PUBLIC MEETING

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Thursday, March 2, 2023
10:01 a.m.

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P R O C E E D I N G S

[10:01 a.m.]

CHAIR BELLA: Good morning. Welcome to the March meeting of MACPAC. We are going to start off with countercyclical DSH. Always lovely to start the morning with DSH.

Welcome Rob and Aaron. Just turn it over to both of you.

Just a reminder to the Commission, we're working on giving some feedback on a recommendation that will come back to us next month for inclusion in the June report.

So I'll turn it to you guys. Thank you.

ADDITIONAL ANALYSES OF POTENTIAL RECOMMENDATIONS FOR COUNTERCYCLICAL DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS

* MR. PERVIN: Good morning, Commissioners.

This presentation follows up on the Commission's discussion of countercyclical DSH policies at the October meeting. Like Melanie said, we're going to be discussing a couple of policy options today for consideration, and then depending on how the Commission decides, we'll come back with a chapter in March -- or sorry -- next month.

So I'll be presenting a bit of background on DSH and also a rationale for why the Commission agreed to move forward with the countercyclical DSH policy during an economic recession. Today we're going to be discussing about whether that policy should also apply to periods of normal economic growth.

So last October, Commissioners asked for some additional analysis on this policy. So I'll lay that out, summarize its effect on states, and also how that option relates to different measures of need for DSH payments.

Then I'm going to turn it over to Rob who's going to summarize the tradeoffs associated with each policy options, before discussing next steps.

All right. So just a bit of background. So I know you guys are all DSH experts, but just as a DSH refresher, total DSH funding is limited at the state level by federal allotments. These allotments vary widely by state and are based on 1992 spending and share no meaningful relationship with measures of need for DSH payment.

Allotments grow annually with inflation, and because of a cork in how DSH allotments work, increases in

the FMAP actually ends up lowering DSH funding for states.

We're also going to be talking quite a bit about the FMAP in this presentation. So as a refresher, FMAPs are determined using states per capita income, and states with increasing incomes get a lower FMAP. All states with decreasing incomes get a higher FMAP. While annual changes may be small, they can grow over time. Also, many states are at the statutory minimum of a 50 percent federal match. So their FMAP can only go up if their income decreases.

We're going to talk a bit about the principles that the Commission used for its previous recommendations on DSH allotments. So in 2019, the Commission made a package of recommendations regarding DSH allotment reductions should they go into effect. Two of the recommendations were trying to minimize disruptions to safety-net hospital financing, namely that the reduction should be phased in gradually, and then they should also apply to states with unspent allotments first.

The third recommendation was around rebasing allotments with different measures of need. The Commission recommended that the reduction should improve the relationship between allotments and the number of non-

elderly low-income individuals within a state. Non-elderly low-income individuals was the Commission's preferred measure of need because it is correlated with uncompensated care and is not affected by state choices about whether to expand Medicaid.

Our countercyclical DSH work started as a response to the most recent recession to see if there was any broader lessons that we could glean for Medicaid policy moving forward. During the previous three recessions, Congress increased the FMAP to help offset declining state revenue and increase Medicaid enrollment. However, for DSH, increasing the FMAP leads to lower total DSH funding, which is why the congressional response for DSH during a recession is typically treated differently.

In 2021, Congress tried something new. Under ARPA, the cap on total DSH funding stayed the same as if there had never been a pandemic, and the increased FMAP was then applied to DSH payments, therefore, creating these increased allotments. This was the first time Congress attempted this for DSH payments, and stakeholders we interviewed preferred this approach compared to other countercyclical DSH policies because it preserved funding

for both hospitals and for states.

So we've seen how the math works on this before, but we're just going to do it quickly again as a bit of a reminder. So under pre-pandemic policy, federal allotments are fixed at $13 billion. Total DSH funding is calculated by dividing the allotment by the FMAP, and that leads to $22.8 billion under pre-pandemic policy. However, when the FMAP increases, like it did during the PHE, that $13 billion allotment is divided by a higher FMAP. This yields over $2 billion less in total DSH funding, so $20.5 billion instead of $22.8 billion.

Now, an ARPA-like adjustment is slightly different. The APA policy preserves the same amount of total DSH funding as pre-pandemic policy; in this case, the same $22.8 billion. Under the ARPA policy, the federal allotment is determined by multiplying that total funding amount by the FMAP, 22.8 times 63 percent equals $14.4 billion in total aggregate DSH federal funding for states.

In October, the Commission came to a consensus that there should be countercyclical DSH allotments during future recessions modeled on ARPA. This is because there's a higher need for DSH payments because of more uninsured

and Medicaid enrollees and decreased state revenue to finance DSH payments. Because FMAP increases during recessions are typically much larger than during periods of normal economic growth, the disruptions in total DSH funding tends to be substantial, and therefore, it's particularly important to apply countercyclical policy in these instances.

The Commission also agreed that this was a good countercyclical response because the FMAP increase tends to be much larger changes than annual changes -- oops. Sorry. And finally, when compared to status quo policy, this policy increases federal funding for all states when they need it most.

In addition to the consensus surrounding ARPA approach to DSH allotments, there was a consensus for a conforming change to our previous countercyclical FMAP recommendation and a technical change to streamline allotment calculations by removing the requirement to compare allotments to Medicaid spending, both of which would help states and providers during an economic downturn.

So in October, the Commission debated the merits

between applying an ARPA-like policy to periods of normal economic growth and debated the merits between these two policy options. The Commission asked for more information on state effects and federal spending over the long term.

In your reading materials, staff assessed both options based on the principles that were articulated in previous DSH recommendations, namely avoiding disruptions in DSH hospital financing and improving the relationship between allotments and measures of need.

Okay. So on to these additional analyses that staff executed.

So this figure shows the disruption to total DSH funding under status quo policy from 2014 to 2019, and under the status quo, DSH funding increases slower for states with increasing FMAPs.

The green line, that shows the rate of inflation between 2014 and 2019, so 7.5 percent. States in this red box had increasing FMAPs, and as you can see, their DSH funding increased at a rate slower than inflation, even though their income decreased compared to the national average. States in the green box had decreasing FMAPs and had DSH funding increase faster than the rate of inflation,

even though their incomes also increased faster when compared to the national average.

So how does per capita income and a state's FMAP relate to measures of need for DSH payments? Well, this graph shows how states with lower per capita incomes have a higher share of non-elderly low-income individuals, which again would indicate that these states have a higher and larger need for DSH payments.

To show the state effects of a permanent ARPA-like adjustment, we looked at changes in DSH funding for states that had an increased FMAP, a decreased FMAP, and no change in their FMAP over a five-year period.

Under status quo policy, the allotments increased with inflation, while under ARPA-like adjustment, total DSH funding increases with inflation.

States with an increasing FMAP benefit the most from this policy because their total funding would have increased from 3.9 percent to 7.5 percent, mirroring the rate of inflation.

Meanwhile, states with a decreasing FMAP would not benefit under an ARPA-like adjustment. These states would receive a lower increase in total DSH funding when

compared to the status quo. Instead of a 9.3 percent increase, they would instead receive a 7.5 Percent increase, again, consistent with the rate of inflation.

Meanwhile, 16 states saw no change in their FMAP. For these states, there would have been no difference between the two policies.

So just to summarize the previous three slides about the summary of state effects, the status quo and permanent ARPA-like policy both results in disruptions to total DSH funding based on changes in the FMAP. On the one hand, the permanent ARPA-like policy benefits states with increasing FMAPs, which do have declining per capita incomes and also more non-elderly low-income individuals, which is a measure of need for DSH payments. On the other hand, relative to the status quo, a permanent ARPA-like policy results in less funding for states with decreasing FMAPs and increasing per capita income. Meanwhile, states with no change in their FMAP, including most states at the statutory minimum, are not affected by either policy or by a change in either policy.

With that, I'm going to kick it over to Rob.

* MR. NELB: Thanks, Aaron.

So in terms of federal spending, an ARPA-like policy would increase spending during recessions commensurate with the increased FMAP, but during periods of normal economic growth, there would likely be no net effect overall. This is because any increases in spending for states with increasing FMAPs would largely be offset by decreases in federal spending for states with decreasing FMAPs. We're still awaiting an official score from the Congressional Budget Office that they've confirmed our underlying assumptions.

One other issue to consider is how DSH allotments should be affected by other changes to the FMAP that aren't a result of an economic recession or normal year-to-year changes in per capita income. Some examples of these temporary adjustments in the past include adjustments for specific states during natural disasters. A permanent ARPA-like policy would help these states by avoiding reductions in DSH funding when their FMAP increases.

Another unique case to consider is whether DSH allotments should be adjusted to account for the increased FMAP during the unwinding of the continuous coverage requirements. So the current ARPA policy is scheduled to

expire this fiscal year when the public health emergency ends. However, under current law, there's a 1.5 percentage-point increase in the FMAP scheduled for the first quarter of FY 2024. As a result, this increased FMAP would reduce the total amount of DSH payments a state could make during that quarter.

This increased FMAP is a bit unique compared to prior ones because it's contingent on state compliance with a number of new reporting requirements. Overall, if an ARPA-like policy were in effect, it would increase FY 2024 DSH allotments to account for the increased FMAP unless CMS lowers the state's FMAP for non-compliance with the reporting requirements, in which case the state's allotment would be the same as it would be under current law.

All right. So now that we've reviewed some of these effects, let's look at how they all come together and compare to the Commission's policy goals.

So overall, we find that applying the ARPA-like policy during economic recessions would help reduce disruptions in DSH funding during these recessions, and it would only increase allotments relative to the status quo.

The permanent ARPA-like policy has the added

benefit of also helping to avoid disruptions in DSH funding with other changes to the FMAP, and it particularly helps benefit states with increasing FMAPs because of lower per capita incomes. These states likely have a greater need for DSH payments.

However, relative to the status quo, the policy would reduce funding for states with decreasing FMAPs. Instead of having their total funding increase faster than inflation, their total funding would only increase at the same rate of inflation, the same as other states, but relative to the status quo, it's slightly less than they're getting.

Commissioners also asked at our prior meetings about how these recommendation options would interact with our prior recommendations if DSH allotments took effect. Overall, these policies complement each other, but the order of operations would be a bit different depending on which option you choose.

So in a temporary ARPA-like policy, federal allotments continue to increase each year based on inflation, and then reductions are applied to federal allotments to improve the relationship between federal

allotments and measures of need for DSH payments. Then in the future, if there's an economic recession and the FMAP increases, DSH funding is adjusted so that total funding is the same as it would have been without the application of the increased FMAP.

With a permanent ARPA-like policy, total DSH funding, state and federal, would increase each year based on inflation, and then the federal share would be determined by multiplying the FMAP by that total funding amount. If reductions took effect, then the policy would be intended to improve the relationship between total DSH funding and the measures of need that the Commission articulated.

In addition, it's also worth considering how that temporary ARPA-like policy compares to our prior countercyclical FMAP recommendation, which was based on a prototype developed by GAO, and it would trigger an increased FMAP when unemployment increases in two consecutive quarters compared to the prior year for a majority of states.

So if Congress implements our prior countercyclical recommendation, then the temporary ARPA-

like adjustment would apply whenever that countercyclical FMAP is triggered at any point during a fiscal year. However, since Congress has not implemented our prior countercyclical FMAP recommendation, we've awarded the temporary ARPA-like policy broadly so that it could also apply to other changes in the FMAP that Congress makes during future recessions, even if they aren't specifically triggered by the factors in the GAO model.

All right. So putting it all together, here are the two proposed recommendations for you to consider. The first is the temporary option which would increase federal DSH allotments during economic recessions, so that total available state and federal DSH funding is the same as it would have been without the application of the countercyclical FMAP.

The recommendation text also acknowledges that if Congress makes future changes to improve the relationship between DSH allotments and measures of need, this countercyclical adjustment should be applied after making those changes.

The second option is the permanent ARPA-like adjustment, which would adjust federal allotments so that

total state and federal DSH funding is not affected by changes in the FMAP.

The recommendation text also acknowledges that if Congress makes future changes to improve the relationship between DSH allotments and measures of need, the methodology should be based on total state and federal DSH funding.

So that concludes our presentation for today. I know there's a lot here, so we're happy to answer any questions you have. Ultimately, we welcome your feedback on which policy options we should bring back for a vote at the April meeting, any suggestions on how the recommendations are worded and any points we should highlight in the rationale. Also, as Aaron noted earlier the draft chapter will also include two other potential recommendations discussed at the October meeting, the conforming change to the prior countercyclical FMAP recommendation and the technical change to streamline DSH allotment calculations.

Thanks.

CHAIR BELLA: Thank you both.

Just on that last point, you don't need feedback

from us on the other two, right? We've already taken care of that.

MR. NELB: Yeah. I think provided --

CHAIR BELLA: Consensus.

MR. NELB: -- feedback, and the recommendation text is in your materials, but there weren't any comments on that last time. So I think we're good.

CHAIR BELLA: Yeah. Okay. Perfect. All right.

Darin, then Bill, then Fred.

COMMISSIONER GORDON: I know this is your all's favorite topic, so thank you for all the work and us giving you the opportunity to dig even deeper into DSH.

I had one question -- I actually have two questions, but one is just trying to clarify. I was looking at one of the prose in the material, and it was talking about how -- this is on the permanent ARPA-like policy, but it was talking about total DSH funding increases for states with declining per capita income. So my understanding always with federal match changes, it's really your relation -- your change in relation to other states. So you may, in fact, actually have gone up in per capita income but just not at the same rate as everyone.

Is that accurate?

MR. NELB: Yes, yes. It's your per capita income relative to other states.

COMMISSIONER GORDON: Okay. I just wanted to make sure my understanding was correct there and making sure it was the same for DSH.

Did we talk to states? Did we get any feedback from states on the policy options or their perspective?

MR. PERVIN: So we asked states about -- we actually asked states about a series of different countercyclical policies, namely the ones that were implemented under Families First Coronavirus Response Act and also the American Recovery -- ARRA back in 2008 and then the ARPA approach, and states confirmed that they appreciated the ARPA approach because of the balance it provided for states and hospitals. And I think the thinking is, too, that states don't think of DSH in terms of just that federal amount. They think of DSH in terms of that total funding amount, and so that's why this would kind of promote a little bit more administrative certainty, both for states and also hospitals, regarding what total DSH amounts are available on a year-to-year basis.

COMMISSIONER GORDON: Yeah, totally agree. Very helpful. Thank you.

CHAIR BELLA: Bill, then Fred, then Martha.

COMMISSIONER SCANLON: Thanks very much for all the new information and also probably bigger thanks for sort of your patience over the last months listening to my concerns sort of about this issue. And maybe I should say in part -- sort of acknowledge that I was not able to attend the October meeting, so I was not part of the consensus that was reached at that meeting.

My concern about this -- and my feeling is that the recommendations in some respects sort of have the wrong priorities in the sense that previously we've recommended the DSH allotments need to be improved. They need to be aligned with measures of need to reflect appropriate targeting of federal dollars.

In the materials that you gave us, you referred to the fact these allotments were based on 1993, and you called it cost. But I think we need to be more precise. They're not really costs. They were payments that had the label "DSH" attached to them. Whether they actually went to hospitals that were doing disproportionate share or not

is not clear. In fact, there were no limits earlier because there was no concern about DSH payments. It was in that period that we became concerned about the abuses that were going on, and the limits were imposed. And in imposing limits at that time, reflecting what the spending was at that time, it was a fulfillment of one of those unfortunate rules, which is no good deed goes unpunished.

So the people with low allotments are potentially the people that were not making payments under the DSH label at that time. So I think we really need to fix the DSH allotments as the first priority, as we said in, what, 2019 and as we repeatedly say in our reports on DSH, the allotments do not correlate with sort of measures of needs. So that to me is the number one priority.

After one determines then what are the needs for DSH-type payments, we need to then think about what should those payment be and what do we need to do with respect to these types of policies, these countercyclical or sort of FMAP adjustment policies to make sure that happens.

I think it was in September, you talked about that the DSH monies go for two purposes. One is to compensate for care to the uninsured and secondly to deal

with some of the Medicaid shortfall. The Medicaid shortfall -- and this was my concern in September -- can be dealt with simply through the ordinary Medicaid spending. States can increase their payments to hospitals during recessions with the increased FMAP they're going to get from a countercyclical adjustment, and everything will be the same.

Okay. The question is, is there a need beyond that in terms of dealing with sort of the recession or sort of any other shortfall of revenue to deal with sort of the underfunding sort of for Medicaid? For that perspective, I think we actually need to sort of start to say we need transparency about what the Medicaid shortfall is. It seems to me very sort of appropriate or apropos sort of that we are having this discussion today about hospitals, whereas last month we had a discussion about nursing facilities. And we adopted what I would say is an incredibly good set of principles with respect to nursing facilities. We said that we should be fully transparent about sort of our payments to them and what their costs are, and that the payments to them should be enough to reflect the cost of efficiently and economically operated

facilities. We should have those same principles when we're talking about hospitals.

Last month, we mentioned that and we talked about that the Boren Amendment had that principle of paying for efficiently and economically operated nursing facilities. It had the same principles with respect to hospitals. So we should be thinking about how do we return to that instead of thinking about anything that a hospital spends is a legitimate, necessary cost that we should be thinking about reimbursing.

So it's in those regards, I think we need to step back, think about fixing the allocations, and then thinking about how much of an adjustment is really necessary to compensate for the true and genuine sort of needs that DSH is intended to meet, which are care to be uninsured and a legitimate Medicaid shortfall.

Thank you.

CHAIR BELLA: So, Bill, I do think we have had those -- we do have those principles as far as understanding in all of the payments going to a hospital. We've said that, repeated -- if we haven't made it clear, we can make it clearer.

I guess the question I have for you -- I don't -- you know, we could bring back the work that we did in 2019 and sort of looking at what the best measure is and all that stuff. I don't think it's mutually exclusive with moving ahead with one of these recommendations, and I just want to understand where you are on that.

COMMISSIONER SCANLON: My sense with these recommendations is what we're doing is in, in some respects, is we're implicitly endorsing the current allocations. We're not saying -- it doesn't say that if you don't adjust the allocations to measure need in an appropriate way, don't make this adjustment. It says make the adjustment, and then there's a follow-on sentence. If you make the adjustments, then it's going to apply.

So I think it's this issue of priority, first of all, and my problem with these recommendations is that they really do seem to be implicitly endorsing the current allocations, and I think there's too much of a tendency to let those allocations continue.

Remember, they've been now in place 30 years.

CHAIR BELLA: Oh, I know. And we've made comments about them every year in our chapter.

COMMISSIONER SCANLON: Right.

CHAIR BELLA: Every year we say these have no relationship to anything.

COMMISSIONER SCANLON: All right. So that was my one point.

My second point is, what problem are we fixing?

CHAIR BELLA: Yeah. I think that's a fair question.

COMMISSIONER SCANLON: You know, what shortfall are we talking about here? And my sense is that if you give a state an increased FMAP, they should have the funding to be able to compensate to provide appropriate payment for the care that's needed to be provided because essentially, they can increase what they're spending on the non-DSH side and get this higher FMAP. And it can be labeled in a way that it goes to the hospitals that need that money.

And temporary adjustments, the payment rates are not a rarity in Medicaid. They happen.

CHAIR BELLA: Okay. Thank you, Bill.

Fred and then Martha.

COMMISSIONER CERISE: So I agree with Bill. I

think, like you said, we've stated this year after year. There's not a good correlation between DSH spending by state and the demonstrated need, and that it's based on some figure that aggressive states that got in, in the late '80s and early '90s have had a much bigger baseline, and that's just been perpetuated, so no disagreement there.

And I think these are relatively small. These move in the right direction. If we say we want to align DSH payment with the policy that says you should allocate according to need, if these adjustments are made, these are -- I looked at the table. These are like, you know, single-digit million-dollar adjustments by state, generally speaking, not the hundred-million-dollar adjustments that you're talking about that really ought to be done if you're really going to sort of look across the states and see where your needs are.

So I think they're relatively small adjustments. States could do things individually, but this is kind of a policy level that says we're not going to -- you know, not that you're penalizing states, but the impact of actual payments would be less for those that have higher FMAPs because of their economic situation. So I think they're

relatively -- not I think -- they're relatively minor changes. They're in the direction that we want DSH policy to go. Other Medicaid programs don't have those caps like that, so you don't have to make those adjustments. When the FMAP changes, the states take advantage of it. This is more of a special situation.

And so I think both the temporary one makes sense, but rather than do it every time, I think having it as a permanent change to the allocation makes sense. So that's my preference.

I mean, I think it's a relatively -- it's a small change, but it's in the right direction.

CHAIR BELLA: So you're going for B. Okay.

Martha?

Thank you, Fred.

COMMISSIONER CARTER: No, that makes it easy. I'm going for B too.

But I'm confused about a couple things, and we've been talking about this for a long time. I took notes when I read the material days ago.

So my question is about how nimble adjustments can be under the permanent arrangement, especially because

FMAP adjustments are made well in advance. Would that model that the GAO put forward be also in -- we're recommending that as well? Can you help me sort of with the nimbleness aspect of this over time?

MR. NELB: Sure. So I could start. So I guess from the state and the hospital perspective, the permanent option is the benefit of -- you know, there's a set amount of total funding that they can make each year that's sort of pretty much stable and wouldn't change depending on the FMAP.

In terms of the annual changes to the FMAP, states do know that in advance. It's sort of published in the Federal Register, and there's a process for that.

In terms of countercyclical, that would be -- you know, recessions are sort of by definition sort of unexpected, right? And so that could trigger at any point during a fiscal year or, you know, we've seen other cases where you, you know, some event happens and then Congress makes these FMAP changes.

But in terms of -- I think the benefit of these policies are that, you know, from the state and hospital perspective, the total amount of DSH funding that they

could make wouldn't change when that FMAP changes during the recession, and so there's a process. You know, CMS would have to work with to adjust the allotments, the federal allotments to make sure that that's the case. They would do that, but the idea of these policies is that they would sort of automatically happen whenever the FMAP changes.

MR. PERVIN: Yeah. And I would just also point out the FMAP tends to be published prior to the start of the fiscal year around two years, and then DSH allotments are published usually the year of. So there's ample time for CMS to take the FMAPs that have been published and then incorporate them into the notice for what those new allotments are.

COMMISSIONER CARTER: Okay. Thank you.

And I've got one more question. I'm sure there's a good answer. So D.C. was included in this, even though their rate is fixed in statute, but not the territories, right?

MR. PERVIN: No. Yeah, we did not include the territories. We did include D.C. which has an FMAP fixed in statute at 70 percent.

MR. NELB: And the territories do not have a DSH allotment.

MR. PERVIN: Yeah.

COMMISSIONER CARTER: Oh, they don't have a DSH allotment as well?

MR. NELB: Right. Yeah. It's only --

COMMISSIONER CARTER: Well, that's --

MR. NELB: -- the states and D.C., so one of the other --

COMMISSIONER CARTER: Thank you. Thank you very much.

MR. NELB: -- parts of this program.

CHAIR BELLA: If only they were all that simple, right, the answers.

Other comments from Commissioners?

Dennis, do you have any comments?

[No response.]

CHAIR BELLA: No? Okay.

COMMISSIONER HEAPHY: Well, I'm looking more towards the permanent Option 2 right now. But it's just really complicated.

CHAIR BELLA: Verlon and then Sonja.

COMMISSIONER JOHNSON: Now I'm on. Okay.

This is very helpful. Twenty-three years at CMS and I avoided this, so I appreciate coming here and all of a sudden, I have to learn more about it.

But I know we had those three principles. We talked about avoiding disruption in funding. We talked about alignment with measure of needs and administrative simplification, and I got that for the permanent. And so is that the same, then, for -- how does that differ from the temporary in terms of meeting those?

MR. PERVIN: Sure. So the temporary, we actually felt was a little bit more administratively complicated, but again, it depends on what the vantage point is. So the temporary policy also requires this additional assessment by some other body of determining when an economic recession is and when that -- and so like because it requires kind of an additional consideration, we thought that that does add to the administrative complication.

But it can also possibly depend on where you're sitting. So at the state level, it might be different because -- it might be different at the state level because you'd have a better understanding of what that total amount

is. You'd have more certainty regarding what that total funding is, but at CMS, it might have more complications.

COMMISSIONER JOHNSON: Okay. That's helpful. Thank you.

And I'm leaning towards the permanent as well.

CHAIR BELLA: Darin?

COMMISSIONER GORDON: On that point, I mean, haven't we historically seen that there is always a determination whether or not a downturn is occurring? Maybe not timely, as we've discussed quite a bit, but I don't see it as an additional determination. It is riding on the back of determinations when they're made. Is that fair?

MR. NELB: Yeah. That's partly why I think that was in your materials, but we took it out of the slides because it depends on what side you look.

And so if Congress implements our prior countercyclical FMAP recommendation, then there's a clear identification of what's a trigger, but the recession -- with the pandemic, for example, it's an example where Congress made this increased adjustment at the time. There was an economic recession at the beginning of the pandemic,

but we're currently at a point where they're -- by the economic measures, it's not considered a recession, but there's still this increased FMAP. And so that's where some of the complexity comes in with -- when Congress doesn't -- hasn't implemented our countercyclical FMAP recommendation, but there are these other FMAP changes that are happening and, you know, who decides what's a recession or not.

COMMISSIONER GORDON: I think that's a very helpful clarification, because what you're articulating is, because of history, it's not always because of recession. There may be other issues, and so you may still have the dynamic where they're out of sync, where you would have a -- that's super helpful. Thank you.

MR. PERVIN: And just to make that a little bit more tangible, like in October, there's going to be an increased FMAP of 1.5 percent, but there's not going to be a corresponding change to the allotment. So for payments that are claimed in that quarter, there is going to be a lower -- there is going to be a lower total DSH funding amount.

CHAIR BELLA: Thank you.

Sonja?

COMMISSIONER BJORK: Just to go along with the point that Darin just made, I feel like Option B most closely aligns with the principles that we laid out, so I favor that one.

CHAIR BELLA: Thank you.

Heidi?

COMMISSIONER ALLEN: I just wanted to say that the materials that you provided were so helpful, and I found like all of -- just the information presented in these different ways with these like simulations just to really take something that was super complex and walk me through that. So I hope in the chapter that you can do that with the audience because I just found it enormously helpful. So thank you for that. And I'm leaning towards Option B as well.

CHAIR BELLA: I'm in the minority because I'm still on Option A, and I'm trying to be able to articulate why. Can you help me think about from the state perspective? So if there's no adjustment, like when the 1.5 happens, all states take a hit, like states will take a hit, and the temporary adjustment, all states win, right?

There are no losers. And the permanent adjustment, there are some winners and some losers. Am I thinking of that the right way from the state perspective?

MR. PERVIN: I would say yeah. That's accurate.

MR. NELB: Yes. Then I guess it -- yeah. We tried to avoid the winners, losers --

CHAIR BELLA: I know, but there's -- all the work we've ever done is on winners and losers.

MR. PERVIN: Yeah.

CHAIR BELLA: So going back to Bill's point that we're making a change in a flawed system, do the winners and losers created by the permanent option exacerbate the winners and losers that are already built in? They do, right?

COMMISSIONER SCANLON: They would, yes. To the extent that you believe that they're not correlated with need, if you're going to increase them or decrease them, you are going to exacerbate sort of the -- I mean, we had in one of our principles is that our spending corresponds to need, and so we are actually going counter to that principle.

MR. NELB: Yeah. I guess the -- couple things

I'd just point out is that we had from this other graphic, the view that this sort of winners and losers under current policy, right, and the proposed policy would just make sure that all states have their total DSH allotment increased by the same amount. So it -- rather than some benefit or get less funding, it would be sort of equal.

And then just another point too, you know, we did this sort of simulation looking at past changes between 2014 and 2019. But, you know, the states with increasing per capita income or decreasing per capita income in the future will probably be different from what they were in the past, so just a note there. It's not that the states that would have been worse off in that past five-year period are going to be the same states that would have been worse off in the future.

CHAIR BELLA: And on a level of like -- what you were saying, administratively, it's more burdensome to do A, Is that like by a factor of 10 or 100 or 1 million? Like how much worse is it?

MR. NELB: I think we've struggled with how to actually quantify sort of complexity and it's sort of in the eye of the beholder. Again, the benefit of Option B is

that the amount that a state can make in DSH payments to a hospital is pretty much consistent year to year and just increases with inflation with -- under current law, there's sort of this added complexity that, you know, in addition to accounting for inflation, you also have to account for the FMAP change which is just different from how other Medicaid payments work.

The rules for how much payment you can make to a hospital is based on your total funding but at the hospital level. But at the state level, you know, it's based on this federal funding, which is just a little bit different, so --

MR. PERVIN: Right. And that's also kind of just consistency between different Medicaid payments. So the upper payment limit, that's all set. That limit is set at the total amount. Section 1115s, that budget neutrality is set at a total amount. It's not based on the federal amount. It's based on both combined spending, and so I think from -- I think we were thinking from the state and provider perspective, it provides a little bit more administrative certainty, but from the federal perspective, it might add more complications.

CHAIR BELLA: All right. So I know where Bill is. I know we're parts of this side of the room are. Can we just take a little informal show of hands? Let's start with Option B because it's more popular.

All right. Dennis, are you're leaning toward B, you said?

COMMISSIONER HEAPHY: I'm leaning towards it. I'm leaning towards B, and I think it's a leaning because Bill completely blew my mind. I came in sure I wanted Option B, and then when Bill spoke, it just made me rethink my decision. So I'm still leaning towards B, but now I've just got so many other things to consider.

And the winner/loser piece, Melanie, has been something that we had. I think we discussed it last meeting, and how do you decide who the winners and losers are? And that's what makes it really tough.

So I just thought whatever we did in the report that the permanent was less painful overall, and I don't know if I'm reading that correct or not. But that's in part how I made my decision or why I'm leaning the way I am.

CHAIR BELLA: Thank you, Dennis.

COMMISSIONER SCANLON: Thank you, Dennis. I know I'm in a lonely minority, but I really appreciate your comments.

CHAIR BELLA: I'm hanging out somewhere there too, Bill.

Tricia and then Martha, and then we'll wrap it up.

COMMISSIONER BROOKS: I was definitely leaning toward B until the sage beside me shared his experience.

I guess my question is, can we at least lift up in the chapter, maybe in the recommendation, the fact that this is a flawed system? It doesn't represent cost. This is a step in the right direction, but it by no means endorses how DSH is currently constructed, and that that still remains a high priority.

CHAIR BELLA: Yes. And for those of you that don't read our March chapter every year or don't read the press release where I'm quoted every year, every year we do say this has no relationship to anything. So I do want to assure you that we get that measure out -- or that message out as much as we can. But yes, we can make sure.

Martha and then Fred.

COMMISSIONER CARTER: I am in agreement, Bill, with what you're saying, and I'm going to maybe ask to put you on the spot a little bit. Since we don't want to necessarily endorse rearranging the deck chairs, what do you think we should do?

COMMISSIONER SCANLON: Well, I guess I think it's not so much of a risk of rearranging those deck chairs, because again, I think -- I'm not sure exactly how necessary this change is. As Fred said, the amounts are small, okay, relative to the overall total. And I think that if you look -- when you look at the totality of Medicaid spending, you think about a countercyclical FMAP or sort of FMAP just generally that is open, is available for monies that the states can spend, other ways, and target them in to the same -- for the same purpose, essentially, dealing with sort of DSH-type problems, that we're not creating sort of an issue.

I actually am wondering if I -- and I've been contemplating this a lot -- would be comfortable more if there was a repeat of our recommendation that the allocations, the allotments need to be -- that's the number one priority. They need to be aligned with need.

And secondly, when you do that, as opposed to here where it's the second sentence and it says "if you make future changes," it should be "make those changes to the allotments," and then think about also either having a countercyclical adjustment or an FMAP adjustment. That to me is the reasonable approach. It's the Commission standing up and saying, We've told you before. We're telling you again. This is very, very important." That's kind of where I come from.

COMMISSIONER CARTER: Thank you.

CHAIR BELLA: Thank you, Bill.

Fred. And then we're going to wrap it up.

COMMISSIONER CERISE: Yeah. So I wouldn't disagree with that, although I would not say "and then" I would say "and," because I think there are two things that both should be done, and the bigger one, they've ignored year after year. And I think if we say do that first and then this, the "and then this," we'll be here 10 years from now as well. And it doesn't hurt to make these adjustments that go in the direction that we'd want to go.

And I'm not sure like it exacerbates the underlying changes. I think you said half of the states

are already at 50 percent. I'm looking at the big DSH states, New York, New Jersey, California, that are already at 50 percent, and then some of the other ones like Texas would go down. Pennsylvania would get worse. The other big -- so just kind of looking at the list, it's not all in one direction, the ones that sort of got in early and have big DSH amounts that all win. In fact, most of them are either the same or get a little worse.

CHAIR BELLA: Thank you, Fred.

So I think the consensus is for you to bring B back to us, and also, please heed the comments that have been made about reinforcing prior recommendations and strong concerns about the relationship of DSH.

I kind of feel like, Bill, we should -- every couple years, it should just be a given that our recommendations that have been ignored come back alongside, because I'd like to pull back a couple -- pull forward a couple in the past as well.

But do you have what you need from us?

MR. PERVIN: Yeah, I believe so. This was really helpful. Thanks for getting to a consensus.

COMMISSIONER SCANLON: If I could just add, I

would be happy, Fred, to drop the word "then" from my recommendation, but have an "and," that Congress needs to do these two things, okay, because to me Congress is approaching this from kind of a math perspective. That means you do both. Okay.

MR. PERVIN: So would you -- sorry. Just so that we can maybe hash this out now, maybe I'm opening a can of worms, but so would you say first sentence permanent, so Congress should amend Section 1923 or to adjust federal DSH allotments so that total state and federal DSH funding is not affected by changes in the FMAP? And then -- and then if Congress -- or and then when Congress makes future –

CHAIR BELLA: No "then."

MR. PERVIN: Just "and." Okay.

COMMISSIONER SCANLON: Well, and I guess I would reverse the order. I mean --

CHAIR BELLA: Okay. Time out. We can't re-litigate it. Please bring it back to us like it is and with the "and" that you guys can work on offline. Bring both of those back to us, please. We can just -- I'm going to ask them to take the feedback back, because I think -- and Bill wants to consult with them offline, we can do that

and bring it back to us with the little word change, and then we can give you -- we can move pretty quickly, I think, in April as to which direction we're going to go. Thank you very much.

All right. So we're going to move into a session on pre-release services, and I'm going to turn it over to Kisha.

VICE CHAIR DAVIS: All right. Hello, everybody. We are going to invite Lesley and Melinda to join us talking about pre-release services.

And just a reminder to folks, this is driving towards a descriptive chapter that we'll review in April, so comments around direction and tone, are we recapturing the right information, I think, would be really helpful. So thank you.

And I'll turn it over to Lesley and Melinda.

CONSIDERATIONS FOR PROVIDING PRE-RELEASE MEDICAID SERVICES TO ADULTS LEAVING INCARCERATION

* MS. BASEMAN: Wonderful. Thank you, Kisha. Good morning, Commissioners.

Today Melinda and I will provide an overview of considerations for providing pre-release Medicaid services

to adults leaving incarceration. This will culminate in a descriptive chapter in our June report to Congress on access to Medicaid coverage and care for adults leaving incarceration.

As a reminder, our work this cycle has been focused on adults who have justice involvement with state prisons and local jails. This work does not address adults in federal prisons or youth who are incarcerated. Staff are considering future analytic work focused on justice-involved youth.

We'll briefly revisit some background information on Medicaid's role in covering justice-involved individuals, state efforts to improve care transitions, and recent administrative actions. Then we will provide a high-level overview of California's first-in-the-nation Section 1115 demonstration approval to provide pre-release Medicaid services. We'll then highlight some implementation considerations raised by states and other stakeholders. Lastly, we will detail next steps in our work.

The Medicaid inmate exclusion policy prevents Medicaid payment for any services delivered to incarcerated

individuals, with the exception of inpatient care lasting 24 hours or more. However, Medicaid is an important source of coverage for adults with justice involvement upon their return to the community. Medicaid can cover individuals on parole or probation as well as those released to their homes in the community.

Across interviews with 16 states, we learned about efforts to improve health outcomes for justice-involved adults. Examples of these include suspension of Medicaid benefits upon incarceration rather than termination of benefits, providing state-funded in-reach services through MCO contracts, and providing application and enrollment assistance prior to release.

We also learned about Section 1115 demonstration requests to provide pre-release Medicaid services. California has received the first approval for a demonstration of this kind, and there are 14 other states that have pending waivers. Details on these requests are included in your materials.

In January, the Assistant Secretary for Planning and Evaluation released a congressionally mandated report on challenges and best practices for improving health care

transitions upon reentry. This report is based on findings from a stakeholder convening, which included managed care organizations, enrollees and advocates, providers, the National Association of Medicaid Directors, and representatives from state prison and local jail systems.

Lastly, we await additional guidance from CMS in the form of a state Medicaid director letter, which will include details on Section 1115 opportunities for facilitating health care transitions during reentry.

In January, CMS approved California's Section 1115 demonstration request to provide pre-release services to justice-involved individuals. CMS has additionally indicated that the forthcoming SMDL and any subsequent approvals will closely align with California's approval. This approval is for a targeted set of pre-release services to be provided up to 90 days prior to release.

Allowable pre-release services include in-reach case management, physical and behavioral clinical consultation services, lab and radiology services, medications and medication administration, medication for opioid use disorder, and services of community health workers and peer navigators with lived experience.

Eligibility for these services is limited to adults and youth in state prisons and local jails who meet health-related criteria, including confirmed or suspected mental health condition, substance use disorder, chronic or significant nonchronic clinical condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, or pregnancy or within 12 months postpartum.

Youth incarcerated in juvenile correctional facilities do not need to meet clinical criteria for eligibility.

CMS also approved funding for one-time transitional and non-service investments that support implementation of this reentry demonstration. For example, this can include data systems upgrades.

California can begin claiming federal match for pre-release services following CMS approval of its implementation plan, which is anticipated by April 1st, 2024. This implementation plan must document how the state will operationalize Medicaid coverage and delivery of pre-release health care services. The implementation plan must also include how California will achieve five milestones related to increasing coverage, ensuring access to pre-

release services, promoting continuity of care, connecting to post-release services, and ensuring cross-system collaboration.

To avoid cost shifting to Medicaid, CMS is prohibiting the use of federal funds to supplant existing state or local funding for reentry services. Instead, federal funds for demonstration services that are already being paid for by state and local corrections authorities must be reinvested in other activities.

California is required to report both quarterly and annually on key metrics, including utilization of pre-release and post-release services, and to stratify by demographic subpopulations.

The state must also conduct an independent midpoint assessment of the reentry demonstration by the end of the third year. This assessment is meant to understand the state's progress toward the stated milestones and goals and outline any mitigation strategies where necessary.

Lastly, California is required to conduct independent interim and summative evaluations using data stratified by demographic subpopulations. They're also required to produce estimates of the cost of the

demonstration.

We'll now switch gears, and Melinda will talk about considerations for implementing pre-release Medicaid services. These are based on findings from state interviews conducted with Academy Health and the expert panel from December. We also draw on the ASPE best practices report and CMS approval of California's demonstration.

* MS. BECKER ROACH: Thanks, Lesley.

All right. Implementation of pre-release Medicaid services will require a strong collaboration between state Medicaid agencies and state and local corrections officials who oversee prisons and jails. A common theme that we heard is that siloed organizational structures and competing priorities can make such collaboration challenging.

Medicaid and the state corrections authority are typically housed in different state agencies that report to the governor, while jails are generally operated at the local level by a sheriff, police chief, or other local official who may be appointed or independently elected.

Panelists noted that early engagement of state

and local corrections leaders is critical to gaining buy-in and anticipating and overcoming operational challenges associated with implementing pre-release Medicaid services.

We also heard that additional federal support could be used to promote cross-agency collaboration and disseminate promising practices for improving the health of justice-involved individuals. This could take the form of convenings or other technical assistance provided jointly by CMS and the Department of Justice.

Panelists also suggested that there is a need for additional federal support to expand administrative capacity and enhance staff expertise at both the state and federal level.

States and other stakeholders have also noted the importance of data sharing to support pre-release services and care coordination as individuals leave incarceration. The ability of state Medicaid agencies and correctional authorities to share timely and accurate data related to eligibility and anticipated release dates will be critical, though many states have noted that establishing and enhancing these cross-sector data systems can be a significant undertaking, particularly for jails with more

limited resources and staff capacity. It will also be important that correctional and community health care providers can share patient information for purposes of care coordination.

There's currently limited or no sharing of health information between corrections and community providers, in part, because many correctional facilities lack the information systems needed to exchange electronic health records or connect to health information exchanges.

Correctional facilities also generally lack systems needed to bill Medicaid, and one panelist in December noted that establishing that Medicaid billing infrastructure in some cases may require additional guidance and staffing resources.

States will also have to consider who will provide pre-release Medicaid services. Under California's demonstration, the state has flexibility to determine who provides those services, whether that be community-based or carceral providers, and whether those providers are Medicaid-enrolled. Correctional health staff and health care vendors who most often provide health care to individuals in state prisons are likely not Medicaid-

enrolled providers because of the inmate payment exclusion. Whereas, community-based providers who typically deliver healthcare in jails are often Medicaid-enrolled providers with experience billing Medicaid.

Whether a provider participates in Medicaid is a consideration which may also arise as states think about addressing the health-related social needs of individuals leaving incarceration.

Many stakeholders have stressed the importance of addressing these health-related social needs through partnerships with community-based organizations, which may not be Medicaid-enrolled providers.

We also heard about the potential for peer support specialists with lived experience to support individuals as they reenter the community. States and correctional facilities may need to address formal and informal policies that limit employment of people with criminal backgrounds and their ability to engage with individuals who are incarcerated or living in the community under probation or parole.

Lastly, given that one of the major goals of providing pre-release Medicaid coverage is to improve

continuity of care and health outcomes for individuals following incarceration, states will want to consider the capacity of community-based systems to address the physical, behavioral, and health-related social needs of those enrollees.

One of the panelists in December noted concerns that Medicaid funding for pre-release services could supplant existing state and local investments and shift costs to the federal government. As we previously discussed, state and local correctional authorities are generally responsible for providing and paying for health care services delivered to individuals who are incarcerated, and some state prisons and local jails are already providing reentry services like MOUD and case management that could potentially overlap with those that states are seeking to cover in their Medicaid programs.

CMS emphasizes that California's demonstration is not meant to absolve carceral authorities of their obligation to provide health care nor to transfer that obligation from corrections to Medicaid. And to that end, as Lesley noted, California will be required to reinvest or, in essence, redirect federal funds for any services

that are already being paid for by state or local corrections so that they're not supplanting funds that are currently supporting reentry.

Finally, panelists and other stakeholders have suggested that monitoring and evaluation of these initiatives should be prioritized, given the unprecedented nature of these efforts and the complex health needs of the populations affected.

One of the panelists emphasized the importance of monitoring, given the typical lag in evaluation results and the need for more timely and ongoing insight into implementation of these demonstrations.

States may also benefit from policy-specific Section 1115 evaluation guidance, similar to what CMS has previously provided for other novel demonstrations, such as those focused on substance use disorder and serious mental illness.

Another theme we heard was the importance of making sure that states are gaining insights from beneficiaries with lived experience of incarceration as part of their monitoring activities. For example, states can use beneficiary surveys or interviews to assess

beneficiary understanding of the services available to them as well as their perceptions of access and quality.

Going forward, we'll continue watching for CMS guidance and additional approvals of state Section 1115 demonstrations to provide pre-release Medicaid coverage.

We will also return next month with a descriptive chapter for the June report which will bring together all of our analytic work on access to Medicaid coverage and care for adults leaving incarceration. This will include a description of the demographic characteristics and health status of justice-involved adults, state strategies for improving access to Medicaid coverage and care for adults upon reentry, and the considerations for implementing pre-release services discussed today.

For the discussion, we welcome your reactions to these considerations and any thoughts you may have on particular considerations or implementation issues that you'd like us to underscore in the chapter.

Thank you.

VICE CHAIR DAVIS: Thank you both. I think this is really important work, especially in that this is a continuation of our health equity work. So when we think

about justice-involved persons, that in and of themselves are a marginalized group, and so continuing to highlight and focus on them and their needs is very important. So thank you for bringing this work forward.

Do we have any questions from the group?

Heidi.

COMMISSIONER ALLEN: Thank you. I don't think I fully appreciated how complicated this all was until I read the report, and so I think that that was very helpful.

I know we're not talking about young people, but I would like to just flag for future work that I'd be interested in focusing on kids in foster care as a particular vulnerable population and particularly kids aging out of foster care who I believe have extended period on Medicaid eligibility anyway.

Some questions that I had when I was reading it was in a prior report it, the average length of time that a person spends in jail was reported, and I remember being surprised at how short that is. I think it was like 45 days-ish, and reading this, it seems like the answer will still be to pause Medicaid. But I'm just not sure how that works if you're talking about providing a service that goes

90 days prior. What are they going to do with -- when the most people, the average length of stay is less than the time that the period of retro -- of coverage? So I'm a little confused about that.

I would like to emphasize in the part about training for providers the need to have trauma-informed care, to think of incarceration as a trauma and make sure that providers are aware of that and trained on that.

I also was curious about the incentives for providers not currently enrolled in Medicaid, those serving prisons, it sounds like. Is there a way to incentivize them to want to enroll in Medicaid?

Like right now, I'm thinking, is this a substitution model? So if I'm a provider, why change anything because I get paid? Is it that with Medicaid they might be able to get paid more, and therefore, they are incentivized to do so because they make more money or how that works?

And the last thing that -- you know, we talk a lot about the importance of monitoring and evaluation, and I just would like to take it one step further to say that we have these sources of administrative data that, if

combined, could be very useful in answering these questions. And it's not the same thing as electronic health records related to medical care. It's things like Medicaid claims data with information from like release dates, recidivism. It's including things like mortality data.

If you had a unique identifier that linked all those records and then could be de-identified, you could do some really robust analysis on whether or not you do decrease overdoses and deaths, whether you do have fewer emergency department visits, but without really having that data connected, you have to make really broad assumptions, and the analysis is always very weak.

And so when we're saying these organizations are going to be coming together to talk to each other to try to be more nimble, it just seems to me like an obvious next step that they are required to produce an administrative data set that includes the variables necessary for evaluation.

Thanks.

VICE CHAIR DAVIS: Thank you, Heidi.

Martha and then Rhonda and then Tricia.

COMMISSIONER CARTER: Thank you for the information, and I was really interested to see the list of what all the other states are proposing. I really hope that that comes to fruition quickly.

I just wanted to make the comment that I just see this program, this opportunity as an amazing fit for the community health centers. They already serve vulnerable populations. Some health centers already have relationships with jails and prisons and are doing reentry programming. So I hope to see the health centers really step in here.

And just a point, I see a lot of correlation with the effort to do school-based health centers, and I think there's some lessons learned from that whole endeavor. Again, it's different silos, different information systems, trying to learn the other culture and talk to each other in a way that you can build an effective system. And so I think that's just a message out to the void, I suppose, but just think about what we've leaved from the perspective of community providers going into another system and providing care. And I think it could be really instructive.

One more point. Like a lot of times -- and Kathy

can attest -- people seem to have forgotten that the mouth is part of the body, and I didn't see anything about dental care in any of this. And I wondered --

COMMISSIONER WENO: I didn't pay her to say that.

COMMISSIONER CARTER: Huh?

COMMISSIONER WENO: I didn't pay you to say that.

[Laughter.]

COMMISSIONER CARTER: Well, I'm right there with you.

So I know nothing about how dental care is provided in jails and prisons, especially when people are there for many years, but is there any provision for that in any of these waivers?

MS. BECKER ROACH: Most of the states that are seeking 1115s to provide pre-release services are proposing a limited set of benefits. I don't believe that dental is included in any of those. We'd have to go back and just double check.

There are a small handful of states that are proposing to provide full benefits, and so to the extent that they cover adult dental, presumably that would be part of the benefit package.

VICE CHAIR DAVIS: Thank you, Martha.

Rhonda, then Trisha, then Bob.

COMMISSIONER MEDOWS: I didn't have my hand up, but good morning. How are you?

VICE CHAIR DAVIS: All right. We'll pass you. I wasn't sure if you had a comment you wanted to share.

CHAIR BELLA: Actually, though, just for folks, Rhonda, just repeating the comment you had in the chat so that it can be part of the public record is important.

COMMISSIONER MEDOWS: The person who said about making sure that foster care is addressed in the next iteration, I would say also includes children in DJJ.

VICE CHAIR DAVIS: Thank you, Rhonda. Just important, wanted to make sure that we got that on record.

Tricia.

COMMISSIONER BROOKS: Two comments. One is I definitely like the idea of emphasizing the importance of the evaluation. I think Section 1115 demonstration evaluations have fallen short in the past. There's not transparency around them. They don't get lifted up. They don't get used to determine whether the demonstration really, you know, accomplished the goals, so, you know,

definitely emphasis on that.

And in somewhat of an unrelated comment but just the social determinants of health or the social drivers of health, looking at impact on local community-based services, because the one thing we know about the United States and the fact that we spend half as much more on health care than any other industrial nation, when you look at spending on a combination of social services and health care, you'll find that the United States falls down to 13th. And I am very concerned in the future as we move toward doing more to somewhat integrate Medicaid and social determinants that we're going to put lots of stresses on the social service system when it is inadequately funded and it's, you know, on the chopping block in Congress potentially. So it's just something we need to keep our eye on in terms of social determinants. There's not an endless source of community-based services to work on these issues.

VICE CHAIR DAVIS: Thank you, Tricia.

Bob and then Fred and then Dennis.

COMMISSIONER DUNCAN: Thank you, Kisha. And first of all, thank you for the information.

To Tricia's point, the one thing I was really interested in is the evaluation, particularly around the cross-agency collaboration, to Kisha's earlier comments around health equity and how that is a drive for this Commission. I think it's going to take some of that cross-collaboration.

Tricia just highlighted some of the shortcomings of dollars. I'm a firm believer there's dollars in the system. It's just there in those silos. So I'm really interested in seeing how the cross-agency collaboration helps both drive the outcome for those incarcerated and then back out to the public as well as from a state budgetary standpoint of the reallocation of dollars driving through that system of care or continuation of care.

And then I also want to go on the record supporting Commissioners Heidi and Rhonda on the foster care and the youth.

VICE CHAIR DAVIS: Thank you, Bob.

Fred?

COMMISSIONER CERISE: Yeah. Thanks, guys, for a great report. It really points out -- it hits on -- in my mind, I'm trying to think of other relevant issues, and it

hits on pretty much all of the topics that I would think about.

To just emphasize a few, on the data-sharing piece, that will be important and important to emphasize because, as you know, out of the jails, they're not on the same information systems everybody else is on because those systems tend to be built around billing or with other functions for practices, and that's not a piece of what's going on with the jail providers.

And so if we're going to connect information from there, in addition to the administrative, which I agree with Heidi, to do continuation of care in an organized way, paying attention to that and investments in data, health information systems, on the jail side is an important piece of that.

And then I agree with Martha's point about the providers. In many areas, it's already difficult to get access to providers in Medicaid at baseline, and then you're talking about a special population coming out of the jail where you need certain -- you know, you've got certain timing constraints and whatnot and challenges sharing data. And so if you can find some provider groups that can create

capacity or can work with the correction system to create that capacity, I think that would certainly help towards coordinating that transition as opposed to kind of an any-willing-provider thing, which you can imagine it would get chaotic.

And then on the monitoring side, I think there's some opportunities to impose some discipline on the jail side with things like HIV screening, SUD screening, initiation of treatment, and those sorts of things. So I'm not sure what measures that we have in mind, but there will certainly be some opportunities to take a population that's going to have some high-risk behaviors where you're going to have a higher prevalence of those sort of conditions and put some kind of quality metrics in place on the jail side. But then you're going to naturally need transition to providers, once they're released, and so there would be some good opportunities to push quality metrics that way.

VICE CHAIR DAVIS: Thank you, Fred.

Dennis and then Sonja.

COMMISSIONER HEAPHY: Thanks.

To me, I can't overstate the importance of peers and removing any barriers to engaging with peers and

actually finding what best practices are actually out there now that can be promulgated in other places.

And then I heard from an organization the other day that they couldn't hire a person because of their felony record. The insurance policy they had wouldn't allow them to hire this person. So barriers like that, I think we need to look into it and better understand what are the barriers to hiring folks to do this work.

Another question is -- this is a great start, but what about home- and community-based services? These are folks who have actually been getting services in the general system, and will they need some of those same services when they leave incarceration?

And then the last one is dual eligibles and what percentage of folks are dual eligibles. Is there opportunity through D-SNPs or other vehicles to improve access to services through D-SNP or MCOs for dual eligibles? Actually, this last conversation we had last month really was exciting, and we started engaging actually in conversation with folks engaged in the 1115 waiver here in Massachusetts and trying to figure out what can be done here. We're not there yet, but I think it

would be really helpful to understand that.

VICE CHAIR DAVIS: Thank you, Dennis.

Sonja. And then we'll come back to Heidi.

COMMISSIONER BJORK: Thanks. What an exciting time in California. This is just a great development. Yeah. And the state has already begun meetings with health plans, and we have a great schedule of meetings to start rolling this out, and I thought your chapter was so well written. And I appreciated how you highlighted the feedback we got from the panel in December. They gave great examples of what some of the challenges will be.

And I just want to make sure that our future work really emphasizes the challenges of the data sharing because even if everyone has the best intentions and they go to all the meetings and they really want to work together, if we're unable to exchange information about who we want to serve, who needs the help, it's going to cause great frustration. And sending Excel spreadsheets back and forth, it won't work for very long.

California is providing some of this incentive funding, because this is not easy and it's not cheap to change data systems or even purchase a care coordination

system, and I think that should be an important factor looked at for any of the waivers. You can't do it for free. You can't expect the jail to go ahead and cover that out of their budget with no help. And so that will be a good factor to look at.

Thank you.

VICE CHAIR DAVIS: Thank you, Sonja.

Heidi?

COMMISSIONER ALLEN: Thank you.

All of this has just kind of brought me back to a thought that I had had during the panel, which is going back to jails and the short stay that many people have in them and the conditions that people come in with, like HIV or substance use disorder, and the fact that they are likely being served in community clinics and FQHCs, so that those are the same providers that are serving jails, as from your report, if I understood correctly, which is different from prisons, which tend to be outsourced. But jails are using providers from safety-net clinics was my -- was that correct?

MS. BECKER ROACH: Yeah.

COMMISSIONER ALLEN: So what about telehealth?

What about continuity of care? What about letting people have telehealth visits with their SUD and HIV providers while they're in jail? I would hate to create a system with these artificial churning relationships when the foundation is already kind of there for continuity. And then really all that would be required is an agreement that telehealth can happen and, you know, that it's not some special Medicaid and some weird like little thing where we shifted into a new program with new providers doing the same things, and then it's like you have a 45-day period where of these Medicaid providers and then you have these Medicaid providers and then you have these Medicaid providers, when we have the technology. And the pandemic gave us the infrastructure and the ability to do telehealth, and so much of this could be done by telehealth. It doesn't require a physical evaluation. It requires, you know, conversation.

So I don't even know if this is part of the conversations, but it just seems like such an obvious thing for me.

VICE CHAIR DAVIS: Thank you, Heidi.

Darin?

COMMISSIONER GORDON: There's been a lot said. There's one area that we haven't talked a lot about. It is on the maintenance of effort, and I think some of the discussion about capacity issues and other concerns, it would be interesting to get a sense of that reinvestment plan and how they're allocating those resources. I think there's a lot of lessons that can be learned for other states in that.

In the same regard, it says that they can't use the federal funding to supplant existing state or local funds. It will be interesting looking at what that reinvestment plan is because it will also help shed a light on what wasn't being provided in correctional settings and where there's maybe gaps there. I think that can inform future policy and others that are venturing to do something similar to California. It may just shed a light to some of the greater opportunities.

Thank you.

VICE CHAIR DAVIS: All right. Thanks, everybody.

I think we gave you a lot. As you can tell, folks are really excited about this chapter. A few themes that came up, I think we hit on all of the topics that you

all are highlighting with kind of special emphasis on that continuity of care and cross-agency collaboration.

I do think it's worth calling out in the chapter where we see deficiencies. There isn't -- there's a lack of a lot of information around dental and what's provided, and that might be something that we want to call out specifically.

Again, thinking about next steps, looking at foster care and youth specifically and calling out that continuity of care, I think this isn't going to be the last time we visit this. But we may want to get to the point where we are talking about lessons learned from this demonstration. What do we think Medicaid care for justice-involved folks should look like? What should be in those programs? How do we make sure, continuity of care being something that is prioritized all along the way?

So anything additional? I hate to ask. Is there anything else you need from the group?

MS. BECKER ROACH: I don't think so. This has been really helpful. I think we have a good sense of sort of where you're interested in us really underscoring some of the topics that we discussed today, so thank you.

VICE CHAIR DAVIS: Thank you both. It's a really good chapter. Look forward to seeing the finalized product in April.

MS. BASEMAN: Thank you.

VICE CHAIR DAVIS: All right. We're going to keep moving and invite Martha up to the table. This is to talk about our ongoing topic, talking about the unwinding of the continuous coverage requirements and other flexibilities, part of our continuous monitoring of this in our role as an advisory.

So, Martha, I would invite you to take it away.

UPDATE ON UNWINDING THE CONTINUOUS COVERAGE REQUIREMENTS AND OTHER FLEXIBILITIES

* MS. HEBERLEIN: Sure. Hello, Commissioners. I will begin today starting with a brief background on Medicaid's response to the public health emergency, or PHE, as well as some updates on recent legislative and administrative actions. I will then share some findings on state preparations for the start of the unwinding.

As you know, 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 PHE ended, while the FMAP increase was available through the end of the quarter in which the PHE ended. The uncertainty of when the PHE would end created challenges for states' ability to plan as well as to notify beneficiaries and engage community partners.

The Consolidated Appropriations Act, or CAA, passed in December of 2022, made a number of changes to the FFCRA provisions. Separately, the Administration also announced plans to end the PHE writ large on May 11th. So as a result, what we have all been waiting for, implementation of the unwinding, can now begin.

So to the specifics. The CAA ends the continuous coverage requirement as of March 31, 2023. Consistent with earlier guidance, states must initiate renewals within 12 months and will have 14 months to complete all pending actions. States also have flexibility in how to prioritize and distribute the workload, and as you heard from last

month's panel, states are taking different approaches here.

The CAA also phases down the enhanced matching rate over the remainder of 2023. To be eligible for the enhanced match, states must comply with the existing requirements regarding processing renewals as well as those authorized under a temporary waiver authority or other alternative processes approved by the Centers for Medicare & Medicaid Services, or CMS.

States must also attempt to ensure current beneficiary contact information by using the National Change of Address database, state health and human services agencies, or another reliable source of contact information. States are also required to make a good faith effort to contact an individual using more than one modality such as telephone, email, or text messaging before terminating them at renewal on the basis of returned mail.

The CAA also adds specific reporting requirements. For each month from April 2023 through June 2024, states must submit data related to the unwinding that the Secretary must make available publicly. Finally, the CAA provides CMS with additional enforcement mechanisms, including establishing corrective action plans with

specific timelines, the ability to suspend some or all procedural disenrollments, as well as impose civil monetary penalties for noncompliance.

Since our last meeting we held calls with CMS, several state-level associations, a national beneficiary organization, and a plan association to get a better sense of what is happening on the ground.

As we have discussed at prior meetings, states and CMS have been preparing for unwinding the continuous coverage requirements for some time, but most states have not yet started to process redeterminations. According to our conversations, more than half the states were aiming to begin the process in April and another quarter are beginning in March. About 8 are initiating renewals in February. So these 8 states are processing redeterminations and sending out renewal packets now, and in some of these states, disenrollments could begin as early as April 1st.

Many states have also solidified their plans and are beginning to share more information with advocates. States are also working with CMS to adjust plans as necessary to meet the time frames described in the guidance

that was released post-CAA. We also heard that states are prioritizing implementing their plans rather than publicly posting revisions given resource constraints, so it is unclear if we will see updated operational plans.

States are also increasing their communication efforts with beneficiaries. In some states there has been a shift toward letting beneficiaries know that redeterminations will be beginning while in others, efforts remain focused on updating individuals' addresses.

As I previously described, under the CAA states must attempt to update contact information as well as make good faith attempts to follow up with individuals following returned mail at redetermination. And while all states have been attempting to secure current contact information throughout the PHE, there are a number of issues that may make these processes more difficult for states to implement.

Specifically, it was noted in our conversations that the sheer volume of returned mail that states are anticipating is a concern, particularly in light of ongoing staffing constraints. In addition, a typical renewal strategy a state may have may be to send out a prepopulated

renewal form and then follow up with an email or other communication without waiting for returned mail. So such processes are often built into systems and the ability to pause the process when returned mail is received or until additional outreach occurs may not be possible. There is also significant state variation in how long it takes for mail to be returned and processed.

Furthermore, there will likely be additional work for states as they reach out to individuals through multiple modes, and there were concerns raised that this could shift staff to calling individuals, for example, rather than processing renewals. Additional avenues for outreach, such as through plans, may help increase responses from individuals and alleviate some of the state burden.

As noted, the CAA required specific state data reporting. However, in guidance CMS noted the alignment of the new requirements with existing data reports as well as that CMS plans to report the federal exchange data. So this will likely ease state reporting burden. However, there may be some metrics that may require additional state effort such as exchange enrollment or call center data

where they may not currently be reporting it.

The advocate noted the importance of the requirement to release the data publicly, although expressed some concern about the lack of a concrete timeline to do so. CMS has repeatedly noted that it is planning on releasing the data but is still working through the timeline and format of that release.

All stakeholders also noted the need to provide context around the data, and CMS specifically noted its intention to work with states to understand the data that they are submitting and the conclusions that can be drawn from them.

CMS oversight and compliance efforts are anticipated to focus on the renewal process given the ties to the enhanced matching rate. CMS is providing direct support to states to develop strategies, and depending on state circumstances this support could include efforts to improve existing processes to comply with ex parte requirements or using multiple modalities to allow individuals to report information.

Some mitigation strategies including using Section 1902(e)(14)(A) waivers have been raised in CMS

technical assistance materials. However, there was also an acknowledgement by state groups that some of these responses could require system changes and may take longer to implement.

We have long heard that staffing is a key concern with high vacancy rates in states and large numbers of eligibility workers who have not processed renewals before. To address these concerns a number of states report a focus on contingency planning and monitoring specific metrics such as processing times that may indicate an issue that requires a change in their staffing approach. These actions could include authorizing overtime or weekend work or allowing the state to implement an emergency contract to assist with call center volume or returned mail.

State staff are also working to assess when and how to unwind other flexibilities and which to make permanent, at the same time that they are preparing to restart determinations. There will also be additional downstream effects on state budgets and other features of the Medicaid program, such as managed care payment rates, that administrators will need to address during the upcoming year. Also in states that have some degree of

human service integration the end of the emergency food assistance allotments may also have implications for staff workload.

So as the unwinding unfolds, staff will continue to monitor the release of CMS guidance as well as state operation plans and data reports. Additionally, we are going to hold follow-up calls with the folks we talked to as well as some provider groups between now and the next meeting to gather updated information on what they are hearing from the ground, and we will report back.

Additionally, because more time will have elapsed since the passage of the CAA and more states will likely have begun the process, we anticipate additional state-level information, including Tricia's survey, on early efforts related to the unwinding that we can share more in April.

So with that I will turn it over to the Commission for questions and discussion.

VICE CHAIR DAVIS: Thank you, Martha. You know that this is really important to all of us, and I think it is reassuring to see the framework that is starting to shape up. We will open it up. Tricia will get us started.

COMMISSIONER BROOKS: Yeah. I just want to point out what Martha commented on, that CMS has said that these data are not new data. So I don't know if folks are aware of the performance indicators that states are supposed to submit to CMS. Those date back to October of 2013, 10 years for over 80 indicators, and the only data we have seen in that 10 years are now consistent enrollment reports. We started to see application processing times once a year for a quarter for 5 years. They are now releasing those quarterly. And I think application volume is actually in the data set.

But as you can see, there is a ton of data that has not seen the light of day. So I just want to point that out because the Commission is so focused on transparency and having the data that we need to make informed decisions and recommendations.

But Martha, good work. We know how hard it is to follow all the moving parts here.

VICE CHAIR DAVIS: Thank you, Martha. And we will go to Martha.

COMMISSIONER CARTER: I am reacting to a bit of information that I saw on my state's SHIP, the State Health

Insurance Assistance Program. Is that right? It is close. And there were some special questions about people who are dually eligible. Are there any effects, and do we want to be tracking the effects for people who Medicaid pays for their Medicare premiums or people who are in integrated dual plans, and what happens to them if they become disenrolled from Medicaid? So just a population we haven't really talked about, and I don't know enough to even ask a good question, but just to raise it as a question.

VICE CHAIR DAVIS: Thank you, Martha. Other questions? Yeah, Heidi.

COMMISSIONER ALLEN: I think we have talked a lot, as a Commission, over the last year about how we can be helpful and gives states the opportunity to have their concerns amplified, CMS to respond to the concerns. And I know that there are states for which we have better information and states that we have little information. And I am wondering if it would be possible to invite the states for whom we don't really know what's happening to come, with an invitation to tell us what their struggles are, so that an action item that we can do is to help amplify the voices of states that might really be losing a

lot of people and what help would look like for them on that.

And then I also just keep coming back to this returned mail situation, and it doesn't seem like there is any -- at least I haven't heard and maybe I missed this -- but that there isn't a reset of the clock when you get these returned mails, and that sometimes the returned mails you don't even know they are returned until after the eligibility window has already closed, and yet from what I can see just nothing happens then.

And it seems to me like that is, administratively, you are going to be processing all this returned mail as well. It seems like administratively to just set that clock from the date that you got the returned mail and start over could be something. I just don't know what it would take to do something like that, but I am very interested in trying to think of a solution to that problem.

MS. HEBERLEIN: I think it depends a little bit on the state system. We heard in some of our conversations that the process is built in. And so whether or not they can track multiple modalities of outreach and whether or

not they have a process for when they get that returned mail that comes back in depends upon the timing of it. Like if you were saying, you know, the 30 days have already lapsed to respond, if that comes in after the 30 days what is the process for then either reinstating or reaching out to the beneficiary.

So I think in some states it may be the case that they have a process that allows for that stoppage, but we definitely heard that in some states that is not built into the system and pausing would be difficult. I am curious to hear what Tricia has to say.

COMMISSIONER BROOKS: So according to the surveys we have done in the past, there are only about 10 states that proactively update addresses all the time -- that is not now; that is in the past -- and another 10 perhaps that do follow-up on returned mail beyond just mailing the notice to the old address.

So there is a lot of work that needs to be done, but CMS has put out a tremendous amount of guidance delineating on the actions that are needed for if mail is returned with an in-state forwarding address versus an out-of-state forwarding address versus no forwarding address.

And there is a provision for reinstatement if mail comes in after the termination, which I actually was surprised to see.

But for in-state forwarding addresses the state is not supposed to take action at all because it does not impact eligibility, and yet they still don't have to necessarily send to the new address.

So there are definitely some hiccups here, but I do feel like CMS has pushed on this a lot, and also, we saw that in the eligibility and enrollment NPRM that came out that I think they are seeking permanent changes. So I think we are moving in the right direction on this. There are still some hiccups, and states weren't quite ready for all of this because the CAA was sprung upon them at the end of the year.

VICE CHAIR DAVIS: Thanks for the question and for the additional clarification. That's really helpful. We will go to Dennis and then to Rhonda.

COMMISSIONER HEAPHY: Thanks. Just to bring in some beneficiary perceptions, what we are hearing from folks is real concerns about the competency and the capacity of the call centers, because already people find

that the competency of the call centers is not great, and so there is concern about them actually being up to speed and being able to deal with these issues.

And then there is a lot of confusion among beneficiaries in general about Medicaid and the benefits, but people are receiving multiple mailings all the time from Medicaid, and being able to distinguish one mailing from other. Right now in Massachusetts people are being switched from one ACO to another ACO, and then they have been getting mailings about that, and they are also getting this mailing about the ending of the PHE.

But I have had conversations with people explaining to them, "You have to do this." "No, I have no changes." "No, no, this still applies to you." And helping people understand that this is a requirement that they have to actually follow through and that it does apply to them. Literally, I have had multiple conversations with people who don't understand the idea that they are on Medicaid, and why are they going to be taken off Medicaid if they have been on Medicaid for years? And so that idea that this is going to affect them is still challenging.

And then another one is making sure that there is

plain language used, not just in English but in other languages, like Spanish. A lot of concern about non-English speakers and how this information is actually going to get through to them and make sure like how are we going to be tracking transparently to folks who are being disenrolled by language as well as race.

MS. HEBERLEIN: Yeah, so a few thoughts. One is that there are a number of states that are doing something fancy with their mailings about the PHE. You know, we heard about the pink letter envelope campaign. You know, states are using red stamps. New Mexico is doing turquoise envelopes, which I always thought was fascinating.

So I think states understand that beneficiaries get so much information that they are trying to figure out ways to show that this is something you really need to open and look at.

I think the language access and access for individuals with disabilities has often come up, and CMS just put out another resource last week about the requirements that states need to meet to provide accessibility for people who are limited English proficient and who have disabilities.

And so I think there is recognition that it might be more difficult for those populations and that they are trying to put out resources to get ahead of that or at least help support states in that.

COMMISSIONER HEAPHY: Turquoise, whatever color the envelope is, when people receive that -- and I have heard this from people in the last couple of weeks -- that that envelope is paralyzing. And when they receive that they don't want to open it because they are afraid of what it is going to say. And it sounds like, it's your responsibility to do this, and whatever folks might say, that seems logical. But for folks in the population that letter spells danger, and put it in the corner and hopefully it will go away.

And so I just think we need to realize that the population we are dealing with has got a lot that they are dealing with. I don't know what else to say about that.

CHAIR BELLA: Just for some levity to explain it, turquoise because their program is called Turquoise Care. So it is not as random as it might seem.

MS. HEBERLEIN: Well, isn't the state gem turquoise? I just appreciate that it is a different color,

right?

VICE CHAIR DAVIS: Thank you, Dennis. That is a really good perspective to make sure that we are keeping at the forefront.

Rhonda and then Darin.

COMMISSIONER MEDOWS: I know we always talk about snail mail and the count about what gets returned, what doesn't, what gets responded to, what doesn't, but I really think we need to actually just ask the states what are they doing. I know that they must be keeping a head count on calling and texting and emails, those kinds of stats for their communication strategy. It would be kind of cool to be able to see what they are doing with those. I am willing to bet that more and more of them are relying on that to actually reach people as opposed to snail mail. I think that would be really important. And then the different languages is an obvious one.

VICE CHAIR DAVIS: Thank you, Rhonda. Darin?

COMMISSIONER GORDON: I just would like to continue to have some focus on the expiration of the Appendix K waivers and states making transition, issues in states making transitions to continue some of those

authorities if they see that they are helpful. I think that is something that gets mentioned but it is like a subpoint to all the other things that we are talking about.

But, I mean, there were a lot of good lessons learned through the PHE, and a lot of those flexibilities, I know by different groups, believe they were incredibly beneficial and should not expire. But I don't really have a good sense where states are in the process of continuing the things that they think are helpful.

MS. HEBERLEIN: Yeah. We have done a little bit of looking. It is not always easy to disentangle from the operational plans. You know, a lot of them only focus on unwinding the continuous coverage period. And if they do include some of those details it is like, "We are going to continue these," but it is not at the concrete level. So we have been trying to figure out how to gather that information in a more comprehensive way, across the states, and to be able to be more specific about what they are continuing and what they aren't.

They also have six months after the end of the PHE from which to run those out. So in pecking order of where their priorities are that might be further down the

list, although we definitely have heard CMS is looking at it and a number of states are thinking about it. So we can certainly try to keep an eye on it as best we can.

VICE CHAIR DAVIS: Thanks, Darin. Yeah, Melanie.

CHAIR BELLA: Yeah. I just want to say, and Heidi mentioned this earlier, our ability to stay close with states I think is just going to be really important and CMS during this period. This is all new for everyone. And I realize they are going to be so busy doing what they are doing that they are not going to have a lot of time to talk to us, but continuing to figure out the best ways that we can stay close to them and opportunities for them to come before us, as the work continues, I think is an ongoing request of the Commission.

VICE CHAIR DAVIS: Thanks, Melanie.

The one thing I haven't really seen leveraged, and maybe you have seen information, but really leveraging the primary care relationship with patients. It is really difficult for the PCP to know where their patient is and the status, and we get updates from MCOs about who is on our rolls. And so that is something that I think could be leveraged more, and say, "Here is who is on your rolls and

here is who is likely to be terminated." Maybe those conversations go a little bit easier when it is coming from their PCP rather than getting the turquoise letter in the mail. And so really trying to engage that provider community and having that conversation with their patients.

We have talked some about community health centers also and how can we leverage them more in using their care navigators and social workers to help folks with that transition so they are getting onto exchange plans or other options that might be available, or even getting onto a sliding fee scale within the community health centers.

So I don't know if you've seen anything or if there is anything that's included on that.

MS. HEBERLEIN: I have seen more on states engaging plans, I think partly because of the FCC guidance but also because of the waiver opportunity that CMS has put out there prior, of getting the address from the MCO without requiring the beneficiary's approval of that address change. So there has been a lot more talk about how to engage and use plans that I have seen than providers, which is why I mentioned we are going to make sure we talk to providers between now and the next time

because I think especially as states start to kick it off, the first time you may learn that you don't have coverage is when you go to an appointment or try to pick up a prescription.

So I think we can learn more from providers. We've heard some from states that as they are developing their plans, they have engaged providers and talked with them, but we haven't heard as much on using them to make sure that the renewal form is in and that way. But we can follow up and see what more we can learn.

VICE CHAIR DAVIS: Yeah. Melanie, to this point, but also thinking about pharmacies. You are coming in to pick up your prescription. You are going to expire next month. Let's have a conversation now, before you are coming back next month to get it.

CHAIR BELLA: Yeah, I am really glad we are talking to the providers. I mean, I have gotten some feedback which is they are being told that they will run afoul of inducement if they are kind of playing too big of a role. But it would be no different than the role that CMS has allowed the plans to play with regard to getting updated information.

So thinking about, I would say the same thing for some of the community-based organizations. I just don't think it's as clear. And so if we can understand that and see if there are ways to give them similar flexibilities to what the plans have -- now I am sure that there are tradeoffs to doing that as well, but I am glad to hear that you are doing that, because that does seem to be a missed opportunity potentially.

VICE CHAIR DAVIS: Thanks, Melanie. Tricia.

COMMISSIONER BROOKS: I totally agree. We really have tried to talk to CMS about giving the same authority to providers, because I don't know about anybody else but I can't walk into the doctor's office without absolutely confirming my address, even if I tell them that it hasn't changed in 27 years. And I don't understand what the hiccup is there because these are providers that are credentialed as Medicaid providers. There is a HIPAA relationship here already for privacy, and the front line are the best source for keeping addresses up to date, if states would provide them with the authority to do that.

And I would like to go the route of the (e)(14)s. Those are the (e)(14) waivers that Martha is referring to

on the MCOs, where the MCO is supposed to verify directly with the member and then they can report it to the state, and the state accepts that as reliable information. We should be doing the same for providers, absolutely.

VICE CHAIR DAVIS: Thank you, Tricia. Yeah, Heidi.

COMMISSIONER ALLEN: I was just going to add onto that, that most of these clinics have social workers that could just sit down with somebody and help them do it too. So it's not even just identifying and communicating information. There are actually resources available often to handhold somebody through the process, whether that's just connecting with the state or getting their documents in order.

VICE CHAIR DAVIS: Thank you, Heidi. Verlon?

COMMISSIONER JOHNSON: So just clarifying a question. I guess I thought the providers were engaged in some ways. It's just more around this issue of -- oh, I'm sorry. Go ahead, Tricia. No. I'm asking a question.

COMMISSIONER BROOKS: Outreach.

COMMISSIONER JOHNSON: Okay. This is an outreach perspective. Okay.

COMMISSIONER BROOKS: And CMS did provide some graphics for providers. It is on the unwinding website. But going back to the point of not all providers can see renewal dates in their portals. They seem to be able to get more information from the MCOs than they are able to see directly. It is very random from state to state. And it seems to me that the renewal date should be something that all providers should be able to see and check at any time.

CHAIR BELLA: And they can't update the information like the MCOs can, which doesn't make a lot of sense.

COMMISSIONER JOHNSON: No, it doesn't.

CHAIR BELLA: You hope it's more of an oversight as opposed to intentional. Or if it is intentional, it would be helpful to understand why.

MS. HEBERLEIN: Yeah. As Tricia said, they have done a bunch of graphics, like rack cards, which are like the small things that say, "By the way the unwinding is starting. Check your date. Check your address and make sure it is up to date." So it has been more on the outreach side. I don't know enough to speak to what the

legal barriers are.

I think there are some things, as Darin and I have talked about numerous times, what is the truth source of what the data are and where that comes from and who controls that. And I think that was some of the concern with the MCOs sharing the beneficiary information that they have, that that would override the state system and that you would want to make sure what you are getting from the MCO is correct.

So I don't know if some of those same concerns trickle down to the provider level, but that's something we can dig into more.

VICE CHAIR DAVIS: All right. Thank you, Martha. This -- well, it always gets us excited to talk about this.

So I think that's all we have from the Commission. Any other questions that you have for us? I think you have lots of suggestions for next steps when we talk about this in April.

MS. HEBERLEIN: I will see you next month.

CHAIR BELLA: All right. Thank you.

We really should put this session after lunch or at the end of the day to keep us fired up, right?

Thank you, Martha.

CHAIR BELLA: We are going to take public comment on the three sessions we have had this morning. So we will open it up to the public. I will remind folks to please state your name and the organization you are representing, and we ask that you keep your comments to three minutes or less.

So we will see if we have anyone who would like to speak.

PUBLIC COMMENT

* [Pause.]

CHAIR BELLA: I do not see anyone. There will be another opportunity for public comment this afternoon.

So that wraps the morning. We are taking a lunch break and we will come back at 1:00 to talk about duals. So thank you very much. We will see you back here at 1:00.

* [Whereupon, at 11:54 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: Welcome back this afternoon, and we are going to kick it off -- welcome, Kirstin and Tamara -- kick it off with findings from some focus groups with dual eligible beneficiaries. Turn it over to both of you.

FOCUS GROUP FINDINGS: EXPERIENCES OF FULL-BENEFIT DUALLY ELIGIBLE BENEFICIARIES IN INTEGRATED CARE MODELS

* MS. HUSON: Okay. Good afternoon, Commissioners.

So, as you know, integrating care for beneficiaries dually eligible for Medicaid and Medicare is an ongoing area of interest for the Commission, and MACPAC's recent work led to a recommendation in our June 2022 report to Congress that all states should develop a strategy for integrating care for dually eligible beneficiaries.

And while the Commission's work has examined the range of integrated models available as well as state strategies to integrate coverage for their populations, we had not heard directly from beneficiaries about the experience of being enrolled in these models. So in order

to better understand what dually eligible beneficiaries enrolled in integrated care value about this type of coverage, MACPAC used a contractor to conduct focus groups.

Okay. So I'm going to start with a quick background.

So based on data from the most recent duals data book, we know that in 2020, 12.2 million individuals were enrolled in both Medicaid and Medicare, And for this population, Medicare is the primary payer for acute and post-acute care services such as primary and specialty care. Medicaid is then the secondary payer and wraps around Medicare by providing assistance with Medicare premiums and cost sharing and covering services not covered by Medicare, primarily long-term services and supports, which includes both institutional care and home- and community-based services.

The division of coverage between the two programs, however, can result in fragmented care. Lack of coordination also creates opportunities for cost shifting between the two programs.

As a result, the goal of integrated care is to better align delivery, payment, and administration of

Medicaid and Medicare services, which in turn may improve care for dually eligible beneficiaries, eliminate incentives for cost shifting, reduce spending that may arise from duplication of services or poor care coordination, and promote equity.

Integrated care models can provide beneficiaries better access to the full range of covered services in both programs and access to care coordinators or care teams who can establish person-centered care plans. And as of 2020, just over 1 million beneficiaries received care through highly integrated models.

There are a number of integrated care models offering varying degrees of clinical and administrative integration, and many states use more than one model. Under the Financial Alignment Initiative, FAI, states enter into three-way contracts with CMS and Medicare and Medicaid plans called "MMPs." The MMPs are responsible for all aspects of the beneficiary's Medicaid and Medicare coverage. The three-way contracts include provisions for health risk assessments, individualized care plans, and access to a care coordinator for each beneficiary.

Fully capitated MMPs provide high levels of

integration because all services are provided by a single organization that receives capitated payments from Medicaid and Medicare, and MMPs operate in eight states.

Dual eligible special needs plans, or D-SNPs, are Medicare Advantage plans designed to meet the needs of dually eligible beneficiaries. They are present in most states and enroll millions of dually eligible beneficiaries. They are required to enter into contracts with states in order to operate. They provide Medicare coverage and may coordinate Medicaid benefits or even cover some Medicaid benefits depending on the type of D-SNP.

Coordination-only D-SNPs, called "CO D-SNPs," provide minimal levels of integration because they coordinate Medicaid services rather than covering them, and they are present in 35 states.

Highly integrated dual eligible special needs plans, HIDE SNPs, and fully integrated dual eligible special needs plans, FIDE SNPs, cover some or all Medicaid services and typically provide a higher level of integration than D-SNPs without these designations. And HIDE SNPs operate in 16 states and D.C., and FIDE SNPs operate in 12.

Finally, another FAI model is found in Washington, which is the only state that uses a managed fee-for-service model.

And for the purposes of our focus groups, we categorized coordination-only D-SNPs as providing a low level of integration and the rest of the models as providing a high level.

So we contracted with NORC at the University of Chicago to conduct focus groups to hear directly from dually eligible beneficiaries, and NORC identified, screened, and invited all focus group participants and conducted each of the focus groups. They conducted 10 focus groups with 40 participants virtually in November 2022 through January 2023 in five states. This included one Spanish-speaking focus group with five participants from New York. Due to challenges recruiting participants, NORC also conducted an additional 15 in-depth individual interviews to give us a total of 55 participants.

On this slide here, you can see the five states that we selected. We aimed for a representative sample based on geographic region, political leaning, population size, rurality, and integrated model types. We were

interested in hearing from beneficiaries enrolled in D-SNPs offering varying levels of integration.

And so as you can see, all of our selected states have CO D-SNPs, but the presence of HIDE SNPs and FIDE SNPs varies across the states.

In addition, we wanted to include states operating FAI demonstrations. So New York, South Carolina, and Texas are operating capitated model demonstrations providing coverage through MMPs. And then we chose New York specifically so we could hear from enrollees in the state's Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities program, or FIDA-IDD. And this is unique among the integrated care models in that it integrates coverage for people with ID/DD, which is a population typically left out of integrated care efforts because of the complexity of care needs and concerns around disruptions to care networks for this vulnerable population.

And then, finally, we chose Washington so we could hear directly from participants in the state's managed fee-for-service model, and Washington's model leverages health homes to integrate care and is seen as a

potential model for fee-for-service states unable to use Medicaid managed care to integrate coverage.

So, as I already mentioned, our focus group design included a comparison group to assess how beneficiaries' experiences enrolled in plans with higher levels of integrated care, which again, we defined as including FIDE SNPs, HIDE SNPs, MMPs, and managed fee-for-service compared to those enrolled in plans with lower levels of integrated care or, in other words, CO D-SNPs. And we had 21 participants who were enrolled in CO D-SNPs and 34 who were enrolled in the plans with higher levels of integration.

And then here you can see this table, which depicts the study participant demographics. We aimed to recruit a diverse group of participants as part of MACPAC's commitment to advancing health equity, representing a range of different races and ethnicities, ages, and geographic locations.

Again, we had a total of 55 participants, and as you can see, we had 22 male participants and 33 female, 33 participants under the age of 65 and 22 people age 65 or older, 7 rural participants and 48 urban, and just over

half of participants identified as white and just under half as another race or ethnicity.

I'll also note that eight participants were caregivers of dually eligible beneficiaries, seven of which were family members and one was a paid caregiver.

So to move on to our findings, our first finding is around enrollment experiences. Here participants described taking various approaches to choosing their plan and receiving assistance from different sources, however, we did not hear noticeable differences in the experience of enrolling between those enrolling in plans with higher and lower levels of integration.

Many participants describe getting help from family or friends as well as conducting their own research on the internet. Some participants used brokers and described positive interactions, noting that the brokers spent a lot of time with them to inform them of plan choices and that they had lasting relationships. And finally, several members of New York's FIDA-IDD demonstration described hearing about the plan at its inception through information sessions targeted to the ID/DD community.

Participants commonly cited the ability to keep their primary care provider, specialists, or health system as well as costs as the most important factors in choosing a plan.

So here we have a quote from a participant from South Carolina who described all the factors they were looking for when choosing their plan, including some of the most common ones, which are costs and provider networks.

Most of what we heard from participants about access was focused on Medicare-covered services, such as primary care, urgent care, and specialty care. And for the most part, study participants did not report issues accessing primary care, and most reported having a PCP and liking their PCP.

Some participants had used telehealth when they had a more urgent primary care need. Many participants also relied on urgent care and described the importance of their urgent care providers. People found this to be a convenient option, such as when they needed a same-day appointment or on the weekends when their PCP offices were closed.

And so this quote and the one that I'll show in a

second on the next slide emphasize the points I just made. So here, this individual is describing their good relationship with their PCP and the ability to make appointments. And then here, this participant is describing how urgent care is a convenient option for them.

Most focus group participants also reported seeing specialists with no appreciable differences among participants in the different types of integrated plans. So participants had between one and six specialists with the average being three, and most participants do not have difficulty finding specialists who are taking new patients and accepted their plan. However, they did describe long wait times for an initial appointment. Once established, though, participants largely described regular appointments and sufficient access.

A few participants, however, did describe calling their plan and getting recommendations for providers who are no longer accepting their insurance, and participants living in rural areas also reported challenges accessing providers due to a lack of local specialists and transportation barriers.

Participants with mental health care needs

experienced challenges accessing providers regardless of plan type. Challenges included a general lack of local providers, high turnover of mental health providers, and long wait times. Some participants also noted how few of the available providers accepted their coverage, and therefore, they paid out of pocket and returned to other options like the county health system or telehealth services.

And so here, one Spanish-speaking participant describes difficulty finding a mental health care provider, and they said, "Before the pandemic, I had the psychologist. Then after that, I didn't because the psychologist left that place, and they didn't take my insurance, and it's a little bit difficult to find someone to take my insurance and close to where I live, because they always send me to another town."

Next on care coordination, overall we heard about half of focus group participants reported having a care coordinator, but variation did exist by state and by plan type. So, for example, all of the participants in the New York FIDA-IDD demonstration and in Washington had care coordinators, but in Texas, for example, of those and plans

with higher levels of integration, only one participant said they had a care coordinator, while others indicated they had been offered the service but declined it.

And so participants had mixed experiences with care coordination, and few reported having a formal care plan. Many participants noted frequent turnover of care coordinators and did not feel like they were getting much value out of the service.

Participants in New York's FIDA-IDD and in Washington, however, reported positive and robust relationships with their care coordinators and had care plans that they revisited regularly and contained goals related to their health.

And I'll note that in Washington's program, the care coordinators are state employees as opposed to health plan employees, and the focus group participants appreciated how they retained the same care coordinator, even if they switched plans.

And then in contrast, only two participants enrolled in CO D-SNPs reported having a care plan with established goals.

And so here, one participant said "Having a care

coordinator who is also running the life plan meetings is a key benefit. They seem to really want to do the right thing. They want to be there. They want to ask the hard questions so we can work things out. The care coordinator is a key advocate."

During the focus groups, NORC asked participants about particular services covered by Medicaid, such as HCBS and transportation. A few caregivers and participants described receiving HCBS, as well as rehabilitation services after a hospitalization, and the importance of these services.

Caregivers for beneficiaries in New York's FIDA-IDD plan, in particular, emphasized the plan's coordination of HCBS as a strength of the plan. Several participants, however, described difficulties with obtaining and retaining home health aides, noting high turnover of these workers. Participants also reported mixed experiences with transportation benefits.

From MACPAC's prior work on non-emergency medical transportation, or NEMT, we know that dually eligible beneficiaries use NEMT with greater frequency than those only enrolled in Medicaid. And in these focus groups, we

generally heard that for those with transportation barriers, they were grateful for this benefit.

Several people, however, noted extended wait times or long travel times, and another person recounted how their driver dropped them off at the wrong location.

And these findings are largely consistent with what we heard in prior focus groups on Medicaid's NEMT benefit, which is published in our June 2021 report to Congress. Participants in those groups said how NEMT plays a vital role in facilitating access to care and was essential to maintaining their health. However, they also reported variation in quality and satisfaction.

And so here, you can read what a caregiver shared about HCBS, about how they found the residential and employment support services for their child to be lacking.

And then we have another quote describing the importance of NEMT where somebody said, "Our car broke down, and it was a very expensive repair. So we had to start using the transportation. That's been a lifesaver, because he's immunocompromised, I'm immunocompromised, and it's not safe for us to go on the bus or train. And it would take three bus rides, a train, and an Uber just to

get to the doctors."

And then in regards to experiences resolving issues with health plans, study participants -- their experiences largely centered around contacting the plan, specifically calling their health plans' customer service line for help. And all of the participants in the Spanish-speaking group said that their plans offered assistance in Spanish.

The majority of focus group participants were unfamiliar with the role of ombudsman in health care, and only one person reported working with one to resolve an issue several years ago. Most people were not even familiar with the term, although one person enrolled in the FIDA-IDD demonstration, who was unaware of the term, indicated that after they heard the definition that they understood who their ombudsman was and how to contact them.

Focus group participants also had limited understanding of the appeals and grievances process, and while most participants understood what an appeal is, very few had used the process. And participants had even less understanding of grievances, and very few participants reported filing a formal grievance. A few participants did

describe filing complaints with providers or their health plans most often due to issues with transportation and dental services.

And one caregiver for an enrollee in New York's FIDA-IDD program demonstrated the most robust understanding of these processes, actually detailing how they were currently going through the appeals process.

And finally, some participants reported receiving unexpected medical bills and working with either their provider or their plan to resolve it. While these bills were sent in error and participants were not responsible for paying them, focus group participants reported that the experience caused stress and frustration. And one person worked with their care manager to figure out how to resolve the unexpected bill.

And so here, one participant said, "I have heard of an ombudsman, but it wasn't in reference to any insurance issues. It was in reference to a nursing home issue for my dad." And again, many participants said similar things about having heard of ombudsman, but that they were unaware of their role in health insurance.

At the end of each focus group, NORC asked

attendees about their overall satisfaction with their health care coverage, and most people were positive. For example, most participants did not report having any unmet needs. Those that did reiterated points they had made such -- that they had made prior such as a lack of mental health providers or dental coverage.

And while most participants rated their plans highly, there was some difference with those in highly integrated plans rating their plans slightly lower than those in the CO D-SNPs. Most focus group participants in the CO D-SNPs rated their health plan between a four and a five out of five. Whereas, the majority of participants in higher levels of integrated coverage gave their plans between a three and a five.

And these are just two examples. But one person said, "I say five. I love my plan." And another person said "three because their network is very limited with the doctors that I want to see or have seen in the past. I don't understand why the insurances, all these doctors, why are they always in different networks? Once you get with a doctor, you want to keep the doctor, and it's not in your network. Their network is limited to me."

Okay. So overall, through the focus groups and the one-on-one interviews with beneficiaries, we found that beneficiaries are largely satisfied with their integrated coverage and are able to access the care that they need. We did not generally hear meaningful differences between the experiences of dually eligible beneficiaries enrolled in plans with higher and lower levels of integration.

One notable difference was that beneficiaries with higher integration reported being more likely to have a relationship with their care coordinator and to report having a care plan.

Participants enrolled in highly integrated plans also described more unmet healthcare needs and slightly lower levels of satisfaction, but this may be due to the fact that these individuals tend to have higher health care needs and therefore more interactions with the health care system.

And while the focus groups were designed to ask dually eligible beneficiaries about their overall experiences in integrated care, we did hear from a number of beneficiaries about challenges with accessing services that are primarily covered by Medicaid, including

behavioral health, HCBS and NEMT.

The challenges that participants noted are consistent with prior MACPAC work on each of these topics, and this additional evidence from the focus group attendees underscores the role of states in oversight and monitoring of integrated products and ensuring that beneficiaries have sufficient access to Medicaid services.

Hearing directly from beneficiaries is critically important to designing services and systems that meet their needs and to making informed policy decisions that affect their care. While we recognize that the results of this qualitative study may not be generalizable to the entire dually eligible population, the findings that people who have integrated care, whether at a high or a low level, are generally satisfied with their health plan, and the care they receive provides additional evidence for the importance of integrated care in successfully meeting the needs of dually eligible beneficiaries.

Elements of integrated care such as care coordination and person-centered care planning emerged as particularly beneficial for individuals with complex care needs.

Our findings reaffirm MACPAC's longstanding view that increasing enrollment in integrated care, making integrated products more widely available, and increasing the level of integration in existing products has the potential to improve care for beneficiaries. This work may also serve as an example of the benefits of stakeholder engagement and feedback on integrated products as states prepare for the transition away from MMPs.

And finally, next steps for this work are to include a summary of the findings from these focus groups in a descriptive chapter on integrated care in the June 2023 report to Congress. These findings will also guide us into the next work cycle as we continue our work in integrated coverage for dually eligible beneficiaries.

Thank you, and I'll turn it back to the Chair.

CHAIR BELLA: Thank you very much.

This will surprise none of you that I have spent a fair amount of time going through this and trying to understand a couple of things here, and so I just want to share those, some dialogue that we've had, and then we'll open it up.

So could we go back to a couple of the slides?

Can we start with slide 27, please?

I think it's really important for the Commissioners to understand that this was not an exercise in looking at the models against one another. This is not meant to say -- this was not meant for us to go head-to-head on a coordination-only versus a HIDE versus a FIDE, and I think some of that nuance may -- it's worth clarifying.

Also, on this slide, I want to caution anyone from taking too much out of the fact that people in higher integrated plans might have reported lower levels of satisfaction. Understand that, for example, the IDD demonstration in New York is arguably the most complex duals population in the country, and so they are a population with very high needs that need a lot of services and coordination and probably have a lot of interaction with their health plan. And so contrast that with someone in a coordination-only plan who may not have much interaction at all, and so the level of complexity of need and the amount -- and Tamara said this, but I think it's worth highlighting. I don't think we should over-index on people in higher integrated products are less satisfied. I

think there's a lot to tease out of that.

And on slide 30, similarly, the point of integrated products is so that people have like a go-to person that helps them navigate Medicaid and Medicare. So if we are finding things that people at higher levels of integration were more likely to have a care coordinator or a care plan, I also think those are important.

And again, I realize we can't generalize necessarily about that, just like I said we can't generalize about the less positive things, but those are the pieces I think we need to be teasing out, which is what is going on with people's ability to access a care coordinator and a care plan. And to do those things, I think we do need to understand within D-SNP coordination types, what are we seeing for people that are in them versus people that are out of them, if we're going to start to look at those kinds of things.

So I would like to ask that as we think about future work, we are looking at people who are in and out of various types of products, and we think hard about whether coordination-only folks are even included if we're really trying to understand how integration is happening between

Medicaid and Medicare.

And I'd also like to ask that we think about in the next work cycle, some focus groups that really drill into what is informing people's choice, because I appreciate that there was some question about that, but with the bombardment of Medicare supplemental benefits and brokers and Medicaid programs, it's so confusing. It's just getting more confusing every year, and so I think we really would do a great service if we would focus specifically on why people are making choices to be in or out of the more integrated products.

And I will now step down off the soapbox and see if other folks would like to comment.

Darin?

COMMISSIONER GORDON: I agree with all those comments. So you have someone else with similar viewpoints there.

But I'm thinking about when they approached all these beneficiaries in very different states, what I have found is in some states, they use some terms, and other states, they use other terms. And there's reactions, stronger reactions about using certain terms over other

terms. How did they account for that when they were doing these interviews, or was it pretty standardized?

MS. BLOM: That's a good question. I think that they tried to work with like people who had expertise in those states in terms of setting up like the recruitment interviews and stuff. So I think that they tried to take that into account, making sure that people understood what the questions were about like what plan you're in and what you're not in, but that is a difficult area. I mean, I think we did find that recruitment for this population was pretty challenging.

COMMISSIONER GORDON: Yeah, I'm sure.

And I think the other thing when I was reading this, just thinking about times where I had overseen like 19 health plans that were in the exact same product, and there was great variability in how well they did compared to one another. So I think that's the other challenge when doing this is you may have folks enrolled in a plan that is maybe fairly new at this or still transitioning and trying to learn how to do this well versus maybe a plan that's been in it for a while and has developed that muscle memory on how to do this well. So it does get challenging, and I

do want to acknowledge that. But these are good data points.

I do personally think looking at this in markets that have been doing this for a little while and looking at it and trying to find ways to compare that to folks that have never been exposed to these models, I think that's the better learning, at least from my perspective. That helps me understand it's at least moving in the right direction. I think that would be helpful.

CHAIR BELLA: Thank you, Darin.

Fred?

COMMISSIONER CERISE: Can you clarify a couple points? One is this population; these are people who are primarily living independently. These are people at home. This is not like institutional level of care. And if I'm reading that right, then what's the primary Medicaid services that you're coordinating? Because it sounds like most of this is Medicare.

CHAIR BELLA: You have to speak in the microphone.

COMMISSIONER CERISE: So it's HCBS --

CHAIR BELLA: It depends. So it's behavioral

health and long-term care, both institutional and community based, and so if you're in -- do you want to go back to the slide that has the types? If you're in a -- the most integrated, Fred, is a HIDE SNP, FIDE SNP. I got my own acronyms confused. So the plan has the Medicare services, but they also have a capitated contract with Medicaid for behavioral health and long-term care.

And so it really is -- it's kind of a continuum of how much on the Medicaid side is the plan contracted to also be accountable for coordinating, and most folks are in what are called "coordination only." And then it really is pretty much the Medicare services.

COMMISSIONER CERISE: So it's people who are at risk for needing -- or they need long-term care. They're not in a nursing home, but they could be.

CHAIR BELLA: They could be, or they could have institutional level of care, but they're getting care at home or in a community-based setting.

COMMISSIONER CERISE: Okay. That helps.

And then what's the other -- just point of clarification. The time to see a specialist, I'm just wondering if they gave an idea of what a long time is. You

said that they said the initial appointment was long. Once they got established, they were good. Do you have a sense for what that -- is that 60 days, or is that six months?

MS. BLOM: I don't know if we have that. We could go back and find that, but while she's looking for that, I guess I would -- just to Melanie and Darin's points before, one issue we did run into is people don't necessarily think of what are my Medicare benefits, what are my Medicaid benefits. So we weren't really able to tease that out in a more like analytic way. It was more just like are you happy, are you getting the things you're looking for.

And another issue is that the highly integrated options, the FIDE SNPs, for example, are not present -- they're not -- there aren't that many of them across the country, and then, of course, within those, there aren't -- it's not that much -- it's not that many people. So we did limit this, the recruitment, to people who are not in an institution. But that did end up leaving us with a pretty small population, which is part of the reason why we thought we'd pull in the CO D-SNPs, but definitely take that point about trying to think about duals versus non-

duals, basically, people in higher levels.

But I think we might -- do we have it? Or we might have to follow up, Fred.

MS. HUSON: I think we need to follow up. I'm going back to the report from NORC, and they say they described months-long wait time for a first appointment. Some participants did note when they got referrals from their PCP, those wait times were shorter. But we don't really have a tabulation on what that length of time looked like.

COMMISSIONER CERISE: That's fine. I was just curious.

CHAIR BELLA: And, Fred, I'm pretty sure most people have no idea that they're in a CO D-SNP or a FIDE or a HIDE, just like probably don't know that we're calling them "duals." The whole thing could use some improvement, probably.

Okay. Other comments?

Kathy and then Dennis.

COMMISSIONER WENO: Well, you know, every time we read about a focus group, it seems like oral health comes up and how it's so frustrating for people that they don't

understand their coverage or their lack of coverage, can't find a beneficiary or can't find a provider. It just really struck home again that we're hearing this again in this population. So I just wanted to point it out.

I also wondered in this particular population if oral health is ever included in their care plan or in care coordination in any way, because we've had that issue many times where quality of life is really tied to oral health. And if they're not addressing that in any way, it seems like a big, big hole.

CHAIR BELLA: I think the answer to that is, as always, it depends on the state.

COMMISSIONER WENO: I understand.

CHAIR BELLA: Yeah, I know. I know.

Dennis?

Thanks, Kathy.

COMMISSIONER HEAPHY: Thanks. Thanks for the report.

I guess I'm going to go through this. I've gone through a number of these different studies. I think there's something to look at in terms of how things are actually reported out, and that's looking at the quality of

the assessment process and the quality of the planning process. And a study done by the Community Living Policy Center, individuals receiving HCBS overwhelmingly viewed person-centered planning as a team effort, between them, their care managers, and their providers. And three key themes that emerged were choice control, personal goals, and strengths and relational communication. And those aren't about medical care. Those are about really larger life than just medical.

It's important also to look at like social drivers of health, including isolation and loneliness, emergency planning, and care team responsibilities in care plans, because having a care plan itself doesn't necessarily mean anything.

Quality of care coordination. Is a care coordinator actually integrated into a person's care team and organizing meetings, or merely giving a personal list of providers in their area? Is the care plan used to drive utilization management decisions? For example, if a person is -- if the care team thinks a person needs a communication device, does utilization management team actually take that into consideration when making a

decision? Continuative care and care coordination, do they see the people experience reductions in the need to go to urgent care as opposed to urgent care being available because they can't see their primary care provider? Because for me, that's -- when I read that, that was not a plus for me. That was actually a minus that someone had to go to urgent care, reducing the need for using the ED and hospitals and from the perspective of the person.

And also the number of appeals that people have made and appeals that were done in their favor, like delving more deeply into that.

I think we need to look more at the care coordination with complex care populations versus just folks within the IDD populations. I could be wrong, if you correct me, but it seemed like a larger percentage of the folks who you looked at who had really robust care coordination were with the IDD populations in New York. Is that correct?

MS. HUSON: Yes. And then also in Washington state, which was not specific to that population.

COMMISSIONER HEAPHY: Okay. Thanks.

So I just think we need to pay more attention to

looking at seamlessly integrated continuative care for care communities for people with high-level needs and not just beyond the IDD population.

Also, I think it would be interesting to find out about conflict-free care coordination for complex care populations. I think it was in the report that there was conflict care coordination for at least one group. Am I right on that, or did I read that somewhere else?

MS. HUSON: Yeah. We did not talk about conflict-free care coordination.

COMMISSIONER HEAPHY: So I'm adding something that's strange. I apologize.

And then it would be helpful -- Mathematica did a study. It's not generalizable, but they did a study of 45 dual eligibles in Massachusetts' One Care program, and they talked about -- they reported less care coordination between their providers and fewer conversations with their care coordinators and relying more on family members for HCBS than English speakers.

And then the piece about gift cards, which may seem positive that people like those, but are they actually far cheaper and in favor of the care plan, the care plan

rather than actually in favor of the person? For example, like I think some people would much prefer to have dental care than having a gift card.

And then I think I'll leave it at that. I'd love to have further conversation with you about the process of creating the questions and the process you go through for writing the reports, because I think there are certain high-level things, things we've learned over the last 11 years, at least within the MMPs. That would be helpful, particularly as we move into D-SNPs.

CHAIR BELLA: Thank you, Dennis.

Heidi?

COMMISSIONER ALLEN: I just wanted to add on to Dennis's comments about trying to really understand the care coordination. I thought it was striking that many people didn't find any value in them or just that they didn't -- said that they didn't want them. And it may be, as was discussed, that it's differences in the population, but this seems like such an important role. And it also makes me think about one advantage of having the state-based ones, as people mentioned, is that when you leave a plan, your care coordinator follows you.

But there's also -- I think this will come up later this afternoon when we're talking about managed care versus fee-for-service. The incentives are slightly different. So a state care coordinator who doesn't have the same -- their incentive is access, right? Like they're there to help the person get access to what they need. And a managed care integrated care coordinator may be more concerned about utilization management, so making sure that people aren't having access to higher-cost services.

And that was what was interesting about when managed care was introduced to state Medicaid programs is it flipped the state from the actor trying to gate-keep care to being the oversight to make sure that people have access to care, and I think that the same dynamic could play out in care coordination. But I think -- I don't know for sure. It's just a thought, and I think it's worth trying to understand more.

CHAIR BELLA: Thank you, Heidi.

Other comments?

[No response.]

CHAIR BELLA: Well, we have always a love of hearing from actual people trying to use the services and

understanding, and I think, look, we all get a little frustrated because we just want more, more information and more people and more generalizability. And so we very much appreciate that you had this work done, and that there will be a more robust and descriptive chapter about it in June and would urge you to keep thinking about opportunities to continue to do so for this population and for others of interest to the Commission. So thank you again for your work.

Do you need anything else from us at this point?

MS. BLOM: No, I don't think so. Thank you, everyone, for your feedback.

CHAIR BELLA: Okay. Thank you very much.

Next up is a panel. We're running about five minutes ahead of schedule. So our panelists might not be quite ready.

Sean, do you want to come on up? I don't know if there's any stage setting you want to do before they join. If not, that's fine also.

[Pause.]

CHAIR BELLA: Do you want to set any context while we wait for the third panelist?

MR. DUNBAR: Yeah, I can do that. I can walk through the first couple of slides. Yeah.

CHAIR BELLA: Perfect. Thank you.

PANEL ON STATE FLEXIBILITIES TO COORDINATE CARE IN THE ABSENCE OF FULL-RISK CAPITATION

* MR. DUNBAR: Yeah. Thank you.

Good afternoon. I look forward to introducing this panel to you and having a good discussion about flexibility that states use to coordinate care.

For some background to help set the stage a bit. So as you all know, state Medicaid agencies have the flexibility to choose how they want to structure their delivery system. When Medicaid first launched, fee-for-service was really the default but, over time, managed care has become the more dominant delivery approach in the Medicaid program.

I think in our last MACStats, over 70 percent of people are enrolled in some form of comprehensive managed care and a little bit more than half of spending goes to Medicaid managed care.

States have decided to pursue full-risk managed care in their Medicaid programs, typically through private

plans, and they've done so with a variety of goals in mind, such as more control and predictability over future costs, greater accountability, and improved care coordination. But there are a variety of reasons why states have decided to not pursue full-risk capitation through MCOs.

Some states may prefer to retain control and oversight over their care coordination and access to providers, or they may be concerned that a capitated approach creates incentives to undertreat beneficiaries.

So today's panel is a few states who use alternatives to full-risk capitation through MCOs, and we look forward to introducing them and having a good discussion about their approach and its effect on beneficiaries.

CHAIR BELLA: Great. It looks like they're all here.

First, thank you. Thanks to the three of you for joining us. You have many other things you could be doing with your time and so really appreciate this. And also thank you for being a few minutes early. We'll try to keep this moving and keep it on schedule, but thank you very much.

And Sean, I think we're ready to go.

MR. DUNBAR: Great. Thanks, Melanie.

So today we have three panelists. We have William Halsey, who's the Deputy Director of Medicaid and the Division of Health Services with the State of Connecticut. We have Juliet Charron, the Medicaid Administrator for the State of Idaho, and Ashley Berliner, who serves as the Director of Healthcare Policy and Planning for Vermont's Agency of Human Services. So thank you for all joining and look forward to the discussion.

So just to kick things off, I was hoping that each of you could spend a few minutes describing your state's approach to coordinating and integrating care for Medicaid beneficiaries.

Bill, how about we start with you and Connecticut's approach?

* MR. HALSEY: Sure, and thank you for the invite. Good afternoon, everybody. Again, my name is Bill Halsey from the Connecticut Department of Social Services, the State Medicaid Agency in Connecticut.

So in Connecticut, we use administrative service organizations to help us manage our Medicaid program, and

we have a distinct administrative service organization for medical, behavioral health, dental, and non-emergency medical transportation.

And within those "ASOs," as we call them, administrative service organizations, they do some things that look like managed care. So they do some utilization management. They do some quality management, member relations, provider relations, data analytics, but they do not pay any claims, and there is no risk.

There is an upside performance target component in each of those contracts. So we negotiate that on the outset of the contract and then annually to achieve performance targets in certain areas where the department is especially interested. It could be PHE unwinding, or it could be improving health outcomes for a specific population.

We have been under that model since 2012. Actually, dental and behavioral health were carved out of managed care, I think, in 2006, and then we went full ASO model with our medical administrative service organization in 2012. And again, that gives the Medicaid agency full line of sight of an integrated claims system.

So we have a fully integrated claims system. We pay the claims through a contractor, but it's all integrated within one claim system. And we develop all the policy. The ASOs help us implement that policy. We set all those, one fee schedule and one entity setting policies and those rates.

So I'm going to just pause there and let my colleagues kick off, and then I think we're taking lots of questions, right?

MR. DUNBAR: Yes, exactly.

Juliet?

* MS. CHARRON Hi. Good morning or good afternoon, everyone. Again, Juliet Charron. I'm the state Medicaid director here in Idaho.

And so just to kind of give you a big picture of our delivery system here in Idaho, we actually have a few different models that we use, but I'll spend a little more time talking about our value care organization.

So our system is predominantly fee-for-service. We do have some presence of managed care. So we have a standalone behavioral health plan, a standalone dental plan. We have our duals in managed care, and then we have

NEMT through the brokerage model.

And then we stood up last year, last calendar year, what we call the "Healthy Connections Value Care program," and that was really built upon our primary care case management program that we had here in Idaho since the early 1990s.

And I think we've recognized, as our program has grown and evolved, the PCCM program, while facilitating really great access to primary care, we were not really containing costs, I think, in the ways that we had hoped to achieve through that PCCM model alone. And so we leveraged that model, though, to build our value care organizations, which is a total cost-of-care model. So our providers that engage in this model are accountable to meet a cost target and six quality measures and then take some degree of risk over time, which I can speak to in more detail, again, as this conversation proceeds. But really, it's kind of us, I'd say, advancing the level of engagement and risk taking that our providers are taking to manage the population.

So again, we just started this model last calendar year. We should have our final data from our first year by this summer. So we'll have final cost and

quality data to really understand the outcomes from this first year.

We have started performance year two in January, and we just included our expansion population as part of this model in this year two.

I will just note, as part of our value care organizations, we do have some services and costs that are excluded. So again, that includes everything that's in managed care, so outpatient behavioral health, dental, and non-emergency medical transportation. It does not include pharmacy. It also doesn't include nursing home or long-term care or ICFs, any LTSS and HCBS. And we also have a process to identify outliers as well with our providers.

So it's primarily focused on primary care engagement and some other services that would be delivered typically within a hospital setting or some specialty. And we're really, I'd say, in the early stages, and I mentioned to Sean in preparation for this call, it's a very interesting time because we're in the middle of our legislative session here in Idaho. And there's actually been a bill presented to move us to full-risk managed care.

So we just implemented this model, and we may be

looking at a pretty significant delivery system transformation ahead. So I'm happy to kind of walk through some of those more recent conversations and what may be on the horizon for Idaho.

So I will pass it over to my colleague.

MR. DUNBAR: Thank you.

Ashley, do you mind introducing Vermont?

* MS. BERLINER: Yes. Hi. Thank you for having me.

So the state of Vermont is quite different than, I think, any other Medicaid program in that we operate the entire Medicaid program under an 1115 demonstration waiver. That 1115 demonstration waiver, which we call the "Global Commitment for Health," is essentially setting up the department under a single state Medicaid agency to serve as a public managed care plan. It is a very unique structure. We're the only public managed care-like model in the country, and essentially, the 1115 waiver allows Vermont to take advantage of some of the managed care flexibilities that exist in federal regulation but are not available to fee-for-service states.

We have functioned under this model since 2005,

and it has evolved significantly since then. We've most recently renewed our waiver for a five-and-a-half-year period as of July of 2022 and are continuing to push forward and focus on expanding services to individuals who aren't typically Medicaid eligible and also providing services that aren't typically Medicaid covered.

So what that looks like in this next demonstration period is taking advantage of a service and authority afforded to states now under CMS policy. It also allows Vermont to provide comprehensive mental health and substance use care to individuals who are not eligible for Medicaid. So for individuals who have acute mental health needs, we have actually eliminated any income threshold. So regardless of income, Vermont now provides a wraparound mental health benefit for anyone who meets clinical level of care.

And newly under this waiver, we have set up kind of a parallel structure in the substance use disorder realm which currently is only to 225 percent of federal poverty level, but we hope that it is successful as our mental health wraparound program has been, and that in the future, we'll be able to expand that beyond 225 percent federal

poverty as well.

I can stop there. That's kind of it in a nutshell, and I'm sure you have questions for all three of us.

MR. DUNBAR: Yeah. Thank you to all three of you for giving us a brief introduction to your respective states.

As part of the table setting for this, I mentioned that states may pursue full-risk capitation or they may pursue other alternatives, depending on whatever their goals or objectives are. I was wondering if each of you could provide a little bit of insight, if possible, on why your state chose its particular approach, why it's kept it, and if there's any thoughts around building on it or pursuing different approaches.

So, Juliet, if you don't mind, if we could start with you, that would be great.

MS. CHARRON: Sure.

So I think that the state initially pursued the value care organization or building upon the PCCM model. I'm going to say, first and foremost, the health care community within Idaho, we are a big state, but we're a

small health care community. It's very provider-driven. The providers have been really central to the development of this model, and I think that there has been a desire to really keep the management of patient care, of beneficiary care with the providers in our state, until very recently. And I'll speak to that in a minute.

So I think that led to the development of this very unique Idaho model, again, with a lot of collaboration, which has been very positive, I'd say, in the whole with our large health care systems, with our primary care organization or for -- our FQHC association has been at the table throughout the development of it, which I will just say there's some pluses and minuses in just trying to bring a lot of different provider groups together to develop one model that they can all leverage. But I think at the end of the day, there's been a lot of ownership and engagement from the provider community.

I think where we are at now is I think there is a concern within our state legislature around the growth of the Medicaid program overall, even regardless of what's ahead of us with the redeterminations starting this spring, but just there's been some significant growth in our

program. We expanded Medicaid in January of 2020, and so the overall budget within our program has increased substantially.

And I think that the -- I think that what we are seeing is a reaction to things not moving quickly enough from a cost perspective, and as we -- I think as we all know, that whether it's value-based initiative or if it's managed care, these models take time. They take time to settle.

And I think what I am seeing and doing a bit of education with our state legislature is around that, that whatever the model is, whatever the delivery system is in our state, it will take time to settle, whether it be achieving improved health outcomes and meeting quality measures or some of our cost containment goals. And so now I think there is an appetite for us to move to full-risk managed care with the anticipation that it will get us to a higher degree of cost containment more quickly, and that we will also bring some services that have not been included under our value care model, such as behavioral health and pharmacy and transportation would be included under a full-risk managed care model.

And so I think that is potentially where we're going. We'll know more in the next few weeks as our session wraps up and bills move forward or they don't, but that is the conversation that I have been having with some of our legislators as they're kind of looking at a macro level at what our program looks like and their concerns with growth and cost containment going forward.

MR. DUNBAR: That's great. Thank you.

Now, Ashley, I know that, as you said, Vermont has a very unique approach that you've been doing for a while. Can you share any thoughts on why and where you are on it? Thanks.

MS. BERLINER: Yes. So 2005 was before my time in Vermont, but what we have done is effectively figured out a way to receive federal Medicaid dollars for services and supports to Vermonters who otherwise wouldn't have access to those dollars.

So the way the managed care structure is set up is we have a single statewide agency that pays a department a per member per month payment for a set of services. The department then serving as the plan provides those sets of services, and any savings that is achieved, they then

reinvest that savings into the Medicaid program and in service of Medicaid goals. And so that's the piece that's really unique about Vermont instead of a health plan that is potentially for profit, that is worried about shareholders or has other priorities related to any savings and how that might be spent in the future. Vermont's savings are directly reinvested into goals that further -- or sorry -- services that further the goals of the Medicaid program.

So since 2005, we've been able to pay for social determinants of health. I think Vermont was very ahead of the curve there in being able to leverage federal Medicaid funds to pay for services.

We have, as I said, expanded access to individuals with severe mental illness. We have payment for years -- since really the onset in 2005, we've been paying for emergency services for individuals who are uninsured or underinsured as well as other health care services, particularly in the mental health space for underinsured, uninsured. So we've really figured out a way to leverage what is considered profit in a normal managed care space as something that we can then use to further

public health goals across the state.

This has been an evolution over time. Originally, I think in 2005, it was a bit of Wild Wild West that CMS in terms of what they allowed managed care organizations to do, and Vermont took full advantage of the lack of regulation.

As time progressed, CMS matured and put a lot more managed care regulatory framework and guardrails in place, and Vermont had to really evolve with that, with the core priority of our Medicaid program really focusing on flexibility to pay for things differently and to pay for different types of people.

So though we've evolved and we've matured along with CMS around what we can and can't do as a managed care-like plan, we have been able to successfully maintain that flexibility. So we pay for services differently than what typically is approved by CMS, and we really prioritize value-based payments in non-conventional spaces.

In addition to paying differently, we also pay for different things, so some of those social determinants of health, a lot of housing supports, public health initiatives, and infrastructure.

MR. DUNBAR: Thank you. That was great.

Now, Bill, I'll look to you now. Connecticut has had an interesting experience having moved away from full-risk managed care. I'd be interested in seeing if you could speak to that transition and how it's gone since.

MR. HALSEY: Sure. Thank you.

So I'll go back in time a little bit too, because there once was a time where we were under full managed care, and I think what happened was, at least related to oral health and behavioral health, I think the perception was that those two service areas were kind of getting neglected by the larger managed care contracts, which really are about medical care. And so the thought was let's carve them out of traditional managed care and try to focus -- have an entity focus exclusively on delivering that service.

So our dental services were carved out. Then our behavioral health services were carved out. And if you think about in terms of a massive managed care contract, those were quite small in terms of the total amount budget. So the managed care companies were not that worried about that. So that was 2006.

Then I will say that the state Medicaid agency was not the only entity focused on managed care in the state of Connecticut. So there were advocates, there were legislators that were pressing our managed care organizations for more transparency, and they just were not getting it. What are we paying our providers? The encounter data, we couldn't sometimes make sense of the encounter data, and it was all in different places. And it was hard to bring it all together and aggregate it in a meaningful way where you could run data analytics in a meaningful way.

And so the precedent was kind of there of like, well, it looks like it's working with dental, and it looks like it's working really well with behavioral health. Why can't we do the same model with our medical services? And so that is really why we decided to move away from managed care and take on full risk within the state and develop our own policies and just have the administrative service organization try to make sure that our Medicaid members have access to services.

So that was -- and I don't foresee us going back anytime soon. Our legislators appear to be quite happy

with the ASO model. We're getting some good results on quality measures, whether they're the CMS core measure sets or HEDIS. So we understand that the full risk is on the state, and so we have to manage that.

I was telling Sean, I think one of the areas where the state -- you know, if you're going to go down this model, the state -- it's really on the state to make sure that you stay relevant within your medical policy and behavioral health policy and rates, right? And so you've got to be committed to making sure you stay relevant with your rate structure to make sure your members have access to services.

And so that's an area where we're focused on right now. We're about to undertake a pretty comprehensive rate analysis, and that will help us prioritize where we think we need to make some adjustments to our rate schedules.

MR. DUNBAR: Thank you. That was great.

So one question I have for you all, one of the areas that we've been digging more into is trying to understand the oversight tools for full-risk MCOs through things like the external quality review process. One thing

I'd be curious to get your thoughts on is in your respective models, what sort of approaches or tools do you use to ensure that care is being delivered and things are going as you want it to, whether it's with the ASOs, or the PCCM and the VCOs in Idaho, and Vermont through working directly with providers?

Ashley, I think I'll start with you this time, if you don't mind sharing a little insight on Vermont. That would be great.

MS. BERLINER: Yes. So we do use EQRO for all of the managed care requirements. So just like any other state, EQRO does our annual audits every three years. They cycle through different managed care regulations, and so we're very much engaged in that process.

Beyond EQRO, there are things that we find very valuable in the state that aren't covered under managed care regulation, and so we pay really close attention to utilization, just like any other state. We, I think, have a slightly different relationship because we are a public plan. It's a little different than a state that is contracting with a private plan and really needing to monitor that services are being paid for, and everything in

Vermont is very aligned towards providing access and ensuring access.

So for us, it's less about like the payer providing payment to services that are delivered and more about just access and how we can make sure that we have adequate workforce throughout what is a pretty rural state with an aging population, and that we are adequately paying for those services, so even when we do have the workforce, which we often don't, wanting to really make sure that we're paying equitably and aren't exacerbating any cost shifts between commercial payers and the Medicaid program.

MR. DUNBAR: Thank you.

Juliet, would you mind talking a little bit about Idaho?

MS. CHARRON: Sure. So I think one of our most significant challenges with oversight over any of our different models, be it managed care, fee-for-service, or our value-based contracts, is our staff capacity to operate in those three distinct models because oversight does look different particularly between managed care and fee-for-service. The levers are different. How we engage with providers is different, providers versus MCO staff.

In the value-based care space and fee-for-service, we do look at utilization data. We look at complaint data, and then in our value-based arrangements, I think we're going to really be looking towards those quality measures, and if our value care organizations are meeting those quality targets -- I mean, the cost targets are important too, but in terms of the outcomes and delivery of care and coordination of care for participants attributed to those value care organizations and served by them, I think we're really going to be looking at the quality aspect of it.

Being very candid with this group, I think we have a long way to go in terms of oversight and really further developing our quality-of-care oversight and quality initiatives generally, and I do think that with a state with limited staff capacity, that is one thing that is afforded to a state through a full-risk managed care model, and that I will never have a ton of case management staff. I will never have a ton of data analytics staff, quality staff to do some of those oversight functions directly with providers.

I think we look at things on a pretty macro

level, unless we're doing a provider-specific audit for a specific challenge that we're having. And I do think that managed care organization with the staffing and infrastructure that they have, they have more resources, perhaps, at their disposal to do some of that oversight a bit differently, and then, obviously, it's incumbent upon the state to do oversight of the plan in accordance with regulations.

So I think it's something that we're still working through. We're still kind of actively looking at how we do this, and then if we do move to a different model, we're going to have to re-look at it again. But I'd say it's evolving.

MR. DUNBAR: Thank you.

And, Bill, if you don't mind, that would be great.

MR. HALSEY: Yeah. I would just want to start by saying I agree. We have some room, plenty of room, for improvement in this area.

For example, like our quality measures in many respects look pretty good, but those are the people that actually access services. But how do we really know about

the people that can't access services?

So our access data needs to improve. I'll just say that, especially related to we're trying to move to value-based reimbursement. We've got a lot of strong advocates about what are your quality measures, what are your access standards to ensure that there is no stinting going on when you develop a value-based payment model, and so they've challenged us. What are the measures that you're going to use in this value-based payment model? That's a challenging conversation to have, but a good one, because we do need to make sure that any value-based payment model doesn't reduce access and reduce the care that people need.

But we use some of the same tools. Utilization management, we track that over time by level of care, by provider type, by member population. We look at quality measures in lots of different ways to see where we could be making improvements.

But the access data is an area where we do need to spend quite a bit of time and think about how do we improve and collect better access data, and that's across all of our service system. That's medical, dental,

behavioral health, and EMT, because it's hard to know who's not accessing the service and who needs to.

MR. DUNBAR: Thank you, Bill, and thanks to all three of you.

We're at about time, I think, to hand it over to Melanie and the Commissioners so we can make sure we have a good discussion and give them a chance to pick your brains, too. So, Melanie, I can hand it back over you.

CHAIR BELLA: Thank you, Sean. Thank you again to our panelists.

Bob, you want to kick us off?

COMMISSIONER DUNCAN: Sure. Thank you.

First of all, I want to thank our panelists. I appreciate, one, what you do. You have a big task before you, and as Juliet mentioned, staffing is always an issue.

Ashley, truly, truly appreciated your comments about reinvestment back into the program, and the social determinants piece, I look forward to learning more about that.

The question I ask, you all brought up the quality metrics in that component. If I were to look at each state's quality metrics and then total health outcomes

for the members in Medicaid, how would that compare to states that have MCOs? Would it be better, about the same, or worse?

MR. HALSEY: That's a great question. I don't know if we -- well, I don't think they slice it by that in the CMS core measures sets or HEDIS, but that's an interesting research project. I'm not familiar with if they compare managed care states to fee-for-service states anywhere. Maybe Robert Wood Johnson.

COMMISSIONER DUNCAN: All right. Thanks.

MS. BERLINER: Yeah. It's also not something I'm aware of specifically. I know the demographics play into to it heavily as well. Vermont happens to be one of the oldest states in the country but also is one of the healthiest, and I think, Idaho probably also has a really active yet aging population versus some of the states in the South, which are younger but might not have as many who are active for as long in their life. So the demographics, I think, are what I see most of that focused on rather than MCO versus fee-for-service.

MS. CHARRON: I'll speak more, I guess, to resources to kind of go back to my earlier comments on

staff capacity. So I'm not aware of a specific analysis to answer that question.

But in my experience, I have worked in states that are predominantly managed care, so Texas and Arizona, and I will say just in comparison to Idaho where we're predominantly fee-for-service, I think one of the tools that you have, perhaps through managed care, although maybe Vermont and Connecticut have figured this out too, but our ability to implement initiatives, targeted initiatives to improve quality measures, I think, was more effective and easier just effectuate through the managed care plans than what I've seen us to be able to do here in a fee-for-service environment.

I mean, I look at some of our quality measures. Let's take breast and cervical cancer screening. We are at the bottom. We are really not doing well in those areas, and we partner with our public health division and our public health partners to do some outreach and targeted work there. We had some conversations with providers, but I do think that it is challenging for the state Medicaid agency to really effectuate larger population health change in the fee-for-service environment.

I don't have provider relations staff. I have two quality staff, I have four data analytics folks, and I have five clinical staff on my team. I have contractors as well that support some of that work. But resource-wise, the ability to do effective member outreach, coordination of care, to really move the needle on quality measures, I think is more challenging, honestly, in a fee-for-service environment.

COMMISSIONER DUNCAN: Thank you. I appreciate that.

CHAIR BELLA: Thank you, Bob.

Heidi and then Darin.

COMMISSIONER ALLEN: Thank you all.

Sorry. I opened the wrong mic.

Thank you all so much for your presentations today. It's been super thought-provoking.

I wanted to direct my question towards Juliet. I'm a native Idahoan, and my family are still Idahoans, and I go home to Idaho on a regular basis. And I have been really, really shocked at the rapid -- I don't want to say it's -- I know that like substance use disorder has been an issue for a long time, but the escalation of that and even

more so the housing crisis, and how ordinary working people are shut out of places to live because of what has changed, I think, really quickly.

For example, my brother has lived in an RV on somebody's land for the last year and using like a propane stove for heat, and he's a working person. He doesn't qualify for Medicaid. He has a job that puts him outside of that, but he can't afford a place to live.

And I'm wondering about your flexibilities or if you have flexibilities to spend money on housing supports and keeping people in stable housing or how much of your resources you've been able to shift towards social determinants of health or towards the opioid crisis and if you think that would be different under managed care.

MS. CHARRON: Thanks for the question.

Yeah. I mean, I think both are public health crises that, nationally, many states are facing, but I think we're seeing it very acutely here in Idaho.

The more global social determinants of health conversation, I don't think is very loud here in Idaho. Kind of to my comments earlier about cost and growth in the program, I think there is a desire to really control the

growth of the program and expansion to any sort of new services and benefits. Especially services that may extend to the Medicaid expansion population, I don't think are of -- they're not high priority, I think, for our state legislature at this time.

That being said, we have had some conversations with community partners about the value of really digging in and looking at that a bit more. There was a community organization that contracted to have a housing supports crosswalk completed here in Boise, the Boise area, because we're kind of -- the housing crisis is across the state, but we're really feeling it here in the Boise area, in particular.

So there's work, there's some momentum in certain communities, but I think as a state, there is not the appetite to really move on that. But I think the conversation has been when may we introduce some of those conversations at the state level in the name of better coordinating care to ultimately save costs to keep people out of emergency rooms, to reduce burden on our homeless shelters, et cetera.

And I don't know exactly where those

conversations will go, honestly, at this point. We just got through a pretty extensive review of our Medicaid expansion program, this legislative session. The legislature has decided to continue expansion, but I think there's just a lot of scrutiny on the Medicaid program generally at this point. So I think we're not in a space of really discussing any expansion of benefits and not in the social determinants of health space.

We have done some work in the substance use disorder space. We have a lot of partnership with, again, our public health department partners. Our medical director within Medicaid, she's an addiction doc. So that's a space kind of near and dear to her heart. So she's led some initiatives and leads in groups with providers across the state to talk about interventions.

So I think collectively as a state, there is some good focus in that area between public health, behavioral health, and Medicaid. So I'm glad that that discussion is ripe, and I think there are listening ears within our state, with our state policymakers to continue to support that, so encouraged, but I think the SDOH is the other part of that, that we will hopefully be looking towards to

further support those services and others in the near future.

COMMISSIONER ALLEN: So just following up on that -- that's very helpful -- what I'm trying to think through is whether if the bill that's been introduced into the Idaho state legislature to move to a fully risk-based capitated program, if that -- you know, one of the complaints about managed care, of course, is there's no transparency. One of the benefits of managed care in this situation might be that there's no transparency, and that actually, if you do invest in the social determinants of health, that you might be able to save money on -- because what I'm hearing from Idaho from my friends and family are these spiraling situations where people lose their housing and then they get sick. And it's just like things rapidly deteriorating.

And yet what you're describing is a situation that if you went to the legislature and said we really need to invest in social determinants of health, they would be like, "No. We're charging you with actually cutting costs, not increasing costs," but if a managed care organization said, "Well, we carry this risk, and we think that we could

actually improve health and reduce costs by investing in some of these social determinants" -- and that would be their purview to do, and it may not have the same level of scrutiny. Do you think that's true, or do you think that it would still be scrutinized within a fully capitated, fully risk-bearing managed care plan?

MS. CHARRON: So I think we would still need to seek the federal authority to reimburse the plans for those services, and there's kind of a variety of ways that could be structured, unless the plans were willing to cover those services somehow outside of the capitation. And I'm not aware of any plans who would be fully willing to take on that risk, perhaps outside of some case management-related services. So, you know, okay, I'm on a call with you talking about why you've had some challenges in getting to your doctor's appointments, and I found out that in the course of that conversation that you are food insecure and you have a housing issue. Can I connect you with some community resources that we're not necessarily paying for, but I'm at least connecting you to those resources? So there might be some -- I'm going to kind of say lighter ways to make some of those connections, while not saying

we're going to actually pay for this service or some of the more innovative things that California, Arizona, Massachusetts, and Oregon have been able to do, for example -- or Vermont.

I think there would probably still be some scrutiny, because at the end of the day, it's still the state paying for these services, and again, I think there's an overall goal to really contain the Medicaid program here as much as possible.

Does that answer your question?

COMMISSIONER ALLEN: It did. Thank you very much.

CHAIR BELLA: Thank you.

Ashley or Bill, I was going to ask if you also wanted to make any comments on that. I know Vermont is doing some stuff, but if either of you would like to comment on the social determinant aspect and the ability to be more creative and have managed care-type in-lieu-of services as part of the state's fee-for-service program, you're welcome to comment, and then we'll keep going with Commissioners.

MR. HALSEY: I'll just say that the housing

affordability issue is not unique to Idaho. That is happening in Connecticut, and we are looking carefully at -- obviously, we don't have in-lieu-of, but we're looking at an opportunity through an 1115 demonstration waiver to see if we could pay for some of the social determinants of health. So we're looking at that opportunity.

CHAIR BELLA: Great.

Ashley, did you want to say anything? You're welcome to pass, or you're welcome to comment.

MS. BERLINER: I'll just say I think it's Vermont's experience that there's a lot more flexibility in managed care regulation than fee-for-service regulation.

That said, as Juliet referenced, private managed care plans have their own priorities and motivation, and so I think Vermont really benefits from being a public-run program where we get to make those investments without needing specific approval through MCO contracts the way other states would. So I think there's definitely potential for kind of altruistic private managed care plans to take that on themselves but unlikely without the state really putting their finger on the scale and making sure that they prioritize those services.

CHAIR BELLA: Thank you.

Darin, then Jenny, then Dennis, then Bob.

COMMISSIONER GORDON: First of all, thank you, all three of you all, for your service. As Bob pointed out, it's not easy.

Ashley, I agree with your earlier comment about Vermont because I always wanted -- like when you wanted to look and make comparisons across states, they look at Vermont. And you know the Southeast. It's a long way to get to the health of the folks in Vermont.

To Bob's earlier comment, we found we had to look at like in our region and see how it's improved or see how it's improved over time.

What Melanie just brought up is where I was going to go, and by all means, you can follow up with some of this. Don't feel like you have to rattle off your list here.

So I just think about the flexibilities that you don't have or the things you wish you did have that are afforded to those who do managed care. I think it would be helpful for us to know those things.

I also know there's different expectations on the

managed care side that may not be applied on the fee-for-service side, but I'm trying to figure out, are there those flexibilities that have not been accessible to you from your perspective, that if you -- you know, we always do that if you had your magic wand, what would you want? It would be helpful for us to know from your all's perspectives.

And, Juliet, I think it will be really interesting as you're going through your transition. It sounds like you already have some ideas and thoughts of where some of those flexibilities are going to come, and you have that unique vantage point from Texas and Arizona as well. But I think that would be helpful for the Commission as we think about making recommendations to Congress or to the administration on these are things that might be helpful so that all boats rise instead of just certain models versus others.

Thank you.

CHAIR BELLA: Yeah. You're free to give us your wish list now, start rattling off, or we'll always take it as follow-up if you want to give it more thought or you think of something later after you rattle off any thoughts

now, like totally defer to you all, but we are very interested in hearing that from each of you.

MR. HALSEY: I will just share our previous Commissioner was a CMS-er for a number of years, and she -- this is one area where it really made her mad that a fee-for-service state didn't have the same levers as a managed care state. And we said to her, "Well, you know, we have the 1115." She goes, "Yes, I know, but we should have the same tools that the managed care states are afforded right out of gate," because 1115 is a big lift. It really is a pretty massive project, and I don't know what the in-lieu-of requirements are in the reporting and the monitoring and all that. But I think her basic advocacy is level the playing field. If it's available through managed care, it should be available through fee-for-service as well.

MS. BERLINER: I totally agree. Kate McEvoy and Vermont have had many discussions about that.

But I think Vermont has figured out a way to circumvent some of the lack of flexibility in fee-for-service. We have a little bit of our cake and get to eat it too, but it's very frustrating when we have conversations with CMS. Particularly, in-lieu-of services

is a really good example of a flexibility that managed care plans can take advantage of, which essentially allows them to pay for a service that's not otherwise covered. If it's cost effective for a Medicaid service, fee-for-service Medicaid programs cannot take advantage of in-lieu-of services, and there's really no rhyme nor reason other than it's just a different regulatory framework.

So I think there are a couple of examples like that, that are just pretty frustrating out there. Another one is payment for institution of mental disease stays up to 15 days per month. I'm sure we could compile a long list of things that are not equitable.

MS. CHARRON: I don't think I have anything significant to add to what has been shared.

I think I'll just echo some of my earlier comments, and this is not even so much flexibility-wise, but I think just for states that are struggling with administration of their programs when there's limited resource availability, to me that is one of the potential gains through moving to, again, a managed care model.

To Bill's point, the levers are really different between managed care and fee-for-service and the resources

that you need to adequately oversee those different delivery systems.

But I'm happy to follow up and give that a little bit more thought too.

CHAIR BELLA: Thank you very much.

Jenny, then Dennis, then Bob.

COMMISSIONER GERSTORFF: Thank you.

Can you guys all give us a sense of the size of your programs by enrollment or annual expenditures and then whether or how much the size of your program contributes to the successes that you have under your unique models?

MS. CHARRON: I'm happy to start. So our caseload is at approximately 450,000 participants. That is expected to go down once our redetermination effort starts. We're starting in April.

Our annual budget is sitting around $4 billion, expected to increase closer to $4.7 billion in the next state fiscal year.

I guess I will say this. I think as our population has grown and as we've brought on Medicaid expansion, it has been more challenging for our team to adequately oversee the program as it exists today in the

different models that we operate.

About half of our participants are served under the value-based model that I spoke to earlier in this discussion, so not all participants, but again, I think that our team as regulators, our attention is divided between very different models, with different levers, with different regulations, which makes it very challenging to be innovative and to do effective oversight at times.

MS. BERLINER: And I think Vermont is about half of Idaho. We have 270,000 people currently, which is also inflated because of the public health emergency. About 200,000 of those have full Medicaid, and the remaining 70,000 have a partial benefit program, either a limited pharmacy benefit, a limited mental health or substance use benefit, or a subsidy benefit on the exchange.

And our program expenditures per year are about $2.2 billion, so just about half of Idaho.

MR. HALSEY: You can probably see me rifling through my notes trying to find my figures. So the enrollment is in about the 900,000, and again, with an asterisk because of the public health emergency.

And so what I was just trying to look for is our

total spend. So in Connecticut, we moved to kind of a net funding. So the gross funding, I think, is in the neighborhood of about $8 billion. But we're appropriated approximately 50 percent of that because of the federal match.

MS. BERLINER: And I did just want to add that I think our success has everything to do with the size of our state. I can't imagine that we would be able to be as flexible and agile if we were a bigger state. We have 625,000 people in the state of Vermont, and it allows us to really be an incubator for a lot of innovation and pilot things and pivot if it's not working or scale if it is. So I think that size is a huge, huge factor.

CHAIR BELLA: Jenny, any follow-up?

COMMISSIONER GERSTORFF: No. Thank you.

CHAIR BELLA: Thank you very much.

Dennis and then Bob.

COMMISSIONER HEAPHY: Thank you.

There's been so much from different states and just the challenges you face, and I'm wondering how do you engage beneficiary voice in the development of your programs and your plans, and is it consistent? Do you have

a process that you use? If you could talk a little bit about that.

MR. HALSEY: I'll jump in first. So every one of our administrative service organizations has a consumer advisory council, and so they are meeting with them. For example, our medical administrative service organization has a -- it's either monthly or quarterly consumer advisory council.

Also, we have a legislatively mandated oversight council, which has a consumer component subcommittee, and then I happen to be really familiar with the behavioral health system within the Medicaid system, and there's at least three behavioral health consumer advisory councils within the state. And those are great opportunities to have face-to-face encounters with consumers or family members, parents of children within our behavioral health system to explain new programs, to hear their feedback of how it's going, how it's not going.

So that's what we have in Connecticut, but I feel like we have a pretty good access to our consumers of Medicaid.

MS. CHARRON: I'll go next. I'd say in Idaho,

it's really strong. Our consumer engagement is really strong with some programs and populations and not as strong with others. I think we would like to have a more consistent approach across programs, and I think it's something that we're looking to evolve here over the next few years.

So we do work very closely with our medical care advisory committee, where we do have some participants who serve on that committee, and I think we're actually kind of in the process of trying to transform the role of that committee to be even more engaged. It's been more of kind of a report-out committee where we come and report out on different initiatives we're working on, and I think we want it to be more like we're receiving more input from that group and also including better representation on the beneficiary side within our MCAC advisory council.

Within our adult developmental disability community, we have actually pretty strong consumer engagement, I would say. We have a self-advocate-led group that we meet with on a regular basis in conjunction with our DD council and with disability rights of Idaho and some other advocates in that space.

We're in the midst of a pretty significant transformation within our adult DD program, and so that was kind of, I guess, the beginnings of the development of that group. But they've been incredibly important as we have made changes to the program, be it from benefits to notices, et cetera. We've really engaged that program, and we have completed in the past a listening tour across the state with the adult DD community, and we're getting ready this summer to do another listening tour with both our adult DD community and our adult aged and physically disabled waiver community as well. And that is something that we want to do kind of ongoing, so not having -- everything seems to happen in Boise.

But really, I think the most need in our state is within some of our really rural communities that we just don't get out to enough, and so that's something that we're working towards starting this summer.

And then the last piece, I'll just note -- or sorry -- the last two pieces, we have some beneficiary or participant councils through our managed care products that we do have, and then we also have some different family advisory groups for our youth -- children's and youth

behavioral health system, because we've been working on some pretty significant transformation there as well.

So I would say not consistent across, but we do -- I think we have pretty strong engagement with specific populations.

COMMISSIONER HEAPHY: Thanks.

MS. BERLINER: Yeah. And then in Vermont, it's a lot of the same of what Idaho and Connecticut mentioned.

I will say the home- and community-based service populations are much better represented than the more community Medicaid folks are, and one of the things that we struggle with in Vermont is making sure that we're actually getting consumer opinions versus provider opinions. We have a lot of providers who are paid advocates advocating for their particular set of services, and it's a challenge to get people to dedicate their time, volunteer their time when they're not paid advocates to really contribute to policymaking. So that's something that we're always fighting against and trying to increase representation from actual beneficiaries.

But I think we do a lot of the same kind of stakeholder engagement that Juliet and William mentioned.

COMMISSIONER HEAPHY: Thank you. Thanks.

I guess, Juliet, just one last is how are the disparities between Boise and the rest of the state? Are they increasing? What's the picture there, the Medicaid picture there?

MS. CHARRON: That's a great question. Yes, I feel like they're increasing, but back to kind of our earlier conversation about housing and access to services, I still hear a lot of access to care -- about a lot of access-to-care issues in our -- I'm going to use my air quotes -- urban Boise area. I mean, we're facing provider shortages across services. I think home- and community-based services has been the most hard hit in our state.

But I really hear it across all services. I think Boise is faring a little bit better than our rural communities. I know in some of our rural communities with HCBS in particular, there's just nothing. There's just no services available.

We have seen a pretty significant rise the last few years in out-of-state care. So we're having to send more folks out of state for services, and so historically, this was more pretty specialized care. We don't have a lot

of specialty care in Idaho as a whole, or it would be highly specialized surgeries that we'd be sending someone to Stanford for. Now we're sending folks out of state for care that we should be able to provide in state, but we just can't because of capacity. And that's across services of HCBS, but it's also hospital stays, thing that, again, we should be able to provide in the state.

COMMISSIONER HEAPHY: You have a lot going on. Thank you for sharing that. Thank you.

CHAIR BELLA: Thank you.

Bob?

COMMISSIONER DUNCAN: Yes. This is just a comment. Earlier when we were talking about doing things outside of what CMS allows or what states are allowed and with the MCOs and their ability, using my previous life, being a provider owned health plan as well as working with other community-based health plans across the country, there were actually partnerships formed where we would reinvest, similar to what Ashley talked about in Vermont, and do models so that we could do it -- we weren't paying shareholders -- and invest and then use that data with the state for them to go back to CMS and say, "By allowing this

service, we're able to provide this much better of a health outcome and save significant dollars."

And so there are some managed care organizations, again, those provider-based or community-based health plans, that are willing to take that route and go that route.

CHAIR BELLA: Thank you, Bob.

I'm going to switch gears a little bit and ask you each a question about Medicare integration for your duals. My colleagues are laughing because I'm kind of obsessed about duals, so I'll just put that right out there.

Juliet, I've watched for a long time what Idaho has done, and congratulations on what you've built and how you're trying to align enrollment. My question for you is, how did you think about putting, arguably, a more complex population, your duals, your behavioral health folks into managed care, and how do you think about that relative to what might be coming next for you?

Bill, my question for you is we talk -- not surprisingly, most of the talk around duals integration is about capitated managed care models, and we remind folks

that there are many states that those models aren't going to work for their duals.

And so I remember when Deirdre was there. We talked about the Washington State model that's built on health homes and uses a managed fee-for-service approach, and kind of the state acts almost like the ACO and gets to benefit in Medicare savings if the Medicaid investment resulted in savings. And I'm curious if you guys are thinking about that or if that's an option.

And, Ashley, I was actually at CMS when Vermont tried to act as the capitated entity to integrate the Medicaid and Medicare dollars, and that request was not met favorably by some. I'm curious how Vermont is thinking about that, if you're going to try to take another crack at it.

I guess the underlying comment for all of you is kind of similar to that theme of what magic wand would you wave. We're really interested in understanding from states who don't run your traditional capitated managed care model for your duals. Is there anything that would be helpful to you? As the Commission, it's a priority area of interest for us, and we do want to make sure that we don't leave

non-capitated states out of the policy discussion.

So, Juliet, maybe I'll start with you. How do you all think about where you're going with that, and have you learned anything about that, that would be worth sharing?

MS. CHARRON: So the duals, as I mentioned, I think at the very beginning, is one of our populations that is in full-risk managed care, and we moved that population in -- oh, gosh. I want to say it was just after 2010. It predates me for sure.

And it took some time. So we have an open enrollment contract actually with both of our plans. So we've never competitively procured the program, because it did take some time to find some interested plans to work with the state.

Now that I think we have a larger, more mature program for our duals, we're actually looking to competitively procure those contracts here in the near future, and we've started down that road.

I think I've been pleasantly surprised to see how well it has gone, and I think that's really been to the credit of our team but also of the local representation

from the plans and their willingness to -- like it's boots-on-the-ground work. It's road shows. It is traveling the state and getting to know the communities and getting to know the providers, and the providers need to have someone they can just pick up the phone and call.

Again, as I said earlier, it's a very small health care community. It's a big state, a lot of miles to travel, but it's a small community. Everyone kind of knows everyone to some extent, and so I think our plans have really embraced that mindset and have learned to work with our providers well.

I've been particularly pleased to see how well they work with our nursing facilities and the nursing facility association. That was not my experience in some of the other states that I've worked in, and they actually all work together quite well and have been able to do some pretty innovative things and are moving into conversations around value-based arrangements.

I think the area that our plans kind of continue to struggle with -- and I don't think this would be any different if we were in a fee-for-service environment, per se -- is best serving our most rural members in our state,

and we don't have great broadband access. So even some of the wonderful technology that we have with telehealth or different member apps and things like that, they're not relevant to the duals population always, or they're just not accessible in certain parts of our state because people don't have an iPhone. They don't have a computer. They don't have internet.

And so I do think those are just some of the challenges, a state like Idaho, but I don't think -- we're certainly not the only ones that have some of those issues. But I think it, it continues to persist as an issue in serving the duals population.

CHAIR BELLA: That's great. Thank you.

Bill or Ashley?

MS. BERLINER: Yeah. So in terms of taking another crack at it, we sure are. We are actively engaged with CMMI on the next iteration of the all-payer model, which definitely seeks to leverage Medicaid dollars for -- sorry -- Medicare dollars for both duals and non-dual Medicare members.

On the duals side, I think we continue to just be frustrated with the lack of coverage provided by the

Medicare program, particularly in areas of substance use and dental, vision, and so we really seek to provide pretty comprehensive wraps to our dual members and then provide limited benefit programs for individuals who are not Medicaid-eligible so that they're able to receive some vision services and affordable pharmacy coverage.

CHAIR BELLA: Thank you.

MR. HALSEY: First of all, I would just say thank you for the offer of advocating for this population. It's an unserved and much needed population.

Unfortunately, I am not the subject-matter expertise in this area, but I am going to pass on your offer to the person within the department, because it is a much-needed service, and it's just an underserved very, very vulnerable population. So I appreciate your comments on this.

CHAIR BELLA: Great. Well, thank you very much.

Other comments from Commissioners?

Fred?

COMMISSIONER CERISE: Yeah. I appreciate hearing from all three of you. It's really been -- it's been great to hear some of your -- the efforts that you're making.

I've seen in states that have moved to managed care. It's interesting, you call these unique models. You know, these used to be -- the unique model used to be going to managed care, and when states went to managed care, then the providers had to adapt, right? And you had to deal with multiple credentialing and different prior authorizations and now directed payments and how you get all that through different insurers to do things that the state wants to do as a priority to address the population as a whole.

And so while it may be more work for your states to do this work, take it on, sometimes it seems like the easy button to say, "We'll outsource these things that are resource intensive," but the efforts that you've made, I think, make a difference to providers.

And so anything we can do to highlight the work that you all have done in this area and areas where you've talked about the discrepancies between what states can do that are not in a managed care model that are different from those that are, I think it's important so that it's just not a foregone conclusion that the way you run a strong program is you've got to do it through the managed

care organizations because these guys have shown that you can do strong stuff through the state.

And then as Ashley has talked about reinvesting that into covering additional populations and doing more creative things, that quite frankly would be difficult to do unless the state explicitly puts that into the rates of the managed care organization. So I think anything we can do to highlight that work would be a positive thing.

And then I just have one question for Juliet. As you talk about moving, you know, the momentum in the state to move to managed care, you started your comments by saying the state legislature is concerned about cost and about rising cost, and you've done an expansion and then sort of a --it sounds like the way to handle that is to move towards managed care. And maybe you get more predictability, but I just wonder about the experience in general in Medicaid moving to managed care and cost savings, what we know about that, Sean or others, and the idea that you will be able to do the things that you're talking about doing that are hard, the quality, the case management, all of that oversight, to be able to do that without paying a premium from what you're doing today to

get there.

Sean, I mean, we've looked at that before, the cost issues.

MR. DUNBAR: Yeah. I mean, I think generally studies I've seen can be all over the board, I think, from very small to larger, depending on the population and whatever the specific study was looking at. So I think it's not necessarily conclusive, and I think when you talk to plans, they say that that may increase over time, the longer they're implementing the program, whether it's two or three or four years or so, to really sort of realize some savings.

I can follow up and see what the most recent research is on that and get back to you.

CHAIR BELLA: Thank you, Fred.

Other comments from Commissioners?

Oh, sorry. Ashley, were you going to respond?

MS. BERLINER: I was going to just say something briefly, and it's not in direct response to your specific prompt. But one of the things that I think we really struggle with as states, fee-for-service, managed care, or otherwise, is being able to demonstrate the quality.

As Juliet said, states just have limited resources to be able to really put in the time for super detailed, high-powered analytics, and partnering with really strong analytic firms is extremely expensive.

Vermont is currently working on an RFP after doing a request for information to get a comprehensive evaluation of its entire Medicaid program because we're really lacking in quantitative data around our efforts. We know anecdotally that it's making a difference, and we think theoretically it's making a difference, but we don't have anything really concrete in all of our spaces to show legislators, to show providers this actually moves the needle on quality or cost or access.

And I think just my little pitch to you guys is it would be really awesome if we have enhanced funding for more analytic power or quality evaluation. Right now, it's considered admin, so it's a 50-50 match rate. CMS does enhance match rates for all sorts of things, for IT infrastructure, for kids, for new adults, but we have 50-50 admin for this really important evaluation component.

And little states like Vermont paying $2 million a year for a university to bring in analytics is just not

affordable, and so thinking about that match rate and whether any federal funds can be delivered to states to get a little more sophisticated in their data would be huge.

MS. CHARRON: I just want to agree with that a thousand percent. That is absolutely one of our biggest areas of challenge is making truly data-driven decisions and not just reacting to crises. I feel like that's at times how we look at provider rate increases. That's how we look at policy changes. It is reaction to crises instead of being able to proactively use our data. And it's all of the reasons to what Ashley said.

I want to respond to the earlier question about cost. I would absolutely agree that a move to managed care does not necessarily mean significant cost savings in the system, certainly not immediately. I think for Idaho, the conversation has been that greater degree of budget certainty, and I think in some states, there has been some reported potential cost savings.

I know when I was in Texas, we consulted with Deloitte to complete a report, and they pulled some hypothetical fee-for-service, because we were a predominantly managed care state, and this was like in

2018, I believe, that they estimated it was somewhere between 4 to 11 percent. So that's a bit of a range, but a 4 to 11 percent savings within the system by moving to managed care.

But I think to what Sean said, I think it's been a little bit all over the place, and I think it's very state dependent. I think it's dependent on the service array. It's dependent on the population and a number of other factors and accessibility of services in the state.

But I think data is paramount to any sort of successful quality, population, health, and cost containment efforts, and I think states with limited resources in particular are just really challenged to best leverage data to help us drive some of those decisions.

And we're working on it, but it's an area of opportunity, and I love the idea of the enhanced match.

MR. HALSEY: I love that too. Or maybe allow states to -- I think we get an enhanced match if a land-grant university does it, but maybe extend that to nonland-grant universities that want to do data analysis, evaluation with the Medicaid agency.

So like right now, we're working with Yale.

We're not going to get any sort of enhanced match with Yale because they're not a land-grant university. We've approached our land-grant university. They're more interested in research than actionable evaluation and things that we can act on quickly.

I do have to apologize. I do have to go to a meeting at two o'clock with our governor's budget office. It's legislative time in Connecticut, and I apologize. I have to drop off.

CHAIR BELLA: You don't have to apologize. We're so thankful that you spent the time. Thank you very much.

MR. HALSEY: Thank you very much. Have a good afternoon.

CHAIR BELLA: And for Ashley and Juliet, I think we will appreciate your schedules as well, and maybe you can like secretly hide for this next 15 minutes since people think you'll still be with us. But we would love to get you all enhanced match for many things, so that we appreciate that explicit recommendation.

We'd also really like to help you on your state capacity issues. I can't imagine how you're doing all you're doing. So thank you, in light of all that for

spending this time with us today, and please feel free to keep in touch with us as things come your way. Do not be shy about dropping us any sort of formal or informal communication because we really do want to be here to help you guys. So thank you so much for your time today. Really appreciate it.

MS. BERLINER: Thank you. Appreciate your time for the discussion.

CHAIR BELLA: Thank you.

Okay. For Commissioners, we are going to grab a short break for ourselves and come back and continue on. Sean is back. So, at 3:15, please be back here. We'll restart. Please enjoy a little short break, and see you all in a few minutes.

* [Recess.]

CHAIR BELLA: All right. Thank you, everyone.

Sean, you are going to lead us through EQR information, bringing us back from our last discussion. So lead us away, please.

MANAGED CARE EXTERNAL QUALITY REVIEW (EQR) STUDY FINDINGS

* MR. DUNBAR: Sure. Thank you.

Good afternoon again. So, I look forward to walking through the detailed findings from our research on managed care external quality review.

For today, I'm going to recap some of the background on EQR requirements that we discussed at the January meeting and highlight the approach that we took for this particular study, and then I'll walk through some of the key findings from our research.

As we discussed in January, EQR is an important oversight tool given the growth of managed care into the prominent delivery system approach in Medicaid. EQR also has implications for several aspects of the Commission's work related to beneficiary access, quality of care that individuals receive, and how states are using available levers to conduct oversight of managed care plans.

In January, we introduced our work on EQR, walked through federal requirements, and shared some of the emerging themes that we were seeing.

EQR requirements direct state agencies contracting with managed care plans to conduct an annual external independent review of quality outcomes, timeliness of and access to services. When conducting EQR, states

must execute four activities, which are compliance reviews, validation of performance measures, and validation of performance improvement projects, which I'll refer to as "PIPs," and now a new requirement on network adequacy validation.

States can also choose from a list of optional activities such as conducting surveys or conducting studies on clinical or nonclinical components of their Medicaid program.

For each mandatory and optional activity, there's a protocol developed by CMS outlining the acceptable methodologies for conducting elements of the EQR.

States do have latitude within these parameters, such as defining plan performance measures and then identifying areas for their PIPs.

You saw this diagram in January. I wanted to recap it since it is really an important component of how EQR fits into other federal oversight processes. In general, states are required to develop a quality strategy that is meant to articulate the state's managed care priorities and serve as a roadmap for assessing the quality of care that members receive.

Federal regulations also direct that states have their plans implement a comprehensive quality assessment and performance improvement program, QAPI, which should reflect the priorities articulated in the state quality strategy and include specific measures and targets from the quality strategy.

Federal rules then have the EQR process validate performance measures and PIPs that are included in the QAPI with the results included in the state's EQR technical report.

So for the comprehensive study we did on the EQR process, we partnered with Bailit Health, an outside contractor. We conducted a comprehensive review of federal statute, regulations, sub-regulatory guidance, and other materials. We also conducted an environmental scan that included reviewing more than 80 recent annual technical reports available, EQR procurement documents, and the state's most recent quality strategy.

To supplement that work, we conducted a detailed review of EQR approaches in five selected states, and we also conducted 18 interviews spanning a number of key stakeholder groups.

The comprehensive analysis led to a number of findings related to states' use of EQR, the extent to which EQR findings are used to influence plan performance, and CMS's role in the oversight of the EQR process.

So for the findings, I've grouped the findings into a few overarching buckets. The first captures findings that are related to implementation of EQR requirements. So we found that the EQR process is supposed to be connected to other quality monitoring and improvement requirements, like we referenced in that graphic, but the environmental scan did not always find a clear link between EQR and the state-managed care quality strategy. For example, states with older quality strategies had less of an alignment between their strategies and the EQR activities.

People we interviewed did note that, historically, quality strategies in EQR were not integrated and to a certain extent were parallel activities. But we did hear feedback that this is trending towards better alignment. In particular, states seemed to be increasingly asking their EQROs to develop the PIPs based on components of their quality strategy or even contracting with EQROs to

evaluate the state's quality strategy.

Stakeholders also noted that increased CMS engagement has helped, which we'll get to little bit later.

So states have latitude in designing their EQR approach. Our study found that most states do more than the minimum federal requirements, with only 10 states limiting EQR to the mandatory activities. Some states contract with EQROs to conduct additional activities that may fall outside of the mandatory and optional framework. We found that these can include supplemental evaluation activities, such as evaluating state quality strategies or waivers, and activities like developing quality guides.

We'll note that for additional activities that fall outside of the EQR framework, it's not clear whether states are receiving enhanced match or regular administrative match when it comes to MCOs.

Our environmental scan found that few states take advantage of other available options to streamline the EQR process through exemption and non-duplication. We talked about those in January, but just to give you a quick refresher, interviewees confirmed that the states don't want to completely exempt plans from EQR because this is

one of the primary tools for monitoring plan performance. But we did find that 14 states used the non-duplication approach to deem plans as compliant with specific but limited federal rules. But we also found that states may set a high bar when they actually use non-duplication flexibility.

For example, one state's quality strategy indicates that the NCQA standard used for non-duplication must fully overlap with EQR requirements, and the plan had to achieve a score of 100 percent on the applicable NCQA standard.

Another finding was that a statutory limit on enhanced match for EQR does not align with the various types of managed care plans for which EQR is conducted. Only EQR on managed care organizations is eligible for enhanced match. CMS reduced the match rate for prepaid inpatient health plans from 75 percent to 50 percent in the 2016 managed care rule after determining it did not have the statutory authority to provide enhanced match to entities that did not meet the definition of an MCO.

However, in our environmental scan, we found that 22 of the 44 states that conducted EQR conducted EQR on a

total of 137 prepaid inpatient health plans, 34 prepaid ambulatory health plans, and 10 primary care case management entities.

Some stakeholders interviewed by MACPAC questioned the discrepancy in enhanced match available for EQR and noted that state staff and resources can oftentimes be very limited relative to the size of their managed care programs, and the amount of follow-up that they can do is limited.

In our interviews, some stakeholders thought it could be worth revisiting the mix of mandatory and optional activities. First, states now have a new requirement to validate network adequacy. Second, we asked interviewees what they believe to be the most valuable activities, and we heard mixed reviews on mandatory validation of PIPs.

CMS views PIPs as a valuable tool in determining what quality improvement areas states are prioritizing in their Medicaid programs, and some stakeholders see PIPs as increasing visibility into plan activities, ultimately informing the domains, measures, and approaches that drive meaningful change.

However, other states, consumer advocacy groups,

and plans express concerns with the value of mandatory PIP validation, noting that the protocols are too focused on process and can be cumbersome to execute.

Additionally, stakeholders indicated that PIPs also tend to be short term and can sometimes be too small to be statistically validated, causing some states to instead implement these PIP-like approaches.

Some stakeholders suggested moving encounter data validation to the mandatory bucket, given its importance to rate setting and T-MSIS integrity. Others suggested creating a mandatory requirement related to EPSDT, given the number of Medicaid beneficiaries that receive that service.

All right. So our next set of findings focus on support for oversight and improvements in managed care.

Our study found that the primary focus of EQROs is compliance with federal managed care requirements, EQR protocols, and state managed care contractual requirements.

For example, during compliance reviews of coverage denials, EQROs typically look at whether policies and procedures align with federal rules and state requirements, such as assessing health plan compliance with

timelines, qualifications of plan staff who are involved in coverage determinations, and the content of notices to beneficiaries regarding decisions and their insights to appeals and grievances.

We heard from EQROs that occasionally a state may ask them to review whether the coverage determination was medically appropriate, but that appears to be more of the exception than the rule.

A consistent theme raised in interviews is that EQR activities and the findings presented in the annual reports are focused more on the process and regulatory compliance rather than changes in performance and outcomes over time.

We did get the sense that there's an interest among at least some stakeholders to see EQR enhance its focus on outcomes.

States are not required to act on the findings or recommendations included in ATR, and we found that states vary in whether they use any tools to enforce the findings. Also, the tools that states use also can vary. Some of the tools we heard about included using the results to inform potential contract changes, corrective action plans,

financial penalties, and reducing or freezing auto assignment.

Notably, one state had a quality-based auto-assignment algorithm that would calibrate to the EQRO findings, which was interesting.

Feedback from interviews with states and EQROs suggests that one of the most effective tools in improving plan performance was reductions or freezes to auto assignment, and some interviewees commented that auto-assignment levers seemed to be more effective than even financial penalties.

It's worth noting, however, that states we spoke to do seem to have a collaborative and iterative approach with their plans when it comes to addressing subpar findings and non-compliance. For instance, states or their EQR, or both, may provide technical assistance to plans as needed and oftentimes provide plans with an opportunity to address findings in the draft EQR report before the report is finalized.

We also found that states do see a lot of value in the support that the EQROs can provide them in the execution of their Medicaid program. EQROs provides states

with the flexibility to pursue a variety of optional activities or additional activities that can advance their Medicaid program goals. For instance, about 24 states use EQROs to conduct focused studies. Thirty states use EQROs to conduct surveys, primarily beneficiary surveys, and some states have started using EQROs, for example, to evaluate directed payment arrangements.

We consistently heard from interviewees that states rely on EQROs for their technical expertise, and that states don't typically have in-house resources with the same level of specialty. Many described EQROs as providing essential technical support.

There was one particular area that came up where there are limitations, it seems, on EQRO support, and that was addressing SDOH and equity efforts, which is something we asked interviewees about. States and health plans have trouble incorporating equity and SDOH-related goals into PIPs and other performance measures when the completeness and accuracy of data on race, ethnicity, language, and disability status are not readily available or are available in such small sample sizes that the data cannot be stratified in a meaningful way.

As a result, states often use PIP-like projects for these initiatives, since satisfying EQR protocols for statistically significant improvement cannot be measured due to small numbers.

Despite states publicly posting their ATRs, the annual technical reports, our analysis found challenges with the usability of the information.

First, the reports can be hard to find, even though they are publicly posted. Whether intentional or not, we did find that some reports seem to bury meaningful EQR results or report on aggregate results that gloss over problematic findings or certain plans or certain components of the EQR review.

Although ATRs note where all or certain plans were non-compliant or partially compliant for a particular component, oftentimes a reader may not be able to clearly determine the extent to which a plan's non-compliance was significant.

Additionally, the technical reports generally do not identify actions a state or its EQR may have taken on behalf of the state to address any non-compliant findings.

Our study found that states use different

approaches for rating plan performance as well, such as a binary met/not met approach. Some states use percentages. This variation can make it difficult for individuals to clearly determine the extent to which a plan was compliant or the extent to which a plan's non-compliance was significant.

The variation in these state approaches to rating compliance and performance can also make it challenging for stakeholders to evaluate plan performance across states, if the need arises, such as looking at the performance of a national firm across multiple states.

The last bucket of findings relates to CMS's role in the oversight process.

There were several key areas where our analysis found notable gaps regarding CMS's oversight role in the EQR process. First, we didn't find any regulations or guidance regarding how CMS monitors state compliance with EQR protocols or describing possible CMS actions if a state fails to follow the established protocols.

We also didn't find any federal policies describing the process and criteria for reviewing and approving state EQRO contracts, which is required for

states to receive enhanced match for MCO-related EQR.

Third, it's also unclear if or how CMS uses the information for compliance monitoring or other purposes. Despite our findings on this point, states and other stakeholders we interviewed did suggest that CMS is increasing its presence, whether through increased technical assistance, looking more at how plans comply, or how ATRs capture information.

Our review also found that CMS appears to be increasing its attention to quality strategies. States we spoke to indicated that over time, they have experienced increased communications from CMS regarding their quality strategies and posting of EQR technical reports. One state, in particular, seemed to think that CMS's presence has grown since the agency issued the Managed Care Quality Strategy toolkit in 2021, which described how states could use information from the ATRs and revising and aligning the state's quality strategies.

So I realize that was a lot, but I do look forward to your feedback on the findings from our study and any questions that you have. We'd also like to hear whether the Commission is interested in pursuing any policy

options in this area. If so, we can return at a future meeting to review options and identify any potential opportunities for recommendations.

In the meantime, our plan is to develop an issue brief describing federal EQR requirements and state approaches that we gleaned from the policy review and the environmental scan, and as you heard in January, there is a companion project on denials and appeals. So I think your feedback through this will also be informative and helpful for that ongoing project.

On that note, Melanie, I am happy to turn it back to you and for you all ask any questions and to discuss.

CHAIR BELLA: Thank you, Sean.

And I was remiss in not thanking you for what you did to put the panel together last time. We sort of all raced out of here for a break. Thank you very much. That was really helpful.

MR. DUNBAR: You're welcome. Yeah. No, this was really good.

CHAIR BELLA: It was great, and I appreciate how you've organized the findings into very clear sections, so thank you for that.

So, Commissioners, I want to open it up, see if you have any questions on the work by Bailit or on the analysis that's here and specifically get very concrete feedback from you on areas that you might be interested in pursuing or exploring for future policy options.

Darin.

COMMISSIONER GORDON: Thanks for the list between what's mandatory and optional. I think it would be helpful to know, for those things that are optional, are there other requirements and expectations? Some of the things that are optional, I have to think that there's other federal requirements with regards to that stuff. So it would just be helpful, because before you start moving things from optional to mandatory, it would be good to know if maybe states are covering it through different mechanisms today.

MR. DUNBAR: Thanks.

CHAIR BELLA: Other comments?

Heidi.

COMMISSIONER ALLEN: I guess I wasn't kind of surprised -- and this makes me feel naive -- about how disconnected it was. I assume this is a very significant

amount of -- you know, it takes a lot of resources, these contracts, and they produce this thing that isn't clear that it has any impact at all.

And so I am very curious at really the states that are using it to have impact, and I was intrigued by this idea of states that are using auto enrollment, tying it to that, and what a motivator that could be.

And I'd be interested to know what other -- you know, what are some best practices for taking these off of a completely separate -- like, you know, this has nothing to do with this or what we read in the report, which is a parallel track to think about like what is -- what are the states that are truly integrating it, and what kind of leverage is this giving them that they otherwise wouldn't have to drive quality improvements and outcomes.

MR. DUNBAR: Sorry. And you're talking about how they're -- what levers they're using to then take the findings and improve plan performance? Okay.

COMMISSIONER ALLEN: Yeah, because I was just surprised. I'm like, oh, you know, they're doing this, and I'm like, does anybody read them? Like anybody? Does it just go on a hidden website?

MR. DUNBAR: Right. Well --

COMMISSIONER ALLEN: Okay. We have a few actuaries who are like I read them at night when I want to go to sleep.

[Laughter.]

MR. DUNBAR: And that is a -- oh, sorry.

COMMISSIONER ALLEN: Yeah. I'd just be curious to -- I like the idea of the states that are not only just reading them but making them part of the way that they, you know, do business.

MR. DUNBAR: Yeah. And I think those are two different takes on a similar theme, and I think the first part, as I was thinking about it, is -- you know, we heard a lot about the usability of the information, right? It gets posted, and it's just hyper-technical. And I think -- and we talked a little bit about this, I think, in January. At the end of the day, these reports are responding to very technical protocols and processes that CMS has laid out. And so I think to a large extent, the audience has traditionally been CMS, necessarily, but I think there is a lot of interest, at least that we heard among other stakeholders, to be able to actually look at these and find

a way to use them. And we did hear some states do provide executive summaries to these reports, which makes it easier, right? Others don't. And so there's just this notion of a lot of the information isn't accessible.

And then I think then there's the other issue of are states taking these findings and how are they -- what levers are they using to then improve plan performance? Yeah. I just wanted to make sure I was clear on which piece.

COMMISSIONER ALLEN: And then this idea of longitudinal analysis, because it almost sounds like there's not many states that have a mechanism to -- so say you ask for improvement. How do you know that you got the improvement in the next report that comes out? Are these different contractors doing these reports in different years? Is there any requirement to create a longer snapshot or -- I'd just be more interested in trying to understand that too.

CHAIR BELLA: Darin, did you want to respond?

And then, Jenny, I'll ask also see if you have any comments to add.

COMMISSIONER GORDON: Yeah. I think Sean hit it

pretty well. There's one, the expectation CMS has, but probably, our most leveraged vendor was our EQRO. It was critical and the backbone to everything we did from our quality strategy to validating things were happening the way we thought they should happen. So whether or not it, I guess, comes across in the CMS-required report is different than how are they actually being used in the organizations, are they a part, are they integrated with your quality strategy? What role do they play? So this is always the balance between "I'm complying" versus "Wow, this is an incredibly helpful tool to use."

And I would tell you just from our experience, we were well beyond the mandatory pretty early on because we saw how valuable a resource that was, kind of to the comments we heard from the state panel. You have limited resources. These folks are out in the community, across the state, working in some cases on the Medicare side with some of these same providers. We use them for provider education purposes as well.

So I do think we always have to separate what is required, and they do that, but then are they using them more fully in other ways?

And the reporting part of it, your point about the longitudinal aspect of it, I think that one of the key questions there is who's driving kind of the reporting and the reporting format, because if I move from Vendor A to Vendor B, as long as the state is the one that's driving, "Here's all the criteria. Here's what it needs to look like. We want it consistent," then I think it works. But you do run the risk if the state isn't doing that, you have, what, three years and two 1-year options that you could stumble into that unintentionally where you have a very different report picking up by another vendor later.

But that's -- it's a good question about whether or not this -- who's holding and controlling and driving it. Are you being completely deferential to that existing vendor? And it may change the next time around.

CHAIR BELLA: Jenny, would you like to add anything?

COMMISSIONER GERSTORFF: Yeah.

Sean, thanks for the information. I thought the Bailit report was really excellent. A lot of time and research has gone into this.

I think a couple of key themes that stuck with me

was the lack of consistency between states. I think to make it really usable, consistency is important, and I know that CMS has been doing great work recently and for a long time really, but improving the consistency of what their expectations are for different things, so hopefully, this is something that's on their radar.

And then the other thing was how this incentivizes MCOs versus other models, and so going back to our panel and whether the enhanced match imbalance disincentivizes other program types and if that's appropriate or not.

CHAIR BELLA: Thank you.

Tricia?

COMMISSIONER BROOKS: Thanks, Sean. The research sort of jives with the work that I've done in this area and my colleagues.

Can you refresh my memory? Are the mandatory versus optional activities in statute, or does CMS determine those?

MR. DUNBAR: I have to go back and double check. They might be -- they're certainly regs. They may be in statute. I think I'll have to go check that.

COMMISSIONER BROOKS: Yeah. That would be interesting, because I do -- you know, CMS has had a goal of just hitting the 80 percent mark on EPSDT on screenings for 15, 20 years, and here we are and most states are not even close. So, certainly, representing the kids community, having EPSDT as well as encounter-level data, I think you made a really good point. I mean, it's the source data for so much of the analysis work that we can do. So I'd be interested in seeing how we could move the needle on making some of those optional activities mandatory.

I actually have a slide that when we talk about managed care that we add in the procurement process to that cycle, right, because the quality strategy should drive what the state is asking the managed care plans to do on the quality front, sets the stage for that, right? Then they put their QAPIs in place and we move on to external review.

So I'm wondering if we can uncover more about do states really use this as they move into procurement so that it's clear contractually that that's what the quality strategy and emphasis is going to be on.

The other thing is that when the managed care rules came out in 2016, they were the first overhaul in more than a decade of the managed care rules, and there was a lot in there about transparency and posting of information in prominent places that people could find them. But obviously, that hasn't stuck yet if we're still having a hard time finding them.

And I totally agree with Jenny. I've scanned multiple documents, and they're all over the place. If you're looking for consistent information that you can find, it's not necessarily going to be there.

And then, lastly, I think Heidi makes a good point about having some historical perspective on quality improvement plans. I do think that some of it, from what I've seen in the EQR space -- and I haven't been spending a lot of time on that lately -- is that they try not to identify Plan A from Plan B, and so plans that have been implementing similar quality improvement initiatives -- and you're getting traction in Plan A and not getting traction in Plan B -- we don't share what Plan A is doing to get that quality. So we should be concerned about taking the lessons learned and being able to apply them more broadly

to what needs to happen to improve quality for folks.

CHAIR BELLA: Thank you, Tricia.

Other comment?

[No response.]

CHAIR BELLA: Sean, was there anything in there that surprised you that we haven't already called out?

MR. DUNBAR: I feel like the lack of detail on sort of CMS's oversight role was interesting, especially with respect to the contract review being sort of really the mechanism for the plans to get the enhanced MCO. There's not really much of a sight line into what kind of scrutiny is applied or not applied.

We tried to find -- the contracts, the EQRO contracts weren't publicly available. So we mostly relied on the procurements and like model contracts to see if we get a sense of what was included or not included. So I think that was an interesting piece.

I don't know if "transparency" is the right word, but just kind of the usability of the findings, like the interest level that people seem to have in wanting to find a way to be able to process what's going on, because I've always thought of it as just like a very technical report

to report on what's been going on, so that was another area.

And then I think also the interest in -- like the discrepancy in the enhanced match and sort of that it had been in place for the PIHPs, the pre-paid inpatient health plans, prior to the 2016 rule, and so that states don't necessarily get that for PCCM and the prepaid ambulatory health plans. So I think those were a few areas that jumped out.

CHAIR BELLA: Thank you.

Dennis?

COMMISSIONER HEAPHY: Yeah. I would love to see the -- I actually looked at the MassHealth document, and it's more usable than some other ones I've seen out there. But I think it would be really great to see some of this in plain language that could be publicly disseminated so that advocates could use this and better understand how plans are performing and therefore be able to influence the procurement process.

And I think Heidi just spoke to that too. How do they actually use this? Should they be required to use this information in the procurement process at the national

level, not just state by state by state, at least have like a baseline set of requirements, like a minimum set of requirements?

CHAIR BELLA: Thank you, Dennis.

Sean, do you want to respond to that?

MR. DUNBAR: I had another follow-up thought to your previous question, too, but thank you, Dennis. I think that's helpful.

I think one of the other areas, Melanie, was just the variation in whether states used it and how they used it. It seemed to be a gap that I wasn't necessarily expecting to see.

CHAIR BELLA: Other comments or questions?

[No response.]

CHAIR BELLA: So we will do an issue brief, and we'll continue to see if -- so far, the things we're talking about are probably things that are interesting, but they're not -- they don't feel recommendation-worthy yet. But we can keep talking about this and see what kind of path we end up on.

Do you need anything else from us at this point?

MR. DUNBAR: I think you flagged some areas where

it may be helpful to start thinking about some options, and so I think I have some good stuff to go on.

CHAIR BELLA: Yeah. I think I would just ask us to always be thinking about like in the order of priority of things we want states to be doing and paying attention to and looking at, like how do -- where does this fit relative to other tools they have, other responsibilities they have, other things that are going to be on their -- like the value and usability? So as we look at their use of it, let's also try to find some measure of the -- Darin has said that it's an incredibly valuable tool, but all states may not feel that way. So just keeping that in mind, I think, would be important too.

Okay. We're in the homestretch, friends. We have one last session, and I invite Drew and Rob up. This is to talk about a CMS-proposed rule on disclosures of nursing facility ownership, and it is our last session of the day.

Thank you, Sean. Thanks very much.

[Pause.]

CMS PROPOSED RULE ON DISCLOSURES OF NURSING FACILITY OWNERSHIP

* MR. GERBER: Thank you. As Melanie said, we're here to provide a briefing on the recent notice of proposed rulemaking that was published in the Federal Register last month.

To begin, I will provide some background on the types of ownership models used for nursing facility care and the extent to which current disclosure requirements facilitate transparency. Then, Rob will walk through the recent notice from CMS, which includes potential new reporting requirements for private equity and real estate investment trusts in the nursing facility sector. He will then highlight areas for comment that might be of interest to the Commission, such as voicing support for changes consistent with our recent recommendation on transparency as well as other Medicaid-specific considerations.

I will begin by describing nursing facility ownership. In 2022, most nursing facilities, 72 percent, were for-profit entities, and two-thirds of facilities were part of a larger chain. Chain ownership is not a monolith. While 11 percent of facilities were part of chains with more than 100 facilities, 15 percent were part of chains with fewer than 10.

There are various different ownership models that for-profit facilities use, including private equity and real estate investment trusts, or REITs. Between 2010 and 2020, about 5 percent of nursing facilities were acquired by private equity firms, and meanwhile REITs, which are for-profit corporations that invest in income-producing properties like nursing facilities, held investments in 1,806 facilities in 2021.

REITs typically own the nursing facility building and then lease the operations to a nursing facility operator. However, these ownership relationships can be quite complex, as I will show in this next slide.

Here we have an example of the complex relationships that can be present in a REIT. This graphic is based on information from a recent article in Health Affairs by Braun, et al. For reference, the solid lines indicate direct ownership relationships while the dashed lines indicate indirect ownership or control.

Beginning with the nursing home operator, which is probably the entity we are all most familiar with on this graphic, the operator manages or controls several facilities. However, the operator itself does not actually

own the property under this model. Instead, it is owned by a REIT, which itself can be then owned by either shareholders or a larger holding company.

Under this model, the REIT signs a lease agreement with a taxable REIT subsidiary, that being one or more entities owned by the same holding company that owns the REIT. After the nursing facility properties are leased to the subsidiary, the subsidiary contracts with an independent nursing home operator to run them. And unlike the REIT, which has a different tax structure, these taxable REIT subsidiaries may collect taxable revenue for basic services, such as for laundry and cleaning services or a management fee.

In this model, the nursing home operator still pays rent and building costs, and profits generated from nursing home operations by the REIT and subsidiary, under this structure, are passed to the holding company or shareholders that commonly own them.

While I described a number of relationships quite quickly in the above graphic, what I have presented is a simplified ownership model, and greater complexity is possible. In some instances, the nursing home operator may

be owned by the holding company that may own the REIT as well, directly owning up to 35 percent of the independent nursing home operator.

Nursing facility ownership type has potential effects on facility operation health outcomes for residents. Stakeholders have raised concerns that private equity and REIT ownership may result in reduced staffing levels and worse health outcomes, and related party transactions stemming from these ownership models may inflate reported costs above what they would be if the facility were operated more economically and efficiently, as we wrote in our chapter.

Another related issue for Medicaid to consider is that in some states public hospitals buy or lease privately operated nursing facilities so that these facilities can receive Medicaid supplemental payments targeted to government-owned facilities.

And finally, before Rob reviews how the NPRM proposes to expand disclosure requirements, I will quickly describe the current ownership disclosure requirements that govern nursing facilities.

Section 6101 of the AC A requires CMS to collect

nursing facility ownership information, yet this section has not been fully implemented, as Rob will discuss. CMS also collects information on corporations that have at least a 5 percent ownership stake in Medicare-certified facilities in its Provider, Enrollment, Chain, and Ownership System, or PECOS.

On the state side, Medicaid agencies must collect similar information for nursing facilities that are only certified by Medicaid. However, we found that these facilities make up roughly 2 percent of all nursing facilities.

And now Rob will explain how this NPRM might expand upon these requirements.

* MR. NELB: Thanks, Drew. So the proposed rule would formally add regulations to implement Section 6101 of the ACA and it would also expand the scope of current reporting to include additional information about private equity and real estate investment trusts.

For Medicare-certified facilities, the ownership data would be collected at initial Medicare enrollment and updated every five years or when there is a change in ownership.

For Medicaid-certified facilities that are only certified by Medicaid and not Medicare, the rule lets states collect data in a state-prescribed format.

So if the Commission would like to comment on the proposed rule there are a couple of areas we could highlight. First, we could acknowledge that the proposed changes are generally consistent with MACPAC's recent recommendation for CMS to collect and report data on nursing facility ownership in a standardized format that enables analysis.

The Commission may also want to comment on some Medicaid-specific issues, for example, the fact that Medicaid-only facilities have slightly different reporting requirements and are not included in the PECOS system. However, as Drew mentioned, the number of Medicaid-only certified facilities is relatively small.

Another Medicaid-specific issue we may want to highlight is the limited data that we have about public hospitals that buy nursing facilities and lease their operations to private entities for the purposes of supplemental payments.

Public entities aren't part of the proposed

definition of real estate investment trusts, but the structure of the ownership is somewhat similar, and so it may be worthwhile to get more data about this.

As we noted in our recent chapter, there are large discrepancies in the data that we have about public and private ownership that's reported by states for the purposes of supplemental payments versus what is reported to Medicare on cost reports. And so at some point it would be helpful to improve these data, to better understand these arrangements.

So that concludes our presentation for today. Comments on the rule are due April 14th, which is the time of our next public meeting, so we are going to try to finish the comments before that, if you would like to comment. We welcome to hear any comments that you have and we will incorporate them in a draft letter if you would like.

CHAIR BELLA: Thank you both. We will start with Rhonda, and then I see Sonja and Bill.

COMMISSIONER MEDOWS: Just a request for you guys to consider putting something in about, whether it's CMS or the state, doing a comparison on the clinical quality of

the beneficiary experience and in equity measures across the different types of ownership models, the compensation rules.

CHAIR BELLA: Thank you, Rhonda. So you are in support of responding?

COMMISSIONER MEDOWS: Yes. I am in support of responding and putting in that additional -- yeah.

CHAIR BELLA: Okay. I realize that was a stupid question when I asked you that, since she was suggesting additional things to add, but just to confirm.

Okay. Sonja, and then Bill.

COMMISSIONER BJORK: I am also in favor of responding, and I like the three areas that you outlined, but I need a little bit more information about the public hospitals purchasing facilities and then leasing them out. Is that the only reason that they purchase the facility? Is it that they want to offer those services for their region? Because some public hospitals are very rural, and that's the only place that they could establish a nursing home. So I'm just wondering are there other factors to consider than just that financial arrangement.

MR. NELB: Sure. And to be clear, we are just

talking about sort of transparency here to understand these different arrangements, so we can understand what's going on and do some of that type of analysis that Rhonda was mentioning.

But what we've seen in a couple of states is that the nursing facility will partner with a public hospital so that they can be classified as a public nursing facility, and then receive supplemental payments that are targeted to public nursing facilities that are financed by the public hospitals through an intergovernmental transfer arrangement. So it's sort of more tied to rules around Medicaid financing.

The public hospital isn't really expanding services to new areas. So like we did interviews in Utah, for example. Virtually all of the nursing facilities are owned by this one public hospital in one part of the state. So the link sometimes with the ownership isn't that region where the public hospital is authorized, but it's more the way that these arrangements are set up for the purposes of supplemental payments. Hopefully that helps.

COMMISSIONER BJORK: Thanks for clarifying that. Thank you.

CHAIR BELLA: Rhonda, did you have a comment on this?

COMMISSIONER MEDOWS: I did, and I just wanted to add is that there are some additional reasons why a hospital may want to own nursing facilities, assisting living, and that is to address along with the state and to have a direct line for placement of people who are medically stable, ready for discharge, and needed a place to go. And then the reverse of that is true. If you can actually coordinate between the nursing home and the hospital, you could potentially reduce your hospital readmission rates and your frequent flyers in the ED. There are some operational reasons, and some financial reasons, to add to the list that you've just talked about.

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

COMMISSIONER SCANLON: Yeah, I'm very supportive of submitting comments because I think this is a step, sort of, in the direction of what we recommended with respect to transparency. It's important to remember it's only a step. It's not going to get us anywhere close to the full transparency that we want.

I would also encourage CMS to be as comprehensive as they can, I mean, this idea that there has been a lot of focus -- and I saw it in their press release -- on private equity and REITs. Yes, they've gotten a lot of broad press about some of the abuses that have occurred, but it's not just those entities. I mean, we have to be concerned about any entity that's operating this, and transparency needs to extend to all of them.

So publicly traded, for-profit corporations, we should know about them with the same amount of detail that we have about these others, and the same thing about nonprofits. We have nonprofits that have essentially holding companies and subsidiaries, et cetera. And so I think you need to think about sort of, if you are CMS, sort of what is it that you need to know for the future.

And the other thing, and this is kind of one of my sort of things about government. You don't get a lot of chances to continually change your mind and come back next year and the year after the year after, and say, "Wait a minute. We forgot to include this. We forgot to include this." Think about it in advance and put out a requirement that can be responded to efficiently but will deal with

sort of needs that you might not have anticipated fully today.

Thank you.

CHAIR BELLA: Thank you, Bill. Can you just flip that one slide back, so we have that in front of us? Okay. Thank you.

Heidi, and then Dennis.

COMMISSIONER ALLEN: Bill said it, actually, very well, kind of the thoughts that were on my mind, which is that there is increasing scrutiny of these nontransparent financial arrangements, particularly related to private equity. And it seems like this is a response to evidence that private equity in nursing home is leading to higher mortality, and it's a GAO report.

But this isn't just happening in nursing homes. This is happening also in hospice. It's also happening in behavioral health. And I feel like I realize that in MACPAC we have to respond based on the evidence that we have, and then that's why we always go back to transparency because we have no evidence because there's no good data, but then we can't say anything about it. And so I feel like we're in a little bit of a vortex. Because there's no

transparency, we don't really know what's happening so then we can't call out abuses or risks to Medicaid enrollees.

And so I know we're limited in what we can say in a comment letter, and particularly before next month, but I do think that this is an important topic for MACPAC to consider, how we can progress, even if we're not able to get the transparency in place, so that we can really understand as much as possible how particularly these short-term private equity investments, where they come in, they extract, and they leave, what that does to enrollee access and quality and outcomes. And I don't have the answer. I don't have the solution. But we've got to find a way to figure this out because this has been very disruptive over the last 10 years, and I think it's profitable enough that it will become even more disruptive in the future.

CHAIR BELLA: So this will probably be a frustrating response because I know you want a path outside of having the information we need. But we have to start with calling for transparency and getting the information, because we can't make assumptions or generalizations without that. So if you're suggesting, you know, this is

an opportunity to comment and we're also keeping an eye on opportunities to initiate or respond to comments to reinforce transparency and ownership stake across many domains that we could be looking for those opportunities, but I do think it does start with being able to get a line of sight into the data, to be able to validate, if what we think is happening is indeed happening.

COMMISSIONER ALLEN: I 1000 percent agree, but calls for transparency have not really led to transparency. And even if you do get a rule, we've found that people don't always do it, and then you're five years out and you know no more than you did before. And so I think that this might be a way that -- and what we're talking about is government transparency, right? We're talking about regulations where people are required to submit information. But there is research happening. There are lawsuits. There are other types of investigations.

And I wonder if we can use other sources of data rather than public reporting requirements to try to get a sense at how private equity in Medicaid is changing the landscape of delivery and outcomes. And it's not that I would ever say we shouldn't ask for those things, but I

wonder if we can pay for analyses of aggregating lawsuits, aggregating data that's been collected for other purposes, to try to understand, if that's possible.

CHAIR BELLA: Yeah, I think we can take that back. We can figure out where it fits in our work plan and try to figure out, you know, there are so many lawsuits going on in Medicaid with lots of different actors. How much risk to access or beneficiary harm do we think this is versus this over here, not that they're not all important.

But I hear you on that and appreciate continuing to raise that. It's bigger than just this in nursing homes right now.

On this, Bill, and then we're going to go to Dennis.

COMMISSIONER SCANLON: I was going to say I agree completely. Why don't we go to Dennis and come back?

CHAIR BELLA: Okay. Dennis?

COMMISSIONER HEAPHY: I agree with what Heidi is saying, and Bill, but I just want to go back to what Bill originally said and say that it is about the private equity, the for-profits and nonprofits. I think we should also add nursing staffing levels and deficiencies across

the three, in terms of transparency, as part of our potential comments to MACPAC, the three of those across.

MR. NELB: Dennis, just to clarify, their staffing levels and deficiencies are sort of reported through that Nursing Home Compare website, which is separate from the PECOS system that this rule is changing. All of them use the common identifiers, so it's possible to use the ownership data from this system to link it to the quality data in that other system.

COMMISSIONER HEAPHY: The reason I asked is there a way to simplify it so that it's all in one place.

CHAIR BELLA: It doesn't sound like because it's going in two systems right now.

MR. NELB: There's two different systems.

CHAIR BELLA: But it does sound like it could be a new project for someone to try to link them once we have this additional information.

Thank you, Dennis. Back to Bill, and then, Rhonda, I see your hand. I'm not sure if that's still from -- okay, okay.

COMMISSIONER SCANLON: Yeah, no. Thank you for putting this slide up because I thought of it but didn't

make the point, which is that I think that the data needs to be standard for both Medicare and Medicaid, so that we are asking for the same information across all states. It's not going to be useful in the future if we have some information for facilities in one state and not the same information in the other states that they're operating in. So our transparency has to be national.

And from a provider perspective, there should be some appreciation, if you're not trying to hide something, there's efficiency. You're not dealing with 50 forms that you have to think about, well, what have I put in this one versus that one.

CHAIR BELLA: Thank you, Bill. Dennis, do you have another comment or is your hand remaining? No. Okay.

Tricia, nothing?

So I think the answer is yes, we would like to comment. Do you have what you need from us?

MR. NELB: Yeah. Thank you so much.

CHAIR BELLA: Okay. We review prior to the next meeting and get this thing submitted. Thank you very much for doing that in advance.

Okay. We are done with this session. Any last

comments from Commissioners before we go to public comment on any of the afternoon, actually, any of the day?

[No response.]

CHAIR BELLA: No? Okay. We will open it up to public comment. I will remind folks to please introduce yourself and the organization you represent, and we ask that you keep your comments to three minutes or less. If you would like to make a comment, please use your hand icon and we will unmute you.

[Pause.]

CHAIR BELLA: We have no public comments so far. We will give it just a little bit, a tiny bit longer.

PUBLIC COMMENT

* [Pause.]

CHAIR BELLA: Okay. Well, if people end up with comments later you are always welcome to email them to us.

For the Commissioners this is a wrap for -- what month are we in? -- March. We forgot that from this morning. We'll be back in April, and thank you to Kate and the entire team for all the work that you're doing. This is another productive meeting, from our point of view, so very much appreciated.

And we are adjourned. Thank you very much, everybody.

* [Whereupon, at 4:10 p.m., the meeting was adjourned.]