They weren't directly tied to a Medicaid authority. So we had to have some more conversations with them about how we saw those as expanding home- and community-based services.

So I can give an example of -- I don't want to go through all of the projects that we have. That would take us all day. But in our housing area there is a good example of how we were able to access this funding to provide more access to home- and community-based services.

In 2020, we launched the Housing Stabilization Services benefit, which is a 1915(i) option, either the first in the country or one of the first in the country that is using that option to provide tenancy support services to people who are homeless or at risk of homelessness, through the HCBS option.

So when we launched that service, we hired two state agency staff who would determine eligibility, and it quickly became clear that that was not enough staff. We now have 5,000 people enrolled in the program, and part of that is due to the additional staff we were able to hire with the ARPA funding to help process those applications. We now, this year, are going back to our legislature to ask for permanent funding for those staff.

Another area in the housing realm where we sought authority was to help build up the infrastructure at our county agencies to help develop housing opportunities for people who were accessing HCBS services. That was a state grant program that we were able to expand with ARPA funding.

And then, finally, we sought the authority to add transitional supports, paying for deposits, furnishings, and those types of things, through the 1915(i) option, and then again, are seeking legislative authority to continue that permanently. But we were able to get that kickstarted through -- well, we are hoping to. Our negotiations with CMS are not quite final on that one.

But that just shows how we were able to leverage

the funding in a variety of ways, across the housing area, and then we did similar things across disability, behavioral health, and aging.

We have also many grants to providers to increase the workforce retention. We tried to be very flexible in how that funding was used, very nimble what we thought would work, and if some things didn't work then move to see if there were other ideas. We are currently, and continue to work very extensively with our stakeholders to talk with them about ideas that they have and ways that that funding can be used.

And as you can imagine, across all of the 54 projects it has been very challenging with project management and making sure that people are having what they need. But we have a contract to have support on that area, and it seems to be going quite well. We are really happy with it.

* DR. BAGLEY: And then I'll share a little bit about Nebraska and our efforts. One of the things that became quickly apparent to us, as we started to try and evaluate what the total amount would be that we would have, we estimated about $80 million of general fund would be

available to us.

We were trying to strike a balance between how do we get some of the immediate relief to our providers where we knew there were workforce issues. Really, we saw the pandemic as kind of the culmination of a lot of ongoing workforce issues. We had been seeing workforce issues continue over time. The pandemic made it substantially worse. And so how do we get that immediate relief to our workforce there but also how do we help facilitate more lasting change and build out that infrastructure better?

So about a third of our spending was spent toward kind of one-time enhanced payments to our providers to help relieve workforce issues, give them the flexibility to decide what made the most sense, whether it was retention bonuses or hiring bonuses, or what that looked like for their workforce. That gave us the ability to quickly get that money out the door, but it is a one-time infusion of cash -- helpful, not sustainable, not long lasting.

And so the second thing that we really wanted to tackle was what are some of those underlying infrastructure type issues that we were grappling with in the HCBS space. We know workforce is one of them. We know, in Nebraska,

and many states have this same situation, but in Nebraska we have a lot of land and not a lot of people. Most of our folks are concentrated in Omaha and Lincoln, and the rest of the state is pretty wide open. Because of that we have a lot of issues with access that are related to things like broadband, transportation, and just the ability to find someone that isn't three hours away to provide some of that care.

So telehealth is obviously a big deal for us. As we have worked to try and enhance that availability, we run into some of those same issues. Broadband access is an issue. All of these infrastructure areas are places where we recognized problems, but we weren't necessarily able to draw down those federal funds to supplement our state general funds. So we focused on areas where we thought we might be able to get the most bang for our buck with just those general funds.

One of those was in establishing a grant program for our home- and community-based services providers. And when I say that in this context, I am talking about the broader definition that ARPA gave it. So that includes our home health and some of our community-based behavioral

health and rehabilitative services providers. How can we help them and, in turn, their clients, better access telehealth services?

So we created a grant program whereby they could give us proposals. What makes sense to you, in your community, for your patients? We aren't in a position to tell you what makes the most sense. Please tell us. And so these grant programs have been a mechanism by which they can request that.

Another thing we recognized was that especially in our rural areas, as the nature of service delivery changes over time you may have an outdated building. You may have an outdated location where you are trying to facilitate services and it doesn't meet the current needs. And so we looked at all of our facilities, out in rural areas in particular, and said, "Tell us what you need to build out better infrastructure in this space in order to allow greater access for home- and community-based services."

One of the places that we actually had a lot of conversation with was our nursing homes in those rural parts of the state. We are seeing them close at an

unprecedented rate. That's been happening, and I know the Commission has discussed a lot of that as well. But we've been seeing that census go down for decades, and these rural nursing homes are the hub of care in the community. It is not in our interests to allow them to wither on the vine, but it is also not in our interest to continue to prop up something and continue to push money into something that isn't necessarily providing the level of care in the community and the level of access in the community that we needed to. And so part of that push is can we leverage that infrastructure, give you the one-time money to make an investment to broaden access to community-based services.

So those are two of the grant programs we have established. Between those two it is just shy of $30 million that we have invested in those, and that is all state funds. There are a handful of others, and these were some of these projects that we have looked at over several years, and we are just trying to prioritize.

So this gave us the opportunity to simply say let's leverage those external resources and contractors and just get it done. So things like reviewing and reforming our disabilities services waivers, looking at some of the

services there, looking at the way we measure quality, how we evaluate that.

And then one of the other things that we have been doing, in particular, is looking at our behavioral health space and how we build that out better, in particular in our rural areas, frontier areas of the state. Access to those services is a huge barrier.

So a pretty broad amount of work. We are still in the infancy, I think, in terms of payments outside of those quick infusions of cash to our providers, and it's because so much of it is tied up in these grant programs while we are looking at these proposals and really trying to make that evaluation.

Thank you.

MS. HUSON: Thank you. And I'm going to turn to Camille. Camille, can you please provide the Commission with more of a high-level overview of what is included in state spending plans, and in particular, how are states using their funding to increase access to HCBS, and have you observed any initial barriers to expanding access?

* MS. DOBSON: Sure. Thanks, Tamara. For those of you that are not aware, ADvancing States is the membership

association for the aging and disability agencies that deliver HCBS. So our jobs is HCBS 24/7, and so this has been the largest investment of federal funds that the HCBS system has actually ever seen.

So following on the heels of my esteemed panelists who have very clearly stated their intention to make long-lasting change, it has been a challenge. As representing our states we did a deep dive into all 51 spending plans and released an analysis in the fall of 2021, based on the states' initial submissions from June. We are in the process of now looking at the most recent updates that came out in October, and we will be refreshing that analysis and putting it out on our website hopefully by the end of February.

What we found in our first sort of high-level take were four areas that states, at a very high level, bucketed their initiatives in. The number one, by far, is the biggest is investing in the workforce, so provider initiatives were, by far, both in quantity, number of initiatives and actually dollars invested.

Second would be services, either enhanced or additional services as well as access to HCBS by adding

waiver slots. For example, initially a number of states were focused on COVID. As you know, or maybe you don't know that HCBS providers were not considered essential providers for getting PPE during COVID. So the states spent a lot of money initially to get PPE into the hands of their direct care workers, both in facilities as well in the community.

And then last but not least, back to the issue of sustainability and long-lasting change, investing in archaic -- is that a nice word? -- information technology systems that are running HCBS. That's a whole other conversation we could have.

But in particular, focusing on the two issues that I think lend themselves to increasing access, first is around HCBS provider initiatives. Thirty-four states included initiatives to address HCBS provider payments. One hundred percent of all of Idaho's funds, that is all they are using their money for is to provide rate increases or raises, bonuses to their direct care workers. It is about 53 percent of Colorado's spending. And that would include rate increases, one-time bonuses, hazard pay during COVID, for example, recognizing the direct care workforce

is going into homes unprotected. And so sort of recognizing the burden that they carried early in the pandemic.

And of those 34 states, the biggest concern was that the direct care workers wouldn't actually see the increased wages. Most of the time they through agencies, so 18 states put in a requirement, either audited or self-attesting for the agencies to pass those increases down to their direct care workers, so it actually got into the pockets of the workers.

In that same space about 38 states included provider recruitment and training initiatives. We could talk about the workforce shortage, right, and have our own panel just on that. It's a growing problem. COVID just exacerbated it. And actually making the jobs attractive, enticing, and rewarding to staff so that they take up this work and they continue to serve. So that is one big piece, because there is no HCBS without a workforce.

The second would be areas around additional services or waiver slots. We had, again, addressing sustainability and long-term issues, and knowing that the funding is going to sort of drop off, 13 states added

waiver slots, so they added more people to their programs. But 43 states actually expanded or added services, and you heard some of that today from the Medicaid directors, adding additional capacity, expanding the scope of services, who can provide the services, I think, in order to make it more accessible.

The last thing I would say is we have been monitoring the spending for the -- this is technical. The CMS-64 reports, where states actually report their spending, we just received the quarter-ending report from September 30th, which is now we are past the year of the opportunity to draw down. CMS estimated that the states would spend, in total, around $25 billion, and so far, the states have only spent $7 billion. So there is about two-thirds that has to get out in the next year and a half. And we could talk about barriers a lot, but I think the difficulty of getting CMS approval, how long it has taken, and the complex nature of the initiatives I think have caused the states to move a little bit slower than I think everyone would have liked that to be.

MS. HUSON: Thank you, Camille, and that's a perfect segue into my next question.

So I know each of you have talked about sustainability a little bit, but if we can dive into this some more. So for our state representatives, can you talk a little bit about how you're thinking about the sustainability of the initiatives and programs you're funding with your ARPA dollars? What plans do you have in place?

MS. MATNEY: I kind of wish we would have all given each other trigger warnings because I've had a couple of triggers, nursing facilities and CMS approval.

[Laughter.]

MS. DOBSON: Yeah.

MS. MATNEY: So for sustainability, like I said earlier, we had -- when we had hammered out our plan -- and when I say "hammered out our plan," I really mean not just as Medicaid staff, but we started with our Medicaid enrollees and our Medicaid providers at the very beginning. And a lot of their recommendations are what came through in our final plan.

When we had that finalized, we sat down with our governor's office and our legislature and talked about how we were going to make this happen and how we planned to

either create self-sufficiency, sustainability moving forward through projected savings in other areas or where we might need to have appropriation conversations down the road. And so we were laying the groundwork of expectations there.

So most of our initiatives are either self-sustaining or they have minimal maintenance and operations investments. We do have a couple of pieces -- like, we're going to be implementing a statewide training platform for all of our home- and community-based providers, not just HCBS waivers, but behavioral health as well, which will have some maintenance and operations. But we feel like there are savings opportunities in other areas where we can leverage those funds to move those forward and not ask for additional appropriations.

The biggest piece for sustainability is what comes out of our community-based service evaluation. We're really looking at restructuring our entire HCBS waiver design, and right now we have really -- we have seven waivers for our HCBS population. Each one are diagnosis-focused rather than needs-focused, and each one of the waivers has a different service array, different caps,

different age limits. It is a mess.

And so we're looking at really restructuring so that we have waivers that are based on need. There's a flat package, that regardless of what your diagnosis is, you have access to those services if you need them, and that is going to require some funding. And so, you know, we don't know exactly what that funding is looking like, but we have a very eager legislature who is wanting to have those conversations. We've been teasing them throughout the year in terms of what that might look like to get their appetite really going.

But we like it when our legislators are excited about giving us money and thinking about money. Let me tell you, it doesn't happen very often.

Also, in terms of just, like, challenges, I would say for the projects that we have put within our American Rescue Plan projects, like, we don't have very many actual, like, sustainability challenges from a funding perspective. The biggest sustainability challenge that I see, though, is our workforce and our economy, and there are pieces of those that are outside of our control. However, we're really gathering coalitions across the state, not just

state agencies but certainly state agencies as well as community-based organizations to think through strategies in terms of how to tackle this problem systemically rather than silo by silo.

So some partnerships that we really have cultivated include partnerships with our economic development authority, our Iowa Finance Authority to work on some housing initiatives from their pool of money, our workforce development authority, our insurance division, corrections -- it really runs the whole gamut -- child welfare.

So we have pretty regular meetings with either all of these groups together or split off to talk about specific, more specialized topics that doesn't interest the whole group, but then we come back together and check off items that have been completed. We're really trying to focus on not having a work group and a collection of people who are sitting around admiring the problem week after week and actually acting on it, and it took a little bit of time to gather that level of enthusiasm. But I think we've got it now.

MS. HAMILTON: In Minnesota, about 70 percent of

our spending plan is directly tied to Medicaid services, and most of that has either become permanent through legislative action or is -- we are proposing this year to become permanent. We're in a situation this year where we have the same political party for the governor, House, and Senate, and so it's looking like a good opportunity to have a lot of the things passed that we haven't been able to get passed in the past. So that's 70 percent of our spending plan.

There are some things in that spending plan that will end with the end of the public health emergency, including the ability to pay parents and minors and spouses through our PCA program. So we're looking at other alternatives to continue that. Unfortunately, there will be a gap from when the public health emergency ends until we're able to have another benefit available for people.

We do have some programs where that is allowed, but it's not allowed to the wide extent it is currently during the public health emergency.

The other 30 percent of our spending plan, some of those are one-time activities. So, for example, we have an initiative similar to what you're exploring in Iowa.

It's called "Waiver Reimagine," where we're taking our four disability waiver programs and which are all based on different diagnoses and different type of populations and condensing them down to two waivers based on level of need. And this has been an effort that's been going on for several years. We're in the middle of that transition.

But what we've been able to use some of the funding for is to convene a Waiver Reimagine Advisory Committee that is really focused on having the input of people with disabilities and their family members to really make sure that we are hearing from that population and incorporating what their concerns are, what their suggestions are in our development. We had some of that before, but we were able to use this funding to really do more of that.

We have a couple studies that we are looking at too, including the best way to support parents who have disabilities and are receiving HCBS programs and are providing recommendations on how to do that and if there's a way through our HCBS services to really provide that type of support.

So we feel that we are really focused on

sustainability, whether it's through actively changing our HCBS services or providing us with information on directions to go in the future so that we can continue to support this population of people.

DR. BAGLEY: So thinking about barriers that we run into, obviously sustainability is one of them, right? And we knew that going in. This was a one-time infusion of support, and so we tried to plan with that in mind.

But one of the things that I guess I would love to impress on all of you is as a Medicaid program, you have a lot of bosses. You've got the governor. You've got the legislature. You've got all of the advocates and stakeholders in the community. You've got -- you know, you've got a lot, and the reality is they don't all agree on what the needs are. And so trying to navigate that is really difficult, and when it's a one-time infusion, we're all coming from a little bit of a place of scarcity where we're not used to having a one-time infusion of, in Nebraska's case, $80 million to spend on HCBS, and so there is this sense of we got to get it out the door.

And so it's a struggle sometimes to change the mindset for folks to really be able to think longer term,

what are the things we need to put in place so that 10 years from now, 15 years from now, we're continuing to make progress and we're not necessarily in a spot where we're saying our system is archaic. And that's a nice way to put it. You know, the system is older than I am.

MS. DOBSON: Both are true.

DR. BAGLEY: Yeah, both are true.

MS. DOBSON: Yes.

DR. BAGLEY: So these are kind of some of those things helping frame that discussion. One of the things that we're trying to drive toward is leveraging this intense amount of interest in HCBS, this recognition of how crucial this set of services is to our Medicaid population but really just to our population in general in the state.

These services matter a lot, and now we've got everyone together, and we're talking about it. So that is something that is progress.

For us, one of the goals we have coming out of this is that we can start talking about value and kind of quality and outcomes associated with a lot of these programs and services, because too often -- and this is true, I think, in Medicaid in general but particularly in

HCBS -- we focus a lot on costs because costs are the easiest thing to quantify. Outcomes and quality and value is a lot more difficult to qualify, especially in the HCBS space, because it's not like hospitals where we have decades worth of HEDIS measures that we can draw from.

So this is a space where if we can help push that conversation in the direction of let's be able to talk about this in terms of a cost benefit where legislators and governor's offices and stakeholders can all come together and say this is an investment we want to make and here is the expected return, then it becomes a much different conversation that's not as politically fraught, that's not as -- not as focused on scarcity and the likelihood that this one-time infusion is not going to come around again for a while. It flips that script a little bit. So for us, that's part of the goal here in overcoming that barrier is getting everyone to think about it in a different way.

But, yeah, plenty of barriers, right? So I can talk a lot about that, but I'll let Camille talk some more.

MS. HUSON: Thank you.

So, Camille, from your perspective, can you please provide a broader picture of how states are thinking

about sustainability and how is ADvancing states engaging with states and other stakeholders around this?

MS. DOBSON: So let me provide some context. The states had exactly one month. Then they got another month. So they had two months to put something down on paper and get it into CMS.

So, as you can imagine, the plans are being refined as they go along, right? The initial -- the initial spending plans that we reviewed had one state that actually had a specific call-out for sustainability and invested money in an evaluation. However we've heard that all of the states have now figured out either through legislative requests to figure out and have made very clear decisions about what were one-time activities and what could be from either cost savings or additional state appropriations could be sustained.

So while I think if you looked for the word "sustainability" in the spending plans, you aren't going to find it. But what we have found is that the states are thinking very carefully about really maximizing this one time that's like a golden jewel that's appeared out of nowhere, right, and really figuring out a way to maximize

that.

We are working with Colorado and our partners that are doing HCBS TA to help them look at -- they have 63 projects. I thought Minnesota had the most, but I found out Colorado does, 63 projects. And they've decided 30 of them have the possibility for sustainability, and so they're working through a very deliberative public process to examine each of those individually about whether there's additional funding, can they be turned into a sustainable project. So I think there will be learnings from that very specific work that will be generalizable across the country.

Related to sustainability that I'm not sure we're going to get to, but I want to make sure we hit, is evaluation, right? Again, it's a one-time infusion. If the states and CMS cannot show that there was real impact at the end of the investment, what's the likelihood that there will be additional congressional appropriations for HCBS?

And so we have been talking to states about how you're thinking about evaluating the impact. I already made a note to follow up with Liz, because she's done some

thinking. They've done some work around the impact of their retention bonuses, their payments to providers.

We have been lucky enough to get some foundation funding to do an assessment, an evaluative work on state's evaluation. So did the state actually take a snapshot of what their system looked like before the money started to flow so that they can compare afterwards? And I don't mean a double blinded research, like Medicaid research, which is real time, get whatever data you can find and put it in a paper kind of research, right. That, we think is going to be very valuable because, while the investments in the workforce are so important, even after all the two years of spending, there's still a crisis in every state. So it's making it and stopping the bleeding, but it's not actually solving the core problem.

And so I did want to talk about the fact that we're really working with a number of states to figure out how they're thinking about evaluating for legislative purposes in particular, mostly for CMS and Congress about the impacts of those, of those investments long term.

MS. HUSON: All right. Thank you.

So my next question is for all of our panelists,

and given MACPAC's role, this is something we're interested in. So what, if anything, from a federal standpoint are the policy levers that could help states be successful in using their ARPA funding to improve their state HCBS systems and beneficiary access?

MS. MATNEY: Oh, boy. How much time do I have?

Okay. So in terms of how this piece of legislation was written and then deployed, there are a couple of areas where we could have used some federal authority to better the results from my perspective.

One is really putting some pretty clear parameters on what the maintenance of eligibility requirements are and are not. This has created such consternation in my state. I can't say it's not because of the issues that we had with the maintenance of eligibility tied to COVID, because that's part of it. But also the fact that it kind of handcuffs us from really doing any type of HCBS program changes while we're under the plan of spending. So it's very -- like I said, it handcuffs us. It prevents us from acting on other things that we wanted to.

I'll give a real example of how this played out.

So shortly after we had submitted our plan, we had also submitted some 1915(i) updates to CMS. Our 1915(i) in the state serves individuals with serious and persistent mental illness. It's an HCBS-like program, and we were updating our assessment, okay, not changing our assessment wholesale, adding one component to make the assessment more easily translatable to individual need.

We went back and forth with CMS for six months because they were not going to approve it, because 5 of 5,000 people might receive, like, 10 units of service less a month. Even though it was appropriate, we couldn't do that. It took like six months of going back and forth. Meanwhile, we could have been working on other things.

The other big piece that I would just say for this particular initiative, I'll just double down and say so grateful, so grateful for any money, but one thing that would have made it easier is to give increased authority to HHS to waive certain things.

So we have a number of different initiatives in our plan that are really geared towards sustainability. Those include health information technology, infrastructure, increased remote monitoring, which really

does get to accessing and workforce, as well as scholarships and training programs.

Well, you know, silly me, I thought maybe they'd be willing to look at our health information technology investments in HCBS and be willing to provide some federal match for those. It does, after all, improve the quality of services, improves efficiencies. We did this historically and spent billions of dollars for our hospitals and physicians in the same way. No. So we have to -- we can still do it. We just cannot get federal match. And so I kind of liken it to like let's just say somebody says, "You can have a thousand dollars to spend on food. You can either spend it all. You can get a thousand dollars to go to the 7-Eleven and buy as much food as you want, or we'll give you a hundred dollars to build a garden." Well, if you're going to spend a thousand dollars, why not give me a thousand dollars to build a garden that's self-sufficient and can last for years? And we just did not have that flexibility with this funding.

So I feel like that's a very big missed opportunity at the national level and something just to think about for future initiatives like this.

MS. HAMILTON: I totally agree with what Liz shared. This morning somebody had made the comment about how challenging it is talking with CMS and maybe not getting to the right person. And we absolutely experience that, especially with the housing programs that I was talking about earlier. Not everybody seems to understand what we're doing with our housing benefit and what we can do with this funding.

Once we did get to the right people, it was a great conversation. We were able to move forward. But it just took a very long time getting to the right people.

I would really like to see the federal level look at these spending plans as an opportunity to really see what's missing from HCBS services and what should be added, what flexibilities can we add. One example is related to the moving expenses, expenses to pay for deposits and furnishing and things. We are being told very clearly that that can only be used when people are moving out of institutions. It's not available in the same way for people who are moving from an unlicensed setting or a homeless situation, for example, and that's just so short-sighted, I feel. Like that's really a big barrier for a

lot of people who are moving out of homelessness, that initial funding for the deposit and furnishings. They point to federal guidance that says that that's the only thing that they can use it for.

So I think this huge influx of money to all the states is a really good opportunity to look and see things like that. Where are examples of things that could be really beneficial to a lot of people? And how do we create those flexibilities in that federal guidance so that states can do what's really the best for people?

DR. BAGLEY: So, Liz, we're even now on the trigger warnings, because I said nursing homes and you said maintenance of eligibility. So that, I would say that has been one of the biggest struggles, because it's not clear where those lines fall. So, Liz, your example is spot-on. We had similar ones. I think every state has had an example where we've said we want to improve the way we do this, and part of that means that we need to reevaluate what the level of appropriate services is, not because we're trying to cut services but because we haven't historically always done a great job at that.

And so as part of that, some folks are going to

have a reduction in services, and maybe in some cases some folks may not be eligible for the program anymore. But part of this is that evolution of these programs and services, and that has been an absolute struggle.

I would echo as well the need for more flexibility in how we leverage federal funds. You know, Liz, you kind of raised the specter of HITECH a little bit, and the level of flexibility that state Medicaid programs had under HITECH to make investments in HIE infrastructure throughout our states where it was almost a "Does it help Medicaid? Great. Can you tie it to the program? Great." That level of flexibility, arguably, probably made for some less than stellar investments when it came to HITECH, but it also gave the flexibility for states to really be able to make some meaningful investments that they wouldn't have otherwise been able to make.

And so thinking about that level of flexibility and where federal funds can be drawn down makes a huge difference. And on that point, the ability to kind of test out these changes. HITECH offered the ability to put something out there and see: Does it work? And the reality is to some extent this is new territory, right? As

we try to move into doing a better job in HCBS, the program itself has really only been around for 40 years, which sounds like maybe a long time, but in the Medicaid space it's not. And so, you know, it's something where having the ability to test and say, "This works, let's invest in this," is really meaningful.

The last thing I'll share is there's really -- there's almost no such thing as kind of a shovel-ready project in Medicaid. Camille mentioned the notion that states had 30 and then 60 days to come up with our plans initially. Sixty days is a blink of an eye in that space, right?

And so these projects are 9- to 18- to 36-month projects, and the amount of planning that goes into some of these is months and months and months. And so to kind of say, "Okay, what have you got? What's shovel-ready?" There is no such thing.

And so when these come -- and, again, there is no lack of gratitude, I think, from any state for the ability to make these investments. But when these come, it often comes as, "Okay, so you're ready to go, right?" And maybe this is a trigger warning to you. In fairness to our

partners at CMS, they didn't have a plan for how to spend all of this money either, and they weren't sure what would qualify and what wouldn't. And so for them in their position, they're trying to fly by the seat of their pants as much as every state is. And everyone's scrambling and grappling with, "Okay, but what does this mean and where are the actual constraints?" That is one of those pieces of uncertainty that makes the planning process and the implementation process so much longer and so much less effective, because no one's exactly sure for a year and a half what can even be done. And by then -- and I'll share this was true in Nebraska. By then, all of our stakeholders had lost patience with, "What are you going to do?" And it was, "Look, just give us the money." And it's hard to argue with "Just give us the money," because we spent a year and a half trying to figure out what to do with it and what we can do with it.

So I don't know how to solve that. I'd loved to be able to say, "Here is the treatise on how we fix that issue." But driving out what is the right level of flexibility, what is kind of the ability of CMS and the states in this space, is really helpful, because that

uncertainty creates more issues and difficulty than it actually solves.

It seems like it's flexible because there's not a lot of parameters around it, but what that means is we default back to the morass of federal and state regulations that is sometimes darn near impossible to navigate. And so being able to put those parameters in place really helps.

MS. DOBSON: So I appreciate your defense of my former employer. As a recovering CMS employee, I recognize the very difficult position that CMS was put in with no time, no additional staff either. I think I would just double down on basically what Liz and Kevin said about the extreme interpretation of the maintenance of effort.

So for those of you that don't know, the statute required states to not impose stricter eligibility standards, preserve covered HCBS, including the services themselves, as well as the amount, duration, and scope that's authorized, and maintain HCBS provider payments as of the date of the bill passing, April 1, 2021 -- which seems rational on its face. But the interpretation around the assessment change -- and Liz was -- Iowa's was very mild. There were 14 states that actually had in their ARPA

spending plan implementing new, more efficient, technology-savvy assessment tools that were modernizing very old diagnostic-based systems that didn't address people's functional needs. Those were prohibited, because one person, me possibly, no longer qualify for services.

Likewise around rates, states wanted to update their rate methodology sort of across a class of providers, and that was prohibited, because even if one provider got paid less, even if the whole class overall would have gotten an increase, CMS wouldn't permit that. So I recognize the federal requirements. It's the interpretation where things start to fall apart.

I would also add the time, the process for the states to actually make some of those initiatives permanent, to actually build them into their 1915(c) waivers or their 1115 demonstrations, is excruciatingly difficult, because all of those decisions about what's approvable and not approvable now get adjudicated again when the authority is presented to the specific CMS staff. And -- okay.

But moving on -- and I'm struck that none of my fellow panelists have talked about the constrained state

staff capacity to do this work. They didn't get any new staff; most states did not get any new staff to implement this initiative. Most did not have project management structures that would do multiple projects at the same time. Right? They might be able to do one big IT project or one rate study, but to literally juggle 12 balls at the same time, all with competing demands and stakeholders, was a real challenge, and I think that wasn't recognized at all. We used some funding from foundations to support 12 states on building a project management plan just to figure out how to work plan out their initiatives. And they were most grateful because they didn't have -- a small state like Wyoming, Lee Grossman, the Medicaid director now, he says, "I have one staff that works on HCBS. I don't have a project management system. We use Excel," maybe. And so Wyoming was incredibly grateful to have a way to have somebody help them sit down and think through those processes.

And then, last, I would say maybe people forgot that there's a PHE going on, a public health emergency going on during this process, and the HCBS settings rule becomes effective in less than two months. And so three

major HCBS impacted projects going on simultaneously, I think those all sort of -- they're amazing humans, is all I can say, to try and navigate all of those competing demands, again, with no new staff, and trying to do their very best with what they've got to work with and really wanting to make meaningful, lasting change.

MS. HUSON: Thank you. So this is my last question before we turn it over to Commissioners, and maybe we can make this a little bit more of a lightning round so we leave time for Commissioner questions.

Are there any additional challenges or barriers that we haven't discussed yet -- I know we've hit on a few -- that you are currently encountering that you would like to highlight? And I'm going to maybe go backwards and start with Camille.

MS. DOBSON: Oh, my. I have such a long list That we haven't already discussed? You know, again, Liz addressed it sort of obliquely, but the impact of state legislators in this process cannot be understated. One of the states in the South had a very ambitious plan to do lots of really good improvements, and their legislature said, "Nope, give it all to providers." Three-quarters,

like almost a year and a half into the planning of all these projects. States have had varying levels of engagement from their general assemblies, I would say, and some have been very supportive. Some have really wanted to put their imprint on it. The money came after most legislative sessions were over, so now the states are a year into it. This passed in the '21 session and now -- or the '22 session, and are now going, "But, wait, we have already talked about this. Why are we switching gears?" Because this is their first time to engage.

So I wouldn't put that as a small piece. I think typically the federal government doesn't give enough weight to the challenges that the state Medicaid agencies are doing -- face working with their state legislators.

DR. BAGLEY: Well, Camille, I think you stole --

[Laughter.]

DR. BAGLEY: It's okay. I mentioned this earlier, but state Medicaid agencies really do have a lot of bosses, and so one of the barriers that you run into with the timing is -- well, I'll share the analogy that I've shared with some of the legislators in my state when they ask why government moves so slow. I have four kids.

Going anywhere with my kids is like -- it takes an act of Congress. And so, you know, you finally get everyone into the car, and you say, "Why aren't you wearing socks? Where's your jacket? What do you mean you don't have underwear?" These are the kind of struggles, right? And as a state agency, you have all of these competing -- sometimes they truly are competing requirements from different groups, and you've got to navigate all of those, and it just takes time. And it takes patience, and it takes an ability to navigate all of those spaces and all of their different concerns and constraints.

Time -- things just take time, and we all have to be kind of cognizant of the need to take that time, but also be able to balance that with getting things done. And it's hard to do both, but I think that's something we really need to be able to focus on as well.

MS. HAMILTON: I think related to that, it has been mentioned how quickly states had to put the plan together, and then the plan ends March 2024, and then there was the ability to add an additional year, which sounded great, but the maintenance of effort really made us put a pause and not seek that additional year. So I think that's

an additional barrier, too.

MS. MATNEY: All right. I'm going to get heavy for a second. I'm just going to be direct about like the elephant in the room. We -- and this is something that things like the American Rescue Plan provisions can't fix, right? And that's the fact of HCBS is an optional service; nursing facility services are a mandatory service. We have just this fundamental tension in our Medicaid program that it's hard to overcome unless we get congressional support and legislation to alter the program.

Technically, home- and community-based services are optional services to the state, but I can tell you, I'm in the middle of a Department of Justice investigation telling me otherwise. And so until we can get some movement on that, these type of initiatives, while really appreciated, are just Band-Aids.

MS. HUSON: Thank you. And I'll turn it back to Melanie now.

CHAIR BELLA: Perfect. Perfect segue. So I think we were going to have all of you until 2 o'clock, which is about eight minutes from now. Do you have a little flexibility to run a little bit over? Okay. I'm

going to prioritize Commissioner questions over our own independent discussion because we don't get time with people like this very much. So let me kick it off with questions, and because I do want to be somewhat efficient with our time, it would be helpful if Commissioners could be fairly direct with their questions and not sort of broad and invite all four folks to sort of weigh in, because we've gotten a really broad brush. And I can assure you they will get the question at the end, which is: If you had a magic wand, what do you want to tell us on your way out the door? So please be thinking about the answer to that one.

Who would like to start us off with questions? Tricia and then Sonja.

COMMISSIONER BROOKS: I want to go back to something that was said this morning about the interviews that were conducted on HCBS and the suggestion that in the eligibility process, you first determine eligibility for non-MAGI or disability and then HCBS, right? And I'm just curious to get a little more understanding about how long that takes, how much more involved it is. Do you think that combining eligibility at the front end going as far as

to test for HCBS makes sense? And then another piece of that is do you put people in Medicaid expansion if they qualify? Once you've determined the income eligibility, you put them in expansion first while you do the rest of that, so that at least they can access some services.

DR. BAGLEY: We're all looking at each other because I'm -- if you're anything like me, you're not exactly sure of the answer to some of that.

I think part of that struggle is what Liz mentioned, and that is because HCBS is that extra optional service. To some extent, that piece of eligibility is almost looked at after. Functionally, every state is going to do it a little bit different, and depending on the nature of the program, it may be relatively seamless.

I know in the case of a lot of our individuals with intellectual disabilities in Nebraska, most of them are already enrolled in Medicaid, and so the financial eligibility for them isn't really the issue. It's that level of care and the waiting list, frankly.

When you're looking at folks who aren't otherwise enrolled in Medicaid, that's where you end up with the longer time frame. Whereas I think if making a whole bunch

of hypothetical assumptions in my head going down the path of what would it look like if HCBS were a mandatory service and just kind of part of that routine, I would say we still run into delays in eligibility when we deal with our nursing home population, where it is a mandatory service, because of those more extensive asset tests and pieces like that. That takes time. It's particularly difficult when you have an individual who doesn't have a lot of family nearby. They don't necessarily have a group of people already ready to help support them in that application process. Taking someone who is kind of vulnerable and is struggling that much and saying, "I need you to help me compile a list of all of your assets," it's just not realistic. And so that takes a tremendous amount of effort.

I don't know that that goes away because -- unless there's a fundamental change to how we're evaluating folks' eligibility.

So I think it may help streamline the process, but ultimately, we still deal with those struggles with the mandatory service of nursing homes.

I don't know if that answers the question for you

or not.

COMMISSIONER BROOKS: No, that does, more or less.

So a newly determined individual, do they get on expansion first while you're doing the rest of the eligibility determination, if you see that they are eligible?

MS. MATNEY: It really depends what their financial and asset situation looks like. If they are on Social Security disability, they're going to immediately qualify for Medicaid. So that's not a situation for a lot of these populations. That would really be an impact to put them on expansion while they're waiting.

I do think that there is tremendous opportunity, especially with our home- and community-based service wait list, to do some additional pre-screening to see what other type of more robust state plan services might benefit them while they're on a wait list.

On the intellectual disability side, one of the big hangups that I do see in terms of getting level of care assessments completed timely and getting that intellectual disability waiver eligibility started is getting into a

psych eval, because they have to have that IQ test. And that can take months with the shortages of psychiatrists.

DR. BAGLEY: So I'll add to -- one of the interesting technicalities that goes with the eligibility for expansion is you don't qualify for expansion if you would have otherwise qualified somewhere else, and so we have to go through that full -- would you have qualified anywhere else, including under HCBS? And so you almost have to do that full evaluation to see if they would qualify for expansion, which sounds a little bit counterintuitive, but that's the reality, right? That's one of those requirements to being able to draw down that 90 percent match versus whatever the standard federal funds participation rate is for a state.

CHAIR BELLA: Heidi, did you want to add anything?

MS. HAMILTON: I'm not a state Medicaid director. So my knowledge of this is a little less than the others, but I know with the housing stabilization services, we don't require people to have a certified disability in that program. The level of care is a little different, and so there are people who I believe are in the expansion

population that are still able to access that HCBS service. They are required to have a disabling condition but not necessarily a certified disability.

But that was a big barrier because this was a new benefit. A lot of the people that we had worked with have never been on Medicaid before, and so that was a step they had to take first, and some of them didn't go through with it because of how complicated it was to go through the Medicaid process just to get on Medicaid.

CHAIR BELLA: Thank you.

Sonja?

COMMISSIONER BJORK: The time pressure to get those plans in was just incredible, and so I'm wondering how were you able to engage the rural stakeholders on such a short turnaround. Were there any particular strategies to get the people in Elie or any of the rural areas to trust that this was really going to happen and that their time was worth it and that dollars really would come through to them?

DR. BAGLEY: So I can share, you know, for us. We'd already been doing a lot of outreach, and so we were able to kind of integrate this discussion relatively

seamlessly into that outreach which was incredibly helpful, that for us, going and having those discussions, the interesting part was timing, right, because we were, to Camille's point, still dealing with the COVID public health emergency. And so, to some extent, a lot of that had to be virtual, which has its own barriers for folks with disabilities. We struggle even still to have ASL interpreters available on our Zoom calls. And so, you know, that is a potential barrier.

So now as that kind of need to socially distance has receded, we've been able to go out in person a lot more. But really, it's an ongoing process. There really -- the 60 days was too short of a time frame, but there was also a broad recognition with every state and eventually with CMS that it's going to have to be a living document. There's just no way that everyone's going to be able to come up with all of these ideas in 60 days and say, "We're good. We've got it all set." It just isn't realistic.

MS. HAMILTON: Yeah. I wish we could say that we did really robust stakeholder engagement. It was during our legislative process, and so a lot of it was talked about during the legislative hearings, and people were able

to give input that way.

Also, a lot of our initiatives built upon things that were already happening, so stakeholder groups that already existed and talking with them about what would be beneficial.

But I totally agree that we're revising as we go if things we thought were going to work aren't actually working, then we're making those changes. But it really wasn't enough time to have that great stakeholder engagement.

MS. MATNEY: Ditto to everything. Not enough time.

I would say we have -- like Kevin said, it's a living document. We have evolved here and there.

But to Camille's earlier point about the number of cascading documents that you have to complete in order to make any changes, we've been pretty conservative about the changes that we're willing to make because we don't want to fill out another 1915(k), seven 1915(c)s, and two state plans every time we make a change. So, to the extent that we can, we've been sticking to it.

CHAIR BELLA: Thank you.

Jenny, Rhonda, Verlon, Darin.

COMMISSIONER GERSTORFF: Okay. I have just a couple of questions. One, given your state staffing limited resources, the reporting I've heard is kind of duplicative for your ARPA spending and your CMS-64. So I don't know if you might have challenges you could speak to there.

And then if any of you had any of your workforce infusions or other funding go through managed care plans, any challenges that might have come up there?

CHAIR BELLA: We should mention she's our resident actuary, so if that gives you some context as to what would be helpful to hear.

MS. DOBSON: Yeah. That was a very focused question. I'm like wow, she -- okay. That's helpful.

Go ahead, Kevin.

DR. BAGLEY: All right. Interestingly, I would say the reporting, at least the financial reporting, hasn't really been as big of a barrier for us. I think for us, a couple things right from the start is we said, look, this huge infusion of cash means that there are, you know, however many years down the road, going to be a trove of

auditors who will be coming out to the state to say, "I want to know how you spent every half penny of this," and then make a judgment call on whether or not we did it right. And so for us, it was -- we started from the very beginning to say, okay, we are going to be very thorough in our review and reporting of this.

It is a little bit duplicative, but that hasn't really been an issue for us. I would say the issue less than financial reporting has really just been kind of the, okay, we're making a quarterly update to this document, and maybe we'll add a new initiative. Yeah, because then you get five pages of questions back from CMS of, well, explain to me how this really actually fits in with the criteria. So then it becomes a 12-week discussion of is this something that we can actually do, and then at the end, it might be a "Well, we're okay with it, but we're not going to let you draw down any federal dollars." And that's where I think most of the duplicative effort comes in.

And then in terms of actually implementing some of these for us, what we've done is leverage a lot of external contractor resources, which we pay a premium for. It is more expensive to do that than it is to have my staff

to do it, but I'm not immune from all of the workforce issues that everyone else has either. So, yeah, we've had to spend several million dollars of this ultimately on those contractor resources.

MS. HAMILTON: We were able to hire quite a few staff to help with the initiatives, with the temporary funding, and then hoping to get permanent funding if the programs continue ongoing.

And then as far as the duplication reporting, it's the same staff who are working on both reports, and so I think that's helping a little bit with doing work that is duplicative.

MS. MATNEY: The only thing I would mention on the CMS-64 that is kind of duplicative and has been mildly irritating at times is when we submit for our supplement. If you're requesting a higher drawdown during a period of time, you have to request a supplemental, and the amount of documentation that they require to be attached to that, it would be much more streamlined if they could just talk to each other on what they approve through the spending plan or not, rather than us attach a few different documents to support it.

In terms of the managed care payments, no problems. I mean, we gave them -- for the recruiting and retention, those were directed payments. We gave them the list, how much money they needed to shoot out to each agency. We did that for individual contracted providers too and kind of divided and conquered that way, but no problems.

MS. DOBSON: But, Liz, those required new directed payment preprints, right?

DR. BAGLEY: Yes.

MS. MATNEY: Yes.

MS. DOBSON: Oh, you all can't cry in baseball.

MS. MATNEY: Okay.

MS. DOBSON: I'm just saying that's additional paperwork that managed care states had that the fee-for-service states did not have. So another set in addition to the authority documents were the state-directed payment preprints that are no joke themselves.

DR. BAGLEY: So one other thing I would add, on the managed care front for us, the issue wasn't getting the payments out. The issue was calculating what CMS agreed was the amount we spent that qualified for that 10 percent,

because that gets tied up in that per-member-per-month capitation payment, and so there was not general agreement on the methodology for extracting that with our actuaries. That took some time and some back-and-forth.

CHAIR BELLA: Jenny, do you have any follow-up questions? Are you good? Okay.

Rhonda, then Verlon, then Darin.

COMMISSIONER MEDOWS: So just first starting off with the statement for you of deep gratitude and empathy. While you were talking and triggering each other, there were several of us over here having flashbacks from the times when we ran Medicaid programs for the states as well. In all sincerity, it's amazing how you're able to do what you do, right? A short time, not enough people, not enough resources, and a lot of people touching you and touching your program, so very good.

When you talked about different programs, did that include any mental health? So can you talk a little bit about what kind of mental health programs you might have included in the mix? Because that's the other big thing I get concerned about.

Thank you.

MS. MATNEY: Mental health providers were definitely included and also substance use providers were included in our recruiting and retention bonuses as well as our rate increases.

We also are looking at -- well, not looking at. We're implementing a therapeutic foster care pilot, which we're looking -- we have some legislative support to make that a state program after we see some success with this piece.

We're also looking at, with the community-based service, evaluation. Mental health is definitely a piece of that.

And I know because I just read the final report, it does highlight a lot of gaps in our continuum of care on the mental health side that we look to correct as quickly as possible.

And then any way that we can show mental health providers love through our American Rescue Plan, we definitely keep them looped in.

Also, they remind us quite frequently, so we never forget, but we always try to consider them because they have been forgotten for many years.

MS. HAMILTON: Yeah. We were able to add to the rates for behavioral health, both mental health and substance use, and create community of practice for the providers to learn from each other and then also provide additional training on culturally and linguistically appropriate services.

DR. BAGLEY: Yeah. We have several initiatives around mental and behavioral health in our plan. One that we had proposed initially was that we wanted to implement an 1115 waiver for individuals with severe mental illness which would have included a tremendous amount of new services in the community, but because it also would have included our IMD exclusion waiver, we were told that that would not be an allowable expense. And that was a source of some argument back and forth of we're not asking for you to pay for the services in the IMD with this money. We're asking for the money to be able to plan this out so that we can move forward with this.

This is one of those rare instances where we kind of had a little bit of a shovel-ready project we wanted to start on, but we just didn't have the resources and the initiative ready to go. We got turned down for that.

We since rewrote it so it doesn't reference the IMD exclusion, and we're waiting for CMS's approval of that. So for any of the CMS folks listening, it's fine. Don't worry about it. It's good.

MS. DOBSON: You're doing good things.

DR. BAGLEY: Truly, I mean the point is what we want to do is really go through and do an evaluation of what do we lack in the community. What are each of these communities' needs? That IMD exclusion is a recognition of -- it's part of the continuum of care, but ideally, we don't even need that 25 years down the road because that's going to be a rare occurrence. Ideally, that's where we're at, but it's not where we're at today. So there's got to be that recognition of the broader continuum of care.

CHAIR BELLA: Okay. Verlon, then Darin, then magic wand and then we are going to quit badgering you with questions.

COMMISSIONER JOHNSON: So I am trying to get my feelings for the former CMS employee, but it's okay, and what Camille knows, right? And I will say that one statement that I really liked, or quote, is "admiring the problem," the sentiment around that. So I really want to

make sure that you guys understand just how passionate we are about this area and how we really want to make changes to the program.

But having said that, I know that some have brought the stakeholders' comments, and there was some dialogue earlier about the barriers, and one of them, of course, was the knowledge gap. I'm just wondering, were there some ways that you all used these plans to kind of help bridge that gap and some of the knowledge to get the information out about what your program is like, that you do for folks?

MS. HAMILTON: I have an example. The Waiver Reimagine Advisory Committee that I mentioned where we are redesigning our waiver program, we used some of the funding to work with the people on the committee who have disabilities for accessing our programs, and spent six months informing them, making sure that they understood the programs, making sure that they could meaningfully contribute to the conversation when they are in a roomful of providers. And we have heard really good feedback on that process, because they really do feel engaged. So we are using that in other groups that we have as well.

COMMISSIONER JOHNSON: Thank you.

DR. BAGLEY: You probably have something even more meaning to say than me. You know, that has been part of the struggle for us. There is no shortage of folks who are willing to come and tell us what they think, and that matters. We need to be willing to hear that and understand that and meet people where they are. But part of the problem is that those groups don't always get together to really meaningfully discuss some of those issue and understand each other. So one of the things that we have really been trying to do is to be that convener in our state. It is still a struggle, if I am really brutally honest.

So this has helped start to bridge that, but we tend to fall back into those old ways of this is a forum for this group, and this is a forum for this group. Bringing everyone together is harder. They are not used to being together in the same discussion. One of the ways that we have started doing that in Nebraska is through our Medical Care Advisory Committee, and bringing these kind of topics up there, because of the more diverse membership. But, you know, that's just part of it. There's a lot more

to do on that front.

COMMISSIONER JOHNSON: Thank you.

MS. MATNEY: We had a, I think it was a 16-person Consumer Advisory Board as part of our community-based service evaluation, and they will continue through implementation as well. Definitely a part of that, with education. But as we were going through that evaluation and doing listening sessions and interviews -- I say "we." I certainly was not doing it -- a lot of the feedback from families and members was, "We feel like we know kind of what's out there but not how to get there or who to contact if we want it."

So the interesting thing that has unfolded is discovering this spider web of social networks that exist, and they are just treasure troves. And so we really have started to think about how we tap into those to communicate our own updates and ask for feedback as well.

One of the other things that came out of the community-based service evaluation is, you know, back when we had the balancing incentive payment program and we were supposed to create a No Wrong Door, well, I mean, yeah, we literally created 10 No Wrong Doors, but there's no lobby

for people to come together in. So we are working on building out a warm handoff and referral system out of that, so that people can come in, and really across health and human services and community-based organizations, access anything that they want and identify. But more to come on that.

And then we have -- just one more piece -- for the past 19 months we have had a member town hall every single month. Initially, the first three were just people yelling at me. But then we got onto educational and describing how Medicaid works, how capitation payments worked, what's a medical loss ratio. So each member town hall we have different topics. You know, if I get the vibe that they just want to vent, though, I'm going to push those off to the side and just open the floor.

But right now, since we are unwinding from COVID, and we are also going through a new managed care onboarding, we are increasing those to two times a month. But they are really great opportunities to hear feedback as well as to educate and inform.

And there are definitely spaces also where I appreciate the feedback from people who don't understand

the programs, and that's because sometimes they have the best ideas on how to fix a problem, whereas I have my staff over here who are like, "We can't do it because we have this rule and this rule and this rule." I'm like, "Well, we built those rules. We can change them."

MS. DOBSON: Just really quickly, harkening back to the feedback from the interviews that Tamara and Asmaa did, the options counseling, we have the luxury of representing the aging directors who mostly run the I&R systems and the No Wrong Door systems. And I would just make two points. One, there is no wrong door in most states. In reality, people find their way in mostly from hospitals, typically, find their way in in very different places.

And because it's not funded -- let's be clear, it is a service that is provided under the Older Americans Act. The Older Americans Act funding is budget dust compared to what Medicaid spends, and the burden of going through the administrative claiming process to get funding from Medicaid to support the No Wrong Door is mostly not worth the effort. So the fact that people don't know, and there is an options counseling, is a direct result of the

disconnect between Medicaid and non-Medicaid services.

CHAIR BELLA: Darin.

COMMISSIONER GORDON: Thank you all for what you do. This has been super informative.

I would like your perspective, because I heard it come up. I mean, I'm guilty of having done it when I was a director too, or at least there was a major emphasis on it. But when there is money available and you are pushing it out to providers there is this almost easy path by which we all just say, "Give it to the direct care worker." And as I just try to understand that industry more and more and more, it isn't just the direct care worker that we are having challenges with. In fact, when you don't have good systems in place, as you all hit on systems, you don't have schedulers, you don't have trainers, you don't have compliance folks, the system is worse off.

So what have you all done or what have you all seen done that does a good job recognizing and helping educate more broadly that there is no shortage of challenges in this area, but that we can't neglect some areas, which -- again, every time we push money out it was always "Let's go to direct. Let's go to direct." And I

feel we have almost furthered the problem we were getting frustrated with, because if scheduling is not working out and we don't have good systems there's abrasions with providers and providers end up leaving. That's not helpful. If I don't have anybody doing compliance, you know, or training, then I have quality care issues that I have concerns with as well.

But I would love you all's perspective on if you have seen different approaches or strategies that help raise the awareness of the broader system problem versus just direct care workers.

DR. BAGLEY: So I'll say one of the things we really pushed on was talk to us about what the real underlying issue is for you as a provider. Most of them came back with, "Well, our issue is turnover." Now part of that is direct care but part of that is schedulers. Part of that is supervisors and trainers and everyone else.

And so we said, "Okay. If turnover is your issue, give us some baseline data, and then let's collect that data, ongoing, following these infusions of cash, or following whatever corrective action we have taken," because then we want to be able to show that we addressed

the issue. Maybe it didn't solve it but did it improve? And so that was part of our effort was to say, "Well, let's talk about what the real issue is and let's put some data to it."

The other piece of that is politically. The easy button is that's something that is straightforward to talk about, hard to argue, that we need that. So there has been, from our agency, this effort to kind of educate legislators, folks in our Governor's Office, and other places of there are kind of two classes of providers in Medicaid. There are hospitals and physicians who are accustomed to working with a dozen different insurance companies, and that's just run of the mill. They are used to that. They have their way of managing this.

But then you have providers, and this is typical of our home- and community-based services providers, writ large, not just within 1915(c) waivers but particularly there, who are almost entirely reliant on Medicaid for payment. And so we have to think about those classes differently, and that, I think, hasn't always been apparent to everyone. We tend to just think about things in terms of hospitals and physicians, and it's not. You know, there

is a spectrum there, and at the far end of that, where they are completely reliant on Medicaid, is our home- and community-based services providers.

MS. MATNEY: So when I think about direct care workers and some of the struggles that we have had, I mean, wages are certainly part of it, right? And when we were doing our recruiting and retention bonuses, we did push those out for supervisors as well, because we were hearing of some churn, you know, and trainers and things like that.

I think that it is reasonable to have the expectation that a certain percentage of any type of rate increase goes out to direct care workers, understanding that there's going to be a reserve amount, like maybe 20 to 30 percent that's reserved for the folks at the top.

When we talk about things like turnover the most common thing that I hear from individuals, besides wages, is the feeling of competence and confidence, especially with some of these more challenging populations that have aggressive behaviors. You know, you are making $13 an hour. How many times do you want to get punched before you go find another job?

And so we have done a couple of different things.

One is with our American Rescue Plans we have implemented a statewide crisis provider. We have contracted with an entity. They are responsible for providers who serve individuals with co-occurring intellectual disability and mental health or behavioral health issues. They have a 24/7 line for providers to call to ask for assistance, tell them what they have done already in terms of trying to deescalate, ask for advice. Also offering mobile response specifically for those populations.

And then throughout the state, crisis respite, because sometimes, I don't know about you guys but sometimes I get sick of the people I live with, so I imagine sometimes people have relationship issues and they just need a break. And so providing those respite opportunities as well, which, in turn, really alleviates a lot of the stress and tension that folks are feeling when they are providing those services. That will stay there if they feel trained adequately to meet crises and if they feel supported. And that's what we are trying to wrap around not just the direct service providers but then simultaneously pull some of that like burden and responsibility from the supervisor staff as well.

CHAIR BELLA: Thank you. So this is your 30-second-or-less, if you had a magic wand, if you haven't already told us, what would it be? And then we are going to thank you and release you from this questioning.

MS. DOBSON: I'm going to go first. Seventeen percent of the housing in this country is accessible, and so agreeing with the issue about mandatory versus optional, CMS has got to recognize that housing is the first thing that makes community living possible, and allowing room and board to be paid for in the community when it is, in fact, being paid for in a nursing home.

DR. BAGLEY: So I ditto that, but I would also say that for me, what I would really love to see is a really concerted and thoughtful effort on how do we talk about quality and outcomes in HCBS. It's a struggle, and if we could start to solve that it would change the discussion politically around HCBS, to being something much more meaningful.

MS. HAMILTON: I would say removing the institutional bias in Medicaid and having home- and community-based services be the, yes, be the preferred option, and then if somebody needs an institution that is

the higher level, than have it the way that it is now.

MS. MATNEY: Agree to all of those things. Additionally, if I could have my staff, and me by proxy, not focusing at 90 percent on following rules and flip that to 90 percent focused on member outcomes and provider performance, that would be fantastic.

CHAIR BELLA: Those are four amazing things, and actually like really important for the conversation we are going to have about what direction to go in, so thank you. Thank you especially to the state folks who flew and had weather delays and who have to go back, in light of everything you have going on. Camille, thank you. You didn't have a flight but still, we appreciate it. Tamara, thanks very much.

We really appreciate you being here. Please know that you are always welcome to reach out with more ideas, ways we can help you, ways we can give cover, whatever it is. This is a priority area for us and it will remain so. So hopefully you will be contributing to that as we try to sort our way through this. Thank you.

To the Commission, we are changing up the agenda a little bit. Believe it or not, we are going to bump the

duals Data Book for right now. See, I know. I know. You didn't expect to hear that from me, did you?

[Laughter.]

CHAIR BELLA: We are going to do that so we can have about 15 minutes just to sort of try to get our thoughts organized about what we have heard in this panel, and in the report on the interviews before the panel.

I will say, Kate and I have already been talking. We are going to need much more time to sort through. There are so many things here to figure out how we thoughtfully and meaningfully and deliberately want to go through it, but also don't want to lose any momentum right now.

So I think similar for the Commissioners, kind of a little fire round. What are we calling it? Lighting round. Lighting round. Some sort of eat the frog. Some sort of round where anybody that has got something on their mind let's just quickly sort of run around the room so that we don't lose that thought, with the promise that we will come back to a deeper discussion on where we go next.

Bob, I'm going to start with you.

COMMISSIONER DUNCAN: Thank you, Melanie. Mine is the connection, I believe it was Liz said, around

mandatory on the nursing home, home- and community-based services is optional, tying it back to what Bill had shared earlier. I think that's something we need to look at, because I think it ties a state's hands on what they can do.

COMMISSIONER GIARDINO: I would just wonder and ask if there's some data that shows the superiority of getting services in the community versus institutional, and then what's the typology there? I'm sure there's some populations that do better in institutions and some that do in the community. But as we try to think about policy, I'd love to see what the data would be so that if we did want to say something dramatic, like make home and community services the default, I'd love to see some evidence that we should say that.

CHAIR BELLA: We would be fulfilling Kevin's wish, too. That's great. Verlon?

COMMISSIONER JOHNSON: Yeah, I really want to do a really deep analysis of ARPA and so really compare how it has improved. So looking at -- I think someone said in there, see what's missing, you know, as we look at the plans, and then really make some recommendations from

there.

CHAIR BELLA: Jenny?

COMMISSIONER GERSTORFF: This may be a little bit of a twist on the theme, but kind of tying a couple of things together, is hearing about infusions for compensation for direct care workforce and knowing that these are low-wage jobs, so we likely have Medicaid beneficiaries doing those jobs, and whether any of this short-term funding affects their health care coverage long term.

CHAIR BELLA: Yeah, I think that's come up in the past. Thank you for bringing that up again. Sonja?

COMMISSIONER BJORK: Perhaps some investigation or information about how we can support rural providers and rural potential beneficiaries who sometimes seem to get left out of access to these services.

CHAIR BELLA: Thank you. Rhonda?

COMMISSIONER MEDOWS: I'm just going to second Angelo's suggestion, because I think that work started years ago. Maybe there's something that's available to refresh and compare the performance and outcomes with home- and community-based care patients as well as compared to

those that are going into skilled nursing.

CHAIR BELLA: Thank you. Martha?

COMMISSIONER CARTER: There's so much there; it's hard to pick one. I think, again, we heard about the IMD exclusion and how it's really difficult to have a full continuum of care if Medicaid isn't paying for those services or you have to do a lot of contortions to get them paid. And so in HCBS and in substance use disorder services, behavioral health, how do we do something about the IMD exclusion and make sure that people have access to the full continuum?

CHAIR BELLA: Thank you. Kathy?

COMMISSIONER WENO: Yeah, I would agree with Bob, but I think all of us would go with that one. But as far as workforce goes, looking at things that have been done, specifically when she was talking about, you know, the $4,000 bonus, I mean, you're pushing money out. It's an easy thing to do to quickly push money out. Has it had any impact? And are there other things that are done that states could put on the shelf so the next time there's a shovel-ready project that they could pull them off? Because I'm not sure so much about direct bonuses, you

know.

CHAIR BELLA: Thank you. Darin?

COMMISSIONER GORDON: There's so many places to go here, and I agree with a lot of the things said, and I'll follow up with some of the other things, because he said one thing. I'm going to pick the EMR/HIE kind of discussion, because we looked at this when it came to behavioral health providers before, and we talked about how they were somewhat neglected. And here's another area when you're talking about -- then there's workforce efficiencies, and then when you don't have systems to help with optimizing and improving those efficiencies, it just makes it harder. So looking at how you can support updating, bringing into the year 2023 the IT infrastructure of some of these providers.

CHAIR BELLA: Thank you. Fred?

COMMISSIONER CERISE: I'll mention workforce as well. You know, I do worry. They expand services, the capacity for us to do that with such competition for the workers, and the intermittent things that have been done with an infusion of cash, how do you sustain that? But I think it's a critical issue we have to solve. I'm in a big

institution, and it's a challenge with a lot of support around that level of worker. I can't imagine how much harder it is, you know, in a series of one-on-ones out in the community to support that. That's what I would vote for.

CHAIR BELLA: Thank you. Tricia?

COMMISSIONER BROOKS: I missed the question. Sorry?

CHAIR BELLA: It has evolved into what one thing kind of are you putting on the table. It's really, like, what did you hear that most interests you that you really want to make sure we don't lose as we define the work going forward.

COMMISSIONER BROOKS: So I had a little chat with Bill on the way down, and, you know, it makes a lot of sense that if we can serve people in the community, we should make that a priority over institutional care. But I know so little about -- I am not an expert in this field at all. I feel like I need to learn a whole lot more, and I think there are challenges to that. But the more we can make HCBS work well in Medicaid, it just -- it's better for the beneficiary; it's better for the states; it's probably

going to be better financially.

CHAIR BELLA: Thank you. Kisha, then Bill, then Heidi, and then Dennis.

VICE CHAIR DAVIS: So I echo many of the things that have already been said, especially Bob's point around, you know, what should be a priority. But I want to put my emphasis on workforce and what are the levers, again, that we have to keep folks in the workforce. So bonuses are one, but training, education, child care support, what are those other things -- health care, you know, all of those things that would help incentivize that workforce to stay.

And then one other thing that we didn't talk much around is family caregivers, and so how are we thinking about incentivizing them, reimbursement for them, to continue to be part of that workforce.

CHAIR BELLA: Thank you, Kisha. Bill?

COMMISSIONER SCANLON: To me, one of the most important comments was to remember that what we're talking about with HCBS services is something very different than doctors and hospitals. It's like an entirely different sort of task for a Medicaid program to be working with this sector and to be effectively serving beneficiaries and

doing it efficiently.

I think one of the things that disturbs me about most HCBS conversations is we operate at too high of a level. There is so much variation in HCBS across the country. We need to take the opportunity to learn from that variation, what matters, what doesn't, okay? What's actually sort of important to avoid in terms of the negative? And the workforce keeps coming back, but these are really tough jobs. And how we overcome the workforce problems without money is like beyond -- beyond an economist's dream, okay?

CHAIR BELLA: Thank you, Bill.

COMMISSIONER SCANLON: Thank you.

CHAIR BELLA: Heidi?

COMMISSIONER ALLEN: So I'm now going to say probably the opposite of what Bill just said, which is I think sometimes we're not -- we don't think enough about the intersection of multiple systems. And I wonder if there's any way to think about, you know, for example, low-income housing and city and state and federal efforts to support, you know, helping people age in place, and thinking about how -- you know, right now I know Medicaid

is paying for a lot of what we think of as the downstream social determinants of health, but thinking about aging in place as potentially one of those investments.

And then, you know, really, we're not the only country in the world that's struggling with a caregiver workforce, and I think that trying to understand our immigration policies and visas and just a real creative look at, you know, who is our caregiver workforce besides family members? How could we make it more appealing? How do we actually have enough actual people to do it if we want more people to stay at home? Those are the kind of thoughts that I've been having, is really just the bigger picture -- I mean, everybody keeps returning to this, workforce, workforce, workforce, and it's like -- it's not clearly, you know, going to go away with one bonus payment and, you know, minimum wage law. I just think that -- I think that I'd love to see some bigger-picture thinking on it.

CHAIR BELLA: Thank you, Heidi. Dennis?

COMMISSIONER HEAPHY: There's so much that needs to de-medicalize in the system because living in the home is radically different than in an institutional setting.

And so what does that look like, to provide services in a way that's for people to live in the home in a way that doesn't -- that's not institutionalizing people in their home settings, and by that, I mean what services people actually need to live in the community as opposed to looking at home- and community-based services from an institutional perspective. So an example would be what do people actually need to live in the home environment as opposed to how do we -- why are we continuing to medicalize home- and community-based services in a way that reduces the concept of people with disabilities? I guess that's what I wanted -- one of the big issues that people with disabilities face is really how -- like a determination of ours of people we see, how do we make sure that that determination isn't just based on a medical concept of services as opposed to what people actually need to live in the community. I know I'm not being really clear on this. I've been thinking a lot about it. It's -- this is --

CHAIR BELLA: This is not our last discussion. Don't worry.

COMMISSIONER HEAPHY: I know.

CHAIR BELLA: This would be the start of a

healthy body of work here.

COMMISSIONER HEAPHY: Yeah, I think it's -- I think for me, because it's how do we make sure, when we talk about home- and community-based services, we're actually talking about home- and community-based services as opposed to institutionalizing people in their homes. And that's a big issue that we're facing right now, is determination of people's needs based on medical constructs. I know I just said that, but to me that is the big issue. How do we reduce the medicalization of people with disabilities in the community?

CHAIR BELLA: Thank you, Dennis. I think that's important for us to keep in mind.

I would just pull across three themes. One is administrative simplification. We heard that in the interviews. We heard that in the panels. It's obviously a mechanism that's blocking access in many different ways. I don't know if it's blocking workforce, but, you know, there's -- it's complex.

Two is I do think we could actually really contribute to the field on the data and the performance piece, and that will help build an evidence base for making

more and more of home- and community-based less optional and maybe moving down on more of a -- a less optional route. And on the less optional route, we have heard feedback and we've had people in the past who have given us tangible suggestions around presumptive eligibility, or Camille mentioned around looking at the treatment of room and board. And there are some things that are concrete and tangible that we could be looking at that would help get at -- again, chipping away at some of these things.

So, obviously, like the -- it was very helpful to get this inventory of things, and Kate and team will go back and digest all of this. And then we will have future conversations about how to make sure we're tackling it deliberately and softly, because this is not sort of a one-and-done.

COMMISSIONER HEAPHY: If I could say one more thing, and it's about the workforce, that the workforce is an issue that's impacting everyone and not just the home- and community-based service arena. And so when we're looking at workforce, we should take a much more holistic look at what it means, what workforce means, because people don't necessarily want to do this work anymore. And so if

people don't want to do this work anymore, what can we do to incentivize -- how can we incentivize this type of work for people so as not to stay a medical -- again, I say medical, but make sure that people are getting the service they need, that people get the respect and dignity that they deserve who are doing this job, because I don't think that's really happening right now.

CHAIR BELLA: Thank you, Dennis.

All right. We're going to wrap this up. I'm going to open it up to public comment. Then we're going to take a quick break. So I'd invite anyone in the public who would like to make a comment to please raise your hand at this time.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Everybody's ready for a break. All right. I don't see any hands, so we're going to take a break until 3 o'clock. We're going to come back and do managed care. We're going to ask the managed care folks each to shave two or three minutes off their remarks so we can squeeze in the Data Book and get everyone out of here on time. So please be back at 3 o'clock. Thank you very

much, everyone, for your level of engagement in this.

* [Recess.]

CHAIR BELLA: All right. Moira is going to get us back on track. Welcome. Thank you.

We're going to spend the rest of the afternoon, most of it, on our managed care work, and so Moira is going to set the stage for that, and then we'll have two sessions that go into specific details around various related areas.

So, Moira, I'll turn it to you.

MEDICAID MANAGED CARE QUALITY OVERSIGHT OVERVIEW

* MS. FORBES: Thanks, Melanie.

Yes. So this afternoon, we're going to have two sessions, which are each kicking off some new work we'll be bringing over the next few meetings to examine some key features of Medicaid managed care.

But first, I'm going to provide a brief overview and recap some of our recent work under this general umbrella of managed care oversight, and also highlight some recent policy developments that we're tracking that may affect these projects but also provide some information that may be useful for future work.

The Commission has had an interest in examining

Medicaid managed care since the start, of course, and much of this focus of our federal commission has been on the adequacy of CMS's oversight of states and states' oversight of managed care organizations.

We've examined many different aspects of managed care oversight. Our work generally asks, are the right structures in place to ensure that managed care plans are providing access to high-quality care for Medicaid beneficiaries? How do state practices and policies affect the delivery of services and the achievement of state goals and having a managed care system, as opposed to fee-for-service? And how do federal rules and processes affect efficiency, access, quality and value?

CMS did a major update of the federal Medicaid managed care rules in 2016. They expanded the federal oversight role. They standardized and updated program standards and added a lot of new rate-setting standards, a lot of new quality provisions. They created a lot of new oversight mechanisms, including new reporting requirements for states and for managed care plans.

The Commission commented on that draft rule and at the time noted the importance of having a robust

regulatory framework that included beneficiary protections, accountability, and transparency.

A lot of the provisions of that rule, the mega rule, went into effect immediately, but some were delayed until 2018 or later to allow states and CMS time to develop standards and reporting tools.

Those implementation delays and then several changes to the regs, to certain pieces of the reg since 2016, have made it difficult for us to assess the effectiveness of the role of various federal protections and oversight activities. So it's only in the past few years that we've started looking at this.

But we have started looking at the effects of some of the regulatory changes. Last year, we brought back findings on how states procure contracts and develop capitation rates to achieve those goals of efficiency, access, quality, and value. We've published a few issue briefs based on that work. We've conducted some additional research, and last fall, we held some additional discussions in anticipation of further regulatory changes that we still expect will come out this spring. Depending on what's in the proposed rule, the Commission may want to

comment or may want to do some further work on rate setting.

In addition to continuing that work on managed care payment, in anticipation of the rule, we've started two new projects that will explore managed care accountability from the perspective of quality and beneficiary protections. Specifically -- and this is what we'll be talking about in the next two sessions this afternoon -- we're examining the role of external quality review and managed care oversight and accountability and assessing how the managed care denials and appeals processes function to ensure that beneficiaries have access to medically necessary care. Staff have already been conducting research and analysis, and they'll be presenting those findings to you.

We're also beginning to review some new data that have just become available to see if they can help inform any of our ongoing work and maybe help us identify some new areas of interest for future work.

As I said, that 2016 rule introduced a lot of new reporting requirements. They didn't all go into effect immediately because the underlying provision that was

supposed to be reported on didn't go into effect until 2017 or later, because the data that had to be reported on wasn't -- it had to have a data collection period or states or CMS needed time to develop data collection standards and reporting tools.

While some data have been available, there are things that we've been looking at. States are just now beginning to submit some of the key reports, particularly beginning to submit some of them in standardized formats that are going to allow us to do some comparisons across states and better comparisons over time.

Those are the annual managed care program report, the medical loss ratio report, and the network adequacy and assurances report. We're hoping that we can obtain information on many aspects of Medicaid managed care that up till now, we haven't been able to get or we could only get from a handful of states that voluntarily reported them.

I'll go over these briefly. There's a memo in your packet with some more detail, and I have -- there's citations in that memo with links to the actual templates and designs, and I have copies of them if anyone wants to

look at them.

The report we've been waiting for is the annual program report. What was described in the 2016 rule, but not available at all until about 2019 and not available in a standard format until this year is this annual program report. Obviously, states produce all kinds of data and reports -- the encounter data, external quality review reports, and so on. But there's no standardized comprehensive report required of all state Medicaid managed care programs besides this one.

In 2021, CMS gave states guidance on the content and form of this report in a standardized Excel template. So every state will be reporting on a number of dimensions of program outcomes, characteristics at the plan level, the state level, the program level. They have to produce it for every managed care program-- if they have a behavioral health carveout, they have to report on that as well as the comprehensive program.

They have to submit it to CMS within six months of the end of the contract year. A lot of states go on the state fiscal year, which is July to June. The first ones were due December 2022. We've started looking for them,

and the last reports under this new format should be submitted by September 2023.

They're required in the rule to be made available to the public via the state website, and so we are starting to look for these and downloading them as we find them. They have information, as I said, on nine topics -- program characteristics; grievance, appeals, and state fair hearings; medical loss ratios; quality and performance. A lot of information on this that we're going to start -- now that they'll be available in these standardized Excel formats -- we can start to look more easily across states and across time.

There's also been a requirement for plans to submit medical loss ratio information to states and for states to submit a summary description of those health plan MLR reports to CMS along with the annual capitation rate certification. States have been required to submit these for a couple of years. CMS just changed the requirement for the states to start submitting those using a standardized reporting template.

But the MLR data -- like everything else in those capitation rate certifications -- they're not required to

be made public. There are some services that do collect that information and we've been able to find some of it. We're going to monitor CMS and websites for release of either the reports or some of that aggregated data. We're hoping that we may be able to ask and get some of it from CMS. We're not sure, but at least it will be in a more standardized format. So if we are able to get it, it will be more useful for analysis.

And then there's another report that states are now required to submit in a standardized format, and that's the assurances of network adequacy and compliance. So states have been required -- the 2016 rule required states to submit every year, along with a contract, an assurance of compliance that every MCO and partially capitated health plan met the state's requirements for availability of services. The state also had to submit documentation of an analysis to support the assurance of adequacy of the network. Those analyses were based on the state's network adequacy requirements for each specific provider type.

They've been submitting these assurances and documentation annually since 2018. CMS is now asking them to submit this information whenever they submit a new

contract or contract renewal or amendment, not just annually. And since 2022, so since last October, CMS is now also asking states to submit this information using a standardized template, which again would allow comparison of this information across states.

This is also information that's never been made public. They're not saying they're going to make it public now, but the fact that it is going to be more standardized and being submitted in CMS's web-based portal means it is theoretically more accessible. And it may be something that we could potentially get our hands on, so fingers crossed.

So that's some of the new information that might be available. It might be things we could find from the states themselves. We're definitely going to be able to be collecting those annual program reports, which will be very helpful. We'll be looking out for the other information, and in the meantime, we'll be continuing with our work on external quality review, grievances and appeals this year as sort of the next phase of our work on, are the ways that CMS is implementing its federal regulatory oversight framework sufficient to be getting what we want for the

money we're spending on Medicaid managed care.

And so I don't have -- and I can answer questions. I don't -- this is sort of descriptive information. It was really just to sort of catch you up before we turn it over to the EQR and grievance and appeals session, so --

CHAIR BELLA: I have one question.

MS. FORBES: Sure.

CHAIR BELLA: Can you go back to the last slide?

MS. FORBES: Sure.

CHAIR BELLA: It says states are now asked to submit this information whenever they submit a new contract -- that's new, right?

MS. FORBES: Yeah. And they haven't put that in the rule. They're just asking for it.

CHAIR BELLA: That's kind of big.

MS. FORBES: Oh, yeah.

CHAIR BELLA: Okay. All right. Interesting.

MS. FORBES: And that's something they could put in one of these rules that they have coming up.

CHAIR BELLA: Nobody's ever going to want to renew or do anything new anymore.

Bill.

COMMISSIONER SCANLON: Quick question. The information that's not required to be made public, is there any reason why it wouldn't be FOIA-able?

MS. FORBES: I don't know.

And we do ask for things, and we do get them sometimes.

COMMISSIONER SCANLON: Well, I'm thinking besides us.

MS. FORBES: Yes.

COMMISSIONER SCANLON: I mean, thinking of journalists, advocates, et cetera, wanting to ask for things.

MS. FORBES: Yeah.

CHAIR BELLA: Bill is looking for his next gig when he rolls off the Commission.

[Laughter.]

COMMISSIONER BROOKS: What we typically hear is that there's proprietary information that can't be disclosed, and that seems to have been a barrier in the past to disclosure.

COMMISSIONER SCANLON: And I think with respect

to certain financial information that it's potentially very legitimate. The question is in terms of compliance with standards for access, et cetera. There's a question of whether that should be proprietary or not.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: Just a quickie. Let's not forget CHIP. Most of the managed care rules apply to CHIP, and this has been all focused on -- and EQR as well. So let's not leave it behind while we're doing this work.

CHAIR BELLA: Thank you, Tricia.

Other comments?

[No response.]

CHAIR BELLA: All right. Moira, thank you. This is actually really helpful.

And Sean will join us. and we'll launch into the panel on external -- or I keep calling it a panel -- session on external quality review.

COMMISSIONER HEAPHY: This is Dennis. I apologize. I couldn't get it off mute. So the other thing I think it is really important to look at is rebalancing in spending of the MCOs to make sure that MCOs are actually focusing on rebalancing spending and away from

institutional care and hospitalizations and ED visits, because that is something that advocates are very concerned about.

For instance, are plans using administrative denials? Are plans reducing services by using modification in services as opposed to just denials? There is a lot there that really needs to be looked at. I don't know if that's relevant but it is relevant to advocates.

CHAIR BELLA: Okay. Thank you, Dennis. It is being captured, or some place to figure out where and how it would make the most sense to address it. Thank you.

Sean, take it away.

EXAMINING THE ROLE OF EXTERNAL QUALITY REVIEW IN MANAGED CARE OVERSIGHT

* MR. DUNBAR: Hello. Good afternoon. As Moira said, one of the projects we have been working on is examining the role of external quality review in Medicaid managed care. I am going to walk through some brief background information on some of the pieces that touch on EQR, and then I'll walk through MACPAC's analysis of federal EQR requirements, some findings from an environmental scan that we did, and then highlight some key

1 themes that we see as emerging from this project. And then
2 we will talk about next steps.
3 All right. Overall, you all know managed care
4 has become the dominant delivery approach in Medicaid. The
5 majority of beneficiaries are enrolled in some form of
6 managed care, whether it is comprehensive full-risk managed
7 care or one of the lesser forms of managed care that states
8 can pursue.
9 One of the catalysts of the growth in managed
10 care was the Balanced Budget Act that eliminated the 75/25
11 rule, which opened up more plans to be able to participate
12 and also added some state plan flexibility for states to
13 pursue managed care through state options instead of
14 waivers, but it also enacted quality requirements including
15 EQR, which has been an important oversight tool for states.
16 And it touches on a number of areas that have been a
17 priority for the Commission, such as beneficiary access,
18 quality of care that individuals receive, and how states
19 are using this lever to conduct oversight of the plans that
20 they contract with.
21 We can save a few minutes on this slide. In your
22 background materials, we provided a refresher on the

different approaches, managed care plans that states can pursue, from the more comprehensive full-risk MCOs down through primary care case management. And the relevance here is that EQR now applies to all of the plan approaches that states pursue, and we will talk about that shortly.

In this slide, I wanted to illustrate how EQR relates to other quality oversight tools. Federal regulations require states contracting with managed care plans to develop and implement a quality strategy for assessing and improving the quality of care and services provided by the plans. The quality strategy is meant to articulate the state's managed care priorities and serves as a roadmap for states and their contracted plans to assess the quality of care that members receive and for setting measurable goals and targets for improvement.

Federal regulations also direct states to require Medicaid managed care plans to establish and implement a quality assessment and performance improvement program, which I will refer to as QAPI, that should reflect the priorities articulated in the state quality strategy, including any specific measures and targets from the quality strategy.

And then this third piece is the annual EQR process, which validates the performance improvement projects and performance measures that are included in the QAPI. Those results are included in the state's EQR annual technical report. The technical report must include recommendations on how states can target quality strategy goals and objectives to support improvements in quality of care.

The EQR requirement directs states' agencies contracting with any type of managed care plan to conduct an annual external and independent review of quality outcomes and timeliness of and access to services. The requirements of EQR have evolved over time, but the 2016 managed care rule really provided the biggest change and sort of strengthening of those requirements. I think the most notable ones were really -- it added a new mandatory activity for validating network adequacy, and it also added an optional activity for EQR to support state activities around quality rating systems. It clarified that enhanced match only applied to MCOs and not the other plan types, and it also strengthened conflict of interest requirements and what we will talk about around some non-duplication.

Next, I want to talk through some of the federal requirements and some observations around how states have some flexibility within those requirements to implement their own EQR approaches.

In conducting this analysis, we reviewed federal rules, guidance, and other resources related to the role and use of EQRs in Medicaid managed care. We also conducted an environmental scan to gather data across states to understand how they are pursuing it, and some specific components of their programs.

First off, although there are these federal requirements, states do have some flexibility in executing EQR approaches. While there are the four mandatory activities that they have to provide, states can also choose from one of six optional activities, one or more of those, to pursue other program goals.

And CMS, for each mandatory and optional activity, there is a protocol that CMS develops that outlines what the acceptable methodologies are for conducting the elements of the EQR that are specified in the regs. But states do have some latitude within these requirements, such as defining what plan performance

measures they want to use and identifying areas for performance improvement projects. But in order for a state to conduct any EQR activity, CMS must first release a final protocol, which will be explained in a minute.

This is the list of the mandatory and optional activities. A couple of things to note is that the compliance reviews for standards in 438 subpart D are conducted within the previous three-year period, and those are the ones that relate to access, care coordination, amount, duration, and scope of coverage services, and other plan standards.

As far as optional activities, one of the things we gleaned from our environmental scan is that the most common ones that states seem to pursue are encounter data validation, provider or enrollee surveys, and focused studies.

CMS has issued final protocols for all of these activities except for the two that were added in the 2016 managed care rule. Some states are already, on their own, doing network adequacy validation, but until CMS releases the protocol for that, it is not required to do so until a year afterwards. And states can pursue the optional

activity once that protocol is released. There are some states doing that but it is not yet required for either of those.

Only certain entities can perform the EQR-related activities. A state must contract with at least one EQRO to publish the annual technical report, but they have the flexibility to contract with multiples if they want to have one do medical services, they want to do one for the carveout plans that they do. We found that states typically only contract with a single EQRO, but there were a few states that did contract with multiples.

To qualify as an EQRO they must have experience in Medicaid policy, quality improvement and performance measurement, research design and methodology, and some other organizational criteria. There are conflicts of interest standards that apply to an entity functioning as an EQRO. For example, the EQRO may not review any managed care plan over which the EQRO or the plan exerts control over the other. It may not deliver health care services to Medicaid beneficiaries of conduct quality activities outside of the EQR process on behalf of the state.

There is a very narrow way in which a state can

qualify as an EQRO, but in our review we didn't see any states that were functioning in that capacity.

As you can see from the third bullet here, we found that there are only a few number of EQROs that handle the process for most states.

As part of the EQR process, states can receive enhanced match for any activities performed on MCOs. For the other plan types, like PCCM, PIHPs and PAHPs, it is the 50 percent match rate, and if there is a situation in which an entity conducts EQR activities on an MCO but they are not qualified as an EQRO, the state will get a 50 percent match. And then standalone CHIP plans get their enhanced match rate for all the plan types.

In order to get the enhanced match, states must submit their contracts to CMS for review and approval. But we did notice that there are no parameters that we can find that specify what the CMS process or criteria is for review and approval of those EQRO contracts.

There are a couple of provisions in the EQRO requirements that give states flexibility to streamline the process a bit. First, they can use components from accreditations from other entities to fulfill EQR

requirements, and this is known as non-duplication. The use of this non-duplication approach is at the discretion of the state and not the health plans. Plans must be in compliance with Medicare Advantage or private accreditation standards, and those standards must be comparable to EQR protocols.

The information from these other accreditations can either fulfill EQR requirements in full or in part, and if the state is using non-duplication for some EQR activities they just need to make sure that the other activities that are not met by this nonduplication process are fulfilled.

States also have the option to exempt MCOs from the EQR process under certain circumstances. In order to qualify, the MCOs must have a Medicare and Medicaid contract that cover all or part of the same geographic area, and it satisfies the EQR requirements in the previous two years. It is worth nothing that our environmental scan found that states seldom use either of these. Hardly any plans were exempted from the EQR process, and only a handful that we could find really used the non-duplication process for some or all of their EQR.

The EQR process culminates in a detailed summary report that has all of the EQR's findings, called the annual technical report. Those reports must be published by April 30th of each year, and there are certain requirements and components that need to be in those reports, such as the EQR methodology, plan performance, assessments, and comparisons, and any recommendations to improve quality of care or recommendations to bolster the state quality strategy. And there are some others that we note, I think, in the background materials that you have.

CMS also publishes some summary tables based on the reports that it gets from the states, at an aggregated level. It typically includes a list of the EQROs that states contract with, the number and type of plans included in each state's EQR technical report, validated performance measures, and areas of care and populations covered by the performance improvement projects.

We did find that despite the requirements some states don't post their ATR publicly and other states' ATRs can be hard to find. We did find some other variations. EQRs sometimes take different approaches to organizing the required information in the technical reports, and

depending on the time frame covered by the ATR, sometimes the most recent CMS protocols or quality strategies didn't line up.

Our analysis of the EQR process is still underway, as Moira mentioned, including stakeholder interviews and deeper dives into five selected state Medicaid programs. Insights of these ongoing efforts, in conjunction with the information we presented today, will generate some detailed findings and potential policy options for the Commission's consideration at the March meeting.

In the meantime, our analysis to date highlighted a few emerging themes that we wanted to share with you, that are worth nothing.

The first is that states see value in the EQR and their contracted EQROs. In particular, states seems to lean on EQROs for their expertise, given the complexities of the CMS protocols, and most states typically do not have in-house resources that have the same level of technical expertise as the contracted EQROs.

Also, while some states may only use EQROs to ensure compliance with federal requirements, such the

mandatory activities, there are other states that use EQROs more strategically to advance program goals, whether that is conducting focused studies that address areas of SDOH and other priorities. We found that there are opportunities that exist to improve the transparency of ATRs. As I mentioned, not all states publicly post them, despite the requirement, they can be hard to find in other instances, and generally the challenge in obtaining them can prevent stakeholders from gaining insight into plan performance and monitor outcomes for beneficiaries.

Consumer groups also see the EQR process as a little too process-focused sometimes, and would like to see some report findings be structured in a way that can be compared across states and to national benchmarks as a way to improve monitoring of plan performance.

CMS also appears to have a limited oversight role, based on federal regulations. For example, states are required to submit the contract for CMS approval to receive the enhanced match, but there is not a lot of information available in terms of how CMS reviews and provides input on the contract. And it also isn't clear to the extent how CMS monitors state compliance with the EQRO

protocols.

And lastly, we did find that the link between EQR and quality and other oversight tools can be unclear sometimes and can vary. For example, time periods covered by the quality strategies and the EQR process may not always be aligned. It wasn't clear in some cases the extent to which states used EQR findings to influence their quality strategy. And lastly, just based on some of our interviews and our findings, there is varying perspective as to whether or not the EQR process is too process-focused or does delve more into an outcomes focus.

For next steps I look forward to your feedback on the discussion today, including any comments or questions you have on the material that we covered, or what findings or questions might be of most interest to you as we come back at the next meeting. Again, we will come back with a more detailed discussion of our key findings that reflect the other pieces of our analysis -- the interviews, the deep dives -- and I think at that point we anticipate being able to discuss some potential policy options for your consideration.

So on that note, Melanie, I can hand it back to

you and look forward to the discussion.

CHAIR BELLA: I feel bad. You didn't have to cut out line -- we don't want to give it like stripped here.

MR. DUNBAR: We were being efficient.

CHAIR BELLA: One question for you. On the ATR, the annual technical report, for those of us that aren't intimately familiar, what does it look like? What information can you actually glean off of the report, and what would it help us know?

MR. DUNBAR: That is a good question, and that came up in a bunch of interviews. You know, from a content perspective they are very long, very, very long. And it will include summaries and sort of more information on the methodologies for each of the activities that the EQRO conducted. That will include sort of diving deep into the performance improvements projects that it was evaluating, any performance measures that the state had for its MCOs, whether it's HEDIS, non-HEDIS, any other particular measures.

So, you know, there are tables that will sort of show plan performance on certain things. There may be tables comparing plan performance across the different

metrics and dimensions that the EQRO was looking at.

But I think the one takeaway that stood out is that we did hear a lot of comments so far about the digestibility of the information, and that these entities' reports are so technical and so detailed and long that for most people they are not very useful tools for monitoring performance and kind of understanding how their plans are performing. I mean, they are helpful for CMS. They are helpful for the states in monitoring all these metrics. But I think we heard from some advocates and national experts and other folks that they could benefit from some more digestible summary type of material.

CHAIR BELLA: All right. That's helpful because I'm trying to understand. Transparency is one thing of having them posted, but if you can't make anything of them then how do we make them meaningful, I guess.

MR. DUNBAR: We did hear a tension.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: On that point, we talked with some states about this too. It's like, you know, it is hard to make a document serve everyone's purpose. And so when they were wanting to put something out on the Web

with regard to their EQRO report, what is the intended purpose? Is the audience the health plans? Is it the general public? And we did find where some states did have kind of a higher-level overview of results for the general public page, but you didn't want that being the tool or the discussion your quality folks are working with the health plans on different quality strategies or even having plans understand where they measure compared to the other plans. You wanted more of that detail.

So, I mean, I would say, I mean, when we looked out there, there are some that have tried to adapt the information for different audiences, but the quality reports we had out there, it did serve the purpose we had, which was to give a broader overview and have a third-party objective perspective on it, and give tools to the quality unit for when they are working with the plans, coming up with quality strategies to see how they all map.

So when I heard that comment I just wanted to be clear. Yes, they are dense and they serve one purpose, but some states have taken that extra step. We didn't. We had the whole report out there. But some states have taken steps to try to have a consumer, public-facing report at a

higher level.

MR. DUNBAR: Yeah. I think that's fair, based on what we heard, and I think my comment was more generalizing, I think. And we did hear of efforts to do a little bit more standardizing around how the reports were organized to make it a little bit easier to compare, you know, if one were to dig into that. But I think to a large degree, too, the reports are really geared towards meeting the federal requirements for the EQRO process. So I don't think it really started out as meant to be a consumer-facing tool, to your point.

COMMISSIONER GORDON: And. And that's, I think, one thing it would be worth, if we look more broadly at this, is just trying to understand how some states are doing just what is required with regard to EQROs versus using them for other purposes.

I always think about this when it comes to compliance. In some cases, you just heard the prior panel we had. It's like they had to get a report in within 30 to 60 days. Well, guess what that report is going to be a 30 or 60 days-looking report. It's not going to be of great quality. But they had to comply, and sometimes compliance

is, okay, I did what I had to do. And then there are others that, okay, I have to comply but how can I also leverage this for broader intended purposes?

And it would just be good to have that perspective of how states are really approaching it. Are they leaning into and using it more broadly or are just doing the minimum? And that's not casting judgment on the ones doing the minimum. It just gives us a perspective of who are maybe leaning in a little bit more hard and leveraging that tool.

MR. DUNBAR: Thank you.

CHAIR BELLA: Tricia, and then Angelo.

COMMISSIONER BROOKS: Sean, you mentioned the disconnect potentially between EQRO and the -- or EQR and the state quality strategy. So to me, we've got to start at the state quality strategy because that -- there are more specific requirements in the elements of the state quality strategy and that are broader, that start to talk about the goals and objectives and the performance improvement areas. You know, I've got a long list. We did a whole series with the National Health Law Program when the managed care rules came out. And then you have the

EQR, and we tell at least child health stakeholders, you've got to look at your EQR and just search for child, maternal, or pediatric to see -- when you consider that that's half of the Medicaid population, you know, are we in our quality strategy focusing on the needs of the population served by Medicaid? And I feel like that part of the process gets sort of pushed aside, and you know, the managed care rules were supposed to beat this up, and, granted, the quality strategy only has to be updated every three years or when there's a major change there. But I think it gives you a broader picture of what the state thinks managed care should be accomplishing and where the emphasis should be on quality.

And then, you know, on the other side of the EQR reports -- because I do think they're highly technical, and they are hard to -- in many of them, not all of them, to sort of really understand what the quality ratio is, is how things flow into the quality measurements, the core sets, and the recent rules for the core set still doesn't mandate reporting of the measures by MCOs. It leaves room for the Secretary to define disaggregation, including by plan, but we still aren't quite there.

So I think it would be helpful at some point to hear from what I consider to be more transparent states. Pennsylvania comes to mind. They have all kinds of quality data on their website, broken down by plan, including EPSDT delivery by plan. So there's just some really good examples out there of when you really embrace quality, what all the components are, and not just to, you know, keep focused on just EQR and that part of quality, because I think that's just one piece of the pie that most people, their eyes will glaze over.

CHAIR BELLA: Thank you, Tricia. Angelo, then Sonja.

COMMISSIONER GIARDINO: Just a couple comments. I'm assuming since it's called "EQRO," so external quality review, that there was some intent to get to quality, and that's usually on a maturational level. So, you know, you start structure, then process, then outcomes. So, you know, I don't know how many years this has been going on, but we're probably from a maturation perspective ready to start, you know, cracking that egg and getting to the outcome part. So I would just love us to have that framework, because the word "quality" is in the documents.

So I guess a couple things. One, since there's a few EQROs doing a lot of states, I wonder if there would be a policy opportunity to come up with some of collaborative so that they as an industry could standardize, particularly if the challenge is to think about getting to the outcome part of quality. Structure and process is part of quality, but the thing we're interested in is the outcome.

Having been a consumer of EQROs in a previous life, there is an element of the local ecology, you know, so there's local markets and then the plans compete with each other. So the EQRO would really be ideally suited to comment on local ecologies, and I can talk about that some other time.

And then the last thing is I'd really want to understand if the technical report has anything around how risk adjustment can be used to incent plans to take care of vulnerable populations. So in our previous meeting, we had some presentations around outreach into the juvenile justice population. That's a catastrophe for a plan if they want to get really high scores on HEDIS measures and what-not. The way to address that is through risk adjustment so that plans are incented to take care of

vulnerable populations.

So because it sounds like it's a check-the-box compliance thing, there would be an incentive to avoid adversely affected populations. So EQROs could really kind of help with that.

MR. DUNBAR: Can I make just one quick comment? The notion of process versus outcome sort of came up a lot in our examining this area, and I think one of the examples -- you know, obviously, it can vary by states and state Medicaid programs, and to Darin's point, you know, even just doing the process evaluations that the protocols call for are yielding lots of insight and actionable things for states, right? But, you know, we did talk to some EQROs, and they gave us examples of -- you know, for the -- and you'll hear from my colleagues on denials and appeals. I don't want to steal their thunder too much. But, you know, as part of some of the compliance reviews, you know, for that particular aspect, you know, it's very process heavy. Like are the MCOs abiding by the right plan and processing, communication per member, and things like that, but, you know, in a lot of cases isn't actually looking at the medical appropriateness of that, right? And so we heard

one EQRO that at least one of their states, maybe a few of them were having the EQRO look at that aspect, too.

So it varies, but I think there is some that are kind of going into the outcome side, and not necessarily just the process side.

CHAIR BELLA: Thank you. Sonja?

COMMISSIONER BJORK: Thank you. To Tricia's point about where to start, you mentioned that some states aren't conducting the reviews or they're just not posting them? Can you say a little bit about --

MR. DUNBAR: Yeah, it was more -- not being able to find the ATRs posted publicly by the --

COMMISSIONER BJORK: So they're probably doing the review, but they're not presenting it publicly, which is one of the requirements, right?

MR. DUNBAR: Right. So it just, you know, was more some transparency --

COMMISSIONER BJORK: How do you get a view of what's going on if there are big gaps like that?

COMMISSIONER BROOKS: Yeah, and the rules had a lot of transparency, a lot of requirements on posting of certain information, and making it timely because there's a

big lag in that often.

CHAIR BELLA: So remind us, the stakeholder interviews will be starting now or are ongoing?

MR. DUNBAR: We're wrapping them up, so we'll be able to incorporate feedback into -- and findings from those into our discussion in March.

CHAIR BELLA: Excellent. Okay. Other things on people's mind that you want to get on Sean's mind as he continues this work? Jenny.

COMMISSIONER GERSTORFF: So I'm just curious whether you've heard in any of your interviews whether states are using EQR to evaluate directed payments for managed care plan compliance with directed payments or any of the outcomes from providers getting those funds?

MR. DUNBAR: The short answer is yes. I need to go back and check some notes from our interviews and such, but we did hear that there were some states that have started using their EQRO for directed payments, yes. Still very preliminary.

CHAIR BELLA: Other questions or comments?

[No response.]

CHAIR BELLA: Do you have what you need from us

at this point?

MR. DUNBAR: This was helpful. I think you've flagged some good areas to think more about and come back to you with in March.

CHAIR BELLA: It feels like a teaser, so you'll be back to us with --

MR. DUNBAR: Yeah.

CHAIR BELLA: Good. Thank you very much.

MR. DUNBAR: Thanks.

CHAIR BELLA: All right. We will invite Amy -- well, Lesley will come up. Amy's joining virtually, I believe, and we will talk about denials and appeals.

[Pause.]

CHAIR BELLA: I see Amy. Welcome, Lesley.

MS. ZETTLE: Hi. Can you hear me okay?

CHAIR BELLA: Yeah, we can hear you great. We're ready whenever you guys are.

DENIALS AND APPEALS IN MEDICAID MANAGED CARE

* MS. ZETTLE: Okay, great. Well, I'm going to start it off, thank you and good afternoon.

Lesley and I are going to be introducing this new area of work today in managed care and access. So with

over 70 percent of Medicaid beneficiaries enrolled in managed care, this work is going to examine health plan denials of care and the beneficiary's right to an appeal.

So since this is the start of our work, we want to begin with a brief overview of our project plan and what you can expect to hear from us over this work cycle. We'll then provide some background on this policy area and walk through the federal policy requirements. Then Lesley will share some key findings from our state scan and discuss next steps.

So this work cycle we were trying to answer two questions. One, to what extent are Medicaid beneficiaries in managed care experiencing denials and filing appeals? Secondly, how do states and CMS monitor and oversee denials and appeals in managed care?

So today our goal is to lay the groundwork for these first two questions by sharing what we learned from our literature review, federal policy review, and our state scan. Then in April, we're going to come back to you and present findings from our interviews with states, managed care plans, provider groups, beneficiary groups. And then in September, you'll hear from us again, and there we will

present our findings from beneficiary focus groups.

So from there, based on your interest and your feedback, we could continue this work by exploring essential policy options for the next report cycle.

Okay. So before we get any further, I just want to stop here and kind of walk through some key definitions and share more about the scope of this work.

First, this project is focused specifically on denials of care in managed care. So we're not looking at fee-for-service in this project or eligibility denials. We're examining the point in time in which a beneficiary is denied care by their health plan and the process by which they can seek to appeal that decision.

In the federal managed care rules, CMS uses the term "adverse benefit determination," and so for the purpose of this work, we're using that word interchangeably with "denials." An adverse benefit determination can happen at several points in the beneficiary's care experience, so if we wanted to just use the example of, you know, a beneficiary who is referred to physical therapy. So physical therapy could be subject to prior authorization, and the plan could determine during that

process that that service is not medically necessary, thereby denying that service before the beneficiary actually receives it. So that would be one type of denial.

The plan could also choose to reduce the spend or terminate a previously authorized service, so in the case for physical therapy, the beneficiary is receiving physical therapy and then receives a notice that that therapy will no longer be authorized or maybe they'll reduce the extent of that service.

And then the third example would be where the beneficiary had received physical therapy, but the plan denied payment to the provider.

So next I just want to define the terms "appeal" and "grievances." These words are often linked, but they are two very distinct processes. So the appeal is a review by a health plan of that denial or adverse benefit determination. So once a beneficiary receives a notice of an adverse benefit determination, it triggers their ability to appeal that decision. And then after that plan decision -- or after that plan review, that could then go to sort of a state review, which we'll talk a little bit more later.

Whereas a grievance is an expression of

dissatisfaction about any matter other than that adverse benefit determination, so an example might be a beneficiary is unhappy with how they were treated by a health plan representative on a recent call or unhappy with an experience with a provider, they could then file a grievance for that situation.

So for the purposes of this project, we are not focused on grievances. We're focused on the denial and then the appeal.

So there's little published research about the extent to which Medicaid beneficiaries are denied care. One study estimated that denials were more frequent in Medicaid than in Medicare, and, you know, from our literature review, we did learn that very few denials end up getting appealed. So for individuals who are in the federally facilitated exchange, only one-tenth of 1 percent of denials end up appealed. And of those appealed denials, 27 percent were overturned. In Medicare Advantage, that rate's a little bit higher, 1.1 percent of denials end up getting appealed, and 75 percent of those denials were overturned by the plan.

So while the current literature offers little

insight into the scope or the extent of denials in Medicaid managed care, some of these denials have garnered significant media attention, and it's something that we've been following over the years. And sometimes these media reports do prompt further investigation by the state. So a more recent example of one investigation led to an investigation -- media reports led to an investigation in a state where it was found that the MCO had not been providing health care services in a timely manner, and that they were not responding in the adequate time to enrollees' appeals. And at the end of that investigation, they found that there were instances of delayed cancer treatments for patients, for example.

Okay. So now let's talk about the federal rules related to denials and appeals. So as you can see from this graphic, we're starting this process at the denial and then the two-step appeal process, which is, you know, the plan review and then the state review.

So federal rules allow managed care plans to limit or deny services for beneficiaries. MCOs are able to apply medical necessity criteria to allow -- to ensure that beneficiaries are receiving appropriate and necessary care.

They're also allowed to apply utilization management tools, and so a common tool is prior authorization, as I shared earlier.

But these federal rules do place some restrictions on these tools. At a high level, the services must be no less than the amount, duration, or scope for the same services under fee-for-service, and MCOs can't arbitrarily deny services based on an illness or condition.

And, with that said, MCOs also have specific regulations from CMS, on how these requirements need to play out in authorizing services and in the appeals process. So this includes requirements around timeliness, so, you know, how quickly does the plan need to make a decision, what's the timeline for the appeals process, the rules set those sort of minimums. The rules also prescribe the process by which MCOs need to authorize services and go through appeals.

And then, lastly, the rules lay out some flexibilities that the states may apply. For example, states may create an external medical review process that's separate from the plan appeal and the state hearing process.

Okay. So now I'm just going to quickly walk through this appeals process at a very high level. So starting at the very beginning, the beneficiary receives the notice from their MCO that a service or an item has been denied. The beneficiary then has 60 days to appeal this decision, and they can do this either in writing or orally. The MCO then has up to 30 days to review that appeal -- okay, so in urgent cases, I will note that this becomes 72 hours, not 30 days. And at this point the MCO must ensure that the person reviewing the appeal was different than that person who initially denied the claim, and the person reviewing the appeal must have relevant clinical experience.

The beneficiary then is notified once this plan has made a decision, and if the plan decides to reverse that denial, they need to authorize the service within 72 hours. If the MCO decides to uphold their denial, the beneficiary then has the opportunity to request a state fair hearing, and the federal rules requires that beneficiaries should have at least 90 days to request that hearing.

If the beneficiary goes down this path, the state

will schedule the hearing, and a final decision will need to be made within 90 days of that request.

Okay. So federal rules provide states with flexibility in how they oversee and monitor this process, but they do set some requirements. So through that, federal requirements, which we heard just before, focus a lot on compliance review and making sure that plans are complying with these processes and timelines that we just discussed. And they also require that states monitor some trends related to appeals that are happening within the managed care plans.

So the goal of monitoring these trends related to appeals is really to determine whether there is an access issue, though the appeals indicator is a bit of a lagging indicator.

Federal requirements do not require that all states monitor denial rates or the reason for denial. They don't require that states all states monitor the outcomes of appeals, and there's no requirement to audit denials or appeals to assess whether those denials were clinically appropriate.

So as you heard from Sean in the last session,

states contract with EQROs to also do this external review of compliance with these processes and, again, it's largely focused on compliance, but there is some flexibility there. And, also, states can require plan accreditation, which also has a separate compliance review.

I'll turn it over to Lesley.

* MS. BASEMAN: Thanks, Amy.

So shifting gears now to the state scan, we sought to answer four key questions listed here on the slide, namely: What is publicly available about denial rates and appeal rates among Medicaid beneficiaries enrolled in managed care plans? What are state Medicaid agencies collecting from MCOs regarding denials and appeals? And are MCOs in compliance with federal regulations regarding the appeals process?

In order to answer these questions, we reviewed publicly available information on state websites, including Medicaid dashboards, EQRO Annual Technical Reports, quality strategies, and managed care contracts, and we looked at these documents for 40 states and D.C.

Eleven states publicly report some information on denials; however, reporting across states is very

inconsistent. For example, New Hampshire reported that 12 percent of all prior authorization requests were denied. Louisiana reported denial rates ranging from 9 to 24 percent by MCO. And West Virginia reported a total of nearly 1.3 million denials. Additionally, there's no uniform time range across states for these data.

Of these 11 states, only a few report the reason for denials or the types of services denied. Eleven states publicly report on appeals metrics, including total appeals or appeals per 1,000 members. These data indicate that very few beneficiaries ultimately file an appeal for a denied service. For example, Hawaii, with nearly 380,000 Medicaid beneficiaries covered by MCOs, reported a total of 1,216 appeals filed to MCOs and 35 appeals filed to the state in a one-year period.

Nine of these eleven states also report on appeal outcomes. Across these nine states, denials were overturned in favor of the beneficiary between 19 and 74 percent of the time. Iowa was the state with the lowest overturned rate, and Ohio the state with the highest overturned rate.

Publicly reported data in Iowa allow us to look

at the universe of all claims all the way through to appeal outcomes. In the fourth quarter of 2021, roughly 19 percent of all claims were denied. Of these, only 0.041 percent were appealed. Appeals were upheld nearly 60 percent of the time and partially or fully overturned nearly 30 percent of the time.

As Amy just explained, states must collect data on appeals as part of the federal monitoring requirements. States are not required to collect data on denials.

Looking at managed care contracts and other documents, we found that 24 states require MCOs to report some data related to denials. Some states require reporting on all denials while others limit denials in some way. For example, Georgia requires only denials under prior authorization, and Colorado requires behavioral health denials only.

Eleven states require that MCOs report denial reasons. In some states this is required for all denials, and in other states MCOs are only required to list the top reasons for denials.

Fourteen states require that MCOs report a breakdown of denials by service type. There is no uniform

breakdown of service types. For example, some states like Florida, get very granular and require reporting across 56 unique service types, while other states, like Mississippi, require reporting for behavioral, medical, and pharmacy claims.

This map indicates the results of our scan as it pertains to denials data. Eleven states have both public reporting as well as reporting requirements for MCOs. Reporting from these states allowed us to get a better sense of the scope of denials in Medicaid managed care.

Fifteen states have no public reporting, but do have reporting requirements for MCOs. While these states are collecting data, because they're not publicly reporting it, we were unable to add more data points to our findings on the scope of denials.

We were unable to find reporting requirements in 15 states, and 10 states were not included in our review. We excluded states with fewer than 10 percent of Medicaid beneficiaries enrolled in managed care.

And as Sean overviewed earlier, states with managed care must contract with External Quality Review Organizations to conduct compliance reviews with federal

regulations, among other things. More than half of reviewed states had at least one MCO out of compliance with federal regulations on coverage and authorization of services or on the grievance and appeals process. Twenty-two states had at least one plan out of compliance with coverage and authorization requirements, and 25 states had at least one plan out of compliance with the grievance and appeals process. And 18 states had at least one plan which was non-compliant with both sets of regulations.

However, it's difficult to assess the extent of non-compliance and compare both across and within states. Across states, scoring and methodology can vary with different standards for what the threshold of compliance is. Some states calculate a percentage for compliance while others simply say met, partially met, or not met, or even just met and not met. Within states, a finding of noncompliance can include both small or one-off issues as well as larger or more systematic problems.

The findings from the state scan serve as the foundation for our next steps and continuing this work. As a part of that, we will continue to monitor updates in this space. For example, the Office of the Inspector General is

currently examining denials in Medicaid managed care across a number of states, and we await these reports. As Amy mentioned, we're currently interviewing Medicaid officials and key stakeholders in six states, and we will return with these findings in April.

We're also kicking off a contract through which we will conduct focus groups with Medicaid beneficiaries in order to better understand their experiences with the appeals process.

At this time we would appreciate Commissioner feedback on any specific areas of interest for interviews or for the focus groups as well as on the overall direction of this research. If Commissioners are interested in moving this work toward policy options and potential recommendations you may wish to consider in the future, it would be helpful to know what kind of evidence the Commission would like to see. We look forward to the discussion, and thank you.

CHAIR BELLA: Thank you. I am going to guess the answer on whether we're interested is yes. Darin and then Angelo and Martha and Heidi and Bob.

COMMISSIONER GORDON: Thank you for this, looking

at this. I would ask, when you looked at the states that said there were no requirements -- and I know Bob is intimately familiar with this, too -- I think you need to drill down a little bit further. For example, Tennessee was on that, and you've got to understand that appeals go to the state. Even if it's 100 percent managed care, they go directly to the state first, not to health plans. So the need for the health plan to report it is irrelevant because the way the process was set up, after litigation back in the day, to have more visibility into what was going on, wanted them directly, and then they would work with the plan.

So I'm just curious about some of those other states that don't have requirements, if they may have a process that makes the reporting of it from the MCO less relevant because they're getting it directly. It would just be good to understand that.

Thank you.

CHAIR BELLA: Thank you. Angelo, then Martha.

COMMISSIONER GIARDINO: I think a couple things I'd suggest. One is really looking to see if there's any information from a variety of sources on what are the

patterns of those denials. So, for example, in the state that had 74 percent of the denials overturned, is that because there wasn't information submitted or, you know, what kind of denials are happening? And then why would so many be overturned? So I think patterns for both the denials and then the reversal of the denial would be really important.

The other thing I would add is you mentioned a lot about the beneficiary, but the providers have a huge burden when it comes to denials and appeals. For example, if a pre-authorization is denied for the PT, for example, frequently the physician or the nurse practitioner or the physician assistant has to get on the phone and talk, and then routinely a letter of medical necessity is requested. So there's a big hassle factor that I think we should characterize, particularly in a state that overturns 74 percent of their denials. That could be viewed as really kind of punitive approach to make it really tough to work with the MCOs, so eventually you stop asking for things because it's so burdensome to work with them.

And then I would just say there's really -- you know, there's different areas that you talked about, like

before the service, like the pre-authorization or the mandatory second opinion, that's before the service. Then there's the concurrent review, while you're actually delivering the service, you get a denial. That's kind of a panic mode to a provider and a beneficiary.

And then the retrospective denials are particularly vexing for providers and beneficiaries, particularly providers, because you've already delivered the service, and based on the information you had when you delivered the service, you did it in good faith. And then a month or two later, somebody tries to claw back that payment. And those are probably one of the biggest reasons why people don't want to work with Medicaid as a provider, because they deliver the service and then a couple months later they're told, "Well, you should have known that that wasn't medically necessary."

I'll just throw that out there. Thank you.

CHAIR BELLA: Thank you.

Martha?

COMMISSIONER CARTER: Angelo, we're on the same page on this one.

I think the overarching theme here is

transparency, and thinking about, you know, we've got state Medicaid and we've got beneficiary, but we kind of forget sometimes provider level. Over the 20 years that I was the health center CEO, I got multiple managed care contracts. Sometimes it was a new managed care company. Sometimes it was a company that had been in other states and wanted to move into our market, and all I was ever presented with was how they were going to pay us and those sorts of legal gobbledygook that you get in contracts.

But what I really want to know is how do they treat us and how do they treat our patients, and I actually googled West Virginia. And I'm surprised there's actually an annual technical report I never knew existed. Maybe it didn't exist back then, but it's there, and it's actually -- it's got information on denials, and it's got information on their quality performance and -- what do they call performance improvement plans? They're PIPs? And that's like a light bulb, like, "Oh. Well, why didn't you tell me these things?" That might have helped me make some decisions about how I wanted to work with you, whether I wanted to work with you, and maybe I didn't want to work with you because you've got a wretched record for denials.

So I think transparency is really important, and it needs to be useful at the provider or the provider organization level as well.

CHAIR BELLA: Thank you, Martha.

Heidi, then Bob, then Tricia, then Kathy.

COMMISSIONER ALLEN: I'm really excited about this body of work. I think it's really important, and I appreciate the comments that were made right before me. I agree with those too.

I happened to just look at Kaiser Family Foundation's analysis of the marketplace denials, which I thought it was interesting that about the same percentage of claims are denied in the marketplace as Medicaid, and I also thought it was interesting about the same number of appeals. But they have more information at this point about what happens, and it seems like a lot of it is partly what Angelo described, where the service is provided. It's rejected later, or it's a pre-authorization, or it's a provider who's not in-network, or it's a service that's not covered. And yet they have 72 percent in this other reason, and that's the part that intrigues me.

And I guess what I really -- as much as possible,

I'm interested in what represents foregone care, meaning the person doesn't get what they need versus what represents, like an administrative process by which you're denied because you don't have pre-authorization, and then you get pre-authorization, and you get it later. Is that still in the records as a denial, or is that then erased and no longer considered a denial?

Same with -I try to see a provider who's not in network. Then I get sent to a provider that is in network. Just trying to get a little bit, this -- the kind of mystery of what does it represent.

In particular, just why do only, you know, like a tenth of 1 percent -- you know, so few people go through the process of appeals, and I wonder if that's something you could focus on in the qualitative interviews. I'm wondering if people even know that they can appeal and how clear that information is made to people, if it's clear to them that it can be done verbally. Yeah. I just think this is really intriguing work, and I'm glad that the Commission has taken it on.

CHAIR BELLA: Thank you, Heidi.

Bob.

COMMISSIONER DUNCAN: Thank you, and again, thank you for the work.

In the realm of transparency, as we were discussing, I'd be interested if we could go even a little farther and deeper in looking at a comparison of denials in this era of consolidation from the for-profits or bigger plans versus your local community-type plans, if there's trends or patterns there in the denial differences.

CHAIR BELLA: Thank you, Bob.

Tricia, then Kathy.

COMMISSIONER BROOKS: So I thought that mine and Fred's friend and maybe others know Ruth Kennedy, who was a rock star among Medicaid directors for many years in Louisiana, had the best idea. Unfortunately, when she left, it didn't get fully implemented, but they were requiring all complaints, grievances, and denials, which are different things, to be submitted through the state. And the state then would send them to the managed care plans and require the managed care plans to report back on what the resolution was, and that gives you that ability to aggregate all of that information, because that is your first window into access. And we talk about access a lot,

but if we don't know where people are complaining, where they have grievances, where they're getting denied for services, we don't fully have a good picture of access.

And the Urban Institute and HMA and some other folks got together and put out a proposed Medicaid access measurement and monitoring plan back in 2016 when the new rules went into effect, and they actually recommend that CMS give guidance to states on collecting and analyzing the grievance and appeals data.

So I think it's something to keep in mind because I think it's got a lot of promise.

CHAIR BELLA: Thank you, Tricia.

Kathy and then Darin.

COMMISSIONER WENO: Well, a lifetime ago, I was an MCO ombudsman. So I participated in a fair number of these grievance and appeals and represented beneficiaries.

So the first question I had was -- and this was a long time ago, so my experience could have changed. But when you got an MCO denial, you had the option of either appealing to the MCO or you could go directly to state fair hearing, and I'm wondering if that's still true, because your figures don't show that direction, because there are

certain issues that are not worth going through the MCO when you're actually practically doing these denials.

And then the other question I had, with the low rate of appeals here, is there a way that beneficiaries are told that they can be represented in these appeals? Because where I worked, it was on the denial notice, and it also was given -- you were given a phone number if you wanted representation. So we handled a lot of them. So that would be something I'd be curious about.

MS. ZETTLE: Yeah. I can answer your first question and the second -- or try to. So the first question, under the new managed care rules or that mega rule that Moira talked about, you do have to exhaust the plan appeal before you go to the state fair hearing. There is that option of an external medical review that the state could utilize. So some states do that, but yeah, you do have to exhaust that before going to the state fair hearing.

And then the second question is -- you're right. So in the denial notice or that adverse benefit notice that they get as soon as the denial happens, it's required through the regs, that it lays out all that information

related to their rights to an appeal. And the rules do require that the managed care plans need to provide assistance to the beneficiary. Maybe it's language services, for example, to help the beneficiaries go through that process, and we really want to explore that more in our focus groups to understand sort of what is that experience and sort of are they getting the information that they need, is it accessible, and those are the kind of questions that we're going to try to uncover.

COMMISSIONER WENO: Well, the kind of representation I'm talking about is independent representation, not by the MCO.

I worked for legal services. So I was not associated with any particular MCO. So it's great if the MCO that you're working with is helping you, but an independent person to help navigate the process and also help you go to state fair hearing, because that is a whole other enchilada.

CHAIR BELLA: Thank you, Kathy.

Darin.

COMMISSIONER GORDON: Yeah. So this can become a very, very large project as we keep throwing more at you,

and I recognize that.

So just a couple things. One is the number of appeals that you see for a particular state could indicate, if the number is low, not that they're doing everything right, but they're not doing a very good job in informing people of their rights to appeal. And I'd say if you looked at Tennessee 20-some-odd years ago, that was probably the case, but again, after many years of intentional investment, we saw a big change.

But I just think we have to drill a little bit further into do they put it in every notice that they put out, not just on the denial notice, but are they putting out you have the right to appeal? Are they posting it? We had to do it in pharmacies. We do a regular notice once a year or twice a year, just letting them know you have these rights. So what kind of efforts they're doing to help inform folks.

The other thing, it would only be in those states that -- you know, like I was talking about Tennessee, and Tricia ignored that I was saying Tennessee was doing that. But that where it comes to the state, one of the things that we saw -- so if there's other states that are doing

this and it's something, it's worth looking at. A lot of the -- when it came directly to the state, a lot of what we saw -- and I don't remember the percentages, but they were pretty compelling. A large percentage of the appeals had not -- it actually had not been denied. It did not go to the plan. There was no communication with the plan of the service, and so when we would make them aware of it, it actually got approved. So it just muddies the data a little bit, because there was a -- just from a process perspective, but, I mean, I know at least we had data on -- I'm assuming the other states, where they get it directly, would probably have some way to be able to ascertain which things were resolved primarily because they just never raised the issue with the plan to begin with. And then when we made them aware, it was taken care of.

So there's just always like these next layers to go down to, but I do think it's worthwhile on some of these just to get a better understanding of truly what's going on. And it may just be looking more focused at what is a true appeal and what looking at those that are upheld -- or those that were denied and then there were upheld. That may get some of that noise out of there, but just wanted

you to be aware of that noise in some of the data.

CHAIR BELLA: Thank you, Darin.

All right. Heidi, Kathy, Tricia, and Angelo, you all have hands up. Do you have additional comments? Angelo? Heidi? No? Okay. Angelo?

COMMISSIONER GIARDINO: I guess the other thing I would just ask is when you do the qualitative interviews with the beneficiaries -- you know, I've been part of these fair hearings, and like the way you described it, people have rights. And for someone who's in the dominant culture, that's great. I mean, I'm thrilled that I have rights, and I have a lot of confidence in all these institutions.

Many of the beneficiaries I was meeting with don't have positive regard for institutions. So the notion of going to a hearing where you get sworn in to fight for your rights is not actually a positive in many communities. So I just kind of feel like we have to kind of see how they feel about that assurance that they have rights. Did they experience that as having rights, or is that just another threatening thing where they're going to be facing people that could put them in jail or say they're lying or

identify that they're immigrants who are here illegally? Their kid is a citizen, and they're not. You know, they're not interested in bringing a lot of attention to their situation.

So even though it's diagramed like you have a lot of rights, I bet it's not experienced that way. So if you could just see if that's true.

CHAIR BELLA: Thank you, Angelo.

Sonja.

COMMISSIONER BJORK: And also in the interviews, it would be interesting to find out if we can tease out the nuances between the types of denial. So there's an administrative denial. The person wasn't eligible, or the thing that was asked for is not even a Medicaid benefit, versus a denial because there wasn't enough information and more information was provided and the service got covered, or what I would say, a medical necessity denial. And those are the ones I think that everyone is so concerned about and making sure that the protections are very strong.

I also am really wanting to know from the beneficiaries if all of the messaging that Darin was talking about, if it gets through to them. A state fair

hearing or a grievance process being posted might not sink in until it's you that got the denial, and how clear is the messaging on websites and in denial letters?

CHAIR BELLA: Thank you, Sonja.

Fred.

COMMISSIONER CERISE: Just a real quick follow-up to Angelo's, and just more detail on what that fair hearing procedure is like and how that varies from state to state and what impact that might have. I don't know what that process looks like, but if there's some that are easier than others, it would be helpful to know.

CHAIR BELLA: Kathy will describe some of that over dinner later. Yes.

Other comments from Commissioners?

Angelo.

COMMISSIONER GIARDINO: I would just say, again, just to put a finer point on that, I was the chief medical officer of the plan, and I was frightened going to the fair hearing. And nothing was going to happen to me. So I just really would like to hear from the beneficiaries how they experienced that.

CHAIR BELLA: Yeah. Go ahead, Dennis.

COMMISSIONER HEAPHY: I want to echo Angelo's points because it is very daunting for beneficiaries. It's very daunting.

CHAIR BELLA: Thank you, Dennis.

We are always appreciative of stakeholder engagement, particularly beneficiary focus groups, so thank you. I think we could never get too much of that. So we will be anxious to hear those results.

We're giving you both a lot of things to take back. Do you need anything else from us at this point?

MS. BASEMAN: No, I think we're good. Thank you.

CHAIR BELLA: Okay. Thank you for kicking off this work. You can tell that the interest is very high. Appreciate it.

Okay. The moment you've all been waiting for. Drew, come on up, and we're going to do the Duals Data Book, and then we're going to take any public comment on the everything else we've done this afternoon, and then we'll be ready to break for the day. Appreciate everyone's flexibility here as we've tried to accommodate the flow of the conversations today.

Welcome, Drew.

HIGHLIGHTS FROM DUALS DATA BOOK 2023

* MR. GERBER: Good afternoon. I will be quickly presenting some highlights from our 2023 edition of the Duals Data Book, a joint publication with our colleagues over at MedPAC.

Our Data Book describes the dually eligible population in calendar year 2020, including demographics and characteristics, enrollment and use of different eligibility pathways, service utilization and spending, as well as the use of LTSS and spending. This edition also features trends in population composition, spending, and service use between 2018 and 2020.

Some updates for this edition, we were able to add back in some trend data that's been missing previous years. Previously the transition to the Transformed Medicaid Statistical Information System, or T-MSIS, created a data gap that caused us to suspend the trend exhibits until enough years of data had become available.

Additionally, we did drop one of these trend exhibits as we found that the ongoing shift of beneficiaries from fee-for-service to Medicare Advantage and Medicaid comprehensive managed care was disguising

actual trends in the use and spending on LTSS in fee-for-service.

The 2023 Data Book also adds back in some data on attainment of dual status during the year, including which program the beneficiary was covered by prior to becoming dually eligible.

The full Data Book will be out in the coming weeks but here are a few key statistics that shed some light on the dually eligible population in 2020.

As in years prior, full-benefit dually eligible beneficiaries account for a disproportionate share of Medicaid spending relative to enrollment, representing 29 percent of spending and only 10 percent of enrollees. In contrast to Medicaid-only beneficiaries who are under age 65 with a disability, which was our non-dually eligible comparison group in Medicaid, dually eligible beneficiaries primarily qualified for Medicaid via poverty-related pathways.

As I alluded to earlier, use of managed care is growing in both Medicare and Medicaid for those dually eligible. In 2020, 41.2 percent of dually eligible beneficiaries were solely enrolled in Medicare Advantage

and 40.6 percent had at least one month in Medicaid comprehensive managed care.

Looking at the trend since 2018, managed care enrollment has grown steadily, by 8.6 percentage points in Medicare and 5.6 percentage points in Medicaid. And as we have seen before, dually eligible beneficiaries were more likely to use institutional LTSS relative to those who were Medicaid only.

We have a visual here, looking at some comparisons. The Data Book presents several comparisons to non-dually eligible populations including those who are Medicaid-only, as I described, as well as Medicare-only beneficiaries. As you can see in the chart, we compare Medicare-only beneficiaries, in light blue, with dually eligible beneficiaries, in dark blue, on select demographic characteristics, and we can see that relative to those with only Medicare, dually eligible beneficiaries are more likely to be Black/non-Hispanic and Hispanic.

We also compared the use of different Medicaid eligibility pathways for those dually eligible and for Medicaid-only beneficiaries, in green.

Looking at some service utilization and spending

in 2020, differences in use of LTSS by those dually and non-dually eligible proved interesting. Dually eligible beneficiaries in fee-for-service were more likely to use institutional LTSS and accounted for a greater share of total Medicaid spending than those with only Medicaid.

While home and community-based services, or HCBS, provided through waiver programs accounted for 36 percent of total Medicaid spending for dually eligible beneficiaries, spending on HCBS provided through the state plan option was much lower. Notably, those dually eligible under age 65 were more likely to use HCBS waiver services, and those services accounted for the majority of Medicaid spending for that group.

Moving on to trends, now that we have sufficient data in T-MSIS, we are able to examine how the dually eligible population has changed over this three-year period between 2018 and 2020. The population grew by 1 percent a year, on average, to include 12.2 million individuals in 2020. Similarly, spending has grown.

Per beneficiary, Medicaid spending grew on average by 4.9 percent a year, while Medicare spending grew by 5.1 percent a year. Spending per user for Medicaid

services such as inpatient hospital services, institutional LTSS, and prescription drugs also grew, even as the share of dually eligible beneficiaries using these services declined.

Beneficiary service use did grow for some categories. The share of dually eligible beneficiaries using state plan HCBS, HCBS waivers, and managed care capitation each grew by about 1 percent over this period.

Those were some quick highlights, and we look forward to sharing more data with you as the publication is released in the coming weeks, and look forward to any questions now or after the official release date.

CHAIR BELLA: That was speedy. Just thinking about for duals in particular, how are you thinking about COVID impacts and how we would interpret some of these data around these periods of time?

MR. GERBER: Yeah. So that is something that we thought about. Unfortunately, none of the questions, in the way that the Data Book is designed, necessarily susses out the effects of COVID, and as we saw in many of our trend tables, nothing seemed to have a drastic impact from COVID that we were able to at least immediately identify.

I think this is something that we are going to be thinking about as we prepare to do the Data Book again in the next work cycle.

CHAIR BELLA: Questions?

[No response.]

CHAIR BELLA: I will have some questions when it comes out, but I will save those and perhaps spare the rest of the Commission.

Anything else that jumped out at you that you would highlight for us?

MR. GERBER: I think it will be interesting to hear more from the Commissioners when the full Data Book is released. I think we were looking definitely at some of the trends in LTSS and HCBS use. And as always, I think we welcome insights and questions as we continue to do this work over the next cycle and future cycles in terms of how we can either better capture this data or other areas of comparison that might be of interest.

CHAIR BELLA: Thank you. Dennis, and Sonja.

COMMISSIONER HEAPHY: I'm sorry. Maybe I missed it. Did you break this down by age?

MR. GERBER: Yes. So we have some comparisons in

both the full Data Book as well as, I think, some of the points I highlighted, between the 65 and older as well as under 65.

COMMISSIONER HEAPHY: And what about types of diagnoses?

MR. GERBER: I believe in the full Data Book we do have some analyses of different conditions towards the front of the book. These can vary from Alzheimer's diagnosis and dementia to a few other select conditions. But that's something I can look into, and when we have the full report released, we can send that along.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Thank you. Other comments or questions?

[No response.]

CHAIR BELLA: All right. Drew, thank you very much.

CHAIR BELLA: We will open it up to public comment on any of the things we have discussed today, in particular the managed care session. So if anyone would like to make a comment, please use your hand icon.

I will give people just a second.

All right. It does not appear that we have any public comment. Oh, we do. Amanda, please introduce yourself and your organization, and a quick reminder that we ask comments to be limited to three minutes.

PUBLIC COMMENT

* MS. BOYCE: Just to confirm this is public commenting on the denials and appeals process.

CHAIR BELLA: Yes.

MS. BOYCE: Okay. I have something written here that I would like to read. My name is Amanda, and I am speaking today for myself as a Medicaid recipient. Thank you for giving me the opportunity to share these experiences regarding denials and appeals. It is a topic that is very relevant in my day-to-day life, and probably will be forever if changes in policy are not made.

Firstly, I would like to acknowledge and give thanks that I have Medicaid coverage as that wasn't always the case. My first experience with a denial in coverage was in South Carolina. I had recently learned that I was pregnant, and I wanted to have my legal pregnancy test done so that I could start my prenatal care. I was homeless and without a job at the time, so I applied for medical

coverage through the state.

I thought with my current situation as it was that I would qualify for assistance, but I was wrong. I was denied coverage, and that denial letter did not come until after my son was already born. I didn't file an appeal at the time because I wasn't aware I could, and I had plans to relocate to Washington State.

Once I was in Washington, I applied for and received coverage for myself and my son, and we have had that coverage ever since. This coverage is greatly needed and appreciated, but it hasn't come without issues, though.

While I am blessed with a healthy son who rarely needs medical aid other than his checkups, the same cannot be said about my own health. I have struggled for the majority of my life with oftentimes debilitating gastrointestinal problems. When these medical crises happen it makes it difficult to function, let alone care for my son uninhibited. It took me years to find a doctor that not only understood my medical issues but also had a treatment plan to help me manage my symptoms.

That doctor prescribed me a medication, and I only received my first bottle by luck. My pharmacist told

me that they had the ability to force a first-time prescription, and from there on I would have to pay because my insurance had denied coverage for that medication. So I asked the question, "If I were to buy it myself, how much would that medication cost?" $3,200.

I knew I would never be able to afford that, but I had one bottle. My doctor told me to start taking it because she thought if it really did help me, and she thought it would, then maybe we could show that medical proof to my insurance, and through an appeal they might change their decision.

That medication literally changed my life -- no embellishments, no exaggerations. I was, for the very first time in my life, functioning like a normal person. I thought it was a miracle, a miracle medication that I now couldn't get again.

My doctor helped me file an appeal, but again I was denied. A medication that solved my gastrointestinal issues, allowed me to function and gave me a new lease on life, was again denied, even with medical proof that it had done so. This left me with very limited options. My doctor told me it could be ordered from another country at

a lower cost, but I would still have to pay for it out of pocket.

Having now learned and experienced what it was like to have a normal functioning digestive system, I was willing to do anything to keep that my reality. While spending time with family over the most recent holiday I found myself not far from the border to Mexico, and I had been hearing stories of other Americans going across for medications and dental work and other minor medical procedures, because like me they could not afford to maintain their health in America.

So with these stories and the knowledge from my doctor about medicine being cheaper in other countries, I took a risk. Without a passport, unsure if I would be able to come back to America, I walked into Mexico, praying that I could find what I desperately needed, a life-altering medication I had been denied access to by my insurance, twice. I did find that medication there, and at a cost of $180, compared to the $3,200 it would have cost me in America.

Because I am not familiar with getting medications from other countries or other pharmaceutical

manufacturers, this newly obtained medication, I was about to put into my body came with great anxiety. What if the formulation was different? What if there was an ingredient in it and their processing that I could be allergic to? All of these possible what-ifs were just things I had to risk if I wanted my medication, because my insurance had left me with no other options.

In closing, I would like to express my views on Medicaid benefits as I have experienced them. These are benefits that are greatly needed for my son and myself, and I am extremely grateful for them. When the family dog knocked my son over and he fractured his arm, insurance was there. When I woke up and an old arm injury was acting up and I couldn't move my arm, insurance was there. These are examples, though, of urgent and emergency care. When it comes to maintaining your health or taking medications as preventative care to avoid urgent care and emergency care needs, Medicaid falls short.

It is my hope that changes in the denial and appeal processes are made. I hope that more credibility is given to the doctors out there helping patients like me with these appeals. They are the ones caring for us and

trying to help us be healthy in a system that is making that difficult to achieve.

Thank you again for giving me the opportunity to share with you today, and I urge you to make these much-needed changes. There are millions of Medicaid recipients counting on it. Thank you.

CHAIR BELLA: I think you left us all very speechless. Thank you so much for taking the time to share what is a very personal journey and a very difficult journey. It sort of punctuates the importance of our work. There are a lot of heads nodding in here, appreciating your willingness to share that with us, so thank you very much.

Any other comments from the public or Commissioners?

[No response.]

CHAIR BELLA: Okay. Well, I think that's an important way to end the meeting and a reminder to us all. Thank you again, Amanda.

We will be back here tomorrow. We will start with taking votes. We have three sets of votes to take. The votes will begin at 9:30 Eastern time tomorrow. I look forward to seeing you all then. Thank you very much,

everyone. We are adjourned.

* [Whereupon, at 4:37 p.m., the meeting was adjourned, to reconvene at 9:30 a.m. on Friday, January 27, 2023.]

PUBLIC MEETING

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

Friday, January 27, 2023
9:30 a.m.

COMMISSIONERS PRESENT:

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

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E D I N G S

[9:30 a.m.]

CHAIR BELLA: Good morning. Welcome to Day 2 of our January MACPAC meeting. We are going to start off with taking votes on the recommendations that were presented yesterday. Thank you all for being at the head of the table. We are going to start with Linn.

VOTE ON RECOMMENDATIONS FOR THE MARCH REPORT TO CONGRESS

* MX. JENNINGS: Yes, and before reading the recommendations we just want to acknowledge that OMB released initial proposed revisions to the collection of reporting of race and ethnicity data yesterday, and the anticipated revisions are still expected in the summer of 2024. We anticipated revisions so it's reflected in the chapter in the rationale, but we just wanted to make everyone aware and that it doesn't change the recommendations that you are voting on today.

So the first recommendation reads:

"The Secretary of the U.S. Department of Health and Services should update the model single streamlined application to include updated questions to gather race and

ethnicity data. These questions should be developed using evidence-based approaches for collecting complete and accurate data. The updated application should include information about the purpose of the questions so that the applicant understands how this information may be used. HHS should also direct the Centers for Medicare & Medicaid Services to update guidance on how to implement these changes on a Secretary-approved application."

EXECUTIVE DIRECTOR MASSEY: And the second recommendation?

MX. JENNINGS: Oh, sorry.

And the second recommendation:

"The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to develop model training materials to be shared with state and county eligibility workers, application assisters, and navigators to ensure applicants receive consistent information about the purpose of the race and ethnicity questions. The training materials should be developed with the input of states, beneficiaries, advocates, and application assisters and navigators, user tested prior to implementation, and

adaptable to state and assister needs."

CHAIR BELLA: Thank you, Linn. Are there any questions or comments from the Commissioners before we take a vote?

[No response.]

CHAIR BELLA: Okay. I am first just going to remind folks that we do have a Conflict-of-Interest Committee that is chaired by our Vice Chair, Kisha Davis. On January 19th, the MACPAC Conflict of Interest Committee met by conference call and determined that for purposes of our votes today, under the particularly, directly, predictably, and significantly standard that governs our deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest related to the recommendations under consideration.

And with that we can take our first vote.

EXECUTIVE DIRECTOR MASSEY: Okay. So we will take one vote on both of the recommendations that Linn just read, and at the outset of the voting session I want to note that Laura Scott will be recorded as not present.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR MASSEY: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR MASSEY: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR MASSEY: Robert Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jennifer Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: William Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR MASSEY: Laura Scott recorded as not present.

Katherine Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. For the record, 16 yes, 1 not present.

Rob, can I ask you to read the two recommendations tied to nursing facility payment policy?

MR. NELB: Yes. So we have a package of two recommendations that the Commission will vote on. The first reads as follows:

"To improve the transparency of Medicaid spending, the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services to collect and report the following data in a standard format that enables analysis: facility-level

data on all types of Medicaid payments to nursing facilities, including resident contributions to their cost of care; data on the sources of non-federal share of spending necessary to determine net Medicaid payment at the facility level; and comprehensive data on nursing facility finances and ownership necessary to compare Medicaid payments to the costs of care for Medicaid-covered residents and to examine the effects of real estate ownership models and related-party transactions."

The second recommendation reads as follows:

"To help inform assessments of whether Medicaid nursing facility payments are consistent with the statutory goals of efficiency, economy, quality, and access, the Secretary of the U.S. Department of Health and Human Services, HHS, should direct the Centers for Medicare & Medicaid Services, CMS, to update the requirement that states conduct regular analyses of all Medicaid payments relative to the costs of care for Medicaid-covered nursing facility residents. This analysis should also include an assessment of how payments relate to quality outcomes and health disparities. CMS should provide analytic support and technical assistance to help states compete these

analyses, including guidance on how states can accurately identify the costs of efficient and economically operated facilities with adequate staff to meet residents' care needs. States and CMS should make facility-level findings publicly available in a format that enables analysis."

CHAIR BELLA: Are there any comments or questions from Commissioners? Any discussion?

[No response.]

CHAIR BELLA: That's a mouthful. Thank you, Rob. Okay, we will take the vote.

EXECUTIVE DIRECTOR MASSEY: Okay. Again, we will be voting on both of these recommendations as a package.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR MASSEY: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR MASSEY: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR MASSEY: Robert Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jennifer Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: William Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR MASSEY: Laura Scott not present.

Katherine Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: For the record, the total is 16 yes, 1 not present.

CHAIR BELLA: Chris, can you please read the two recommendations tied to drug policy?

MR. PARK: Sure. The first recommendation reads:

"Congress should amend Section 1927(d)(1)(B) of the Social Security Act to allow states to exclude or otherwise restrict coverage of a covered outpatient drug based on coverage with evidence development requirements, implemented under a Medicare national coverage determination."

The second recommendation reads:

"Congress should amend Section 1903(m)(2)(A)(xiii) to require the managed care contract conform to the state's policy with respect to any exclusion or restriction of coverage of a covered outpatient drug based on coverage with evidence development requirements implemented under a Medicare national coverage determination."

CHAIR BELLA: Thank you, Chris. Are there

comments, any questions or discussion from Commissioners?

[No response.]

CHAIR BELLA: Okay. You can take the vote.

EXECUTIVE DIRECTOR MASSEY: Okay. These two recommendations will be voted on as a package.

Heidi Allen?

COMMISSIONER ALLEN: No.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR MASSEY: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR MASSEY: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR MASSEY: Robert Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jennifer Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: William Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR MASSEY: Laura Scott not present.

Katherine Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: For the record, the total is 15 yes, 1 no, 1 not present.

CHAIR BELLA: Okay. Thanks to the three of you for all of the work in getting us to this point. Congratulations, newest Commissioners. You have just set

forward your first set of recommendations. So I appreciate everyone's hard work on this. You too, Kate. Your first set of recommendations, yes.

CHAIR BELLA: Okay. Let's move into the next session. Oh, Linn, you stay right up there. That is perfect.

All right. We're going to be talking about the Commission's potential responses to some HHS rulemaking.

[Pause.]

CHAIR BELLA: All right. Welcome to the three of you. I will kick it off whenever you're ready.

DISCUSSION OF POTENTIAL RESPONSES TO HHS RULEMAKING

* MX. JENNINGS: Great. Good morning, Commissioners.

Today I'm presenting on a couple provisions in the proposed notice on benefit and payment parameters for 2024.

So I'll start with providing some background on the proposed rule, and then I'll summarize the provisions on the exchange effective date of coverage, extended special enrollment period, and considerations for data

transparency. And then I'll provide an overview of areas for Commissioner comment and discussion.

CMS released its annual proposed rule on the benefit and payment parameters for health insurance exchanges on December 21st, and comments are due on January 30th. Given the short amount of time between this meeting and the comment due date, we provided a draft comment letter with your materials.

Although the Commission doesn't usually comment on health insurance exchange rules, this rule includes a couple provisions intended to ease transitions between Medicaid and CHIP and the exchange, which has been an area of focus for the Commission's recent work.

So the first change that the Commission could comment on is the proposed update to the effective date of coverage. Exchanges would have the option to make the effective date of coverage for individuals transitioning between Medicaid and CHIP and the exchange the first day of the month that Medicaid or CHIP coverage is terminated rather than the first day of the following month. And this change only applies to individuals who notify the exchange of the terminated coverage during the month prior to

coverage termination and for those with mid-month terminations. So, for example, if an individual knows that the coverage ends on March 15th and they notify the exchange of this termination prior to March 1st, the exchange would have the option to begin that coverage on March 1st rather than April 1st. And currently, individuals with mid-month terminations otherwise wouldn't have a way to avoid a gap in coverage.

In our prior analysis, 7.9 percent of adults who transitioned from the Medicaid to the exchange experienced a gap in coverage of less than a month. So it's possible some of these individuals would benefit from this proposed change.

The Commission could support this change while also acknowledging that we know from prior MACPAC work that many beneficiaries may not know in advance when they'll be disenrolled and the actions that they need to make in order to ensure a seamless transit.

The other proposed change that the Commission could comment on is the extension of the special enrollment period. The proposed change is that exchanges could opt to extend the SEP for individuals who lose Medicaid or CHIP

coverage from 60 days to 90 days. And this extension is intended to align the SEP with a 90-day Medicaid and CHIP reasonable opportunity period to submit a renewal form after losing coverage due to procedural reasons.

In most states, individuals using the reasonable opportunity period would first submit a renewal form to Medicaid or CHIP prior to submitting an exchange application, and based on our prior work, we know that there are many challenges with the transition process to the exchange, including that Medicaid and CHIP often sent incomplete account transfer information to the exchange, requiring a full application when transitioning, and individuals receive inconsistent notices from Medicaid, CHIP -- or CHIP in the exchange. And so both of these could slow the transition process and potentially make it difficult for these individuals to complete the transition even with the extended 90-day period.

And so the Commission could support this change in that it could help some individuals transitioning to the exchange, and the Commission could reiterate comments from the 2022 CMS eligibility rule, which proposed changes to ensure seamless transitions between Medicaid and separate

CHIP and comment that CMS should require similar changes to ease transitions to the exchange.

At the December meeting, the Commission discussed a range of policy issues to consider at each step of this transition process, including making data about each step publicly available to better understand the beneficiary experience and challenges with transitioning to the exchange.

The Consolidated Appropriations Act added new reporting requirements for states on transfers to the exchange, including reporting the number of account transfers to the exchange, the number determined eligible for exchange coverage, and the number that select qualified health plan on the exchange.

Although the rule doesn't explicitly address these areas, the Commission could consider using this as an opportunity to comment on the importance of data transparency and evaluation of coverage transition during the unwinding of the Medicaid continuous coverage requirements.

So we'd appreciate your feedback on whether MACPAC should comment on the proposed rule and on the

proposed comments for the effective date of coverage and SEP changes, including encouragement for an additional actions to smooth transitions, and on the importance of data transparency and the evaluation of coverage transitions.

And with that, I'll turn it back to the Commission.

CHAIR BELLA: Thank you, Linn.

I'm going to suggest that this is something that we do want to comment on. Does everyone agree with that?

Heads nodding.

Okay. So that answers your first question: Would we like to comment? Yes.

I'll open it up for specific comments from Commissioners.

Tricia.

COMMISSIONER BROOKS: Thanks, Linn.

Can you go back to the slide on the extended special enrollment periods? So the second bullet here would require an individual using the reasonable opportunity period must first submit a renewal form to Medicaid or CHIP before submitting the exchange

application, and part of the rationale here is that account transfers are incomplete. Well, account transfers really don't work right now. People do have to start a new application, and that bullet concerns me.

I like the first bullet, going to the 90 days, but if I get a renewal notice saying here's the information we have, it looks like you're over income, and I know I'm over income, I agree with that notice. They say if you don't respond, you're going to be terminated. I get terminated. That's fine. I don't need to respond to that notice if I know I'm going to be ineligible.

So why would we make people submit that renewal form back to get that account transfer across? I think that's a barrier, and that is not the way I would like to see the Commission comment.

Now, the other piece here is that I would like to see CMS extend special enrollment period to anyone losing Medicaid during the unwinding period. There's going to be a lot of turmoil. We're not going to have enough consumer assistance for people to access help in filing the application and selecting a plan. We could go over the 90 days, by the time someone decides to do that.

I think there's an appetite at HHS for this. We've asked about it. The response has been we're going to be putting out some more guidance, stay tuned, but it wasn't we don't think we can do this kind of thing.

I think in our comments, if we get them in, I think that's just additional support for having that special enrollment period, specifically for the loss of Medicaid.

CHAIR BELLA: Tricia, can you say a little bit more about that? They have the authority to do that?

COMMISSIONER BROOKS: They, by administrative action, have an ongoing SEP for under 150 percent of poverty, and that didn't require statutory changes. As I understand it, they do have the administrative authority to do that. Now it's conceivable that's wrong, but that's my understanding. And simply because of the feedback that we have gotten when we've made that suggestion, it appears that it's certainly under consideration. I don't think it would be under consideration if they've ruled out their authority to do it.

EXECUTIVE DIRECTOR MASSEY: So, Tricia, I understand the point that you're making in terms of

prioritizing coverage for individuals losing coverage in Medicaid and CHIP.

I think the challenge that we have with this particular rule is that it's an exchange rule that is promulgated outside of Medicaid and CHIP policy, and so the reason why we were planning to comment here was very narrowly to reemphasize the research that we've done on those transitions of care. So we wouldn't formulate a policy recommendation to CCIIO to take certain administrative or operational or policy action. But I do think that we can get across the point or the priority that the Commission holds, which is making sure that people maintain coverage throughout the PHE unwinding period.

So let us kind of work through some language options.

CHAIR BELLA: Other comments?

Rhonda.

COMMISSIONER MEDOWS: I think I'm going to be with Tricia on the whole part about why would we be encouraging people to try to renew Medicaid or CHIP if they know they're not going to qualify, but they're trying to go into the exchange.

MX. JENNINGS: So the second point, just trying to -- I guess that's how it currently works.

COMMISSIONER MEDOWS: Right.

MX. JENNINGS: And so, yeah, in presenting, that was just the -- yeah, that's how the policy currently --

COMMISSIONER MEDOWS: Well, so not you.

MX. JENNINGS: Oh.

COMMISSIONER MEDOWS: But why did we think that was a good idea? Why don't we just help them apply directly for the exchange? I have flashbacks to when HealthCare.gov happened, and we were trying to build out all of the account transfer stuff for Medicaid. Doesn't sound like anything got really fixed.

So I'm not criticizing you. I'm simply saying that why wouldn't we just offer the alternative that they just apply directly during the time frame when they are still on Medicaid and they know what change is going to occur. Does that make sense? Am I --

CHAIR BELLA: Tricia has a comment on that.

COMMISSIONER BROOKS: Yeah. I mean, I guess I have a different perspective on that that's the way it works. That's the way it works to get an account transfer

across, but it's not the way it works for someone to just simply apply without an account transfer. So it's limited.

And again, the account transfer process is not working, and therefore why -- and it's not going to be working for the unwinding. People can't go in and find their application and have all the information populated from Medicaid so that all they have to do is a few more tweaks. It just doesn't work that way. That's what it's supposed to work like, but 10 years later, it's not. So I just -- particularly during the unwinding, anything we can do to remove barriers to coverage, and I think that's a barrier.

COMMISSIONER MEDOWS: So can we just propose a direct application to the exchange as an alternative to this thing that is currently being done? I just worry that if I'm on Medicaid and I know I don't qualify, I am not going to go through steps to go back through Medicaid to get to the exchange. I also worry that the people that are in the states on the ground, meaning the person who is on Medicaid, when they come in and go, "I want to renew, but I really want to be in exchange," I don't think they're going to make it pass door one. I think they're not going to be

prepared to help and do it because they know they're not going to qualify.

Does that make sense? I just want to make sure, because I haven't had eight cups of coffee yet, and I want to make sure that I am at least being coherent. And I just worry a little bit about it just being unnecessary, even though it's the way that it is now.

CHAIR BELLA: Do you want to say something? Can you hold your comment for just a minute while we're checking something, Rhonda? And then in the meantime, Dennis, if you'd like to make your comment?

COMMISSIONER HEAPHY: Yeah. Can you tell me how this impacts people with disabilities who are currently on Medicaid?

MX. JENNINGS: The impact on those with disabilities? Is that --

COMMISSIONER HEAPHY: Correct.

MX. JENNINGS: If I heard correctly.

I don't -- I guess that's something we can consider in the comment, if there is something specific.

COMMISSIONER HEAPHY: I guess my concern is that there are people with disabilities who are currently

unmedicated, that they will lose -- that they'll lose their coverage.

MX. JENNINGS: That's something we can talk about including in the comment or how we want to address that.

COMMISSIONER HEAPHY: Because these are folks that really need their coverage, and so I guess I'm with the Verlon and with Kisha on this, because I really think we have an obligation to protect people. And so I don't know why we wouldn't protect people from losing their coverage.

CHAIR BELLA: So I think we are. Like, our goals are always protecting, like, maintaining coverage and promoting smooth transitions. And I think --

COMMISSIONER HEAPHY: Right.

CHAIR BELLA: -- Kate, the point you're going to make, what we need to do is take Rhonda's comment and Tricia's comment back under the theme of efficient, effective transitions and see what we're able to say in that regard, because, Rhonda, I think that's your ultimate point, right? Just make sure that there's -- like, the transition makes sense. Okay.

All right. Let us take that back and see how to

weave it in most effectively, but I think we understand the points that all three of you are making. Thank you.

Anything else you want to say, Kate or Linn?

MX. JENNINGS: No. Thank you.

CHAIR BELLA: Okay. Any other Commissioner comments on this one before we move to Kirstin?

Kirstin, you're going next? Yes?

[No response.]

CHAIR BELLA: Okay. Thank you, everyone.

* MS. BLOM: Okay. Well, good morning, everyone. So I'm going to talk about Medicare Advantage, a recent Medicare Advantage rule, and Medicare Part D rule that CMS published recently. I'll walk through some changes that are affecting dually eligible beneficiaries.

So I'll provide a little bit of background on the proposed rule, walk through a summary of these pieces that we're highlighting because they affect duals, and then end with some areas for Commissioner discussion.

So CMS published this rule on December 27th of last year, and as I said, it would make changes to the Medicare Advantage and Medicare Part D programs. And although both of those are Medicare programs, which is not

necessarily our lane, the MA changes are going to include some changes that are going to affect dually eligible beneficiaries because they are going to make changes to dual eligible special needs plans, which are MA plans that are specifically tailored to provide coverage to the dually eligible population.

Because of the widespread availability of D-SNPs and the number of duals that are enrolled in them, D-SNPs themselves have become an area of focus for MACPAC, even though they are Medicare Advantage plans.

The proposed rule is also going to implement sections of several recent laws that are familiar to you guys, including the Inflation Reduction Act and the Consolidated Appropriations Act.

This rule is also informed, I just want to note, by feedback that CMS received on a July 2022 request for information on Medicare Advantage for which MACPAC submitted comments. Our comments were generally supportive but emphasized the meaningful opportunities to advance equity and address disparities that might exist in policies affecting dually eligible beneficiaries.

So I'll summarize some selected provisions for

potential comment for Commissioners that affect duals starting with language access. So the proposed rule would require that MA plans provide materials to enrollees upon request or upon learning of the enrollee's preference or need in any non-English language. That's the primary language spoken by at least 5 percent of individuals in a service area.

CMS would also require that highly integrated dual eligible special needs plans, HIDE SNPs, or fully -- and fully integrated dual eligible special needs plans, or FIDE SNPs, as well as all applicable integrated plans translate their materials into any language that the Medicare standard requires in regulation as well as the Medicaid standard that states are using for their Medicaid capitated contracts.

CMS in the rule does not expect that this provision will create any additional burden for states because the responsibility will rest with plans to translate the materials.

As Drew noted yesterday, MACPAC has found in our work in the duals data book on spending and utilization that duals are more likely than non-duals to be from racial

and ethnic minority groups, which might highlight an increased need for materials in non-English languages.

Also, CMS is suggesting a number of changes to marketing rules for Medicare Advantage and Part D that are designed to protect beneficiaries from confusion or misleading information. These changes are not specific to duals, but the dually eligible population is likely to benefit from them if the changes are finalized.

The proposed rule would prohibit misleading use, for example, of the Medicare name, the CMS logo, and information issued by the federal government, such as a Medicare card.

CMS notes in the rule that there are already prohibitions about the use of inaccurate or misleading information, but because of certain examples and instances that they've found, they are reiterating and specifically calling out these pieces, such as the CMS logo. For example, they cited an instance in which a beneficiary received a notice that had a customer ID number on it in addition to a Medicare notice on the top with the customer ID number formatted to look like an official Medicare beneficiary number, which CMS is concerned is giving people

the impression that they're receiving communications from the federal government when in fact these are communications from an MA organization.

CMS is also proposing some changes to D-SNP look-alike plan requirements. D-SNP look-alike plans are traditional MA plans that are set up to with certain design elements such as supplemental benefits that might make them look like they're actually D-SNPs.

D-SNPs, as I mentioned, are MA plans that are designed to cover dually eligible beneficiaries but look-alike plans are not part of that. They're just a traditional MA plan. They're not subject to the requirements that D-SNPs are subject to, such as needing to contract with states or develop a model of care.

Prior CMS rulemaking spent some time on restrictions around D-SNP look-alike plan offerings, and MACPAC commentated in support of those changes because of MACPAC's concerns about how look-alike plans might work at cross-purposes with federal and state efforts to integrate care for duals.

In the 2020 rulemaking, CMS established that the agency would no longer contract with traditional MA plans

in which duals comprise 80 percent or more of total enrollees. But since that rulemaking, CMS has found two unforeseen loopholes, which it is intending to correct in this proposed rule. One of those is to apply limitations to the segment level as well as at the plan level and also to apply these rules to renewing contracts, not just contracts that are brand-new.

The other piece on this slide is about codifying sub-regulatory guidance on D-SNP models of care. I'm just sort of mentioning this for Commissioner awareness, but this one is a little bit smaller in that CMS believes plans are already doing this and is just making sub-regulatory guidance part of the federal regulations.

Okay. So then the rule is also making a change to the Part D LIS program. The Commissioners might be familiar with this program because we've talked a lot about the linkages between it and the Medicare savings programs, or the MSPs. So there's an automatic link in that if you're eligible for the MSPs, you're also eligible for LIS, and we have provided recommendations to the Congress about improving participation in the MSPs by aligning the eligibility determination process for the LIS program with

the one that the states use for the MSPs.

Also of note, the LIS program has the same upper income eligibility threshold for the full subsidy, which is 135 percent, and will be raised to 150 percent under this rule. But as one of the MSP programs, the qualifying individuals program, so there's -- this will kind of create a little bit of a misalignment in that. Now the LIS with this change will be at 150, and that the MSPs will be at 135.

Okay. And then, finally, The LI NET program. This is the Limited Income Newly Eligible Transition Program. This is a demonstration program under current law. It will be made permanent under the proposed rule.

So this program provides transitional point-of-sale Part D coverage for beneficiaries who demonstrate a need. It also provides retroactive and/or temporary Part D coverage for people who are determined eligible or likely to be eligible for LIS.

This proposed change would make permanent a program that helps low-income Medicaid beneficiaries transitioning to Medicare or to dual status avoid gaps in their drug coverage.

So prior to passage of the Medicare Modernization Act, which established Part D, duals received their drug coverage through Medicaid, but starting in 2006, they get their drug coverage through Part D. So when a Medicaid beneficiary becomes newly eligible for Medicare, their Medicaid drug coverage ends, but they may not yet have enrolled in a Part D plan, which could create a gap in coverage. And this program, the LI NET program, covers that potential gap.

Okay. So I'm interested in any feedback you guys have on these potential areas for comment that I flagged and that are listed here again, for your awareness. I did take off the codifying sub-reg guidance from this list since that's perhaps not an area as great of interest, but happy to take your comments.

Oh, as I noted on this slide, comments are due February 13th. So, unlike the two, on the rules that my colleagues are talking about, this one has -- we have a little bit more time.

Thank you.

CHAIR BELLA: Thank you, Kirstin.

Questions or comments from Commissioners?

Bill.

COMMISSIONER SCANLON: Yeah. I have a question about, you said there is an automatic link in eligibility between LIS and MSP program. What about a link between enrollment in those two programs?

MS. BLOM: There is not a link between enrollments.

COMMISSIONER SCANLON: So in theory you know that you are eligible for both but you are not actually in both.

MS. BLOM: The information gets transferred from SSA, so in theory the state can set up the application. But yeah, you don't automatically get enrolled. That is right.

CHAIR BELLA: All right. I have some comments. I will take Bill's first. If there is an opportunity, I think, to reinforce the earlier comments the Commissioners made about linkages and making it easy for people so that we can support people who are eligible for MSP, actually being able to get on MSP, that would be helpful, very consistent with what we've already recommended.

Number two, I want to put in a strong plug for the LI NET program. It's a little-known jewel for people

who are risking gaps in coverage. CMS has been trying to make this permanent since like 2011, so it's really exciting to see that it's on the cusp, and it really does help people, and I think most people aren't aware of it. So I really would like to support CMS, if my fellow Commissioners agree.

And third, on the look-alikes, just to put a little more color on that, the look-alikes, the more that CMS is putting policy in place to allow states to have levers to sort of align their products with Medicare, the more opportunities it creates for unaligned products to try to find ways around that. And so the look-alikes were a pretty big way around that, and CMS put that 80 percent threshold in there.

There are still a number of plans under 80 percent threshold who are managing to avoid model of care requirements and avoid contracts with states and avoid integrating things for their members. And so I would like to see us suggest to CMS that they need to take another look at the 80 percent threshold as they are looking at look-alikes and the loopholes in general, because it continues to be an opportunity to undermine integration

efforts.

Dennis, did you have comments?

COMMISSIONER HEAPHY: Yeah. I agree with everything you just said, Melanie. I do think it's really important that we address the concerns you just raised. That's it. Thanks.

CHAIR BELLA: Oh sorry, Dennis. Did I cut you off?

COMMISSIONER HEAPHY: No, no, no, no. I think that these look-alike plans really jeopardize people. I think they put people in jeopardy of being enrolled in plans that do not provide the protections available under state control.

CHAIR BELLA: Thank you, Dennis. Other comments or questions? Verlon?

COMMISSIONER JOHNSON: I thought it was interesting yesterday that we talked about, with HCBS, that there wasn't enough information for beneficiaries, and with this one, with the marketing you see there is a lot that comes at them. And so I really appreciate us looking at the fact of expanding language to access given all the research we have done around beneficiaries, health

equities, and making sure there is information that can be helpful to them. So commenting on that, I think, is something that's really important, and bringing in all the research that you said about what we have done before would be really important on that one. Thank you.

CHAIR BELLA: Thank you, Verlon. Any other comments or questions on this one? Sonja, you look on the cusp. Are you good?

COMMISSIONER BJORK: Yeah, I'm good. I'm excited about this. This is going to be a very interesting body of work that we are doing.

CHAIR BELLA: Keeping Kirstin busy, for sure, all of this exposure to duals and then Medicare rules.

All right. Wonderful. Thank you, everyone.

Aaron, you are up.

* MR. PERVIN: All right. Last but not least. We are here to talk about the proposed 42 CFR Part 2 (Part 2) rule which implements provisions of the Coronavirus, Aid, Relief, and Economic Security (CARES) Act, which was passed in 2020. The rule was promulgated by Office of Civil Rights and Substance Abuse and Mental Health Services Administration (SAMHSA) within Health and Human Services

(HHS). The goal of this session is to determine whether or not Commissioners want to provide comment on this rule, given our history of work on this matter.

We are going to start with an overview of the NPRM and a summary of Part 2, along with some of our work on this issue in the past, and then we are going to discuss the specific CARES Act changes and updates to Part 2.

As a little bit of background, Part 2 governs the disclosure of substance use disorder treatment records. Notably, Part 2 predates Health Insurance Portability and Accountability Act (HIPAA) by almost 20 years. The regulations for Part 2 were promulgated in 1975, and last updated in 2020.

Part 2 requirements are also stronger and supersede the protections under HIPAA, which governs the use and disclosure of all other treatment records.

The intent of Part 2 is to encourage individuals to seek treatment and protect them from potential negative consequences, such as criminal prosecution or employment and housing discrimination.

So a little bit about the Part 2 requirements. Just as a refresher, Part 2 applies to what we call Part 2

programs, which are federally assisted entities that hold themselves out as providing SUD treatment. To share Part 2 information, providers must obtain written patient consent to disclose treatment information in connection to substance use disorders, including diagnosis and rehabilitation plans. It also prevents the use of treatment records from being used in criminal proceedings, and law enforcement is not allowed to access Part 2 records absent a court order.

There are certain disclosures that can be made without patient consent. This includes things like medical emergencies and the purposes of scientific research, as long as the patient information is deidentified. The results of these different regulations regarding Part 2 records or records that originate within a Part 2 program must be separated and segmented from all other health information.

The Commission has expressed concern in the past that Part 2 is a barrier to integrated care by hindering the exchange of substance use disorder (SUD) information, which has implications for care quality. Part 2 regulations can lead to information gaps, resulting in

inappropriate use of services and poor outcomes. For example, an information gap may lead a provider to prescribing opioids to someone receiving SUD treatment, which can lead to relapse.

In 2018, the Commission did a roundtable with stakeholders and gathered feedback regarding Part 2's effects on care integration for Medicaid beneficiaries. As a consequence of this work, Commissioners made several recommendations around Part 2. These include recommending that HHS clarify key Part 2 provisions and also direct coordinated effort to provide education and technical assistance on how to best operationalize Part 2 regulations.

When SAMHSA updated the proposed 2 rule in 2019, MACPAC commented and was supportive of these changes because it allowed records to be shared with a larger group of entities, including those that do not have a treating provider relationship with the patient. These can include organizations such as agencies that help with eligibility determinations within Medicaid.

The second recommendation the Commission made was around using information technology to help providers share

information in a compliant manner. The Commission recommended that HHS develop a voluntary certification for information technology (IT) used in behavioral health and integrated care settings which would permit compliant segmentation and sharing of Part 2 information.

So just as a brief bit of background, in our 2018 roundtable with stakeholders we heard multiple concerns around the misalignment between HIPAA and Part 2. The Commission noted that misalignment contributes to confusion around Part 2, but at the time the Commission did not feel like it had an evidence-base to support a recommendation around Part 2 and HIPAA alignment.

Part of the reason for this is that patient and privacy advocates argued that creating more avenues for records to be disclosed without consent could discourage them from seeking SUD treatment. The CARES Act more or less put this issue to rest by aligning specific elements of Part 2 and HIPAA while also strengthening enforcement of Part 2 within HHS and adding new patient protections.

Now I am going to go through some of the specific provisions, some of which we added in our comment letter.

The proposed rule retains the requirement for

Part 2 programs to obtain consent prior to disclosing Part 2 information for the purposes of treatment, payment, and operations. However, the rule now allows patients to provide a general consent to provide Part 2 information in accordance with HIPAA. When that information is being disclosed directly to another provide the patient can describe a category of individuals instead of specific individuals. The proposed rule's model language reads that the records can be shared with treating providers, health plans, third-party payers, and organizations or entities helping to operate the Part 2 program.

However, if the records are to be shared with an intermediary, such as a health information exchange or an accountable care organization, the patient must name that specific intermediary and then that intermediary can then share or redisclose the records with entities that have a treating provider relationship.

The proposed rule also allows for general redisclosure similar to HIPAA so long as records are not used for civil, criminal, administrative, or legislative proceedings.

The proposed rule also gives patients the right

to request a restriction on disclosure for these records, but a program is generally not required to agree to these requests, which is also consistent with HIPAA.

Upon request, the rule also requires Part 2 programs to provide an accounting of disclosures to patients unless all disclosures made over the last six years or three years for disclosures within an EHR.

The proposed rule also adds new protections against the use of records in civil, administrative, or legislative proceedings, absent a court order or patient consent. The proposed rule also aligns the notice requirements, so NPP or Notice of Patient Privacy for both Part 2, and HIPAA and HIPAA entities that receive Part 2 records would now be required to include a provision in their notices indicating that these records are now subject to strengthened Part 2 requirements.

The proposed rule also aligns Part 2's breach notification rules with HIPAA, which means that Part 2 programs would be required to report all breaches to individuals, HHS, and in certain circumstances, media outlets.

For complaints, the Part 2 rule implements a

complaint process similar to HIPAA and prohibits Part 2 programs from taking any retaliatory action against any patient who files a complaint.

The last set of provisions are around enforcement. The proposed rule now allows HHS to seek civil monetary and criminal penalties for Part 2 violations, similar to HIPAA, and this change is expected to enhance federal enforcement of Part 2 rules.

We have included a draft comment letter on the proposed rule, which Commissioners may want to consider. The specific areas of comment within the proposed letter have been to reinforce our prior recommendations and the need for clarifying guidance, technical assistance, and also education for stakeholders that are involved in Part 2 and operationalizing Part 2.

We would also reinforce our prior recommendation around a voluntary certification for health IT used in behavioral health and integrated care settings. And then we also expressed some concern around the stricter standards for sharing Part 2 records with intermediaries such as health information exchanges (HIE) and accountable care organizations (ACO).

I look forward to your feedback and comments.

CHAIR BELLA: Thank you, Aaron. As with the other two I am assuming our preference is to comment, that it would be helpful to know if anyone disagrees.

Okay. Comments from Commissioners? Rhonda.

COMMISSIONER MEDOWS: I am very much in support of commenting. Did you say Rhonda or Martha?

COMMISSIONER CARTER: It's okay. You go.

CHAIR BELLA: I thought that doesn't sound like Rhonda. I am going to let you duke it out. Whoever goes first, the other can go next, and then Sonja.

COMMISSIONER MEDOWS: Oh goodness. I need more coffee. See, I told you. It's not working.

Is there a way in our comments -- so the answer to do we want to comment? Yes. Is there a way to actually add into the comment pieces about actually educating the patient about these changes? I mean, they all sound like they are protections to be added, but if you don't even know that you have got these rights and these protections, is that already in your draft?

MR. PERVIN: The draft comment letter does have a component around education and technical assistance for

providers, patients, and others. I will say that the Notice of Patient Privacy (NPP), so the new NPP that will be shown to patients, has not be fully drafted, and there is not a lot of model language on that. So that might be something that we can potentially add to the comment letter.

COMMISSIONER MEDOWS: And then when you mentioned the part about the intermediaries, that, in particular, there's like tons of intermediaries, right?

MR. PERVIN: Yes.

COMMISSIONER MEDOWS: So I don't even know how a patient would even begin to understand how many layers that they are actually agreeing to let people use their data. I just think there needs to be a whole education and training on it, and then support. Thanks.

CHAIR BELLA: Thank you, Rhonda. Martha.

COMMISSIONER CARTER: I apologize. So yeah, I'm really in support of making comments. I think our theme here is access to care, and that's, I think, where our strength for commenting on lies. About something like only 28 percent of people who need SUD treatment receive it.

And so I think that these proposed rules go hand

in hand with another change that happened at the end of the year, in the Consolidated Appropriations Act, where the requirement to obtain a special license to prescribe buprenorphine was lifted. They lifted the X waiver requirement for buprenorphine only, not methadone. So anybody with a drug enforcement agency (DEA) license can now prescribe buprenorphine.

And the intent of that is again to increase access, but research shows that providers, clinicians still, for a lot of reasons, do not integrate addiction treatment into their practices, and one of them is administrative burden. So getting rid of the X waiver is important, but also simplifying the privacy rules so that they don't have to have two very unique systems functioning. To align Part 2 rules with HIPAA is really a good idea because, first of all, we all know HIPAA. We all know HIPAA. We can do this. And so I think that's really important. And because of the additional penalties for disclosure, it makes it stronger and I think more workable.

To your point, Rhonda, I don't know if we can go this far, but in terms of patient education I would like to see us suggest that there be a sample or template Notice of

Privacy Practices. I was around with HIPAA first came out, and if I recall it took a long time. There weren't any templates. Everybody was at the mercy of law firms to try to come up with a template that was compliant, and then in another time frame, to come up with something that was in plain language. So not only do we want, I think, something that educates the patient but it's something that is readable in plain language.

So that's two of my points.

I think there is language in the CARES Act around antidiscrimination, and those rules are supposed to be coming separately. And I think that that's really important. In a study that I was working on the second most common reason for people to not seek treatment was stigma or discrimination. The first was they weren't ready, and I'll talk about that in a minute. So I think really implementing the anti-discrimination provisions that were in the CARES Act is really important, and we should urge all possible speed on getting those completed.

The part about being ready, I think that, you know, seeking addiction treatment is a very personal choice, and what the health care system, what we as

clinicians and payers and health care systems need to do is be ready when people are ready. So that means removing barriers as much as possible. This doesn't go into all that, and I could go on, but this is a way to help remove barriers so that people can get into treatment when they are ready.

And you said something about avoiding -- I mean, the big harm is that they don't die if they go into treatment. You know, if they have a chance at treatment there is less chance that people are going to overdose and die.

CHAIR BELLA: Thank you, Martha. Aaron, did you want to comment?

MR. PERVIN: Well, I just wanted to make sure I caught everything. So one is around the theme around administrative burdens for previous Part 2 requirements, which I think we can talk a little bit within the letter. And the second piece is around actually implementing the anti-discrimination provisions that are in the CARES Act, but was not in this current rule. I think we can definitely say something like we would encourage HHS forthwith to write these regulations around anti-

discrimination, because that was notably not included in this proposed rule, and we have had some discussions with patient advocates that were also concerned that that piece wasn't added.

CHAIR BELLA: Sonja and then Kisha.

COMMISSIONER BJORK: Thank you.

So the third bullet point is one I'm really concerned about and would like the clarification that you're seeking, because the example you gave earlier about making sure the physician knows that someone is getting treatment and we want them to be able to safely prescribe, the vehicle that they might get the information could be an HIE. And so I don't want that to work at cross-purposes of our goal of keeping people safe while they're getting treatment and sharing information with those who really do need to know.

And it's going to be very hard to explain to any non-health-care-involved person what an HIE is and how many of them there are, and I don't think anyone would ever be able to write down all the names of the HIEs that their records could possibly be involved in. So we need to have a realistic approach to that part of the rule.

CHAIR BELLA: Thank you, Sonja.

Kisha?

VICE CHAIR DAVIS: Thank you for the letter. This is something that MACPAC has talked about for a long time, and so it's great to be able to comment on seeing greater alignment between Part 2 and HIPAA.

I think it's just important to kind of bring through in the letter the importance of how that alignment really helps to further the treatment of patients and how integrated primary care and behavioral health is better for patients, and so being able to align HIPAA, as Martha mentioned, we all know so well and know how to operate within, and Part 2, which often seems like a foreign entity and sometimes can create an artificial barrier to getting folks into treatment, that that alignment really is helpful for patients and for the broader health care community.

MR. PERVIN: So just one thing to put out there for thought, which is previously in 2018, we did not recommend that HIPAA and Part 2 be aligned, though it is required within the CARES Act. I guess that could be a little tricky for us as we're drafting the letter, and I'm wondering if there's a more general statement around the

importance of integrated care and the importance to these new redisclosure changes in improving the ability to integrate care for Medicaid beneficiaries. Is that something that we could think about saying instead?

VICE CHAIR DAVIS: Yeah. I think that's something that we can say. I think commenting as much as we can facilitate, getting back to how can we facilitate patients getting the care that they need in a way that's an efficient and effective way and making sure that these -- even if the programs aren't merged -- some of us did advocate for that, but that's not how the Commission went -- how do we really make sure that they're aligned and working together harmoniously and not working against each other.

CHAIR BELLA: Yeah. I just want to say something there because I'm re-rereading our 2018 chapter to try to refresh my memory.

I don't know, Aaron, that there was -- there wasn't necessarily opposition. I think we hadn't -- there was more work that needed to be done, and what we say in the chapter is we'll continue to explore aligning the two.

And then I think our work evolved in '19 and '20,

and we kept thinking about when the CARES Act passed, we thought this was coming, and it would be premature for us to kind of jump the gun on that before we saw what was proposed.

And so I think we can be careful. You're right that we did not make that recommendation in the past. But I don't think it's because there wasn't interest. I think it was because we felt that there was more work to be done and/or we knew something else was coming.

But we may want to continue to work on this, if we don't feel like this gets us what we need, in terms of being able to make sure people are getting the care they need in a protected manner.

Dennis.

COMMISSIONER HEAPHY: Yeah. I guess my concern is about exacerbating inequities for minority populations. How will you protect folks, African Americans and other populations, that are subject to discrimination?

MR. PERVIN: Yes. I can just quickly comment. We've done some work in the past on the extent to which racial and ethnic minorities do seek out mental health and other types of behavioral health treatment at lower rates

compared to white beneficiaries. So we can add a little bit of that into the comment letter as well.

And then, also, Dennis, to your point about anti-discrimination writ large, I do think, yeah, we can also add a paragraph within the comment letter that discusses the fact that antidiscrimination was left out of the current rulemaking and ask HHS to make sure that they get on the ball and start working on that rule.

COMMISSIONER HEAPHY: Thanks.

And I think also, to Sonja's point, the ability of people to understand the complexities of this really needs to be addressed. I think of folks whose language is not English and other populations, that this is really complicated.

I'm for this. I just think there are a lot of concerns that need to be addressed.

CHAIR BELLA: Thank you, Dennis.

Sonja, do you have another comment? No? Okay.

Any other comments from Commissioners? Any other clarifiers, Aaron, you need?

MR. PERVIN: No, I don't think so. This was very helpful. Thanks. We will get you a reply --

CHAIR BELLA: We will say thanks to you since you'll be turning this around quickly.

MR. PERVIN: We'll be sending you something at some point in the next 48 hours.

CHAIR BELLA: Thank you for that.

All right. Any final comments, questions, thoughts from any Commissioners on these three rules?

[No response.]

CHAIR BELLA: Okay. We are a little bit ahead, and because what we have coming up as a panel, we won't start that panel early. I'm going to go ahead and open it up to public comment, just to see if there's any public comment on any of what we've discussed so far today. So if you have comments, please use your hand icon, introduce yourself and the organization you represent, and a friendly reminder that we ask you to keep your comments to three minutes or less.

PUBLIC COMMENT

* [Pause.]

CHAIR BELLA: It appears that we have no comments at this time.

Appreciate the three of you staying up there.

You are now done with your portion for this. Thank you very much.

We're going to come back at 10:45 with our panel on the PHE unwinding. So we'll see you all back here in about 15 minutes. Thank you.

* [Recess.]

CHAIR BELLA: And Kisha is going to moderate this session, as soon as we are ready. I will turn it over to you, Kisha. Thank you.

VICE CHAIR DAVIS: All right. Good morning, everybody. Thank you, Martha. We will have you kick it off with our panel. We are excited to have our guests virtually today.

STATE UPDATE ON UNWINDING THE PUBLIC HEALTH EMERGENCY (PHE)

* MS. HEBERLEIN: Thank you. Good morning, Commissioners. Today we'll be hearing from a panel of representatives from Colorado, Oklahoma, and Nevada to provide an update on unwinding the continuous coverage provisions. But first a little background.

The Families First Coronavirus Response Act provided states with a temporary 6.2 percentage point

increase in the federal matching rate if states met certain conditions, including a continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020. The continuous coverage requirement was in place through the end of the month in which the public health emergency, or PHE, ended. This FMAP increase was available through the end of the quarter in which the PHE ended.

However, the recent Consolidated Appropriations Act (or CAA) delinked the end of the continuous coverage requirement from the PHE. The law established an end date of March 31, 2023, for the requirement and phased down the enhanced matching rate over the remainder of 2023. States may now begin initiating renewals as early as February 1st, although they cannot disenroll anyone until April 1, 2023.

The CAA also included redetermination processing, beneficiary contact information updating, and reporting requirements for states to meet during the unwinding. Additional information on these provisions is in your materials.

Federal and state Medicaid officials have been preparing for unwinding the continuous coverage period for

some time, and the Commission has been closely following these developments. Prior Commission meetings have focused on the potential risk of eligible individuals inappropriately losing coverage, state administrative and system capacity to handle the large number of redeterminations, certainty around the timing of the end of the PHE, and the disconnect between the end of enhanced matching rate and the end of the continuous coverage requirements.

Today's panel discussion will provide an update on how states are now approaching the impending unwinding given passage of the CAA and the challenges they anticipate. We know that states have shifted into high gear with their preparations, and truly appreciate our panelists taking the time to update us today.

To introduce our panel, first we will hear from Chris Underwood, who serves as the Chief Administrative Officer for the Colorado Department of Health Care Policy and Financing. Next, we will turn to Traylor Rains, the State Medicaid Director at the Oklahoma Health Care Authority, and then we will hear from Sandie Ruybalid, the Deputy Administrator at the Nevada Division of Health Care

Finance and Policy.

I will turn it over to Mr. Underwood to begin.

* MR. UNDERWOOD: Thank you. Thank you for having us here today. First off, I want to start with Colorado, when we reviewed the Consolidated Appropriations Act, we got a lot of what we requested. We had been lobbying hard to have a date set for the continuous enrollment end. The uncertainty when it was attached to the public health emergency was very difficult from a systems planning standpoint. And we are also very happy there was a phase-down of the FMAP that was provided in that. We had been definitely lobbying for at least a year of FMAP phase-down, and so we were happy to see that it went through December of this year.

And we are also very happy that it was following CMS's guidance that they had been working on with states for over two years now, through the PHE, that we could actually have that process set in the act, that we could still follow that. And they didn't make a lot of changes for us, for the states.

For our Medicaid agency in Colorado, our population has grown by almost 40 percent since March of

2020. We now cover 1.7 million people. And we have chosen our unwind process to be an Option B state, which means we are going to issue renewals in March for May renewals, and our disenrollments then occur on June 1st.

We have about 700,000 members who are in this continuous enrollment condition. We expect to lose about 315,000 of those individuals. We have about one-third who have failed to provide any verification since March of 2020, and we have another third who we have determined are over income, who will no longer be Medicaid or CHIP eligible.

We have continued to do renewals during this unwind period so we have very good data on our individuals who are kind of what we call in the locked-in population.

We also chose to be an Option B state because on April 1st we implement the FPL increases, and we wanted to make sure that 8 percent change in FPL would be in our redetermination process. We are also very aware of the SNAP benefit loss that is going to occur in March, and we are a county-based eligibility, so with that our county workers will be very busy answering SNAP phone calls and trying to address individuals' concerns when those

significant decreases in SNAP benefits occur.

And also prior to the Consolidated Appropriations Act being passed we had been planning for the PHE ending in April, so we had already kind of lined up our systems to be ready to go for that Option B implementation.

With that we have done a lot of work with our county partners to get ready for this implementation. We have requested and got approval for additional funding for our county partners so they can staff up and train and get people ready for this implementation. That funding actually was available early in the public health emergency, because we didn't know when it was going to end. So they have actually had the ability to begin to ramp up and get ready for this.

Unfortunately, at the county level that is our biggest risk when we begin this disenrollment process, because they are having a tough time hiring staff at increased wages. In Colorado we do have an employment issue where our wages are increasing dramatically and our county workers, our counties can't keep up with that wage inflation to hire eligibility technicians. But they will be able to use that funding to pay for overtime and other

benefits for their current staff, hopefully to keep up with the processing.

We have also done a lot of performance management with our counties. We have done continuous improvement with them to help during this three-year process of how they can make business improvements to make eligibility faster. We have created new dashboards and reports for them. We have created incentive payments for them to meet timely processing deadlines. And we really begin to measure what matters to us at these counties and hold them accountable. And with just measuring and holding them accountable for their error rates we have actually cut those error rates in half over the last two years, just by having performance dashboards.

And we continue to have internal teams that monitor counties' performance to make sure that we can keep up during the renewal process.

In addition to our workforce, we have done a lot of technology changes. We have increased our ex parte rate significantly in the state. We have implemented the Equifax connection through the federal data hub during this time period. So now we are getting faster income data than

we did prior to the public health emergency, when we were just getting the data from our state databases.

We have expanded that look-back period from four to six months. We are now at an ex parte rate of about 32 percent, on average, but that jumps up to 64 percent when you just look at the active MAGI population, and when I say "active," those are people that are currently enrolled and have stayed enrolled during the public health emergency. They haven't been put into the locked-in category. Unfortunately, when you looked at a locked-in category, our ex parte rates fall to almost 1 percent, because they are not returning their paperwork or they are over income.

Our return rate for packets, when we actually have to mail out a renewal packet, we are going to be doing that 60 to 75 days prior to renewal, and we get about a 60 percent return rate for active members, but only a 26 percent rate for that continuous enrollment locked-in population.

We have done a lot of work electronically to update our electronic applications, so people can actually do it more online. You can now do your entire renewal online for our members. So we are encouraging a lot of

that renewal online so they no longer are interacting with their county caseworker and taking up that valuable time.

We have actually updated our renewal packages. We have actually made it easier to complete, and we put it on a landscape so you can see the old information and how you can put the new information right next to it. And members only need to return the pages that have changed, along with the signature page.

And we have also updated our envelopes now. For when the renewals begin, we will have little red lettering on the front of it that says "Urgent. Please Reply." And that way we are hoping to get more attention to those applications.

We have done a lot to do electronic signatures also on our applications, and we have the ability to store those electronic signatures so everything can be done online hopefully.

We have also implemented a return mail center during this time period, so the counties no longer have to open up returned mail. That goes to a centralized processing location, and then that centralized processing location is linked to the ability to look up contact

information with a vendor, so they can make outreach phone calls to try and find out where that individual is, so they can actually update those addresses directly into our eligibility system.

We have done a lot of the waivers that CMS has given us the ability to do, so we can now waive the acceptance of zero income through our ex parte, and we have aligned with our SNAP renewal processes.

Along the way we have also eliminated CHIP enrollment fees and we have waived premium buy-in premiums for our members. So we are optimistic this will help our population get enrolled faster and easier during this time period.

With that I think my time is almost up so I am going to hand it off to the next presenter.

MS. HEBERLEIN: Thank you, Chris. Traylor, can we turn it to you?

* MR. RAINS: Absolutely. Thanks for having me today to talk through Oklahoma's plan as we move forward in next step of the unwinding. I will say going back to just kind of the basics around Oklahoma, we have a real-time eligibility system through our online enrollment platform.

We are not a county-based state, at least for the majority of our populations that are MAGI. For those non-MAGI members, there is still a county presence through our sister agency that conducts the eligibility for them.

We will have two different tracks for our unwinding plan for MAGI and non-MAGI. For the MAGI, we plan to take a 9-month unenrollment approach, and a 12-month regular renewal unenrollment process for those non-MAGI members.

Right now our population, in Oklahoma we have a little over 1.3 million what we call Medicaid Sooner Care in Oklahoma, so we have 1.3 million Sooner Care members. We estimate just south of 300,000 of those will be identified for unenrollment beginning in April. Because of our online enrollment platform we have been encouraging members for the last two years to update their information through MySoonerCare.org. They can go and update their address there, go on with any income information, and then we verify that through a series of data matches.

We have started the communications plans. We have a very robust communications packet for internal as well as our stakeholders and provider community. Since we

are majority non-county-based system it is really important that we rely on our providers and stakeholders to help us get the word out and work with the members in terms of updating their information.

So a lot of the communications packet is example messaging for our stakeholders, our FQHCs, community mental health centers, the free and charitable clinics. For example, it gives them messaging, social media messaging, signage that they can often put in their offices, and directions with how to help the clients access MySoonerCare.org to update their information.

We also did a large media campaign midway through last year, really the focus of which is to let members know kind of what's going on. We did several news spots, have run articles in local papers to let them know that, hey, go update your information. This is going to be really important at some point, and we are going to notify you at the time that the unwinding starts.

So our communications plans regarding how we notify our members is that -- so in about a month we will send out the initial notice, letting them know that, hey, the unwinding is happening, it's going to begin in April.

And then the members will get two other notices that are date-specific to their actual disenrollment date. So they will get a letter to them 45 days prior, and then one again 10 days prior, which is just more reminders to say, hey, if anything has changed go update your information so that we have more accurate information.

We also have a robust communications plan around how we communicate this with our legislators, because we know that as soon as members start losing their eligibility in certain counties and congressional districts that we are going to get calls, and we want them to be prepared for that ahead of time. And so we have a couple of pamphlets that we hand out to our legislators. We are actually drilling data now in various counties, so we can give our legislators and key stakeholders accurate information down to their county level and district level as to how many members will be impacted, so that they can be prepared to be able to respond.

We have also submitted our operational plan to CMS for review and consideration. We have also posted that to our public website. The plan in Oklahoma is we are doing this very intentional and in a compassionate way such

that, for example, we have around 70,000 members that we have identified that have come on to the program since March of 2020, who have never accessed any services. So we, of course, would target those individuals for early disenrollment into the process, over Months 1 and 2.

Also trying to be very careful with not overloading and frontloading, just because we can and we have 70,000 to 80,000 that have never accessed a service. We still want to spread those out some as to not overload our internal staffing abilities.

We are also creating what we are calling buckets of individuals that we will then, throughout the process, prioritize in terms of need. Just to give you an idea of what that looks like, if you have a -- well, first of all we will combine cases. So if there is a family and they have different circumstances that would put them in a different bucket towards unenrollment, we are combining that case. So let's say Mom doesn't have a severe need but the child does, so Mom might fall in a different month for unenrollment. We are putting that together as a case so they would unenroll at the same time.

We are looking at, let's say if you have third-

party liability coverage and you have no children under the age of 5 in your home, you would be targeted for earlier unenrollment, whereas if you are the opposite, you do have a child under 5 with no third-party liability coverage, then you would be targeted later on.

The very last group going into December is going to be those with high chronic needs that are relying on Sooner Care for high-cost medications, they are in the middle of an episode of care, for example, that we want them to continue. We will identify them, of course, for a later unenrollment to make sure that they have that continuity of services.

We have had a lot of meetings and dialogue with our Health Alliance for the Uninsured, our primary care association, so we can really stay in close contact with those free and charitable clinics as well as our safety net providers to just let them know that, hey, your volume is going to change and this is how it's going to change. And we let them know our plan as it evolves so they can be prepared. They have also been crucial partners in getting that messaging out to the members, so they have played a vital role in the whole process.

As far as internal staffing, I think we all know that we expect the volume of appeals is going to -- we expect to maybe double throughout the unwinding process. And so we have already begun staffing up in our Eligibility and Coverage or Member Services Department so that we have not only more call center representatives but also more managers. In Oklahoma it is our managers that kind of handle all the appeal work and pulling the paperwork that will eventually go to hearing with ALJ.

Speaking of ALJs, we have entered into memorandums of understanding with sister agencies to have shared resources with their ALJs, so that we don't overload the one or two that we have internally. But will be prepared to handle that level of appeals volume as it comes. We know a lot of legal organizations are encouraging members to appeal the decision regardless of merit, and so we want to be prepared for that and be able to respond timely.

Something else that we are doing is we have an open request for proposal on the street to procure a comprehensive solution that can help us care coordinate members and refer them not only to the health exchange,

which we will send our file to the Marketplace, but also aligning them with those free and charitable clinics, safety net providers, and have a closed-loop referral so that we get a signal back letting us know that that member was able to access services through another provider and be able to continue their care, and make sure that they have all the resources available that they need in terms of records and continuity of care from the Health Care Authority.

We have also identified ways to use our health information exchange throughout the state to update address information. One of the kind of complications in the consolidated budget that came out was the requirement that states use a vendor to update all of that and verify address and contact information. We all know as a state you can't quickly procure a solution to do that, and so we are trying to rely on our health information exchange to make sure that, hey, when a member goes to a physician, for example, they are prompted to update their address, and we can receive that information from our HIE. So we are quickly trying to make sure that we are in compliance with that requirement of the act.

One of the other -- and my colleague mentioned this, the new FPLs. We know that those come this time of year, so we are doing a lot of systems testing within our online enrollment platform to make sure that we are compliant with those new FPL standards. We do expect the number of potentially unenrolled to go up as we implement those, but we just need a couple of weeks to do that to ensure that everything is good to go.

As part of our open RFP, in addition to the closed-loop referral, we are also asking for a vendor to bring a level of data analytics and datasets that don't currently exist in our state. So that as we talk about those buckets throughout the 9-month unwinding period we can further refine the data that we are using to identify those members, and also help to identify other referral sources for them.

There is also an evaluation component to that request for proposal that would have them continually evaluate how we are doing in the unwinding process so that we can quickly pivot if we need to or address things as they come up rather than kind of get through the process and do an overall evaluation of how we did. We will

include that as well. We want to make sure that we are staying on top of things, not missing anything. As we go through this process, we know how crucial these services are to our Oklahomans.

I believe I have covered everything so I will defer to our next panelist.

MS. HEBERLEIN: Thank you, Traylor.

Sandie, can we turn it over to you?

* MS. RUYBALID: Good morning. Thank you. Thanks for having me.

So in Nevada, we're doing a lot of similar things that my colleagues have mentioned, so I won't repeat all of those, and maybe I'll just highlight the contrast.

So in Nevada, we are a state-based eligibility system. We don't have county eligibility. We also have a state-based exchange. So that's a little bit different.

Our planning and communication has been going on for quite some time. We also have our unwinding plan submitted to CMS and posted publicly on our website.

We are an Option C State. So we will begin redeterminations in April, with a 12-to-14-month runway.

The goal in Nevada is to keep as many -- well,

everyone's goal, I'm sure, is to keep as many insured as possible. We do have over 900,000 on the Medicaid program in Nevada at this point.

We did check some data points, and of those that we believe will be over income, we did check and see that 86 percent of those have been accessing services. So that's a bit of a concern with continuation of care, making sure that they do have coverage after we do the redeterminations.

What is unique in Nevada is we did not do any major system updates to our eligibility system. We pretty much kept it status quo, continued redeterminations, as Chris from Colorado mentioned. We just didn't take negative action. If they did not respond, we just extended their eligibility another six months and then checked again.

So that spread the work out, which is a good thing in that when we do begin, we will do it based on when the renewal date is due, and we will just continue month by month, working through those to help with the caseload.

We have similar problems, as my colleagues, as far as staffing goes. We have staff shortages. The

training runway for eligibility workers is really long. Many quit very soon after being trained, so that's a concern.

Some other key points in Nevada. So, for communications, we've been communicating for quite some time about updating your address, and so one of the opportunities we found is that it's not as easy as one would think to update your address with the Medicaid program. You would think you could just update your address. No, you can't. You have to call. You have to come into the office, or you have to have a login to a website. And so what we decided to do as a project team was create a web form, a very simple web form that we posted on our website, blast it out everywhere with QR codes. And anyone can submit this form, and it goes to an email that is a dedicated address correction unit, like a return mail unit, as Chris also mentioned. So we've been focusing a lot on that for the last several years, it feels like.

And so our communications has shifted now to more the redeterminations are coming, here's how you get coverage if you're not qualified, please return your

paperwork, those sorts of targeted messages. So that's exciting.

The recent FCC ruling on Monday is also very helpful for us in relation to text messaging, going back to thinking that you could text message members without having consent wasn't actually the case, and so we had to get clarification.

Nevada is also a managed care state, and so 75 percent of our members are enrolled through a managed care plan, and we've relied heavily on them because they have the marketing budgets. They have the ability to use things that states aren't able to use, like TikTok and non-traditional communication methods. And so we've relied heavily on them for that.

Our Phase 2 communication plan is rolling out now. We will do weekly communications over social media, email, any method we can find to make sure that the audience is receiving the messages.

Another technique we've decided to use is a short survey that the managed care plans will provide to their members, just four questions of do you know that redeterminations are coming, do you know that you can

update your address, here's where you do it. So it's both educational and inquisitive, and we can then target on where the weaknesses are in our campaign to try to gear up and make sure that we're covering everything.

The other thing in Nevada that we found as part of this project -- so, in Nevada, we have our sister agency, the Division of Welfare and Supportive Services that actually determines the eligibility for us, and then the Medicaid program administers the state plan and benefits. And so through that, when you have it separated, there's things that happen that you aren't quite aware of, and so we found a lot of opportunities to make things more streamlined, better. We were on the watch list for ex parte for a little bit. So we had the opportunity to increase our ex parte percentage using more automation. So that's really exciting because we just implemented, had our first run in December for the fully automated ex parte, and the percentages were good. So that's exciting, but we are watching that very carefully to see what we can do to increase it as much as possible, because in those cases, a case worker doesn't have to intervene. And then you get 12 months of eligibility, and you can move on to the next case

that you need to work. So that's really exciting.

We do have reporting all covered, and we do have dashboards planned to be publicly posted to monitor our progress through this, which is really exciting.

We are waiting further guidance as a result of the passage of the CAA to refine our dashboards, to meet all of the requirements, and make sure we're covering all those bases.

So I think that pretty much covers what's happening in Nevada. So I appreciate the opportunity to share that and happy to answer any questions when we get to that point.

MS. HEBERLEIN: Thank you, Sandie.

With that, I'll turn it back to Kisha to facilitate the questions.

VICE CHAIR KISHA: Thank you. Thank you for this. We always appreciate hearing from states. We've been monitoring the public health unwinding for quite some time and hearing really the kind of on-the-ground what's happening, it's really important. So thank you all for taking the time to join us. I know for some of you, it's still a little early.

MS. RUYBALID: Yes.

[Laughter.]

VICE CHAIR DAVIS: So I will open it up to Commissioners for comments and questions for our panelists.

Tricia.

COMMISSIONER BROOKS: So, Sandie, I don't think you mentioned the FPLs. Are you also getting in the 2023 FPLs before you get started on an initiating renewal?

MS. RUYBALID: Yes.

COMMISSIONER BROOKS: Anyway, I should have said to start with, thank you all. I really love hearing the details of this plan. This is something I've been following extremely closely, and I think you've touched on many of the high points.

Obviously, people are well aware of staffing challenges that both Medicaid agencies and call centers are encountering. Can you each tell me what your plan is for follow-up if someone doesn't respond to that initial renewal?

So let's say the ex parte is not successful. You send the pre-populated renewal form. If you don't get it back, do you have a plan for doing any kind of follow-up,

preferably through other non-mail communication modes?

MR. UNDERWOOD: So I'll start. In Colorado, we have a -- I didn't get into the details, but we have a pretty large communication plan and toolkits for our stakeholders, managed care partners. We have started that outreach already with update-your-address campaigns, and then with our managed care partners, when the renewal packages go out, we actually are sending ourselves from the Medicaid agency, we're going to send another notice through our enrollment broker to all our members who get those renewal packages saying you should have received this in the mail, make sure you take action. Then our managed care partners two weeks after that, have another follow-up where they are reaching out to all members to follow up. And then they will -- two weeks prior to someone being terminated, we are asking them to do phone calls to those individuals.

They're getting weekly data. We've constructed new data feeds to our managed care partners. So they actually get a running list every week of everyone who's completed the application process for that month and who is still outstanding and the reasons for denials. That way,

they can help people also if they get denied for over income transition to the exchange. We have communication toolkits for them to use for people that are over income versus people that are under income but haven't returned the package yet and are about to be terminated. And we've given them very different methodologies of how they can outreach through text, calls, and mailing. But we are hopeful that they'll make those phone calls two weeks prior to someone being terminated who hasn't returned the package yet.

MR. RAINS: I will say Oklahoma is very similar. We have a 60-, 45-, and 10-day letter going out in advance of the individual's unenrollment date. Mixed in between that, we already do a lot of messaging by text and email. So, when they sign up, they check a box that it's okay to communicate with them electronically.

And prior to the FCC ruling, that was important. So we did have that ability to do that with a large swath of our population to send them robocalls and texts and emails, and now, as my colleague from Nevada mentioned, with the FCC ruling, it's going to make it a lot easier moving forward as well.

MS. RUYBALID: Yeah. In Nevada, we don't have quite the resource pools to do all of the exciting things that my colleagues are doing, but again, like I said, we are a managed care state for the most part, and managed care plans are very motivated to keep members enrolled. So we do leverage that tool.

We do provide the managed care plans with lists of people who are up for redetermination, and they do some robust communication before that redetermination is due.

And we are working on the new required T-MSIS termination codes. Those will be passed to the managed care plans through the 834 transactions, so that they will have additional data points that they can work from and maybe do outreach afterwards. But we're still in the process of implementing that.

COMMISSIONER BROOKS: And not to monopolize the conversation, but one more question. Sandie, I love the fact that you've committed to posting all of the unwinding data that's required in putting the dashboard up. I wonder if Traylor and -- sorry -- Colorado -- Chris, Chris -- if you guys could talk about your plans to share data with the stakeholder community.

MR. RAINS: I'll go first, and I'll be honest, I don't know that we are. I was taking notes, as Nevada mentioned that, because I would like to share that level of transparency, and as we get that the successful bidder for the RFP that we have open, we'll have good reports that we can do that. And I know that our legislative community is also very interested in our monthly progress. So it's on my list now.

MR. UNDERWOOD: Yeah. We are planning to post monthly data. We're using the CMS template and turning that into plain language for our stakeholders, and then we're going to post that, and hopefully that data will then reconcile to what CMS posts on a quarterly basis.

COMMISSIONER BROOKS: Excellent. Thank you so much. We really appreciate all the work you're doing, and we know it's going to be a busy period for you all, so thank you.

VICE CHAIR DAVIS: So you can all start thinking about your kind of magic wand, what-you-need-from-MACPAC question, because that's something that always comes up from the Commission.

But, Chris, you touched on it a little bit around

workforce. I wonder if you could all comment a little bit more on just workforce implications, people that have been hired that have never done redeterminations before because it's been so long. You mentioned a little bit about the competitiveness in the market and trying to find folks, and so how workforce is affecting this process.

MR. UNDERWOOD: Yeah. I agree. That's a good point, and we've discussed that. We have lots of workers who have been hired during this process who have never had to process a denial for a member, and when they don't turn in the paperwork, it's okay, right? They aren't following up with the member. So we have a lot of verifications that we found over the last few months who have not been worked. The verifications haven't been entered. So we are trying to get our county partners to catch up on those verifications before the unwind begins.

And that's why we're doing training with our county partners. Now we're going back and doing the continuous improvement and training with our partners to get them up to speed and get ready for that application processing.

But, yeah, it's not just workforce for the

counties. It's also, as we talked about a little bit, touching on appeal officers, where we need to staff up from the increased appeals we expect and have hearing officers. So that's happening at the state level. And hiring those individuals as temporary roles during the unwind period is going to be very difficult. We're hiring staffing agencies to help us do that. In this time of high employment, hiring people for temporary jobs for one year while we do this unwind is difficult, especially at the wages that we're trying to pay. And we're just trying to keep up with the minimum wage in our states that are growing pretty quickly.

MR. RAINS: We might be a little more unique in that our rules engine processes the entire application and gives us a decision, and so our call center representatives are more focused on the appeals process, gathering that information, and handling calls that come in. And we've again addressed the ALJ shortage through shared services with some of our sister agencies.

We have been, of course, in constant communication with our Tier 1 call center through Maximus to make sure that they are doing what they need to through

higher wages and incentives to get the level of the Tier 1 call center representatives needed.

We have been able to successfully add several managers within our ECS division that can handle kind of the appeal work, but we are also -- we have in the future, Oklahoma's transitioning to managed care and will be making those large awards in the next six months, which we know that's going to pull from the same limited workforce that we already have for those types of services. And so we kind of already have our eye on what happens when they start taking -- those managed care entities start taking our customer services representatives throughout the next nine months.

MS. RUYBALID: Yeah. So, in Nevada, we have the same challenges. I think what might be unique is that we didn't do a large amount of ex parte prior to December, and so our first run, about 50 percent of the renewals that were due that month made it through the ex parte process. And so we're hoping that it might level out a little bit. We do have almost a 50 percent vacancy rate for our case workers. So we didn't reduce the number of case workers because of ex parte, because we just don't know what that's

going to look like quite yet. So we're hoping that that will help mitigate the staffing shortages in some way for our state.

VICE CHAIR DAVIS: Thank you all.

Martha.

COMMISSIONER CARTER: Thanks for your presentation.

This is a question that's a little bit in the weeds. My understanding of the FCC communication was a caution not to contact people by phone or text, if they haven't given permission, which means bumping up the numbers you have against the reassigned number database. And so I wanted to know how much of an operational hassle that really is.

MR. UNDERWOOD: We have interpreted that communication to actually be very positive for the state. The state is not considered a person in that definition. So all we have to have is a phone number on the application to have consent to begin text messaging and calling our members.

That translates also to your managed care entities, and so they may need to abide by rules when

someone requests to be disenrolled or not contacted through text messaging or robocalls anymore. But I think for the most part, we have found that to be pretty helpful in our outreach efforts.

MS. RUYBALID: Yeah. I think Nevada feels the same. We were quite relieved, because prior to this ruling, we were of the impression that we had to first get expressed consent and also manage un-consent or whatever you would call that, not wanting to be contacted anymore. Now it's kind of the reverse where you only have to manage if they don't want to be contacted because it's considered consent if they provide a phone number on the application. So it's a huge administrative burden relief for us in Nevada as well.

MR. RAINS: Same for Oklahoma.

VICE CHAIR DAVIS: Thank you.

Melanie.

CHAIR BELLA: Yeah. I want to reiterate the thanks for being here.

For MACPAC, we are always trying to figure out what the best role for us is, and so in the beginning we were trying to hear from states and trying to hear from

others and heard a lot about a date certain, a bunch of stuff that's already been resolved. And so now we find ourselves trying to think about what do we do once eligibility restarts, and what sort of data will be available, and what sort of -- what is our role for understanding if something is going awry in the guise of like we're trying to protect access for people and monitor transitions of coverage.

How would you advise us to think about what's realistic in terms of what you will know when, and how will you know when you might need a hit pause or when there might be some problems? Like, how are you guys thinking about that so we can understand what's appropriate for a body like this and how to have reasonable expectations for what you'll be able to know when?

MR. RAINS: So I'll start. You're right. A lot of the things we've asked for, we've gotten, and so that's been great. One of the unknowns for us -- and I imagine other states -- is we sent our files over to the marketplace, but we don't get a response file. We don't know if they got it or not, and so it would be nice to be able to get some kind of a response file from that so that

we can have that assurance that they were able to obtain coverage through the marketplace.

MR. UNDERWOOD: Yeah. We're a state-based marketplace, and we have the same problem.

MS. RUYBALID: Exactly.

MR. UNDERWOOD: Our state-based exchange does not want to share information with us necessarily of who gets enrolled. That could actually have some HIPAA concerns on their side. But we plan to track it in the future through our all-payers claims database potentially to see where people landed after disenrollment from Medicaid.

But we have monitoring dashboards for our eligibility system and for our counties that are populated in sometimes real time, sometimes weekly, and so we'll be looking and monitoring the progress. And if a county gets in trouble, we have a statewide overflow processing unit so that we'll be able to help out those counties.

But, yeah, we're monitoring through our normal dashboards that we've created and through the CMS data that they're requesting, and hopefully, we'll be able to react when there's a problem. But once again, there's only so many of us. If we get really far behind and there's a big

backlog, it will take quite a while to clear out, and quite honestly, we have backlogs already, right? Probably, everybody already has a backlog of some pending applications or actions that need to be taken during this three-year period and when it's been slow.

So we are going to have pending. We're going to have backlogs, and we just have to figure out how to work through that one county at a time.

MS. RUYBALID: Yeah. And I would say we also have a state-based exchange, and one of the first questions I asked was for that metric, how many of the account transfers that we transfer to them actually enroll and get coverage, and they don't have that data point. So we're working towards that. So that's another example of cross-coordination where we found opportunities to get better information and smooth this process out.

I would say in Nevada, eligibility is not real time at all. So there is going to be a lag in the data. So we have dashboards, but they're not going to be populated every day, you know, real time. It's going to be a data lag of a month or two before we might see some problems that happen.

We do have business process monitoring behind the scenes where we can see if the phone queue is backing up or if applications are backing up, but the impact of the unwind is not going to be something we can react to in real time, unfortunately.

VICE CHAIR DAVIS: Thank you.

Darin?

COMMISSIONER GORDON: Thank you all for taking the time.

A quick question and it's related to the unwinding, but it's going to be a little bit of a jump. As you think about this rapid change -- I mean, granted, it's over 12 months, but it is a pretty rapid change going through the re-verification process -- are you all thinking about how you're looking at how the risk pool is changing, particularly for full risk, for like health plans or ACOs that are in full risk arrangements? Are you all looking at that at a more real-time basis, given that you could significantly change the risk pool? I forget which one of the states was talking about looking at the low utilizers to be in that first several tranches. If you're taking those out of the picture, it could be a matter of months,

and the risk pool looks very different. But I'm just curious about how you all are thinking about that and how you're monitoring that and working with your actuaries.

MR. RAINS: Yeah. The timing for us was perfect since we're going to manage care now and the announcement came around the time that we're getting ready for our PMPMs, and so we were able to quickly adjust and have our actuarials pull those 300,000 members out of the calculation so that we have a more accurate PMPM once we go live.

COMMISSIONER GORDON: Great.

MS. RUYBALID: Yeah. So, in Nevada, we are doing it based on when someone's redetermination is due, and we're doing the one ninth per month. So we are not doing an approach as Oklahoma described, where we're parsing out people based on categories, things like that. If you're due, you're do, and so we're hoping that that spreads out the non-utilizers across the year, hopefully. That's what our managed care plans hope, I'm sure, as well.

MR. UNDERWOOD: Yeah. We actually have a meeting on that this afternoon to talk with our rate setters of how the unwind may impact their managed care rates, because

those are due in three months, prior to the unwinding even begins for the new year. The new state fiscal year starts July 1st. So they have to make some estimates based on our locked-in population.

Luckily, we've been doing renewals during the whole period. So we know the population that is potentially going to fall off and the reasons why they're going to fall off, and so they can take that in consideration when they're forecasting the rates.

COMMISSIONER GORDON: Super helpful. Thank you.

VICE CHAIR DAVIS: Thank you.

Heidi.

COMMISSIONER ALLEN: I thank you so much for this presentation. I first want to say I was just very impressed at how thoughtful you all have been and just really appreciate how every question, it's clearly something that there's been a lot of care put into planning.

I was working in Oregon as a social worker when they had a big disenrollment episode related to some legislative policy change, and I was a social worker at the time. And there were very quick repercussions in the

safety-net system of layoffs and some clinics closing quickly, because suddenly they had so much less revenue.

Particularly, in a state like Nevada, where you have a pretty significant population of people who are probably over income but are using care, are you thinking at all or working at all with your providers to think about how sudden disenrollments of tens and thousands of people could impact the delivery system, particularly like in rural areas?

MS. RUYBALID: That's a great question. Thank you.

We are obviously, of course, thinking about that in Nevada. Not only do we have a staffing shortage, we have a provider shortage, particularly in the rural areas. So there's that factor as well.

We are trying to mine the data and figure out of those who are over income, how many of those actually have employer-sponsored plans on the books. We manage third-party liability and coordination of benefits, and so we're trying to figure out is it really that grim of an outlook if 200,000 people are taken off Medicaid. Maybe they've gotten jobs. Maybe they've gotten employer-sponsored

insurance. We've had people tell us, "I didn't even know I still have Medicaid. What are you talking about?" So there could be a percentage that fall into those categories, but we're still looking at that data. And it is definitely a concern.

MR. RAINS: Yeah. And I'll touch on we've been working closely, as I mentioned, with our Health Alliance for the Uninsured, our free and charitable clinics who -- they actually -- we implemented expansion about a year and a half ago, and they saw kind of the opposite effect. They had a lot of clinics who were like, oh, gosh, we lost a lot of our clients. And so they've diversified their business and are outreaching in other populations, but they are also ready to kind of receive some of these folks back.

I don't know if we should have been surprised, but we were surprised to see a lot of the folks who are no longer eligible, their incomes are well over 300 percent of the FPL. And so income-wise, theoretically, there should be some that can go to the marketplace or obtain other insurance if they haven't already through an employer. But, yes, close contact again with our federally qualified health centers and other safety network providers too.

MR. UNDERWOOD: Yeah. I think we're very similar. We've estimated -- we found the FPL -- about 18 percent of our locked-in population actually has another coverage already. And we also have toolkits out there for our providers to use as talking points when they're actually face-to-face with members about insurance and how to maintain their continuity of coverage and they can use the exchange or other employer insurance benefits once they roll off Medicaid and CHIP.

VICE CHAIR DAVIS: Thank you. Jenny.

COMMISSIONER GERSTORFF: I have a few questions, and I'm an actuary. So I will disclose that up front. That would very actuarial.

Darin asked about how you're managing risk with your managed care plans, and you mentioned rate setting. But I just wanted to check also if you have any special plans for risk mitigation during the PHE unwind. That's my first question, and I'll pause there, and then I'll add my other two.

MR. RAINS: I will defer since we're still fee-for-service. So I'll defer to my colleagues.

MS. RUYBALID: So, in Nevada, we do have the

medical loss ratio is one way to mitigate risk, and we did have a significant refund due back to us during the COVID period from our managed care plans. I want to say it was $250 million potentially that we got back in capitation because it was not spent on medical payments. So that's one tool we use in Nevada.

I don't know if Chris has anything to add there.

MR. UNDERWOOD: Yeah. I don't have a lot of details on that.

I call them "managed care plans." In Colorado, they're not at-risk-based managed care plans. So our capitation rates are actually -- our population that's covered by capitation is actually quite small. So I don't have those answers for you. I'll wait till I talk to my managed care folks this afternoon.

COMMISSIONER GERSTORFF: Okay. And then, I think, Chris, you had mentioned something about waving premiums or something about CHIP and your buy-in programs, and I wasn't sure if that was waiving or extending the grace period or the premiums themselves.

MR. UNDERWOOD: Yeah. We used to have -- prior to the PHE, we had a CHIP enrollment fee for our members

and annual fees they had to pay. We've actually canceled those now during the public health emergency. So those will not come back at all during the unwind period and for the future. So that will help those families stay enrolled.

And then we have premiums for what I call a "Medicaid buy-in program." It's a Ticket to Work program. We have suspended those premiums since March of 2020, and we will continue to suspend them all the way through the renewal process at least one year after the public health emergency. And that will help us get through the renewal process and get those members on the program. And then we'll start the premium collection process, once we're through all this and begin again. Thanks.

COMMISSIONER GERSTORFF: Thanks. That makes sense.

And I don't know, Traylor or Sandie, if your states are considering anything like that.

MR. RAINS: We're a CHIP expansion state, so we don't have a separate CHIP where we would charge those to begin with.

MS. RUYBALID: We did consider that. We just had

a change in governor in Nevada, and so some of those policy decisions have to be reconsidered because of the transition period. So there was a thought just to try to keep as many children insured, but we are looking forward to the continuous eligibility requirement for children that was passed. I think that will be helpful as well on the Medicaid side.

COMMISSIONER GERSTORFF: Thank you. That makes sense.

And my last one, for managed care, do you have any financial incentives or disincentives planned with your health plans for compliance with your communication plan or other metrics?

MS. RUYBALID: I'll go. I wouldn't say we have disincentives. I would say again that managed care plans are the most motivated to keep members enrolled, and the way to do that is to communicate. So it's kind of a built-in incentive that we don't have to manage, and we've been -- our managed care plans have been incredibly helpful, cooperative, innovative, and really, I think we've leaned on them greatly to help us through this, because in Nevada, we're a state that doesn't have state tax. We don't have

the resources that some of the other states have to do these media campaigns and all of that. And so we rely on our managed care plans quite extensively, and it's been very successful.

MR. UNDERWOOD: Yeah. We do have incentive pools that our managed care entities can use for this project. They've provided us communication plans. We have a whole toolkit and memo series out to our managed care plans of how to use data, how to do communications. Here's the texting guidance. Here's how to -- here's the communication templates for our managed care entities. That way, they're using member first, and we actually provide our managed care with the member's choice of how they like to be communicated to and requesting that they use those member preferences.

So we must have weekly meetings with our managed care entities on these outreach programs, and we're providing them as much templates and as much handholding as we can through the process.

COMMISSIONER GERSTORFF: That's great. Thank you.

VICE CHAIR DAVIS: Thank you, Jenny.

Just last question for each of you -- and I really want to thank you for your time here and for your transparency, and we'll go back to that kind of magic wand. Are there things that MACPAC could or should be advocating for you in this process? You mentioned a lot of things you've asked for that you've gotten. Are there other things on that wish list?

MR. RAINS: I can't think of any at the moment.

MS. RUYBALID: Yeah. I -- oh, go ahead, Chris.

MR. UNDERWOOD: I would not say during the unwind process, but we would like people to consider some of the waivers and some of the flexibility CMS has given us during the unwind process to become permanent.

When you have a homeless individual who has zero income, there's no reason you should be trying to re-verify that through an application package and a signature. That should be able to just go through ex parte, and if there's no hit, that should be acceptable permanently. So we're optimistic to have the ability to make those permanent in the long run.

MS. RUYBALID: Yeah, I agree.

COMMISSIONER HEAPHY: This is Dennis. I've got a

question.

VICE CHAIR DAVIS: Go ahead, Dennis.

COMMISSIONER HEAPHY: I was wondering, are there any special precautions you're taking with people with disabilities in your states to ensure that they don't lose enrollment?

MR. UNDERWOOD: Yeah. I didn't touch on that, but our partners who help us with doing the assessments for individuals living with a disability, we are giving them special lists. We are looking at their membership and making sure they're doing their own outreach and their own work with their caseload to make sure people know they actually have to return the applications. So there is the special outreach directly to our case management agencies.

MR. RAINS: It's very similar in Oklahoma.

COMMISSIONER HEAPHY: Thank you.

And is that also true in Nevada?

MS. RUYBALID: Yes. We are working with our sister agencies as well, aging and disability services, and community partners to make sure that all the communication is out there and any assistance that's needed to get that paperwork returned is out there and available.

COMMISSIONER HEAPHY: Thank you.

I guess the last question is regarding folks with limited English proficiency. What are you folks doing to address the needs of these populations?

MR. RAINS: Our communications toolkit has the various messaging in multiple languages. We're able to identify -- I mean, the predominant second language is Spanish, but in other areas, we have a strong Vietnamese population. We've created various communications to be able to outreach specifically.

COMMISSIONER HEAPHY: Thank you.

MR. UNDERWOOD: Yeah. We have similar. I can't remember. I was just looking at one of our websites. I think we're up to 10 languages now in our communications, our sample templates that we can use for member outreach.

MS. RUYBALID: And we're similar in Nevada.

COMMISSIONER HEAPHY: Thank you.

VICE CHAIR DAVIS: Thank you all. Any parting thoughts from our guests before we --

MR. RAINS: I appreciate the opportunity. Thanks for having us.

MR. UNDERWOOD: Yeah. Thank you for having us.

MS. RUYBALID: We appreciate being able to share what we've done in the last few years. I'm looking forward to starting the process.

VICE CHAIR DAVIS: We appreciate having you with us again. We really appreciate the on-the-ground perspective and the work that you've been doing. We know you guys have been working tirelessly over the past few years, so we appreciate that.

We'll transition now just to comments amongst the Commissioners. If you all have any questions or comments, and Martha will help us. Thank you for your time.

CHAIR BELLA: I'll just say kudos to them for the public-ness of what it seems that they're trying to do and kind of trying to align it with the FPL changes. And I need to understand, Tricia, what's happening with SNAP. Like, thinking about all those things, I thought that they really were very forthcoming with kind of what's good and where their challenges are, and I thought that was really helpful to hear.

I always say this, but I'd like to hear from 10 more states. I'd like to find a couple that aren't as confident, I think, in kind of being ready to go.

And, Martha, I don't know if you have any insights on what -- I'm not asking to throw any states under the bus, but is what you heard from these states what you expected to hear when you worked with them, or do they seem kind of above where some of the other states are? Can you give us some grounding of where they are?

MS. HEBERLEIN: I mean, based on the conversations we had over the summer as well as like the plans that we looked at, I think the states seem to all have a plan in place, and I think from what we've seen in terms of the different approaches, like Oklahoma is starting with certain groups and putting off other groups, whereas like other states aligning it based on the renewal date, it seems as if they have put a great deal of thought into their plan and have been given a fair amount of guidance and assistance. We heard from all the states we spoke to that CMS has been great and open and helpful, which is nice to hear.

I think where it comes down to is implementation. You heard that there's staffing issues. There's systems issues. It's, you know, the best laid plans. You have to see what happens. So I think as they start to implement, I

think that's where we might see that things will need to shift or that the systems aren't as functional as they thought they might be.

We talked a little about the systems artifacts where they have to test their systems beforehand. So I think states are doing -- and CMS are doing as much as they can to prepare, but I think it all remains to be seen as how well it goes once they have to hit the start button.

VICE CHAIR DAVIS: Thank you.

Tricia, did you have any comments?

COMMISSIONER BROOKS: I think Martha is absolutely right that there will be surprises. There always are. So the best laid plans are simply that, and the question is what's going to be the rapid response and hitting that pause button that Melanie mentioned. It's a little concerning where the data may or may not be and whether that's available to others that can help convince decision-makers that hitting that pause button is really important.

So it's going to come down to a state-level basis. There's so many components that go into whether there's high risk or low risk in a particular state.

It was encouraging to hear Nevada -- and I think Colorado talked about working to improve their ex parte rates, because if we can really nail ex parte, then we eliminate a whole bunch of administrative burden, both on state agencies and on beneficiaries. And that really should be a goal for everyone. You'll never get a hundred percent rate there.

But I also think that not all states are being this transparent, and some states didn't have much posted information about their plans prior to the Consolidated Appropriations Act. Maybe we'll start to see more of that.

I am particularly concerned -- these were all expansion states. I'm particularly concerned about the non-expansion states, and there's going to be a lot of parents who lose coverage and have no place to go because they're still under a hundred percent of poverty. And just be aware that in seven of the non-expansion states, they base their eligibility on dollar thresholds that are not adjusted on a periodic basis.

Now, we've seen a couple come through that they have made some adjustments, but think about that. I use Tennessee as the example. Tennessee TennCare was at a

hundred percent of poverty at one point, but it is based on a dollar amount. In the new FPLs, they will go from 93 percent -- they've already seen that kind of a drop -- to 83 percent equivalent FPL level. So you've got a compounding problem in those states as well.

But this was encouraging. I wish I could hear from not 10 more. I want to hear from 48 more. Thank you.

VICE CHAIR DAVIS: Thank you, Tricia.

To that end, Martha, do we have anything specifically on the non-expansion states?

MS. HEBERLEIN: Not off the top of my head. I mean, I know, to Tricia's point, we enlisted a number of other staff to help me scan state websites to see what they were producing, and then we stole some stuff that Tricia and her colleagues at CCF had looked at. We didn't see plans in all states. I think in some cases that may be the case that they were waiting for a date to release it, and we did hear that from some states.

So we will see. I think we are going to try to keep looking for more stuff, and again, steal what we can from Tricia and others.

But we did not look specifically at non-expansion

states, but that is something we can definitely, as we start to pull those going forward, we can definitely look at them more closely.

VICE CHAIR DAVIS: Thank you. Fred?

COMMISSIONER CERISE: Melanie, you asked the question, and I'm not sure we know yet what the early warning signs are going to be, what those triggers look like, and then what our threshold to say something would be. And I think it's something worth just thinking about, you know, what should we be looking out for and then how would we want to respond to that.

COMMISSIONER BROOKS: I think there are two things on that. I think first of all call center statistics are the -- and I have said it so many times -- canary in the coal mine, right. When those call volumes start going up, if people aren't getting the help that they need, they potentially will fall off because they are confused, they don't understand exactly what they need to do.

I think the other thing is that we need good feedback loops in each of the states. We need the community of frontline organizations, primary care

associations, navigators, and assisters, all huddling on a regular basis in the early weeks and months, because they often can identify those system glitches and recurring problems before they show up in the data.

So we encourage stakeholders to work together in partnership, not in a silo, because, you know, you need to know that problems are more widespread than these outliers. And so trying to funnel that kind of information up where we know a group of people are trying to compile and assess that early feedback, that is what's going to help us in that first couple of months, and before we start to see the data flow.

VICE CHAIR DAVIS: Thank you, Tricia.

Martha, remind us where we are going next, and do we have plans to include any of those voices in our next round of following up?

MS. HEBERLEIN: Yeah. So I'll be back in future meetings. Yeah, so I think the idea among us is to take a look to see what else has been released, both from the state level, and as was alluded to on the panel, that we anticipate additional CMS guidance specifically around the reporting as well as some of the outreach activities that

they need to do in response to returned mail. So we will be coming back and giving you updates sort on the state of play and what we have heard and what we have seen from states. And our idea is to reach out to some of those groups, both the groups that represent the states. You know, clearly the states themselves are going to be busy, so I don't know how much we will be able to get them directly. But talking to the associations that represent them for sure as well as advocates and people on the ground, as Tricia mentioned, to try to cover all the bases.

VICE CHAIR DAVIS: Thank you. Any final comments, Dennis or Heidi, online? Go ahead, Heidi.

COMMISSIONER ALLEN: Yeah. I am really interested in continuing to collect information about the features that people hope to keep and maybe if we could put together recommendations related to what seemed to really help. I thought the example of somebody who is homeless was a really good one. Are there things that we can learn from this that can inform reenrollment efforts in the future? That's something I would be interested in having more conversation about.

COMMISSIONER HEAPHY: And then for me, if the

states are having problems with staff I am wondering if the advocates are having staffing problems as well. How do you work with these organizations to find out what their staffing issues are, because it's got to be a nightmare for them as well. Has that been, for them, do you know?

MS. HEBERLEIN: Do you mean like application assisters and navigators?

COMMISSIONER HEAPHY: Correct. Yeah.

MS. HEBERLEIN: Yeah. I don't know, but that's a good question because, you know, some of those folks are paid positions. Not all of them are always paid positions, so that's a good question. We can see if we can find out some more.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Sorry, Dennis. I was just going to say, I mean to Fred's point I do think we are going to struggle to figure out what our threshold is for getting involved, and we are going to have to have realistic expectations about lags and about those things. So I think focusing on the things that we can know, like Tricia, the call center, yes, and trying to remind ourselves. Like for example, I can't imagine that we are ever going to go after

a specific state and say like the state of X should hit pause, but I can imagine that we are going to be continuing to have some principles that we are working with CMS on because as Kate reminded me, the Secretary does have the ability to tell a state to hit pause. And so kind of figuring out what those principles and levers are. I think, Fred, to answer your question, is we are probably more communicating with CMS and kind of keeping an eye on things. And I don't know. I'm just putting it out there that it's hard for me to believe we go at a state level. I think we really have value to add with our federal partners, either at CMS or on the Hill.

VICE CHAIR DAVIS: Thank you, Melanie. Sonja?

COMMISSIONER BJORK: Will the states be reporting state fair hearing requests? Is that one of the data points that we could look at?

MS. HEBERLEIN: Yeah, but whether or not that's public. It’s in their report, the unwinding report. So whether or not that will be public I think is still a question. It was not one of the ones in the CAA.

COMMISSIONER BROOKS: Isn't it, though, just those that are over 90 days, as opposed to --

MS. HEBERLEIN: Let me look.

COMMISSIONER BROOKS: -- a straight-up count? And so I think you are only reporting the ones that are overdue. So we won't necessarily see that trend going up in the number of appeals, although states probably have that data.

VICE CHAIR DAVIS: Yeah. Thank you. We are going to transition now to public comment.

CHAIR BELLA: Thank you, Kisha. If anyone in the audience would like to make a comment please use your hand icon, introduce yourself and the organization you represent, and we ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* [Pause.]

CHAIR BELLA: Okay. I do not see any comments.

Any final words from Commissioners, or Martha, or for anything else?

[No response.]

CHAIR BELLA: No? Kate, anything?

All right. Well, then January is a wrap. We will see you all again in March. Thank you all very much

for your engagement. Thank you to Kate and the team. Enjoy the rest of your day, everyone.

* [Whereupon, at 11:57 p.m., the meeting was adjourned.]