PUBLIC MEETING

Ronald Reagan Building and International Trade Center
Hemisphere A
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Thursday, April 13, 2023
10:30 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to the last meeting of our current work cycle session. We are going to start off today with DSH. Aaron and Rob, we will turn it to you.

AUTOMATIC ADJUSTMENTS TO MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS

* MR. PERVIN: Thank you all. Good morning. Today Rob and I are going to be presenting an overview of our draft chapter on automatic adjustments to Medicaid disproportionate share hospital allotments. I'm going to quickly go over the chapter because we have presented much of this material in previous meetings, and then Rob is going to walk you through our recommendation language.

Our draft chapter provides a bit of background on DSH policy and then discusses our analyses that we did to support this work, namely looking at DSH allotments during economic recessions and also during periods of normal economic growth. Then the chapter is going to go over specific recommendation language for each of our four recs, and then our presentation is going to conclude with some

next steps.

Okay. On to some background. Limits to DSH payments are set annually by federal allotments. These allotments vary widely by state and are based on 1992 DSH spending, and have no meaningful relationship with measures of need for DSH payments.

Limits to DSH spending function different from other limits set for other Medicaid payments, which are limited on a total spending basis.

We also provide a little bit of background on the FMAP within the chapter. So as a brief review, FMAPs are determined using a state's per capita income, and states with increasing incomes get a lower FMAP while states with decreasing incomes get a higher FMAP. While annual changes in the FMAP may be small, they can grow over time.

Also, 15 states have an FMAP at the statutory minimum of 50 percent, so their FMAPs can only go up if their per capita income decreases.

At the last meeting, Commissioners wondered how these recommendations related to our previous work on DSH allotment reductions. We wanted to briefly discuss that within the chapter as well.

In 2019, the Commission made a package of recommendations regarding reductions, should they go into effect. The Commission recommended that the reductions should improve the relationship between allotments and the number of non-elderly, low-income individuals in the state. This was the preferred measures of need because it is correlated with uncompensated care and is not affected by state choices on whether to expand Medicaid.

The other two recommendations focused on minimizing disruptions to safety net hospital financing. While these recommendations have not yet been implemented, under current law allotments are scheduled to reduce by half in October.

The next two sections of the chapter analyze DSH policies during both economic recessions and also during periods of normal economic growth.

The chapter begins with an analysis of what Congress did during prior economic recessions. In the three policies we looked at, they increased federal allotments and did not change the FMAP. This is what they did in 2008. Another time they increased the FMAP while keeping allotments based on total federal funding, as they

did in 2020, or they increased the FMAP and rebased allotments on total funding, as they did in 2021.

In interviews with states and hospitals conducted last summer, we found that stakeholders preferred a policy that based DSH allotments on total funding because it preserved DSH funding for providers, it supported states to the increased FMAP, and it was relatively easy for states to administer.

We also found that countercyclical DSH policies had different effects on states and providers, and this could be attributed to how states financed their DSH payments and to the extent to which a state may rely on provider contributions to the non-federal share. It also depended on state decisions on whether to increase or decrease other Medicaid payments to providers.

This figure shows the disruption to total DSH funding under current law from 2014 to 2019. And so we wanted to look at what effect a policy would have if we rebased DSH allotments on total DSH funding during periods of normal economic growth. So we looked at what that change would be between 2014 and 2019.

This green line, that shows the rate of inflation

between 2014 and 2019, so that is 7.5 percent. All states in the red box had increasing FMAPs, and so because of the interaction between DSH funding and the FMAP their total DSH funding increased at a rate slower than inflation, even though their incomes decreased compared to the national average.

States in the green box had decreasing FMAPs and had DSH funding increase faster than inflation, even though their incomes increased faster when compared to the national average.

To show the state effects of basing allotments on total funding, we looked at changes in DSH funding for states that had an increased FMAP, decreased FMAP, and no change in their FMAP from 2014 to 2019. Under current law, federal allotments increase with inflation, while if allotments were based on total funding, total DSH funding would increase with inflation.

States with an increasing FMAP benefit the most from this policy because their total funding would have increased from 2.9 percent to 7.5 percent, which is the same as the rate of inflation.

Meanwhile, states with a decreasing FMAP would

not benefit if allotments were based on total funding. For these states, they would receive a lower increase in total DSH funding when compared to current law. Instead of a 9.3 percent increase, they would have instead received a 7.5 percent increase, which again is consistent with inflation. Meanwhile, the 15 states that saw no change in their FMAP would have had no difference between the two policies.

With that I am going to turn it over to Rob who is going to discuss our recommendation language.

* MR. NELB: Thanks, Aaron. Now I'll walk through a package of four recommendations that are included in the chapter, which the Commission will vote on tomorrow.

The first proposed recommendation updates the Commission's March 2019 recommendation to gradually rebase DSH allotments based on the number of non-elderly, low-income individuals in each state. The only change from our prior recommendation is that this new recommendation notes that the comparison between DSH allotments and measures of need should be done on a total funding basis rather than a federal funding basis, so including both state and federal funds.

The chapter reiterates some of the rationale for

this recommendation, which of course was discussed in more detail in MACPAC's March 2019 report. Overall, as Aaron mentioned, we found that this policy helps align DSH with measures of need, and after reviewing a variety of different measures the Commission chose that non-elderly, low-income measure because it was correlated with state levels of uncompensated care but not affected by state decisions to expand Medicaid.

We are listing this recommendation first in the package, based on Commission feedback at the last meeting about the relative importance of this overall rebasing.

The implications are similar to what we found in our March 2019 report. The policy was designed to be budget neutral for the federal government so there was no expected change in federal spending. However, at the state level, of course, different states would be affected differently based on how their current allotments compare to those measures of need. As a result, the provider effects would also vary by state.

The second proposed recommendation is a new one, and it reads as follows:

Congress should amend Section 1923 of the Social

Security Act to ensure that total state and federal DSH funding is not affected by changes in the FMAP.

As Aaron discussed, the analysis we did in this chapter makes the case for this recommendation, finding during normal periods of economic growth the policy helps benefit those states with declining per capita incomes, which also have higher number of non-elderly, low-income individuals. During economic recessions and other disruptive events this policy would benefit all states, and it was generally preferred by stakeholders compared to other prior countercyclical policies.

CBO does not expect this recommendation to change federal spending during periods of normal economic growth. However, when the FMAP is increased across the board during a recession or other disruptive event federal spending would increase proportionate with the FMAP change that Congress chooses to put in place.

At the state level, as Aaron noted, compared to current law there would be some changes in federal funding for states, depending on whether their FMAP goes up or down. But it is important to note that these changes are much smaller than the redistribution projected under our

first recommendation about larger rebasing in DSH allotments.

We don't project a direct effect on enrollees, but for providers there might be some added benefit, especially during economic recessions if they are able to maintain the same amount of DSH funding when the state's FMAP changes.

The third proposed recommendation updates MACPAC's 2021 recommendation about a countercyclical FMAP. The change we made to our prior recommendation is to include DSH in the countercyclical adjustment as long as total DSH funding stays the same when the FMAP changes.

MACPAC's March 2021 report provides more detail about the rationale for this recommendation, but in general the Commission adopted this model that was initially proposed by GAO because it uses objective and timely indicators of an economic downturn.

Previously the Commission excluded DSH from the recommendation because if DSH were based on a federal funding basis then total funding would decrease when the FMAP increases. However, as part of this package, if the Commission recommendations a fix for this issue that DSH

funding be based on a total funding basis, then DSH can be included in the countercyclical financing model without negatively affecting states or providers.

In this chapter CBO updated their prior estimates of the cost of this policy in light of current economic circumstances. Overall, they projected that federal spending would increase by $10 billion in fiscal year 2024, and $70 billion over the next 10 years.

The DSH component is just a small piece of this overall estimate, just about 1 percent.

It is important to note that CBO's cost estimate in this report is a bit higher than what they had projected in our prior report, and that is because of the increased likelihood of recession in CBO's baseline model.

The chapter also discusses the implications of this change for states, enrollees, and providers, noting the benefit of providing states with additional funding and fiscal stimulus during economic recessions, which can help them maintain coverage for enrollees and support for providers.

Finally, the last proposed recommendation in this package is a new one, and it reads as follows:

To provides states and hospitals with greater certainty about available DSH allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that CMS compare DSH allotments to total state Medicaid assistance expenditures in a given year before finalizing DSH allotments for that year.

As we discussed back in the October public meeting, the current requirement that DSH allotments not exceed 12 percent of Medicaid spending was put in place as a tool to slow DSH spending at a time back when DSH accounted for almost 15 percent of Medicaid spending. However, today DSH accounts for only about 3 percent of Medicaid spending, and so this limit no longer has any practical effect on DSH spending.

During the interviews that we conducted last summer we heard about the many operational challenges that this requirement creates, because CMS can't finalize DSH allotments until it has final data on Medicaid spending, which doesn't occur until several years after the spending is actually incurred. And when CMS isn't able to finalize the allotments then states are hesitant to spend the full

amount, which can result in unspent DSH funding and just delays in DSH payments to providers.

CBO does not estimate that this change will have an effect on federal spending, but we have found that it would help reduce administrative burden for CMS. And hopefully by allowing CMS to finalized allotments in a more timely manner it would benefit states and providers so that they are able to make DSH payments in a more timely manner.

That concludes our presentation for today. We welcome your comments on the chapter, which will be published in our June report, and the Commission will vote on these recommendations on Friday. Thanks.

CHAIR BELLA: Thank you both. So the point of the rest of our discussion is to seek any clarification, ask for any changes to the recommendations. We will vote on them as a whole.

Bill, do you want to start us off?

COMMISSIONER SCANLON: Sure. Thank you very much.

I want to say thank you for what you've done here because I think it is very important in terms of, in some respects, pulling together a discussion that began in maybe

2018, and you referenced our 2019 recommendation. And having the big picture, I think, is very helpful because the recommendation of 2019 has not been enacted. And yet, as you have noted, that CBO has observed, the prospect of a recession unfortunately is on the horizon, and so therefore this becomes even more sort of compelling, in terms of what should be a number one priority, protecting beneficiaries by assuring that there is adequate funding.

Bringing back sort of the recommendation about adjusting the DSH allocations I think deals with a second priority, which is we should be very certain, or as certain as possible that when we're talking about spending federal dollars, we are spending them as efficiently as possible. And so this combination here, I think, is very sort of significant in terms of promoting two fundamental priorities that the Commission should care about.

So I'm very happy about these recommendations and will be very happy to vote for them tomorrow.

CHAIR BELLA: Thank you, Bill. Fred?

COMMISSIONER CERISE: Sure. I will just echo Bill's comments. I appreciate the recommendations and I appreciate the opportunity to weigh in and to address some

of the concerns, and I am supportive of them as well. I think they make sense.

Just one comment on the background piece, and it's a bit technical and you've responded to this in the past when you look at targeting DSH payments. Like many areas, the funds flow gets complex and some of the points get lost there. But the message of when the state share is funded by local governments, those public hospitals end up getting a higher percentage of the DSH payments.

What is not stated there is the net benefit there, because what local governments often do, and I know this well, is will provide state share for all hospitals in the state and then they may get a disproportionate share of the payments. Much of that is replacing the IGT that funded the program for the state. So I know there is now a footnote on that graph of the dots on targeting payments that acknowledge that, and in the report, there is another comment about it.

I would just say whenever we talk about that to be able to state that even though there is a higher percent of payments that goes to those hospitals, the net benefit is much less, or could be much less than that, depending on

the state and how the state handles that.

But overall I think the recommendations are good, they make sense, and I appreciate the work.

CHAIR BELLA: Thank you, Fred. Other Commissioners? You have managed -- oh, I spoke too soon. Darin.

COMMISSIONER GORDON: I'm just curious. With the proposed rule do we think or anticipate that would have any impact on our recommendations?

MR. PERVIN: The proposed rule is mostly around DSH payments and DSH limits, and so they are less affected by the DSH allotments themselves. I would also point out that there is one piece of the rule which is around the DSH targeting factors that are used to calculate allotment reductions. And so that might have an effect on our recommendations just because that would cause a reduction, and so that would have implications for kind of our first recommendation, where we say that reduced total DSH funding should share a relationship with measures of need. Because that total amount is reduced then we would be recommending that that total DSH funding amount should be correlated with measures of need.

MR. NELB: The proposed rule, which Aaron will talk about this afternoon, is about the reduction methodology under current law, and our first recommendation is about proposing a new methodology. So it's a statutory change versus the regulations that CMS is working on.

COMMISSIONER GORDON: Thank you.

CHAIR BELLA: Any other comments or questions?

Well, I was going to say thank you for being able to take especially our last discussion and bring it back to us in a manner that, if Bill is happy, we are happy. Bill and Fred, our resident DSH experts.

So thank you very much. We will be prepared to vote on this first thing tomorrow morning.

CHAIR BELLA: Okay. So we will move into duals. Kirstin and Drew, welcome.

[Pause.]

INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: DIFFERENT DELIVERY MECHANISMS PROVIDE VARYING LEVELS OF INTEGRATION

* MR. GERBER: Good morning, everyone. Kirstin and I will be presenting a review of our draft chapter for the June report, which describes how different delivery

mechanisms provide varying levels of integration for those dually eligible.

Our draft chapter is structured as follows, and we'll walk through this together today. The chapter begins with an overview of the Commission's recommendation in June 2022 as well as other prior work that serves as a foundation for this chapter and our continuing work on integrating care for dually eligible beneficiaries.

Then the chapter reviews strategies available for integrating care in states that provide Medicaid benefits to dually eligible beneficiaries under fee-for-service and strategies for states that enroll this population in managed care.

States are developing their approach to integrated care amid a changing landscape. Our chapter describes how the Centers for Medicare and Medicaid Services is sunsetting one of the three main delivery mechanisms for providing integrated care in Medicare-Medicaid Plan model.

We'll detail MACPAC's ongoing monitoring framework that we first brought to Commission in December, and finally, I'll pass it over to Kirstin at the end to

walk through our recent beneficiary focus groups and next steps.

Last year, the Commission recommended to the Secretary of the U.S. Department of Health and Human Services that all states be required to develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries with federal support to do so. Since then, several pieces of legislation, which we have listed here, were introduced in the last Congress that take up the Commission's recommendation in part or otherwise addressed points the Commission raised, such as building state expertise on Medicare.

As we anticipate states developing their strategies, this chapter intends to describe the different delivery mechanisms that states use to provide Medicaid coverage to dually eligible beneficiaries and the opportunities for integration.

Beginning with integrating care in fee-for-service states, we're using the term "fee-for-service state" to refer to states that primarily provide Medicaid coverage for dually eligible beneficiaries under fee-for-service. As we will discuss, some delivery mechanisms may

operate as a managed care arrangement, but we attempt to highlight a variety of tools that states can use to integrate care for this population without moving coverage of Medicaid benefits entirely to managed care arrangements.

Fee-for-service states have tools to integrate care for this population. While the number of dually eligible beneficiaries enrolled in managed care for their Medicaid services is growing, most are still covered through fee-for-service. About half of states do not enroll dually eligible beneficiaries in Medicaid managed care.

The chapter includes several tools available to fee-for-service states, though the level of integration under each varies. At the low end of integration, there's primary care case management, or PCCM, a model of managing care in which beneficiaries are assigned to a primary care provider who receives a monthly management fee to coordinate and monitor beneficiary care. At least two states, Alabama and North Carolina, target duly eligible beneficiaries with their PCCM programs.

Next, providing a medium level of integration is managed fee-for-service. This model is only available in

Washington, which contracts with health homes to provide comprehensive care coordination services to a targeted subpopulation of their dually eligible beneficiaries. Under this model, Washington is eligible to share in savings to Medicare that may result from improvements in quality due to better care coordination.

And finally, we touch on how fee-for-service states can also contract directly with a Medicare Advantage dual eligible special needs plan, or D-SNP, to cover Medicaid benefits, creating a fully integrated D-SNP or FIDE SNP, which we'll touch on in a moment.

The chapter also incorporates what we learned from our fee-for-service state panel last year. Looking back in September, the Commission heard from officials representing the District of Columbia, Maine, and Washington, who shared their thoughts on federal levers that assisted their development of integrated care under fee-for-service as well as challenges that other states looking to do so might face.

The three main areas officials highlighted included financing support, which included up-front investments, state capacity to set up an integrated care

strategy -- for example, a lack of Medicare expertise was noted -- and protecting consumer choice for these beneficiaries. One panelist in the District of Columbia is ultimately working to transition from Medicaid fee-for-service to Medicaid managed care for its dually eligible population, which we know is not feasible for many fee-for-service states but may be the path that some states end up taking.

Now I'll walk through the strategies the chapter describes for integrating care through managed care arrangements.

In the chapter, we focus on two primary models for integrating care through managed care arrangements, though others do exist, MMPs, under the Financial Alignment Initiative, and D-SNPs. MMPs cover all Medicaid and Medicare benefits with some limited exceptions through a single entity under a three-way contract between the plan, the state, and CMS.

Meanwhile, different types of D-SNPs offer varying levels of integration. While more nuances are included in the chapter, at a bird's-eye view, the majority of D-SNPs are coordination-only, or CO D-SNPs, which meet

the minimum federal requirements for coordination of Medicaid benefits. These plans don't typically cover Medicaid benefits, but some might provide coverage of limited Medicaid benefits, such as Medicare cost sharing.

A level more integrated are highly integrated D-SNPs or HIDE SNPs. They cover some Medicaid benefits, including long-term services and supports or behavioral health.

And finally, there are the FIDE SNPs, which cover nearly all Medicaid benefits under one entity, with some exceptions for carve-outs allowed through 2024.

The D-SNP model is widely available in 45 states and the District of Columbia and serve the greatest number of dually eligible beneficiaries in integrated care.

The chapter acknowledges that the integrated care landscape has seen a number of changes over the last few years. In May 2022, CMS published a final rule, CMS-4192-F, that will sunset the MMP model by the end of 2025. The eight remaining states with MMPs were encouraged to transition MMP enrollees to integrated D-SNPs.

In December, we brought the Commission an update on initial state plans and presented a monitoring framework

for the transition. The chapter includes detailing what we heard from states under four main categories: procurement, stakeholder engagement, information technology systems, and enrollment processes. Staff will be returning to the Commission with additional updates.

With the sunset of one integrated care model and the shift toward another, the chapter also reviews information on how states can leverage their contracts with D-SNPs, known as state Medicaid agency contracts, or SMACs, to maximize integration. In its June 2021 report to Congress, the Commission outlined strategies states can use in their SMACs to require higher levels of integration than the minimum statutory requirements under the Medicare Improvement for Patients and Providers Act of 2008, or MIPPA. For example, all states can require D-SNPs to use specific or enhanced care coordination methods.

The 2021 chapter does note that certain strategies are only available to states that use managed care arrangements, and while there are limitations to this contracting authority, opportunities exist to increase coordination of Medicaid and Medicare coverage under fee-for-service.

And now I'll hand it over to Kirstin to discuss the recent beneficiary focus groups and our next steps.

* MS. BLOM: Thanks, Drew.

So in March, we talked about what we heard from beneficiaries in the focus groups that we had conducted over this past year. Our goal with those groups was to hear from beneficiaries what they -- how the experience of integrated care was for them, what they valued about that coverage. We talked to 55 beneficiaries, just as a reminder, enrolled in different types of D-SNPs as well as in the Medicare-Medicaid Plans. But we did not set out to conduct any kind of evaluation of one plan relative to another or assess the levels of integration. We really were just trying to hear from individuals, what it was like for them having this type of coverage.

Tamara went through these findings in detail in March, so I won't go through them again, just highlighting a couple things. We heard, like we often do, that some of the most important factors for beneficiaries in choosing a plan were -- and enrolling in it, were being able to stay with an existing provider, and that included a primary care provider or a specialist. We heard that repeatedly in the

focus groups.

We also did hear largely positive feedback on access to providers. Again, that was across sort of different sets of providers, primary care, specialty care. We did hear concerns around mental health, but I think we're hearing that in all -- oh, it's quite larger than Medicaid.

And then finally, we did hear some positive feedback from people who had care coordinators. Not everyone did who we spoke with, but people who did, particularly in New York's FIDA-IDD model and in Washington's manage fee-for-service model, spoke highly of their relationships with their care coordinators.

And in Washington, as Tamara noted last time, we did hear that beneficiaries particularly appreciated the fact that they could keep their care coordinator even if they switched plans, because in that state, those care coordinators are employed by the state, not by health plan.

We did also hear for some people about frequent turnover among care coordinators.

Oops. Oh, wait. Sorry. Wrong button.

Okay. So to wrap up, our next steps are to, of

course, continue our work in the duals space. Integrating Medicare and Medicaid coverage for people enrolled in both of these programs has been and remains an area of focus for the Commission. We're continuing to build on our recommendation from last year that all states develop a strategy for integration, and of course, that can occur, regardless of the delivery system in which the state is primarily operating.

So we're interested in any feedback you guys have on the draft chapter either today or in written comments, and thanks to the Commissioners who have already submitted comments to us. We appreciate that fast turnaround. And with that, I'll turn it back to the Chair.

CHAIR BELLA: Thank you very much. I'll open it up to the Commissioners.

Darin.

COMMISSIONER GORDON: I think you all did a great job on the chapter, so thank you for that. Just a couple of comments.

One, in regard to the PCCM comment in North Carolina, I don't know if it -- I personally think it may be worth noting that their intent is to move away and move

that population into managed care, just to indicate that that isn't a model that they're moving toward. That's just a legacy at this point.

The other comment really gets down into the beneficiary feedback. Whenever you talk about beneficiaries commenting about like non-emergency medical transportation, you did do a good job of pointing out that that's consistent with what we've heard more broadly. I do think there's a couple of other areas when we talk about the beneficiary perspective that are larger macro issues that are not necessarily tied to specific components of an integrated model.

For example, we talk about lack of specialists in a particular community. It's not really because of an integrated model. There's a specialty issue in that geographic area. And we talk about lack of mental health providers.

I think similar to what you did on the transportation comment, I think we just had to put that in proper context that these are maybe broader dynamics that are playing in a community that may not be related to an integrated model versus a non-integrated model.

Thank you.

MS. BLOM: Yeah, I appreciate that. I mean, it's tough because we're asking individuals what's your experience, and they're just -- so we're reporting what they said, but you're right. Obviously, the issue like with a mental health provider is not at all specific to integrated care. So yeah, we're definitely trying to strike that balance.

CHAIR BELLA: Thank you, Darin.

It's not a hand? Okay.

All right. Well, I have a few comments. First of all, thank you for the continued work in this area. My comments are probably a little bit more about ongoing work as opposed to the chapter, but first of all, I'm appreciative of the fact that we're continuing to beat the drum for a state strategy and encouraged by the legislation coming out of Congress in a bipartisan manner. I think we have reason to believe that Senate Finance might actually put a legislative proposal out this spring and so based on the feedback they got in that RFI, and so keeping on top of that, I think, will be a really important opportunity for us. And it would be really great if it includes something

that reinforces states picking a path, and then our work around informing them about the pros and cons and the tools for each path, I think, will continue to be really important.

The second point I would make -- and despite all the challenges of finding beneficiary focus groups -- I really would love to see us either partnering with other groups or doing ourselves, trying to get more to the heart of what is guiding people's choices and what is making it difficult for them to make choices.

The proliferation of plans and all of the supplemental benefits that are being thrown at people without a true understanding, I think sometimes of a choice over here results in losing something over there. It's just getting more and more confusing, and it's really hard to be this population in particular. And so understanding how we can inform the discussion about choice and making sure people are getting their needs met, I think, is really important.

The third piece, I guess, is a little more chapter-specific. Appreciative of the work done on the MMP transitions and hopeful that we'll continue to push to be

sure that the more innovative pieces of the MMP are making their way over to the D-SNP. It's not just the state savings that we talk so much about, but it's, in my opinion, this sort of notion of one. And in the MMPs, when they're getting everything from one MMP plan, it really did bring it home where they had one provider directory and one ID card. And I continue to sort of scratch my head on why for duals do we continue -- like no one else has to get their care from two or three different systems, yet this population does, and so trying to keep hitting home that notion of one.

Which brings me to my last point, and then I will be quiet. I don't want to lose sight of the work we've done on a unified program, and as Congress continues to look at this, we're not -- there's no way that we can stop with what we have today, right? We know we have to continue to make it better for the people that receive these services, and so not losing sight of that, that unified coverage work as Congress continues to try to push, I think, for integration is just a request that I would make.

So those are my comments. Thank you very much.

Sonja.

COMMISSIONER BJORK: I saw mention in the chapter about passive enrollment, and I'm sure you've done a lot of work on it over the years, but I'm wondering, as states develop their plans, is there any more work we can do about the impact of passive enrollment in the take-up of beneficiaries getting enrolled in one plan that will take care of their needs? Of course, with the choice that they can select back to fee-for-service or select a different plan.

MS. BLOM: We are monitoring the use of default enrollments in D-SNPs as states make this transition into more of the Medicare Advantage world. So we'll definitely keep an eye on that. It does seem like those automatic enrollment mechanisms pull people in and retain them in a way that other efforts have not. So we are keeping an eye on that.

Thanks, Sonja.

CHAIR BELLA: Any other comments?

[No response.]

CHAIR BELLA: Okay. Well, thank you very much, and thank you for the continued work you will be doing in

this area.

MS. BLOM: Thanks, guys.

CHAIR BELLA: We're cruising right through our morning agenda.

Kisha, we'll turn it over to you.

VICE CHAIR DAVIS: Okay. We're going to move right along. We're talking about access to Medicaid coverage and care for adults leaving incarceration and invite Lesley and Melinda up to share some background on this chapter.

Just a reminder for the Commission; this is really more of an informational chapter as we continue our efforts around health equity.

All right. Lesley and Melinda.

ACCESS TO MEDICAID COVERAGE AND CARE FOR ADULTS LEAVING INCARCERATION

* MS. BASEMAN: Wonderful. Thank you, Kisha.

Good morning, Commissioners. Today Melinda and I will provide an overview of the draft chapter on access to Medicaid coverage and care for adults leaving incarceration. The chapter brings together findings from extensive interviews with state officials and an expert

panel as well as Commissioner feedback from prior sessions.

The chapter starts out by providing contextual information about this population and their health care and health-related social needs. The chapter will then cover state strategies for improving access to Medicaid coverage and care following incarceration, including through Section 1115 waivers.

The chapter concludes with considerations for implementing pre-release Medicaid coverage and next steps.

The chapter starts with a discussion of demographic information, health care needs, health-related social needs, and access to Medicaid of justice-involved adults.

The chapter starts by identifying who we are talking about when we say adults involved in the criminal justice system. This includes adults serving sentences in prisons and jails, awaiting trial or sentencing in jails, and under community supervision such as on parole or probation.

Individuals in federal and state prisons are typically serving sentences of longer than one year, whereas, jails house individuals awaiting trial or

sentencing as well as those serving sentences shorter than one year.

In 2021, nearly 7 million people cycled through jails, and the average length of a jail stay was 33 days. Justice-involved adults are both disproportionately low-income and people of color. For example, in 2021, Black individuals were incarcerated in state and federal prisons at nearly five times the rate of white individuals.

The chapter also includes data regarding health-related social needs of justice-involved adults. For example, they're 10 times more likely to experience homelessness than the general public, and the likelihood of homelessness increases for individuals who have been incarcerated multiple times.

Adults involved in the criminal justice system report high rates of behavioral and physical health conditions, traumatic events, and disabilities. They also experience an elevated risk of death in the immediate period post-release compared to the general population.

The chapter discusses the inmate payment exclusion, which generally prohibits the use of federal Medicaid funds for health care services for inmates of

public institutions. While Medicaid's role is limited during incarceration, it is an important source of coverage for individuals in the community, particularly in states that have expanded Medicaid to low-income adults under the Affordable Care Act.

In most states, adults enrolled in Medicaid have their coverage suspended upon incarceration. A handful of states do terminate Medicaid coverage for adults upon incarceration. The need to reinstate Medicaid benefits or process new applications upon release can contribute to delays in coverage and care. Among the states we interviewed, reactivating suspended benefits ranged anywhere from zero to 60 days, whereas, processing new applications can take up to three months.

In states that rely on managed care, enrollees can also experience delays in enrolling with a managed care plan if they're unable to select a plan prior to release.

The health care needs of justice-involved adults and the disproportionate effects of the criminal justice system on individuals of color has prompted many states to pursue opportunities to improve access to Medicaid coverage and care upon release from state prisons and local jails.

Most interviewed states reported that strong collaboration between Medicaid and corrections agencies underpinned their efforts to improve this transition period, though they also noted that these partnerships can be challenging to establish and maintain for a variety of reasons, including siloed organizational structures and competing priorities.

Most of the interviewed states have programs designed to facilitate enrollment in Medicaid. All interviewed states suspend rather than terminate Medicaid coverage upon incarceration. Interviewed states had differing approaches to data sharing between Medicaid and corrections, with some states relying upon emailing Excel spreadsheets between the agencies and others utilizing a centralized data repository to automate the process of suspension and reactivation.

Most interviewed states also offer varying types of reentry services. Pre-release reentry services, such as mandatory MCO in-reach coordinators, are intended to assess the needs and establish connections with community providers.

Medicaid-covered post-release services, such as justice-oriented health homes, are designed to address the

unique needs of justice-involved adults upon their return to the community.

I'll now turn it over to Melinda to discuss Section 1115 demonstrations and implementation considerations.

* MS. BECKER ROACH: Thanks, Lesley.

The chapter notes that the SUPPORT Act requires CMS to release guidance on Section 1115 opportunities to improve care transitions for Medicaid-eligible individuals leaving incarceration, including through the provision of pre-release services. While CMS has yet to issue that guidance, the recent approval of California's Section 1115 demonstration to provide pre-release coverage provides insight into how CMS may approach similar requests from other states.

The chapter provides an overview of California's demonstration under which the state will receive federal matching funds for a targeted set of services provided to certain Medicaid-eligible inmates of state prisons, local jails, and juvenile justice facilities up to 90 days prior to release. Before claiming federal match for demonstration services, California is required to submit

and receive CMS approval of an implementation plan documenting how the state will operationalize pre-release coverage and delivery of pre-release services.

To avoid supplanting existing state and local investments, California must also submit a plan detailing how it will reinvest new federal Medicaid funds for demonstration services in cases where those services are already being provided by a state or local correctional authority. The demonstration will be phased in as facilities demonstrate their readiness and will be supported by new funding for planning and IT investments.

There's growing state interest in pursuing similar reentry demonstrations. Fourteen other states have submitted Section 1115 requests to waive the inmate payment exclusion and provide Medicaid-covered services to certain individuals who are incarcerated. The chapter provides an overview of these requests and how they vary in terms of eligibility, benefits, and the duration of pre-release coverage that would be provided.

The chapter then outlines considerations for implementing pre-release services, which can inform how states operationalize these programs and provide insight

for CMS and other federal agencies looking to support states in those efforts.

The chapter speaks first to the importance of coordination between state Medicaid agencies and correctional authorities overseeing facilities where pre-release services will be provided. Early engagement of state and local corrections leaders is critical to gaining buy-in and anticipating and overcoming operational challenges related to implementing pre-release coverage.

Stakeholders noted opportunities for CMS and other federal partners to promote cross-agency collaboration, for example, through multi-state convenings and technical assistance.

The chapter also underscores the importance of data sharing to support pre-release services and care coordination as individuals leave incarceration as well as the challenges associated with establishing and enhancing these systems.

The ability of state Medicaid agencies and correctional authorities to share timely and accurate information about eligibility and anticipated release dates will be critical. New systems will also be required to

exchange health information between carceral and community providers and to support Medicaid billing within correctional facilities.

During the last meeting, Commissioners noted the particular challenges associated with implementing pre-release coverage in jails, given the often-unpredictable release dates and relatively short average lengths of stay, so we've added a discussion of that to the chapter.

The chapter also lays out considerations for determining who will provide pre-release services, whether that be carceral or community providers, and discusses the barriers to hiring peer-support specialists who can play an important role in helping individuals successfully navigate the reentry process.

Additionally, the chapter highlights the need for states to address the often limited capacity of community-based systems to meet the needs of justice-involved individuals in the community.

The chapter then discusses the role of California's reinvestment plan in ensuring that any new Medicaid funding for reentry services does not supplant existing state and local investments and shift costs to the

federal Medicaid program. These reinvestment plans may provide important insight into how states are reinvesting new Medicaid funds, where required, and may also provide more transparency into the services that are provided during reentry.

Finally, the chapter discusses the importance of robust and timely monitoring and evaluation as well as some of the historic limitations of Section 1115 evaluations. Given the typical lag in evaluation results, states and CMS may consider additional opportunities to enhance state monitoring activities, such as beneficiary surveys and interviews that assess beneficiary understanding of the program and their experience accessing care.

States may also benefit from policy-specific Section 1115 evaluation guidance, similar to what CMS has previously provided for other novel demonstrations.

Following the discussion today, we'll be working to finalize the chapter for publication in the Commission's June report. In response to Commissioners' interest, staff will also be considering new analytic work on children and youth involved in the juvenile justice system, including those in foster care.

That concludes our presentation. We look forward to your discussion and any questions you may have on the draft chapter.

VICE CHAIR DAVIS: All right. Thank you both for this deep dive into efforts that are under way in ways that we can leverage that support.

Any comments or questions? Yeah, Fred.

COMMISSIONER CERISE: Thanks for the talk. I think it's a great job of capturing a lot of the relevant issues and challenges with this.

I have a couple of questions and a couple of comments. First off, some of the areas of support, like the infrastructure needs, electronic records and that sort of thing, I think those are important points because of the siloed nature of this business. Oftentimes that's going to be an investment on the jail side or the corrections side that they may not appreciate the importance of, but if you're going to coordinate care into the community, having the connection to good data from the corrections side is going to be important. So it was good to see that included, at least in California, in their waiver.

You made the point of difficulty accessing

providers after release and the challenges associated there, which I think is real. If you're going to get continuity of care for things like substance use disorder which is so common or some of these other chronic conditions, I think having that piece is critical, and so tying coverage for whatever period of time or care coordination and those types of services, being able to demonstrate that people are actually getting into meaningful care promptly post-discharge, I think, is an important thing to pay attention to as well.

And then a couple of other points. On the jail issue that you just remarked on and the short stays and then the unpredictable release date, it makes it very difficult to schedule stuff on the back end there. And I wonder if -- and maybe you can tell me. If states suspend coverage there, I know some states turn it back on quickly, and some start states, it doesn't turn back on quickly. Could states do something like, instead of suspending, continue coverage through jail because it's such a short period, but do it for certain services like care coordination and things like that, rather than have a suspension and then turn it on for a 30-day or 90-day post-

release, which that could be their whole stay in jail? So could there be an option to just continue coverage, but you wouldn't be able to pay for things like pharmacy and primary care, like the visits, but the other things that you know are important on the -- while they're in -- while they're incarcerated?

MS. BECKER ROACH: It's a great question. I think, theoretically, yes, and it remains to be seen, for instance, how California is going to address that. I think that's something we anticipate seeing in their implementation plan.

But so long as a state is not paying for services for which they're not authorized to under a waiver or otherwise while an individual is incarcerated, I don't think anything precludes them from -- I think there are options they have in terms of an individual's enrollment status while they are incarcerated, if that makes sense.

COMMISSIONER CERISE: Mm-hmm.

I have one more question. This is coming from a non-expansion state. Even in expansion states, you're going to have a fair number of people, I would imagine, that are still not going to be Medicaid eligible. They

weren't before they were incarcerated. They won't be eligible after. And do any of the waivers contemplate that population like a UC pool or something that would allow states to provide services for folks that are not eligible for Medicaid?

MS. BECKER ROACH: I think we'd want to double-check. I don't recall that we've seen anything like that in the proposals, but let us double-check and get back to you, Fred.

VICE CHAIR DAVIS: Thank you, Fred.

Angelo, then Verlon, then Heidi.

COMMISSIONER GIARDINO: I just want to say I thought the chapter was really excellent and very well documented, and I think it's really sound, your approach.

And that second bullet on the next steps makes me very happy because we're going to get to the children and youth, and as I've been talking with folks about maybe some of the unique elements to the kids that are involved -- mostly they're adolescents -- a number of municipalities have a mental health docket where the adolescents are immediately diverted from being incarcerated and sent through the mental health system. So that might create a -

- from an analytic perspective, a really nice comparison group, because those kids' care is not disrupted. So there's some continuity if they're Medicaid recipients. So I just throw that out there that we might look, as we think about the juveniles, the kids that actually are able to avoid incarceration because their municipality allows them to be diverted through a mental health docket. So there's a whole group of people that actually have continuity, and I think you could match them to the people then that don't have the benefit of that mental health docket. So I just throw that out there.

But really great work, and I think this is a truly vulnerable population, and I'm glad we're addressing it.

VICE CHAIR DAVIS: Thanks, Angelo.

Verlon?

COMMISSIONER JOHNSON: Hi. Thank you so much for this chapter. I'm really excited about what the states are doing in CMS and trying to really move a needle on all of this.

I really appreciate the chapter, the part about the pre-release enrollment assistance. I think that's

really important, but I also want to emphasize the importance of education around how to access those benefits. I think about when we were able to expand Medicaid and we wanted to make sure that people were moving from -- I think the campaign was Coverage to Care or something of that nature. And so I understand that that part is coming in on the reentry assistance, but I think that as we continue to monitor this, if we can just make sure we're focusing on that a little bit more too as well, because again, it's great to have that access to it, but if you're not using it, it's not really going to help you with your health.

The other question I had was around -- if you go to the slide about the 1115s that are out there, what strikes me is the differences between the duration of the pre-release coverage, and so really be interesting as we continue to monitor this, what's the real impact? Do you see a lot more movement on 30 days than 15 days or 90 days? And so I'm just really curious about how states came up with that number or those amount of days and the impact that it would have on that.

And then I think I had one more question. I

realize that we just got finished talking about duals, older Americans, and just wondering too as we think about kids, is there anything we need to be thinking about for older Americans who are actually being released as well?

That's it, but thank you so much for this. As you know, it's a very personal issue for me. So I really appreciate the work you've put into this.

VICE CHAIR DAVIS: Thanks, Verlon.

Heidi.

COMMISSIONER ALLEN: I want to echo everyone's comments about how excited I was to see this chapter and how great I think it is and how I'm looking forward to the work ahead.

This isn't a comment about the chapter, but moving forward, it would be very helpful for me in as much as possible if we could differentiate jails from state and federal prisons, just because of what's been brought up so many times. It's such a different environment and different issues and different levers.

When we write about them as one, I have to kind of go through this bifurcated process in my mind and apply it to each, and then it gets a little confusing. I imagine

that as we see more of these waivers and we see CMS interacting with the waivers, we will be able to differentiate better. So just thinking, moving forward as we're examining the waivers and what states are doing, if we can continually separate those as much as possible so that we can understand best practices across the two settings.

I also was happy to see peer-support specialists mentioned in that. Especially as a social worker, I think that that is so critical and I know that not all states actually have peer-support specialists for substance use disorder. And it seems to me like this might be where it's probably the most important, and I like that you noted that the criminal history of people with substance use disorders disqualifies them for peer-support positions. And I'd like to continue to think through that as a Commission and whether or not we could make recommendations related to that.

And then this is not in the chapter, and I'd like to see it in the chapter, but I understand it's controversial. The criminal justice system sees substance use disorders as crime. The medical system and the mental

health system see this as a disease, and where I think -- the thing that we haven't mentioned and where I think these two things are separated is harm reduction. So we don't mention harm reduction in the chapter, and yet we know that the highest risk for substance use, overdose, and death comes immediately after being released from incarceration.

And it seems to me that one of the most impactful things that we could do to keep Medicaid enrollees alive is to think about how we are taking a harm reduction approach to when they're released, which isn't absence only. It recognizes the fact that many people will leave jails and prisons, and they will use drugs. And that many of them will die from that, but harm reduction is something that we could provide through Medicaid as people are leaving. And I think it's just really important to call that out.

And I think that that was -- oh, and then on the second bullet where we talk about next steps and we talk about the youth population, this is in the chapter, but I would like to continually to bring it forward to think about the foster care population.

That's it. Thanks.

VICE CHAIR DAVIS: Thank you, Heidi.

Again, I think you're hearing themes of lots of support for this. In our next iterations, I've heard some really wanting to dive into some of the specialized populations, even that are within the justice system, so how we think about children and youth, and that will be -- we're addressing that, but also how we think about older adults, how we think about disabled adults, how we think about the substance use disorder within prisons, so bringing that out for some of our work for the future.

And I think highlighting the themes of continuity of care, really measuring what that looks like over time and how potentially the different pre-release coverage, how that relates to continuity of care as we look at things in the future.

But I think what you've heard is lots of support and encouragement for this chapter. Anything else that you need from Commissioners?

MS. BECKER ROACH: I don't think so. Thank you for your feedback. We appreciate it.

VICE CHAIR DAVIS: Thank you.

I think we'll turn it back for public comment.

CHAIR BELLA: Great. Thank you.

We will turn to public comment now, if anyone would like to comment on any of our morning sessions. If you do, please raise your hand, and I'll remind folks that we ask you to introduce yourself, the organization you represent, and limit your comments to three minutes or less.

You both are welcome to stay or you're welcome to go, whatever makes you more comfortable.

Okay. I think we have a hand. Nicolas, you should be able to talk.

PUBLIC COMMENT

* MR. WILHELM: Thank you, Commissioners, for the opportunity to provide comments. My name is Nicolas Wilhelm, and I'm the Director of Regulatory Affairs at Medicaid Health Plans of America.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations, serving more than 49 million Medicaid beneficiaries in 40 states, the District of Columbia, and Puerto Rico.

MHPA's members include both for-profit and nonprofit, national and regional, as well as single-state

health plans that compete in the Medicaid market.

MHPA supports the delivery of integrated care for dually eligible individuals who have considerable medical and non-medical needs and experience high rates of chronic illness as well as food insecurity, housing instability, and challenges in transportation. We believe that taking steps to improve the exchange of data surrounding dually eligible individuals and addressing the health care workforce shortage will serve to improve integration for dually eligible individuals, improving the delivery of care and health outcomes for these members.

The exchange of data between plans, states, and CMS to facilitate both enrollment and care delivery is often limited. Not receiving updated and accurate data creates challenges for health plans in benefit design, member enrollment, and outreach. Improved demographic and clinical data and the interoperable exchange of that data is critical for administrative efficiencies and delivery of quality care. Additional technical systems and the creation of a standardized information system for states to utilize could improve communication between states and the federal government and could assist in the coordination of

care between health plans.

Another key challenge to effective dual eligible coverage is the health care workforce shortage. Provider shortages can overburden the health care workforce and pose a significant challenge to meeting the population of health needs. As more mental and behavioral health professionals move away from insurance-based payment, we remain concerned about having enough contracted professionals to meet the growing needs of the dually eligible population, particularly in rural areas where providers are already sparse. To mitigate the effects of provider shortages, MHPA recommends taking steps to encourage investments and augmentation of the health care workforce, promoting telehealth access by standardizing telehealth offerings across states, and easing licensure and provider enrollment requirements for providers operating across state lines would alleviate workforce issues. Ensuring fiscal soundness and sustainability of health care programs encourages and supports provider participation and is critical to supporting access to service.

States should also be encouraged to consider removing barriers to family members being allowed to serve

as paid care caregivers.

Thank you for the opportunity to provide comments today.

CHAIR BELLA: Thank you very much, Nicolas. We appreciate your comments.

Anyone else like to provide comment?

[No response.]

CHAIR BELLA: All right. It doesn't look like we have anyone else for now. There will be more opportunities this afternoon.

We are slightly ahead of schedule, but we are going to break now. We'll come back at one o'clock Eastern time with a panel on dental. So we'll see everyone then. Thank you very much.

* [Whereupon, at 11:35 a.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m., this same day.]

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AFTERNOON SESSION

[1:00 p.m.]

VICE CHAIR DAVIS: All right. Hello, everybody. Welcome back from lunch.

We are going to get started with our panel on dental. Audrey is going to kick us off with an overview, and then we have three guests that are joining us this afternoon. So I'll turn it to you, Audrey, to introduce our guests.

ACCESS TO COVERED DENTAL BENEFITS FOR ADULT MEDICAID BENEFICIARIES: PANEL DISCUSSION

* MS. NUAMAH: Hello and good afternoon, everyone. In our ongoing focus on access for beneficiaries with regard to a variety of services, we would like to spend some time this afternoon to focus on dental services.

Poor oral health is widespread among adults in the United States and especially affects those with low incomes. Poor oral health can limit communication, social interaction, and employability. It has been some time since the Commission has focused on dental services. So we've invited this panel today to share more about their experiences about adult dental services and the Medicaid

program.

Before we jump into our panel discussion, I will start by offering a high-level overview about adult dental services in Medicaid. I just want to note all states are required to provide comprehensive dental services to children under 21. So this meeting session will focus only on the policy levers and approaches states use to address access to covered dental services for adults with Medicaid.

After this overview, I will facilitate a panel discussion, and then you'll have an opportunity to ask questions of these experts.

All right. So states have the option to cover dental services for adults on Medicaid, including defining the amount, duration, and scope of benefits. Experts classify the service offerings into three categories: emergency-only benefits; limited services which includes some mix of diagnostic, preventive, and minor restorative procedures; and extensive services, which include a more comprehensive mix of these procedures.

This map shows that almost all states offer some form of Medicaid dental coverage, and there's only one state that offers no adult dental coverage.

In recent years, states have been expanding their coverage and payment policies, so this map shows the state of play as of January 2023. States that are not able to offer extensive benefits to all adults have other pathways to expanding. They can either give certain benefits to all adults or give all benefits to people with certain conditions. Some states allow for comprehensive care or more frequent services for certain populations who may be considered to have higher dental needs, such as pregnant women or adults with intellectual or developmental disabilities (IDD).

Prior MACPAC analysis has shown that Medicaid adult enrollees were less likely to have had a dental exam, more likely to delay dental care, and more likely to not receive needed dental care due to cost.

Beneficiaries cite several barriers to obtaining care, such as having trouble finding a dentist that accepts Medicaid, fear of the dentist, long wait times, and inconvenient locations or appointment times.

There are also racial and ethnic disparities in oral health care access and outcomes. Black and Hispanic adults are less likely to have had a dental visit in the

last year and are more likely to face cost barriers regardless of insurance status. Black and Hispanic adults were nearly twice as likely to have untreated cavities and more likely to have severe periodontal or gum disease than white, non-Hispanic adults.

Medicaid delivery systems for adult dental services include fee-for-service, carve-ins to medical managed care organizations (MCOs) or carve-outs from the MCO in which states rely on other dental contractors, such as prepaid ambulatory health plans or dental benefits administrators. MCOs may provide and manage the dental services themselves, or they may subcontract the services to some or all of their Medicaid members.

Some states are using different authorities such as 1115 demonstration authorities or 1915(c) waivers to provide dental benefits for certain high-need populations or for populations with specific health conditions such as those with diabetes or those with substance use disorders. Louisiana will share more today about the use of their 1915(c) waiver to offer comprehensive coverage to adults with IDD.

Ahead of this panel, MACPAC reviewed the

literature and conducted interviews with state officials to better understand the challenges of adult dental coverage. While there are identified challenges in providing dental care to Medicaid beneficiaries, these barriers are not necessarily unique to Medicaid. Examples of these challenges are state budget constraints, limited Medicaid provider availability or capacity to accept Medicaid patients, and meeting the needs of certain populations who may require more time and care.

So in order to help the Commission think concretely about the policy levers that states can use, we are very fortunate to have these distinguished experts joining us today. Our panelists will provide insights on efforts to improve access to dental care and states that provide at least some dental coverage to adults. The panelists' full bios can be found in your meeting materials, so I will only briefly introduce them.

Brandon Bueche is the Section Chief of Program Operations and Compliance from Louisiana's Medicaid program. Justin Gist is the Dental Program Manager for Virginia's Medicaid program. Brandon and Justin will outline their states' efforts. Dr. Marko Vujicic is the

Chief Economist and Vice President from the Health Policy Institute at the American Dental Association and will share more about the current research and utilization of dental services and the effects of certain efforts to improve access to care.

I want to thank our panelists for joining us today and sharing their expertise. We look forward to the Commissioners' reactions, the information they share, and your questions about the challenges to ensuring access, either discussed in the meeting materials or brought up today.

So let's get started. I just want to hear from each of the panelists a little bit more about their perspective about why it's important we are talking about access to adult dental services, and while we'll get into the specifics during today's panel, it would also be helpful to hear a high-level overview about some of the major access issues and challenges that adult beneficiaries face.

So, Marko, why don't we start with you.

* DR. VUJICIC: Great. I first thank you for having me here. It's a real pleasure, and I'm thrilled

that MACPAC is talking about this issue. So on behalf of the American Dental Association, thanks. And, Audrey, thanks for the great overview.

Before jumping into the questions, I would only add a couple things as background. I think it's important to understand that we are paying, in a sense, for poor oral health among adults already in a different way. We are paying an economic penalty. Three out of ten low-income adults in this country say that oral health issues limit their job prospects. We are paying in hospital emergency room costs, which is wasteful. Every 15 seconds in our nation, somebody goes to a hospital for oral health issues.

I'm an economist. That's heartbreaking, but it also costs us $2 to $3 billion per year, most of that, working-age adults as patients, and 40 percent of that cost paid by Medicaid already. So as an economist, I think it's important to have some of that as background as well. There's an additional cost as a nation we're paying.

Now, Audrey, to your specific question in terms of what barriers we see, so the research is crystal-clear on what the top barrier is to getting dental care, and that's across the board. It's cost. It's affordability,

financial issues, many words for it, right? "I can't afford." "My insurance doesn't cover it." When we look at low-income adults, in particular, that's the group that most acutely is facing financial barriers to care of any age group.

For kids? We've knocked down financial barriers to dentistry for kids across the board. We've reduced disparities. You mentioned that. We'll talk about it later. We've done a great job.

For adults, things are going in the opposite direction. We're seeing, if anything, widening disparities with low-income adults, exactly the beneficiaries that your panel is focused on, in Medicaid, by far, are most likely to report financial issues.

Now, they also report, as the second reason, trouble finding a provider, a dental care provider. We'll talk more about that.

In my opening remarks, just very quickly on the first part, I love the map you put up, Audrey, and I've contributed to that kind of research, and reflecting, I'm starting to realize that we have to stop using this word "extensive," because in digging into this, it was pretty

surprising to me that, for example, even the states that do have adult dental coverage in Medicaid, the majority, for example, don't cover like root canals or endodontic procedures or certain procedures, maybe for the front teeth only, or prosthodontic procedures, dentures, deep cleanings for those who have diabetes, for example.

I don't know. I think we need to dig deeper into this to figure out exactly what's covered state by state, because clearly, I think the data are showing, number one, that extensive may not be extensive, and we published the paper last year with some pretty daunting results in terms of what's actually being delivered.

So if you look at -- and we analyzed all the Medicaid claims from the T-MSIS data. We looked in every state, and if you look at the procedure mix of Medicaid adults, what kind of dental care they're getting, and you compare that, let's say, to privately insured adults, which my team has access to large data, you see a massive difference. You see the Medicaid population of adults, extractions, oral surgery. It's not about getting checkups, folks.

Now, when you look at kids, it's very different.

You have a comparable procedure mix among kids in Medicaid with their privately insured counterparts. So one of the themes coming out for me is this: we have a real success story in how we've handled dentistry in Medicaid for kids. Your focus today is on adults. My point, though, is I think we have a major coverage gap, even in those states that were blue in your slide.

MS. NUAMAH: I appreciate that.

DR. VUJICIC: So we'll dig more into that later.

MS. NUAMAH: Yeah, for sure.

Brandon, why don't you go next. Is there anything else you would like to add about this, the question being what are the major access challenges that folks in Louisiana face?

* MR. BUECHE: Absolutely. And before I begin, it's a pleasure being here and presenting to you all today and telling Louisiana's story.

So for years, Louisiana covered denture-only services for adults, so that was extremely limited. Only a small percentage of our population actually needed those types of benefits, but it was even limited to the point where if extractions were needed for dentures, those were

not covered. So there was a catch there. I need teeth removed in order to get my full arch, and then how do I get those? For years, we just tried to refer people to community resources.

When we moved to manage care in Louisiana, that did improve the situation somewhat. We have six managed care organizations in Louisiana, and they provide limited adult value-added dental services to their beneficiaries. Some of them do not provide those services. So even there, having those available, does not mean everyone has access to those.

They're also limited to exams and cleanings, X-rays, some extractions. It's really basic care in that regard.

So what we do is, at the end of the day, when they call us and they have no access, we try to refer them to community resources, but we face the dead ends there. There's just not that many out there. So we've seen this situation improve in Louisiana, and I'll talk a little later, hopefully, about what we've done for those with IDD. This is some new and upcoming programs that we've implemented, but as a general population, the services are

limited here. And we do face these same barriers.

MS. NUAMAH: Thanks, Brandon.

And then, Justin, I'll turn it over to you to talk a little bit more about the access challenges in Virginia.

* MR. GIST: So good afternoon, everyone, and thank you so much for this opportunity. I'm extremely excited to be here today and to be a part of this conversation.

So you posed a two-part question. Why is it important that we're talking about access to adult dental services? I think the majority of us participating in today's meeting understand that oral health reaches far beyond the oral cavity. So the medical and dental integration, it's really picked up steam over the last few years, and there's a growing body of evidence that links one's oral health to their overall health.

Poor oral health is oftentimes a precursor for high blood pressure, for diabetes, for obesity. I actually read a study last year that linked uncontrolled periodontal disease to the neuroinflammatory phenomenon that's seen in Alzheimer's. So it's important. It's imperative to begin and continue conversations around access to adult dental

services.

We face some of the same challenges that other states face, and I'll get into that in a little bit more detail. I will say that we have been able and we have afforded our members the opportunity to access comprehensive services, and again, I'll talk about that later on in this presentation.

Again, I think it's widespread. I think the access issues that other states are seeing is seen not just statewide but just nationwide as well. So, again, I'm excited to be a part of this conversation today.

MS. NUAMAH: Thanks, all of you.

So I'm going to turn to Brandon to ask a state-specific question. So you kind of started touching on this a little bit about how Louisiana offers limited coverage for all adults but recently launched the comprehensive dental benefit for adults with IDD. Can you please provide a brief overview about this benefit and why you chose to focus in on this population?

MR. BUECHE: Absolutely. I'd be happy to do that.

So both of these were implemented by legislation.

In 2021, we had a lawmaker who presented Act 450. This expanded comprehensive coverage to adults who were enrolled in our state's IDD waivers, and that affected about 11,000 Louisiana Medicaid beneficiaries. She also proposed to have comprehensive benefits rolled out to those who were residents of ICFs, intermediate care facilities, in the state.

Due to the financing differences in the two programs, ICFs was stripped out of 2021, and then we later saw it added in 2022 where it was passed.

So we also looked at expanding access to care for all of our adult beneficiaries. The issue there was cost. So it was limited to those with IDD. We've got 11,000 in waivers, and we've got 4,000 in ICFs. The waiver program is now about nine months into implementation and our ICF comprehensive waiver dental coverage starts on May 1st. So we're excited to have those two new pieces of legislation in our state and implementing those programs, and we're excited to see what kind of results we'll get for that.

MS. NUAMAH: Thank you for that.

And then, Justin, I'll turn it over to you. You again also started to preview this a little bit, but we'd

love to hear a little bit more about that comprehensive dental services that you provide for adults in Virginia.

MR. GIST: Yeah. So high level, our adult dental program is comprehensive. Each dental specialty outside of orthodontics is represented within our program.

We really took a leading-edge position with our preventative benefits in that we offer three cleanings per year for adults because we did realize that some of our adults haven't received preventive services at some time. So broadly, we do cover preventative treatment.

We cover restorations. We cover fillings. We cover root canals. We cover crowns as well, and we cover extractions. We really base our adult dental program around three main pillars that Dr. Zachary Hairston, who I'd be absolutely remiss if I didn't highlight and acknowledge his importance to our program and really the Virginia dental space as a whole -- he established these pillars while designing and really fine-tuning the benefit, and the first pillar deals with prevention and education.

So this pillar is really focused on reacquainting our members back into preventative dentistry and maintenance as well. Many of our adult members may have

been a part of our program as children, and then as they transition out of our zero-to-20 population, they may not have been able to have routine six-month cleaning appointments because, of course, prior to 2021, our adult dental program didn't cover comprehensive care. So that first pillar of prevention and education is very important.

And then the second pillar deals with periodontal maintenance. As I stated earlier, many diseases and really ailments originated from poor oral health, specifically poor periodontal health. So establishing sound periodontal health is very important and one of the pillars of our program.

And then the last pillar really deals with building around what's salvageable. So again, we provide restorations, and those restorations support longevity. And then extractions still have a place in our program. So we remove anything that works against long-term success.

So again, preventative, diagnostic, restorative, endodontics with root canals, periodontics, dentures, oral surgery is all a covered benefit under our model.

MS. NUAMAH: Thank you. I appreciate both of you sharing a little bit about what each of you are doing.

And I know, Brandon, you just mentioned that while your implementation for the IDD is relatively new and, Justin, I think you had mentioned that your program has been running since 2021, could you share whether or not you've run into challenges in implementation, and what are you doing to address some of these challenges? Brandon, why don't you start first.

MR. BUECHE: Yeah. I would be glad to. So challenges to implementing that, I would say, first and foremost, budget. I said that the state had explored expanding dental access to all adults enrolled in the Medicaid program. The cost was a bit astronomical. We got legislative funding for this special population, just knowing that they needed -- they were high needs, and they also needed a little extra time when it comes to dental care. So I'd say budget, number one.

Another thing is rolling out this new program and having a new population seek dental care through the Medicaid program meant rolling out also provider awareness, beneficiary awareness, getting providers to participate in the program. So I would say that identification of those providers who were willing to serve the IDD population, we

had to come up with a mechanism for doing so. That was kind of grassroots, reaching out to providers, building a directory that was specific to that population, talking about things such as case management.

Another thing we did, we were really lucky that the release of American Rescue Plan Act (ARPA) funding aligned with the implementation of this program. We were able to take some of those ARPA funds and use them for training and continuing education units for providing care for those with IDD in our state.

There were also issues with access to hospitals when extensive restoration work is needed or sedated dentistry work is needed that was not able to be done within a regular dental office setting. Providers were complaining about that type of access. They needed the operating room time.

One thing we did do was increase the facility fee, and we also increased the anesthesiology rates for those types of services. And we're closely monitoring access and making sure that we're on the right trajectory to increasing those access and improved health outcomes.

MS. NUAMAH: Thank you.

And, Justin, why don't you go next.

MR. GIST: So our team really reflected on the benefit implementation post-July 1st of 2021. I would offer just a few pieces of information or suggestions.

The first is start having a conversation with your benefit administrator around network adequacy early, like as early as possible. You really want to get a run and start here. On July 1st of 2021 at 12 a.m. in Virginia, over 1 million adults could now access comprehensive care. There are very few systems that can handle that from a network adequacy lens. There was a massive overload of members, and this overload was seen throughout the state. Our providers had to deal with, again, over a million members now having access to these services. So I would say take a hard look at your network and begin recruiting to combat the increase in members that can access care. Look at your enroll versus participating provider lists. Who's actually seeing members versus who's just enrolled to say that they're participating? What can be done to encourage the providers that are just enrolled, but not seeing members, to see Medicaid adults?

The second thing -- and I think this is very

important, and it's not spoken about enough -- is addressing the elephant in the room. So what's the elephant in the room? The elephant in the room is the Medicaid stigma. So very few people are wanting to talk about the stigma that our members face, which is unfair, but it's something that needs to be discussed.

So what we see is that providers don't really have an issue treating our zero-to-20 population, our children. The consternation comes when providers have to treat our Medicaid adult members. I did some work on the provider side at a large dental support organization (DSO), and I've had conversations with providers, and I've heard things like, "Those people are lazy. Those people don't want to work. They're freeloaders. They stink." I've heard it all, and this couldn't be further from the truth, especially with our Medicaid expansion population. These members are your baristas at Starbucks. They're your cashiers at Wegman's. They're your cashiers at Target. They work 36 hours a week, but they aren't provided private insurance because they aren't full-time. This is the population that we see as well. So this is the population we serve, working-class adults. So you really have to get

in front of that stigma and really advocate for your members.

In Virginia, in response to combating the network adequacy piece, we work with DentaQuest, who happens to be our dental benefits administrator (DBA), and will implement a program called the Take 10 program. So this program really encourages dentists to accept 10 Smiles for Children families into their practice.

Dr. Hairston and I also, we take our show on the road, so to speak. So we've partnered with the Virginia Dental Association, and we travel to different areas within Virginia to speak about the program to non-credentialed providers. And I ask providers when we go and speak, "Can you take five new members? And if you can take five new members, can maybe four children and one adult? Or can you take three children and two adults?" One of our big picture goals in our program is to get up to 40 percent of licensed Virginia dentists to credential within our Smiles for Children program.

So I would really say that the main challenge really when you take a look broadly is just ensuring that your network is ready to handle what a comprehensive adult

program will look like on day one and then what it will look like 12 months down the road, 24 months down the road, five years down the road, and then plan accordingly.

MS. NUAMAH: Thank you. I appreciate that.

And then before we turn over and think a little bit more nationally, I just have one more question for the state folks. And, Justin, you can start with this one. How are you monitoring access to these services, and is utilization meeting the state expectations?

MR. GIST: Yeah. So we take a look at our utilization from a high altitude, if you will. We break it down into three real categories or areas. Those areas are preventative, we take a look at restorations or restorative, and then we take a look at extractions. We receive a weekly spreadsheet from our DBA that breaks down the number of adult members that receive preventative care, the number of adult members who receive restorative care based on a preset number of restorative codes, and then extractions.

And I'm happy to say that we went live July of 2021, and restorations began outpacing extractions by late November, early December of 2021. So I'll say that again.

We went live 7/2021, and restorations began outpacing extractions by late November, early December of 2021.

So why is this important? And Dr. Vujicic briefly touched on it, but we're saving teeth. He touched on this earlier. We're actually saving teeth. Our benefit model isn't based on extractions. So our members are gaining access to preventative and restorative care, and so that tooth that was bothering Mr. Smith, he can now go into the office and have a restoration done as opposed to it being extracted. So that's really exciting for us.

And I think utilization is -- I don't think it's meeting expectation. I think it's exceeding expectation. All of our trend lines are steady up, and they've been improving since 7/1 of 2021.

Now, we look at access in a little more detail. So we're focusing on areas such as Southwest Virginia, for example. That's very rural. There aren't many dentists in that area. I think the dentist-to-member ratio is like one dentist to over 1,500 members. So we're looking at how we can expand what we have to better serve those members.

And then we look at subgroups and how we can improve their access to care. I've had several meetings

with our Department of Behavioral Health and Developmental Services to take a look at our IDD population. We have meetings on the horizon to address our refugee population as well as other subset of members that we serve.

MS. NUAMAH: Great. Thank you.

And then, Justin, same question -- or Brandon. I'm sorry.

MR. BUECHE: Okay. Yes. Thank you.

So as I said earlier, our programs are really in their infancy. We have one that was just implemented 7/1/2022. The other one won't go live until May 1st. So we are tracking utilization data. We had not really set expectations because we knew it would be slow moving.

But our biggest concern was provider participation. We had an existing provider network, but this was a brand-new population and a brand-new -- I guess let's say level of care, that they may need special care.

We implemented a new -- a type of case management code that would compensate providers for the extra time that they would spend with the patient and maybe things such as desensitization techniques, and so we were really -- we also, like I said, built a provider directory -- it

was kind of unofficial -- just to make sure we had providers that would see this population. You can put -- you can build as many benefits as you want, but if there are not providers out there to deliver them, it's not doing us any good.

So we were happy to see we have six months' worth of data, and we had 196 unique providers in the state provide care to 453 unique beneficiaries, and we -- in those six months, there were 1,744 preventive and non-preventive services that were rolled out to that population.

So small numbers, but, I mean, it was really, like I said, in the infancy. So we are continuing our work, reaching out to providers. We're offering those continuing education units to make them comfortable with treating this population, to make them aware, and we expect to see the numbers grow.

MS. NUAMAH: Thank you. I appreciate both of you.

So, Marko, we've heard from Justin and Brandon describing the approaches that their respective states are taking to increase access. What are other Medicaid policy

approaches states could take, and what is known about their effect?

DR. VUJICIC: First, so we got to congratulate Audrey for bringing great success stories with Justin and Brandon.

Before getting to that, I really want to emphasize something that came through both of your comments. So one is this idea of incremental expansion, let's say. If you have a fiscal constraint -- and, Brandon, I'd love to talk more offline, whether you included the fiscal offsets through reduced medical care costs in the estimates in the legislature or not. That's a wonky discussion we won't bore the room with today.

But the idea of saying if you do have fiscal constraints, in my view, it's better to do exactly what both of them have been doing. And in Virginia, the predecessor to the benefit Justin described was a very comprehensive benefit for pregnant women. So that was kind of the first foray.

You heard from Brandon for a subpopulation with developmental issues. So I think that's right on. Start with a smaller population but a very comprehensive benefit

rather than putting in a limited benefit for everybody. Looking at the research, my take is it's better to do what both of your states did is go comprehensive but a small number of people. Get the network right. Get the administrative right. Get the procedures right. Get the paperwork right. Get the system up and running. And now, like in Virginia, their next step was, okay, let's expand that to all adults now. And again, Justin, it was great collaborating to do some of that costing work with you. So I think that is a really, really important thing.

To your broader thing, what other states are experimenting with, I think the only thing maybe we haven't touched on here is payment reform, but bigger reform in terms of a move away from fee-for-service to value-based payment. I think that's in its infancy. We know broadly in health care, it's still kind of lots of failures, but that train is moving in U.S. health care.

California did some interesting experimentation with value-based payment for oral health services. We could talk more about that, but I think that is something that states are starting to play around with that I think fundamentally has real, real potential and real legs.

Oregon is another one where they've kind of tried to integrate into the Coordinated Care Organizations, the "CCOs," as they call it there. Dental care but with some performance metrics related to dentistry, and that translates into financial bonuses. So I would only add that one other big potential area I think we should explore.

MS. NUAMAH: Thank you.

And then just one follow-up question for that. What does some of the research tell us about the effect of these levers? Like for example, increasing provider payment, does that actually end up increasing provider participation in Medicaid?

DR. VUJICIC: So yes. I mean, the research is clear on that. The catch becomes kind of how much. So we do know that as you raise reimbursement, you do get more providers participating.

I loved what Justin said, and Brandon alluded to it as well. You want meaningful provider participation. And we just did a heavy analysis of which providers are seeing how many patients in every state. We can answer questions on that if you want, but some states have a lot

of, "ghost providers," people that enroll and don't see any patients. So we definitely know on the reimbursement side there are levers.

I'm getting in a gray area here, but somewhere around 70 percent of commercial payment is where you start to see a bigger lift. That's what the research indicates. But again, I think even without the actual reimbursement, there are other things to do, like make credentialing easier or make the administrative part for the providers easier. The type of accountability metrics, make them make sense, and there's legislation floating around now by Mike Simpson, Representative Simpson, trying to kind of do that and help states do that.

So definitely, there's a lift, but moving from really, really low to really low is not where you're going to see a big lift. Justin and Brandon have lived this, so they can talk about their experience. But you definitely -- you have to get that right, but there are other non-financial things that you can do as well if reimbursement is not on the table.

MS. NUAMAH: I appreciate that.

So I have one final question before I turn it

over to the Commissioners to ask you all questions, and anyone can take this first. But are there federal policy barriers to addressing any concerns with access to adult dental services, and if so, what are they?

MR. GIST: I mean, I -- oh, okay. I'm sorry. You go.

DR. VUJICIC: You go, Justin.

MR. GIST: So I have some ideas. When you look at Medicare, Medicare is federally mandated, and because of this -- and I may be wrong, but I don't think medical physicians and Medicare recipients deal with social determinants of health the same way that Medicaid-credentialed dentists and members do. And that really -- that affects access, and I spoke about it earlier, the elephant in the room.

Dr. Hairston and I, again, we've traveled to Southwest Virginia, and one of the questions I asked to a group of providers is, what is social determinants of health? Do you know what that is? And there was a room of about 60-or-so individuals and maybe two, two or three individuals raised their hand. That's very important, and it's troubling. And I think until all states are

specifically required to cover Medicaid comprehensive services for adults. I think we'll continue to see those barriers.

DR. VUJICIC: I was going to echo that point. I know it's a legislative thing, but I really -- having looked at this and kind of -- you know, there's lots of examples of success stories. There's examples on the other side too. I really feel that for some reason, we have disconnected the mouth from body in health policy as you become an adult. And as Justin said, that continues through Medicaid as well.

Whereas, for kids, we've gotten policy right in my view. We've put a framework, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, to kind of govern the benefits. So it's comprehensive. It's medically necessary. It restores the mouth, and for some reason, we hesitate.

Now, I get it. There's fiscal constraints as well, but end of the day, like it's a bigger issue here that we're talking about. Like we're pulling the goalie here on these solutions, but I feel like we are just in a little bit of a very unregulated adult dental benefit

world. And I'm not saying good or bad. I'm telling you the consequences, because I think without a bit more structure around that, it's going to be very tough. You're in the situation you are today, and like Brandon is saying, the reality is as budgets get -- when crunch time comes -- and I hope it's maybe stickier this time around and we won't see states cutting adult dental, because we've seen a really positive trajectory the last five, six years. A lot of states have added. But you all know this better than me. But that's traditionally what has happened.

So I feel there is a need at least for some guidance on what would a comprehensive dental benefit really look like for adults in Medicaid, and in my view, we can look at the child experience through EPSDT on the regulations as a good blueprint.

MS. NUAMAH: Brandon, do you have anything you want to add to that?

MR. BUECHE: No. I would definitely echo everything that the other two panelists just said. We feel the same way here.

There were no barriers. When it came time to -- once we had the money, which was legislatively appropriated

by our state, once we had that money, there were no barriers to seeking CMS approval.

But I'll just add that one thing. Being in the dental program for such a long time here in Louisiana, one thing that happens is you get a call from a Medicaid beneficiary, and they're just absolutely shocked to hear that they don't have dental coverage. They think it's -- they just assume that it's there, "Well, I have Medicaid. You pay for these things." So it's disheartening to have to stop and say, "No, we don't." And then we try to help them find the resources when we don't have them.

But just from a different perspective, when you think about the people we're actually helping, that's something that they have to go through, just that, that call that they feel like, "Well, I have Medicaid. Everything's going to be okay," and then they realize that they don't have access to that care, and they don't know what to do.

MS. NUAMAH: Thank you. I appreciate you for grounding it in the beneficiary experience.

So those are all my questions, Kisha. I'm happy to turn it back to you.

VICE CHAIR DAVIS: All right. Thank you, everybody. Thanks for everybody on the panel. This is really enlightening, so lots of questions are lining up. I will turn to Kathy to get us started and then Fred.

COMMISSIONER WENO: Thank you.

I am so pleased you guys are here. I want to thank Audrey and the staff for putting together such a great panel. You guys all did a wonderful job, and I'm so excited we're talking about this today and have so many comments, but I'll just contain myself.

So anyway, I know that all of you have been patiently listening to me talk about oral health for a long time, but it truly has been something that keeps coming in the back door of all of our work. Every time we talk to beneficiaries, it's always one of the big things they're frustrated with, and we just don't seem to be getting a lot of answers. So hearing from you guys on what promising practices are out there, what you're doing is really helpful to me to form some concrete ideas on how we can improve situations.

And a lot of the questions I had, you guys have already touched upon, but one thing that Justin was talking

about was medical and dental integration, which is one of my big ideas. The way that dental is so siloed from the rest of health care is frustrating to me. People have teeth and dental problems, regardless of whether they have dental coverage, and so if they have a dental problem, it's usually their number one thing in their life. Trying to get help for that is frustrating, especially if they're going to a physician where they do have coverage and asking for help, and there is no help to be given.

So I'm wondering. We've worked a lot in children's oral health of integrating pediatricians into the -- you know, getting them into the fold and doing screenings and fluorides and talking to parents about prevention. But is there anything out there that we are doing, the Medicaid program can do about adult dental with primary care? And if you guys have any ideas on that, I'd be interested to hear them.

MR. GIST: Yeah. So good afternoon. And it's really a great question, and I echo that point that when we look at our zero-to-20 population, when they go in for the well visits, oral health is discussed. But maybe when our 22- or 23-year-old healthy individual goes in to their

primary care provider (PCP), I don't think oral health is discussed. That's something that really can be improved, I think, across the board.

And I think one of the things that we've done and one of the real reasons that we took a look at adult dental and comprehensive adult dentals, that we took a look at emergency departments (ED), and we took a look at the number of adults that were seen in the ED for non-traumatic dental-related injuries. And that number was astounding.

We have members that have tooth pain. Before our adult benefit, they couldn't be seen by a dentist outside of an extraction. So they would have a tooth pain. They may not want to extract the tooth, so they end up in the emergency room (ER), and the ER, of course, can't do anything because there are no oral surgeons or dentists in the ER. So it becomes, they're prescribed opioids, and then they leave. And then it's a revolving door of coming into the ER for tooth pain, getting an opioid, and then leaving and then coming back and getting an opioid and leaving, and we saw that revolving door. And that was really one of the conversations that we had, that, hey, we really can get in front of this.

But, you know, to answer your question, I don't think that there has been really much research done in the medical-dental integration for adults, but it's something that really can be done and should be done. And I think that will bring dentistry out of the silo that it is in and kind of into the light, similar to what's being done in the zero-to-20 population. And I call zero to 20 our children because that's our children population.

DR. VUJICIC: Can I chime in on that? So my team is in the midst of doing a scan of promising practices in this area with some support from the Michael Reese Trust based in Chicago, and the gist right now is certainly, like in the private sector, we found commercially insured populations. We found lots of examples where, you know, either the oral health team is doing some basic medical screenings and referring that way, and they also have electronic health records integrated with the medical side. So when the medical side says, oh, you need a dentist, it's not like, "You need a dentist. See you." It's "Here you go. Refer to this group. We'll make the appointment for you."

But you're asking specifically for the lower-

income population in Medicaid. So there, we've had less of scalable solutions that we've found. So certainly, within federally qualified health centers (FQHCs), we found many that are like, okay, first antenatal visit on the script is book them literally into an appointment today. So there's examples of that.

There's examples of much smaller nonprofits that are doing similar things like that. Let's say with diabetics. A newly diagnosed diabetic, we want you to see our dental clinic.

But I'll get back to you in three months when we have some more of that. But that's all I can share today from this perspective. I have not seen something scalable, broad brush, let's say, in state X. If you're in Medicaid, newly diagnosed diabetic or pregnant, you get referred right away for a dental screening. I have not seen that. That may exist, but I don't know of it.

VICE CHAIR DAVIS: Thanks.

Fred, then Bill, then Tricia, Martha, Sonja, Heidi.

COMMISSIONER CERISE: Thanks, and thanks for a great panel. Thanks for the insights.

One, an observation, it seems like in this area, maybe more than most or others, that this piecemeal approach gets driven by state legislators and initiatives, and Brandon talked about that a bit. And I'm sure that's influenced by the Department. But it tends to be piecemeal and sort of what you can get in session this year when reference to adult dentures in Louisiana. I'm sure that was a legislative thing years ago. That's not connected to other things. They call it the "right to bite," and that's what you got as an adult in Medicaid, but you didn't get other things.

And so I wonder, the fact that it's an optional benefit and that it varies based on one of those few triggers that Medicaid agencies can pull when they've got budgetary challenges, how does that impact your discussions with providers and the ability to set up networks that really take a multiyear investment? If I'm going to get into this business, I need to know that it's going to be here next year and the year after, and I wonder what impact that variability that comes with being an optional program has in putting together provider networks.

MR. BUECHE: I can say a few things to that. In

Louisiana, we try to maintain a very close relationship with our Louisiana Dental Association. That allows us to hear from a collective group of providers, and we have a very interactive relationship with them. And when it comes to anything, they're very vocal about how they want the program to look. They tell us what services are lacking, what they're seeing when they treat our population, when our rates are not high enough, which is often a complaint, and we do work with them on that as well. So I think that's been really important. It's just keeping that conversation going and being interactive with them, and that's helped us to improve the program.

In Louisiana, we've got two dental benefit plan managers. We work closely with them as well. We try to maintain network adequacy. We hold them to those standards that we've implemented, and we also listen to provider complaints very heavily. We make sure that we have an ear out there whenever they have a complaint about those that are managing our dental program for us. So we listen and we interact, and I think that helps to make us successful here.

DR. VUJICIC: I don't know of research that

specifically looks at, okay, here's the provider network. Now the benefit is gone. The benefit is back. Is it the same provider network? So I can't comment on that. But your logic is very sound, and that's why I was waiting for kind of Justin and Brandon. I mean, turn it off, turn it on, turn it off, turn it on. It's administrative work to reenroll in all that, and it can't be good. But I don't know of any research that contributes to this.

VICE CHAIR DAVIS: Thank you, Fred.

Bill.

COMMISSIONER SCANLON: Yes. Thank you very much for coming today. I mean, I too sort of am extremely happy that we have finally had a panel on sort of adult dental care. I regret greatly that this is my last MACPAC meeting but better late than sort of never.

I think that adult dental care is probably one of the least aware issues around. I look back to my time at the US Government Accountability Office (GAO). I was there 11 years. We did over 600 reports, and we did precisely one on adult dental care. So that's the kind of void I think that we're dealing with, and I think we really need to become very specific in identifying the problem.

I agree with you, Marko, about the map. The states that are labeled extensive, it's an overstatement to say the least. I've had the opportunity to work a fair amount in California, which is one of the extensive states. Some recent work done by a group that we were working with found that despite a very large increase in Medicaid dental fees due to California's tobacco tax, utilization of one visit per year was in the teens for the adult dental population. So I think we need to talk in terms of numbers as opposed to comparatives, like less than or more than. When you're saying something is only 10 percent, that's a graphic message in terms of access.

I think we also need to be very concerned about the dental providers, the dentists, in terms of how do we target them to maintain as much participation as possible. It's very simple economics. You've got to cover your fixed cost on average. If you've got too many people that you're covering at somewhat less than fixed costs, you're not going to survive. You're not going to continue in that business, and so I think targeting is an important thing in terms of maximizing the dentist participation in your program.

The last thing I'd like to, in some respects, ask about or maybe say my concern about is the focus on the budgetary impacts. I think we have to pair any discussion of budget with the discussion of the benefits to the population, because I don't think the budget discussion alone is going to make it.

The reality is California in 2008 eliminated its adult dental coverage, and there was extensive analysis of the increase in emergency room costs because of that. And the end of that research was, "but California saved money on net". Not providing the service to this population that could have been in need is cheaper than paying for sort of the emergency care that results. We need to be focused, I think, on the benefit, and maybe my question to you all is, how do we get that message across in a way that is very convincing? Because I don't want promising discussions in this area to be stopped by a Congressional Budget Office (CBO) analysis that says you're going to spend this amount of money and you can't afford it.

Thank you.

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

COMMISSIONER SCANLON: I'm being Pollyannish

here.

UNIDENTIFIED SPEAKER: But the idea if you do stuff early, it's going to save way, most things cost. It's everything. What's the benefit?

COMMISSIONER SCANLON: And what's the benefit?

DR. VUJICIC: I think, Bill, maybe I could -- and, I mean, your last point is, I think, really getting at the core issue here. It's like I don't know. When you see that one out of three or three out of ten low-income adults are saying oral health is affecting my job search, I don't know, whatever. It's a statistic. It's not going to pull at anyone's heartstrings, but I'm sure if you meet those people, it will, right? This is like their economic livelihood.

If you do the rough math, I told you 40 percent of hospital spending on dental is paid by Medicaid. Okay? If you add up that money, it's roughly about -- you take $2 billion. Forty percent of that is about $800 million. And if you look at what it would cost to fund adult dental in the states that don't have it now, our math roughly comes out to a net of $836 million.

So it's kind of like -- I don't know. It is not

like the benefit pays for itself in terms of these savings. That's Pollyannish, and if people are telling you that the math doesn't work out, it doesn't pay for itself, but do you hold other health care services up to that standard? Do I do a percutaneous transluminal coronary angioplasty (PTCA) on somebody so that I can save money, or do I want them to not drop dead of a heart attack? So I don't know.

We're in this issue of I get -- and I'm an economist. I get the fiscal issue, and Brandon, he basically summarized it very well. But at some point, I don't think we need -- you're right on. We can't talk about this as just it's going to save dollars. Like you're talking about wellness. Do you really believe oral health is health? Do you think mouth is connected to body? Do you think people can be well with poor oral health? This is where we're at, this kind of inflection point in health care policy here, in my view, that you got to answer that.

So you can't be saying that, like Justin said, there's all this connection with inflammation in the mouth and the arteries and stuff, and then you say, well, actually, I'm not worth investing that because it will actually cost something.

I think, in some sense, even the oral health community has to stop talking about it in this way, and look, I'm an economist. I get the numbers, but I feel like it's time to either decide in or out. Is this core health care or not?

COMMISSIONER SCANLON: We're in total accord. I think my question or my issue is how do we make this the normal view of the world as opposed to right now -- I mean, we're, in some respects, the last to the supper.

DR. VUJICIC: Yeah.

COMMISSIONER SCANLON: And while you're absolutely right in terms of we do not scrutinize other medical care in anywhere near the same way, trying to initiate this as a new -- some respects, quote, "new benefit," we're forced to develop the rationales that have been very difficult to get people convinced about.

DR. VUJICIC: Well, maybe, Justin, you can -- you guys went all in Virginia.

MR. GIST: Yeah. So I think, you know, we formed alliances. We work with the Virginia Health Catalyst, and they do amazing things for us. And we're beating down doors. We're trying to beat down legislative doors, so to

speak.

I agree with everything you said, and I'm right there with you. And I think everyone that's participating in this meeting agrees. And one of the things I just heard was, do we hold other health care services to that same standard? And that's powerful because I know the answer is no. When you look at the ED utilization and -- I brought it up during the first question. The ED utilization for non-traumatic dental services and the money that is spent is jaw dropping. And we can combat that and we can kind of counteract that with these comprehensive adult dental services, and we've done that.

Anecdotally I can say that our ED utilization for these non-traumatic services have been lowered exponentially. What we did was we -- we're stronger in numbers. We formed alliances, of course, the Virginia Dental Association, the Virginia Health Catalyst, and we beat down doors. I'm hopeful, and listening here, I'm kind of getting nervous about all these states that are having dental services and then doing away with them. I'm hopeful that's not our fate. Again just forming those alliances and strength in numbers, getting the word out about the

benefits of the oral health in the dental program, comprehensive dental program.

VICE CHAIR DAVIS: Thank you, Bill, for bringing that up. Really important.

I've got Tricia, then Martha, and Sonja, Heidi, and Dennis.

COMMISSIONER BROOKS: Well, thank you for the conversation. It's been really good.

I will date myself and say that I go back 30 years ago to founding a nonprofit that created a child health plan before CHIP came along, and I remember the president of New Hampshire Delta Dental, at the time, asking me if I knew of a successful person who was missing front teeth. And it just really drove home that point of the connection between missing teeth, poor dental hygiene, and the impact on workforce.

And I would echo Bill's comments. We need to do a lot more work on public education and awareness of that as well as how preventive care and working on oral health can save on medical cost.

My other comment was -- Marko, it was interesting hearing you throw that number out with a caution of 70

percent, because back in the day when we were trying to improve CHIP benefits, it was proposed doing 80 percent of the commercial rate and dentists were still balking at that. And I think we need to do a better job of, as Bill talked about, covering fixed cost, a better job of looking at the -- maybe the buckets of care that Justin identified, because it's my understanding that preventive costs are where there is lower overhead. And should we be looking at ways that we would have reimbursement that recognizes the difference in those fixed costs and at least get us into the preventive world where we might nip some of these problems in the bud?

But ultimately, we have got to develop the public health dental workforce because I'm not sure that we can really rely on the commercial workforce entirely to serve the Medicaid population.

VICE CHAIR DAVIS: Thank you, Tricia.

Martha?

COMMISSIONER CARTER: Thank you. I think most of you know this is an area that's really -- I get quite emotional about it. I'm actually trying to figure out how to ask a question, but I'm failing, because I just have so

many thoughts around this. And this may be more of a soapbox.

One of the areas I wanted to comment on is working on comprehensive pediatric oral health care and then how to extend that into adulthood.

Well, let me back up with just a little bit of history. So I ran an FQHC in West Virginia, and in 2001, we got funding to add dental services. For quite many years after that, we ran medical, pediatrics, obstetrics and gynecology (OB/GYN), mental health, substance abuse, and dental all together. And so we learned a lot, of course -- and mobile dental to go into schools, school-based health centers. And even when there were times that we could offer preventive care, people wouldn't take it. People wouldn't come. And I think there's probably some research, Marko, that you could help us with that would explain how, if you get people started in maternity care and pediatric care, if they develop the habit of going to the dentist, their fear reduces, because what we heard from a lot of the pregnant women when we offered free cleanings was, they were too scared to go. They didn't want to go to the dentist because it was scary. And so people only go

when they're in trouble when they have pain, and so there's a lot of public education needed, and there's that continuity that has to happen so that when you get kids and they get used to going to the dentist as part of their -- you know, that happens in school. They get to go, and as they grow up, then, if they don't have a break, they have a habit and an understanding of how oral health care can help them. So I think that's an important point.

When you just look at adding preventive care or emergency care, you're not going to get the outcomes that you're really looking for in terms of improved oral health, and a lot of it's due to uptake. People don't go until they're really in need.

I think this topic intersects with a lot, and we don't realize it. And Kathy alluded to it. When you talk about people being successful in substance use disorder (SUD) treatment, employment is huge, and if you don't have any teeth because you've been using meth for years, you've got to have a good oral health care in order to go out into the world and become self-sufficient. And if the goal is to get off Medicaid, then you've got to have a job, and then as we're talking about work requirements, again, it

leads to, you've got to have good oral health care to be able to go out there and get a job.

As a midwife, I ran into issues, of course, even before we knew more about the link between oral infection, periodontal disease, and poor maternal health outcomes. I would talk to my patients about what they needed to eat when they were pregnant, and too many times, I got the answer back, "I can't chew. I can't eat that meat. I can't eat those fresh vegetables because my teeth hurt." And so it's really pervasive. Oral health is part of a lot of what we do, and I think we just have to give it that respect.

I want to reflect that saying we don't pay for oral health is like saying we're not going to pay for kidneys. There's a different set of providers, and it's kind of expensive. There are a lot of people who need these services. So we're just not going to do it, because it costs too much.

And I think that is the same way that we look at dental care. We just say we should -- might as well just not pay for kidneys. So I don't have any other questions except for a strategy to create a continuum so the public,

when they do have the benefit, really takes advantage of it. End of my soapbox, and I'm taking full advantage because it's my last meeting.

VICE CHAIR DAVIS: Thank you, Martha. We appreciate your soapbox.

We've got Sonja, then Heidi, then Dennis.

COMMISSIONER BJORK: Thank you. Marko mentioned some research looking into FQHCs and dental clinics that are part of the services there, and I find that very encouraging. And I want to also encourage our further look into that because the FQHCs provide so much of the safety net. They provide so much of the health care, and if they have a dental available, that is going to really make a big difference for access and also integration. Just being co-located doesn't automatically create integration, but it sure can help.

Earlier when it was mentioned that a newly diagnosed person with diabetes can get a quick referral over to a dental provider, that actually could happen at an FQHC that provides dental. Yeah.

But Martha also mentioned that at her clinic, when they wanted to start up dental, they got grant

funding. You can't just wave your wand and say, oh, we want to add a whole wing that's for dental care. A lot of support is needed to start up those services, and then, of course, it can pay for itself because they can bill as they do all their other services. But I think that that's a really good angle to address those two important issues of access and integration.

VICE CHAIR DAVIS: Thank you, Sonja.

Heidi, then Dennis, then Fred.

COMMISSIONER ALLEN: I'm just going to take over from Martha's soapbox because this is also something I feel very, very passionately about.

If you worked with low-income people, you know how devastating it is to experience dental pain that's untreated and to lose teeth, and I think that there are -- the Medicaid extraction model is so harmful. The number of people that have said to me, "Well, I'm embarrassed to smile," and the idea that you would be embarrassed to smile or you see people who cover up their mouth when they laugh, that just breaks my heart. That has to have an impact on somebody's mental health, and nobody should have to be embarrassed to laugh and be present with the people that

you love because of not having teeth.

A couple of comments of where I would like to see innovation in Medicaid dental services, and I think partly this doesn't exist because we've had such limited coverage over time, but more team-based mental health -- or dental clinics that have social workers. Dental providers often are frontline providers when it comes to things like identifying intimate partner violence or nutritional food insecurity, substance use disorder, and there's even an opportunity to really help with smoking cessation efforts. And I would love to see more social workers co-located in dental clinics, but I don't think that the funding model currently supports that.

And I would also like to say I was running a study where we interviewed hundreds of people who had just gotten Medicaid coverage, and I'd have this weekly team meeting. And my qualitative interviews kept coming back and saying, "Well, I went to interview this person, but they said they had emergency-only coverage." I was like, "I don't know. I know that they have Medicaid. They have full comprehensive Medicaid coverage," and they're like, "No. They said they had emergency-only coverage, and it's

only for emergencies." And so I instructed them to really probe on that because it happened multiple times, and it turns out that the first thing that many people do when they get a Medicaid card is call for a dental appointment. And they speak to somebody at the front desk who says, "Oh, you have emergency-only Medicaid." And because they don't think of the teeth as being separate than the body, they just assume they have emergency-only Medicaid, "Oh, I can only use this in emergencies." That is just so -- like that is such a ridiculous thing to have happen, and yet you can totally see how it happens. And then you have people who aren't even using their regular Medicaid for their physical health care because they think that they only have emergency-only coverage.

I would love to see states leverage their agreements that they have through public employee benefit boards, that if Medicaid -- if dental companies in these dental benefit plans are not willing to serve the Medicaid population, that they lose other government business. I think that's a lever that could be utilized. I don't know that it would be popular, but so many providers just say, "we're not interested in serving this population."

And, Justin, the things that you said about that you've heard dental providers say about people with Medicaid, I've heard those things too, and I think that there's just a tremendous amount of education that needs to be done to center Medicaid and release humanities in this particular specialty care.

And I love the idea of a public dental health workforce as a potential option for -- it could be tied to student loan repayment programs. It could do a lot of things.

We could create a very creative way of getting more dental professionals engaged in treating Medicaid, and I think it's worth looking at. So thank you.

VICE CHAIR DAVIS: Thank you, Heidi. Those are really great innovations.

I just want to do a quick time check. We, as the Commission are slated until 2:30 for this discussion, but our panelists, we had only asked you to be here until 2:00. So if you have additional time to spend with us, we would love to continue to pepper you with questions. But I wanted to honor that commitment, especially for Justin and Brandon who are joining us on Zoom. Are you able to stick

around for a little bit longer? But if you need to step away, we can understand.

MR. BUECHE: I have more time.

MR. GIST: I do as well.

VICE CHAIR DAVIS: All right. Thank you.

We will go to Dennis, unless anybody wants to respond to Heidi's comments before we move on.

[No response.]

CHAIR BELLA: All right. Dennis.

COMMISSIONER HEAPHY: Hi. Thanks for the presentation. It's really helpful.

My first comment or thought is we have to stop calling -- we have to stop using the word "dentistry" and just use "oral health," because I find the more I use the term "oral health" rather than "dental care," the more I understand it's being integrated into the body and the more other people recognize it as being integrated.

I'm a dual eligible on Medicaid and Medicare, and I lost one of my front teeth. And I'm one of those people who for a year didn't have a front tooth and found myself smiling less, talking less, open my mouth just less just and more receding into the background, not wanting to

engage in conversations, and having people view me differently, even people I knew or know viewing me differently, which was very -- just eye-opening. It was not a good experience.

I'm grateful to Massachusetts where they did pay for the implant, but one of the points I want to get to is the network adequacy piece. At least in Massachusetts, we rely very heavily on dental schools and the dental clinics. And the amount of time it takes for a procedure to get done can be years.

I know someone with really complex dental needs, and every time he gets -- every year, he'll get a new student or every two years get a new student and or a new preceptor. And the dental plan changes every time he gets somebody new who's going to be overseeing his care, and so that constant change in the people that are overseeing the care really defeats -- the people just don't want to go, because every time, it's going to be a different -- it's just going to be a different message. So I think we need to look beyond just dental students, dental care, and figure out a way to make it easier for mom-and-pop dental clinics to do this work.

I also think we need to do something about ensuring that these dental clinics that open up in low-income neighborhoods that are there for three years and then gone the next day, that they're not able to get these contracts unless there's some way proving that they're going to be around, because they pop up. They get all this Medicaid money. They leave, and they find out that the level of care received is just atrocious.

We need to make sure that like for the dual eligible special needs plans (D-SNPs) or other managed care programs, that the care teams have to have integration with a dental provider. The oral health provider has to be included, because there is intersection of swallowing in oral health, you know, drug interactions and oral health, opioid use. I think someone spoke to that. Unless a provider is part of the care team, then they're not going to -- they're not going to understand what the person's needs are or address them.

The last thing I'm going to say is that something that we've just talked about for years -- and I'd like to hear the thoughts of the folks from the two states -- is your thoughts on having community-based dental technicians,

not dentists, but dental techs going into homes and just helping people, not just hygienists, but checking people's teeth, doing some prioritizing, looking to see who needs more help than other folks. And also just for folks with teaching people how to take care of their teeth is -- most people don't know how to take care of the teeth. And so this could be a community-based public health initiative. I think it's really important. But what are your thoughts about someone who's above a hygienist, below a dentist, going out into the community and being a partner with folks who don't have full access to dentists because of network adequacy?

MR. GIST: Yeah. I mean, I think that would be a really interesting and possibly a great solution, especially when you look at areas, rural areas where they don't have a dentist for hours and hours, literally hours. To have someone that's a above a hygienist, below a dentist, that could come in and maybe not do wet-finger dentistry, so to speak, but could take a look and then say, "Hey, we really need to get you to a provider," or, "Hey, we see that you're brushing your teeth the incorrect way, and as a result, you have receding gums, and this is what

you need to do." You can take a look at our nursing homes where they have trouble getting to actual brick-and-mortar offices.

So I'll let Brandon speak as well, but I think it's a great idea.

MR. BUECHE: Yeah, I agree. I'll add a few comments to that. So in Louisiana, we just implemented the coverage of community health workers. So I'm not really sure in the realm of oral health care what they do or if they get involved, but I'm going to look into that to see if there's any integration or opportunities there.

Another thing that we've done -- and it's almost like I'm excited to talk about this, but it's also in its infancy. It's almost like a type of pilot program that we're working with our federally qualified health centers on a teledentistry program, and what that does it, it allows a hygienist to go in to underserved rural communities. The dentist does not have to be there, and she works under that dentist's supervision in a teledentistry-type model where the dentist will see the camera images or the video images remotely. He doesn't have to be on-site, and he can authorize her to do some

expanded duties that would otherwise not be allowable under that license in Louisiana.

So that's something that we're looking at that could be kind of a model to getting the care to the person when the dentist is not able to and using a different level of health care provider to do so, and so we're going to be keeping an eye on that as hopefully our FQHCs get on board with the new policies and allowances and hopefully make some changes in those underserved areas of our state.

VICE CHAIR DAVIS: Thank you, Dennis.

We've got our last three questions. It will be Fred, then Darin, and then I'll end this session.

COMMISSIONER CERISE: Thanks. And a bit of a comment, but I'd be interested in your reaction. Just to elaborate on some of the things that I've heard, the challenge of putting a network together and getting providers, it's an office-based practice primarily. People can schedule access, and you combine that with the fact that we'd be -- I don't want to say happy but happy with getting 70 percent of a commercial rate.

It's a setup for disparities already in creating classes of providers in a class that would agree to do

Medicaid. Throw the stigma that Justin talked about on top of that, and so for me, that kind of begs for a solution like several of you have mentioned. And that is identifying some sort of safety net or public option or some entity that wants to see the Medicaid patients and will commit to seeing that, which would be fertile ground for a value-based payment program, getting away from fee-for-service. But the FQHCs are a great example of that sort of a class of providers that you can identify and treat differently with a payment mechanism.

But I scratch my head and wonder how you get at this and acknowledging that it's not a whole lot different than some of the other issues of getting access to specialists in Medicaid where they can do other -- specialists can do other business and not engage in the Medicaid population, but around kind of that safety net dental providers, like you see on the health side, whether it's physical health, behavioral health, but yeah, you don't seem to see as much of it on the dental health side.

DR. VUJICIC: May I react to Fred's comment quickly?

Great point. So there are some success stories

on both ends of that, Fred. In the FQHC model, for example, it's a different reimbursement mechanism. There's also incentives there that are much stronger. It's encounter based. The rates are higher than many states would get, fee-for-service, et cetera.

But also, I want to highlight what Michigan did in terms of their program, which is it's basically blind to the provider whether the patient is Medicaid or not. So it's administered in a way that the back-end, yeah, you can tell who's paying what, but the card presented is not like I'm a Medicaid patient. So that's something maybe you want to look into, Healthy Kids Dental.

Now, they just expanded into adults which, as Justin said, is a different animal in terms of stigma. So let's see how that goes.

But I'm not sure that the only solution would be let's create -- or, well, we should invest more anyway in the public health settings. But I think there are enough states that have good examples of strong provider networks, and we'd be happy to share all the data. We looked at literally -- like there's states like Vermont where 30 percent of dentists are seeing more than a hundred Medicaid

patients, and there's states on the other end like Maine where it's like a tiny share. So something's going on in terms of some states getting it right, some not.

VICE CHAIR DAVIS: Thank you, Fred.

Darin.

COMMISSIONER GORDON: Thank you for the discussion.

A couple of things, because I've lived the experience of where we covered it, then we didn't cover it, and now we cover it again in our state. I don't think anyone sat around the table and said oral health wasn't important. We've had this discussion around the table when it comes to home and community based services (HCBS) services as well.

There are certain benefits that are optional and as a byproduct of time, not necessarily that they make sense, but they were optional and they continue to remain optional. And so you have very limited levers when you're running a Medicaid agency and oftentimes have to make the least bad decision at the time.

I bring that up because the question earlier about looking at, is there an impact from when you had it,

then you don't have it, and then you have it. You have a test case here that someone can do the analysis, and it's worth doing. So that's one point, because as the Commission thinks about this going forward, I mean, a big factor of it is the optional nature of adult dental in the statute. I think that's going to have to be looked at.

The next thing -- and I think it was Justin was talking him about this. I've seen a lot of states where they've done the iterative steps before they got to full-on dental, and looking at the network, I just want to caution, at least from my experience, dots on a map don't necessarily mean that you have a high-functioning network.

We had an experiment. Granted, it was on children, but I think the same would be true for adults. But we did do a risk-based agreement with our DBA, and we moved to some dental homes. And as we moved there, our network actually looked smaller on the map, but we had more utilization, and that was partnering with certain providers, getting them the tools they needed to be successful, incentivizing and rewarding them for the things that we valued. So I think there's a lot to, when you're building your networks, thinking about the partnerships.

And then the last point -- and just any reactions to this -- trying to get the "right" right is hard in the dental space. We had very, very low to no utilization in dental. We took a big step and made a big investment in dental and went to where you had late night ads saying we take TennCare dental. We see it on buses. You saw it everywhere you went. Our involvement by providers was just continuing to go up, up, up for several years.

As the financial guy, I would say I probably took too big of a step right out the gate, that I probably didn't need to go that far. But there's just not a lot of I mean, there's clearly -- I say this because there was clearly a correlation. I mean, it's participation, that rates were out of whack.

But as far as states and setting rates, it's a little -- it is a hard thing to do in this particular space to figure out what is the right rate to get appropriate access.

And I do agree there are examples, and we did it again with the dental home, where you're doing more value-based models. But I would like the reaction, just thinking about your provider networks, thinking about rates. What

are some of the best practices you all have seen? That could be in the states or it can be at the national level.

MR. GIST: Well, I could say for Virginia, we went live with adult dental 7/1/2021, and actually a year later, 7/1/2022, we increased our fees across the board, 30 percent. We did see some increase, but I don't think -- and this was touched on earlier -- I don't think the fees are the entire story. They don't tell the entire story.

And I've said it once. I'm going to say it again. We really have to get in front of the stigma because what we would see is that we speak to providers, and they will say, "Well, you know, you haven't increased the fees since 2005. The cost of a Starbucks coffee in 2005 was $1.06, and now it's $8, and we haven't had any fee increase."

In post-7/1/2022, we go back and speak to that same provider, and it would be something else. And I think when it boils down to and when you really kind of get into the weeds and peel back the layers, again, it is it's the stigma of those members and those “freeloader”s and what they do. And I think provider education to our members and what they do, what they offer, who they are, I think that

can go a long way to increasing network adequacy.

You mentioned dental homes, and that's very -- and I wrote it down. It's very interesting because we have a new contract with our vendor, and one of the things that we'll be paying attention to in implementing is really educating both members and providers on the importance of dental homes. So I thought it was interesting that you said that it didn't look like your network was really adequate, but the utilization had increased.

I hope that answered the question.

COMMISSIONER GORDON: It does, Justin. And I think the point around stigma really was getting to the point I was making that a lot of people may sign the contract, but they may not want to engage with your population.

MR. GIST: Yep.

COMMISSIONER GORDON: And I think that really takes more time to figure out those providers and working with them to make sure that they want to partner with you in serving this population, and so I think I agree with you. I think it's a very important aspect.

VICE CHAIR DAVIS: Thank you, Darin.

In our last five minutes -- and you can kind of weave these comments into your final comments, I'm going to end with the magic-wand question. So, Justin and Brandon, I want you to be thinking about what your magic wand is to ask for MACPAC.

But before we get to that, Marko, I had question for you. You brought up value-based payment, and I want to drill down on that just a little bit more in how that how that plays into the network adequacy conversation. And are there things that we can or should be doing on value-based payment in dental care and oral health that also relate to that network adequacy?

DR. VUJICIC: Maybe not as strongly linked, at least not yet in my head. It's more about -- I'm not sure a shift to value-based payment would lead to a like change in the network. Maybe I'm wrong. That's my first reaction.

But the point is let's start incentivizing not pulling teeth but keeping teeth. Let's start incentivizing I have a dental home versus it's episodic and I keep changing providers. Let's start incentivizing the quality measures that the Dental Quality Alliance has certified and

start reimbursing for that. So it was less towards building the network versus like I think we can do better in terms of shifting to health versus paying for like surgical interventions that are well downstream. That was all.

VICE CHAIR DAVIS: Thank you for that.

And I pose to all of you -- you know, you've heard a very receptive crowd amongst all of us, and thinking about how MACPAC can be impactful and the levers that we have to pull, what are those things that you would love to see us to weigh in and help to advocate for? And this is for everybody in your one-minute wrap-up.

MR. GIST: So I would require all states to cover comprehensive adult services for Medicaid recipients for five years, and at the end of the fourth year, they'll be required to conduct a study on the effects of comprehensive oral health, on overall health of the Medicaid participants, and the impact, including financial impact, of comprehensive Medicaid dental services on adult utilization. And I believe the results would speak for themselves.

So if I could wave a magic wand and it would be

done, that would probably be something that I would definitely advocate for.

MR. BUECHE: And I'll be quick. Basically, the same thing. Let's mandate that that coverage be required, and let's find the funding for it.

As a state Medicaid agency, we are here to do it. We have the manpower. We know how to do it. We have the network. We have the relationship with the dentists, and we have the people in need. So if we find that funding, we can do it. We can make it happen.

DR. VUJICIC: Yeah. I want to re-echo that. I really don't think there will be significant progress on this without some type of federal mandate, and not just saying something is comprehensive and looking to the private-sector model of dental benefits of that but really looking at EPSDT and the success parameters there and really coming up with what an adult benefit in Medicaid ought to look like, some guidance there.

I get maybe that's out of your purview. So let me go one level down, and I love Darin's points. This issue of dots on the map, number of providers, we're measuring the wrong things. And, Darin, you were getting

at this. I would like -- and I will put it very direct. I would love for you to recommend somebody -- CMS -- start collecting data on wait times. Do I know where to get care? Why am I not getting care? It's not important. It's important, but I can't find it. It's important. I could find it, but I'm late, and I can't get a -- you know, you get where I'm going, some type of initiative where you can require, because we report a lot on the children's Medicaid programs through CMS-416 and all sorts of reporting.

If you could at least start small, let's get a short, small dataset that's consistent across states. Go to just the states that have a benefit, and start looking at wait times, distance to providers, how easy it is to find a provider, but really from the beneficiary's perspective, because I'm with Darin. I think we're measuring a lot of the wrong things here.

VICE CHAIR DAVIS: Thank you all.

DR. VUJICIC: We are at your disposal. I didn't mean to cut you off. I apologize, but I want to emphasize we're a research team. We have tons of data. I want to just put it right here bluntly. We're at your disposal and

would be happy to collaborate, give you data, share data, anything we can do. I apologize.

VICE CHAIR DAVIS: Thank you. Thank you, Marko, Justin, and Brandon. This has been a fabulous panel. We love panels. Everybody knows that.

Thank you, Audrey, for bringing them all together. This has been a fabulous conversation, and I think the beginning of several others.

And I think we'll now turn to public comment.

CHAIR BELLA: Yes. I want to echo Kisha's thanks. Thank you very much.

Marko, be careful what you offer. We love data, and we love asking questions, as you can see.

I'm just going to open it up to the public to see if anyone would like to make any comments. If you do, please raise your hand, introduce yourself, your organization, and we ask that you limit your comments to three minutes or less, please.

Okay. I will have an -- oh, we do. Hi, Roy. Welcome.

PUBLIC COMMENT

* MR. JEFFUS: Sorry. I had to find --

CHAIR BELLA: I think you're open to talk.

MR. JEFFUS: Yeah. I couldn't let this go by. Sorry. I thought it interesting to hear all the comments since this is three generations after -- or three decades after I had fought this battle. I'll keep to the three minutes --

CHAIR BELLA: Sorry, Roy. Will you introduce yourself?

MR. JEFFUS: -- as well as possible, but sitting in front of a governor on the same day as he was watching the stock market fall with the Great Recession and I had worked for probably about two years to get funding for adult dental expansion that had been cut 20 years before, he didn't want to do it. However, I would say the best thing you can do is have a champion. You've got to have somebody that you have as a supporter in the legislature.

I made the effort to try to say that, at the same time, a former governor was trying to get rid of my survey and certification and long-term care about the number of findings that we had in nursing homes, one of our top findings was nutrition. And if people couldn't eat, then obviously they were going to have findings. Possibly, this

would actually reduce everybody's temperature in that area.

But I also had the same issue about providers not wanting to support this, and in fact, they actually tried to counteract lobbying in the legislature by saying this was going to reduce funding for the children's program.

We've got a lot of litigation in the past in our fee structure here that, Darin, may be familiar with. But the end result was that I had private organizations that wanted to come in and open dental clinics, and though everybody is concerned about regulation of those and prior authorization, broad and whatever, at least that was the door opening to try to get more access.

And I agree with the FQHCs. However, it's like the FQHCs have the day that the dentist is there and people have to line up. It's the same issue here in my state, where even after adult coverage has expanded, they have their day of mission of mercy. And I'm sorry to tell you, but the private dentist would prefer to have people line up for three days, sleep overnight, and see them there without having some sort of sustained follow-up care.

So it's a fight, and you're going to have to have somebody that stays in the fight with you. That's the best

I can advise.

CHAIR BELLA: Thank you, Roy, and --

MR. JEFFUS: And I compliment you for what you're doing.

CHAIR BELLA: Thank you very much, and just for the transcript, that was Roy Jeffus, former Medicaid director of Arkansas. We appreciate your comments, Roy.

There's no one else who has their hand up. So we will say thank you again to Justin, Brandon, and Marko. And we'll take a break. We'll keep the 15-minute break. We'll come back at 2:50, please. Thank you very much, everybody.

* [Recess.]

VICE CHAIR DAVIS: Hello. We are continuing our conversation on the PHE unwinding, and Martha is here to give us an update. So take it away, Martha.

UNWINDING UPDATE: STATE IMPLEMENTATION AND COORDINATION WITH PROVIDERS AND COMMUNITY ORGANIZATIONS

* MS. HEBERLEIN: Thank you, Kisha, and good afternoon, Commissioners.

I'll start today with some quick background on

the continuous coverage requirements before providing an update on state unwinding implementation activities. I'll then discuss some beneficiary outreach efforts and partnerships with key stakeholders before highlighting some key considerations for particular populations that the Commission has raised of interest. And I will conclude with next steps because there's always next steps on this one.

So, 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 continuous coverage requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18, 2020.

The Consolidated Appropriations Act, or CAA, passed in December of 2022 made a number of changes to the pandemic-related Medicaid provisions. Specifically, the CAA ended the continuous coverage requirements on March 31st of 2023 and phased down the enhanced matching rate over the remainder of 2023 if states meet certain criteria. The CAA also required states to report on specific data metrics and for CMS to make those data publicly available.

Finally, the law provided CMS with additional enforcement mechanisms to ensure state compliance, and we discussed these provisions in more detail at the last meeting, but I'm happy to review them if you guys have questions.

So to give you an update on where things stand, just under half of states started the unwinding process in February or March, with the remaining states beginning the process in April. Only five states began disenrolling individuals for procedural reasons, starting on April 1st. A majority of states plan to take the full 12 to 14 months to complete the process, and most are considering multiple factors in how they prioritize that work.

During the last few weeks in March, MACPAC staff had conversations with CMS, state associations, plan and provider representatives, and advocates to get updates from their perspectives on the unwinding. At that point in time, stakeholders did not identify widespread issues with the process. However, several noted that in some of the early implementation states, call center volume had increased and state capacity remained a concern.

Over the last month, CMS has also been working very closely with states to meet the conditions for the

CAA-enhanced match rate. So, for example, this has included working with those states that don't meet existing renewal requirements to develop mitigation strategies, such as addressing issues with processing ex parte renewals for individuals who are not eligible on the basis of modified adjusted gross income, or MAGI.

CMS has also released a compilation of guidance tools and other resources for states to implement these mitigation strategies. At the same time, these states are developing longer-term plans to come into full compliance after the end of the PHE.

So CMS and states and stakeholders have continued to communicate with beneficiaries about the upcoming unwinding, or now I guess, unwinding now. While much of the early messages primarily focused on updating contact information, the efforts now are really shifting to informing beneficiaries about the steps they'll need to take to renew.

So in a number of states, this includes information regarding what the renewal form will look and how to recognize it when it comes in the mail. The outreach efforts are also encouraged to respond to renewal

requests when they receive them.

A number of coordinated efforts across organizations have emerged to develop and share effective messaging. For example, the National Association of Medicaid Directors reported that they have been organizing affinity groups with states to share strategies as they develop beneficiary communication tools.

Provider groups reported similar efforts under way within their own organizations and as well as among their state affiliates. A broader coalition that includes plans, providers, and advocacy groups has launched a website to share tools and information.

However, it's not clear that all these efforts will reach all beneficiaries. For example, some advocates have raised concern that the outreach efforts will not be sustained throughout the entire 12-to-14-month unwinding process, and that beneficiaries whose renewals are due later in the process may be unaware or have forgotten about the changes by the time their renewals are due.

Also, survey findings from late last year as well as focus groups conducted in January and February of this year indicated that many Medicaid beneficiaries were still

not aware that renewals were approaching.

So, as discussed previously, most states have been working with managed care organizations to update addresses, conduct outreach, and assist beneficiaries in the renewal process. For example, states have provided MCOs with lists of individuals who are due for renewal as well as those who have not responded to requests for information.

Some MCOs have also reported targeting specific populations such as individuals with chronic conditions or pregnant and postpartum individuals or those with mental illness or substance use disorders. Typically, these targeted outreach efforts include additional communication or customized messaging.

CMS and states have also been engaged in community-based organizations to help communicate the upcoming changes. So CMS in a number of states have developed communication toolkits that include key messages that stakeholders can use, and other states have more directly engaged consumer groups as coverage ambassadors or coverage champions to help educate beneficiaries. Some states are also directly funding community-based

organizations to assist with outreach.

CMS and states have also engaged providers to assist with beneficiary outreach. Typically, these efforts have consisted of placing educational materials in offices, and in some states, the primary care association has held community events or conducted more direct outreach to beneficiaries.

In our conversations with stakeholders, community groups and providers are generally sharing information about the unwinding but are not necessarily assisting beneficiaries in completing the renewal process, although this may change as implementation moves further along.

So the Commission as well as other stakeholders have raised concerns that particular populations, including individuals with disabilities as well as those with limited English proficiency, may be more likely to face challenges in completing the renewal process than others. Many of these concerns existed before the PHE, and CMS and states have taken some steps to try to address them in advance of unwinding.

For example, individuals with disabilities and those who are dually eligible for Medicaid and Medicare may

struggle to complete the renewal process, and when they lose coverage, it is more likely the result of not completing the process rather than changes in eligibility due to income assets or functional ability.

Similar to those with disabilities, individuals with limited English proficiency are more likely than those who are proficient in English to experience administrative barriers to completing the renewal process.

The barriers for these groups can be procedural in nature. As an example, many individuals who are eligible on a non-MAGI basis are subject to asset limitations, and verification of assets may be a challenge. While nearly all states are using electronic asset verification systems, or AVS, the results may not always be quickly available, and not all financial institutions participate.

During the unwinding, states are able to adopt a time limit waiver to complete renewals without further action from the beneficiary if the AVS does not return information or does not return it within a reasonable time frame.

There are also accessibility issues for these

populations. For example, advocates noted that some preexisting concerns with translations in language accommodations may be exacerbated by covid, giving staffing constraints and the need for new program materials to be translated.

For example, one advocate noted that a state where call center requests for interpreters, these were getting dropped rather than connected to the language line for further assistance.

Advocates also noted the importance of thinking broadly about accessibility. For example, while some states may have accommodations such as materials available in large print or Braille for those with visual impairments, fewer provide training to call center staff on the accommodations such as speaking more slowly or repeating information for those who have cognitive impairments.

Advocates also noted that where there are fewer staff, additional accommodations and services for those with greater needs may not be offered.

Specifically related to the unwinding of the continuous coverage requirements, most states reported

communication or outreach strategies targeting to seniors or people with disabilities often partnering with health plans, area agencies of on aging, advocacy organizations for individuals with disabilities and state health insurance programs.

CMS and states have also taken some steps to address issues for those with limited English proficiency by making unwinding information available in multiple languages.

CMS also released a slide presentation describing the accessibility requirements for individuals with disabilities and the specific language requirements for state Medicaid agencies as well as key considerations as they implement the unwinding.

In addition, earlier this week or last week, the Office of Civil Rights has reminded states of their obligations under federal civil rights laws as they restart eligibility reviews.

So we will continue to watch state progress as documented in both official reports as well as other publicly available resources such as media accounts, and while some states have and will continue to post public

data publicly, the CMS reporting on key metrics for the earliest implementers will likely not be available until June, and data for states that begin disenrollments in subsequent months will come later in the summer.

Staff will continue also to engage key stakeholders throughout the summer to stay abreast of what they're hearing from those on the ground, and we will continue to report back.

So, with that, I will turn it back to Kisha for discussion.

VICE CHAIR DAVIS: Thank you, Martha.

Correct me if I'm wrong, but overall, what you've shared is encouraging, and I think that to see that there are -- certainly, there are, you know, maybe some that are struggling more than others, but on the whole, it seems like that states are really getting their processes in place and move in a direction that is protective of beneficiaries. Would you say that that is true?

MS. HEBERLEIN: I don't want to speak too soon. I think states are in the early stages of implementation. I think they have developed robust plans, at least the ones I've seen. I think that they are working hard with their

stakeholder communities and working hard to educate beneficiaries of what's going on. I think that also only five states have started procedural disenrollments, and I think it's too soon to say exactly what's going to happen.

I know at the -- I think it was at the last meeting where we talked about the rubber hits the road when you implement, and I don't -- you know, I'm not -- I'm cautiously optimistic, I guess you could say, because I think we're still -- I think it's still too early to say what's going to happen.

VICE CHAIR DAVIS: Thank you.

Martha, can we turn to you? I'm sorry. Tricia, can we turn to you for some comments on this?

COMMISSIONER BROOKS: Well, I liked Martha's response to the question. I think it's still too early to tell.

I think CMS has done a phenomenal job of working with the states, and I think state Medicaid directors really care about the beneficiary, but that doesn't mean that they have the underlying systems and processes that will make it go smoothly.

And I think it will be important for us to take

stock of this after the fact. Martha's slide said something about many of the concerns that have been expressed predate the ACA, some going way back to the ACA. So I think there are a lot of lessons to be learned and for us to continue to streamline the eligibility and enrollment process and to use technology in good ways to make it easier for states to do that.

So still a lot of months left before we can look back and see what damage is done, and ultimately, we're not going to see the real data until we start seeing uninsured data. And that's going to be a longer time coming.

VICE CHAIR DAVIS: Thank you, Tricia.

Others with comments or questions for Martha?

[No response.]

VICE CHAIR DAVIS: All right. Thank you.

Melanie, did you have anything?

CHAIR BELLA: Yeah, I have a lot, but most of them probably are not answerable at this point.

I guess just a request. As Kisha is trying to look optimistically -- I think we all are -- it would be really helpful as we're finding best practices -- like I'm thinking about the part about communicating with complex

subpopulations and navigation. So when we do, I appreciate the areas that you bucketed these things in. If no one else is shining light on some of those important practices happening in other states, it would be helpful if we find a way to do that.

I imagine people -- groups are trying to do that, but those seem to be some important, concrete, tactical steps, that if they are working, it would be great to see them leveraged by other states.

VICE CHAIR DAVIS: Thanks, Melanie.

Okay. Yeah. Go ahead, Tricia.

COMMISSIONER BROOKS: Well, I just want to add a comment to Melanie's point. Yesterday we were on with some advocates and legal service folks, testing the waters, what's going on, and we heard a story coming out of Massachusetts about how Massachusetts had not previously had a callback option on their phone system, and when they added it, they actually noticed that the call volume had gone down. And they were speculating that that was because people weren't hanging up and calling back in to see if they could get a different time.

And so those little nuggets, because those are

the kinds of things that states might have an opportunity to implement between now and the unwinding, if they're not doing it, were actually doing some call center research, finding out how many states, first of all, maybe give you an option to update your mailing address or contact information. How many of them give you access to language services? How many have a callback option? And believe it or not, there are state phone systems that don't actually even tell you how long the wait time is.

So there's tremendous variation across the states, but the more we begin to learn about that and, again, document that and use it for lessons in the future, the better it will be.

VICE CHAIR DAVIS: Thank you, Tricia.

Go ahead, Fred.

COMMISSIONER CERISE: I'd just ask Tricia -- first off, thanks for your work on this. Everything I read on this; it is Brooks behind it.

So to what extent, when you learn those things, does that get shared with the other states? I know you're talking to lots of people.

COMMISSIONER BROOKS: So we really try to do

cross-state collaborations in these calls so that other stakeholders can hear. I don't know that we have a systematic way yet that we've determined that we will capture a lot of these nuances, but it's a good reminder that we need to be doing it. And importantly, we do share this with CMS who can -- is in a better position to share back with the states.

VICE CHAIR DAVIS: Thanks.

One last thing, Martha, that I'd like to add, I appreciate the attention to special populations, so limited English proficiency, low vision, and it's probably too early to really say at this point, but I want to make sure that we are looking at the race and ethnicity as folks are falling off. And if we're seeing that certain groups are falling off of the roles faster than other groups, that we're making sure that we're paying attention to that respect as well.

All right. Thank you, Martha.

We will continue this conversation, I think, at each of our meetings for quite a while. So we appreciate all of your work on this.

CHAIR BELLA: Well, we start the day with DSH,

and we end the day with DSH. So, Rob, are you joining? Is this Aaron? This is Aaron. Okay.

MR. PERVIN: Just me.

CHAIR BELLA: Welcome, Aaron. Well, sorry. Your name is on the agenda, so I'm just double-checking.

Aaron, welcome.

MR. PERVIN: Thank you.

CHAIR BELLA: Lead us into the homestretch. It's all you.

PROPOSED RULE ON MEDICAID DISPROPORTIONATE SHARE HOSPITAL THIRD-PARTY PAYER POLICY

* MR. PERVIN: You have had a full plate of DSH today. That was not intended.

Good afternoon, Commissioners. Today we're going to be talking about the proposed DSH rule. I'm seeking feedback from you all on whether the Commission should formally comment, and if so, what those comments should be.

I'm first going to provide some background on the work we've done related to this rule in the past before providing an overview of the proposed rule and discussing potential comments for the Commission to consider.

CMS proposed this rule on February 24th. The

rule codifies changes to DSH payments made under the Consolidated Appropriations Act of 2021, and comments on this rule are due back to CMS on April 25th and would be effective for DSH payments for the 2022 state fiscal plan rate year.

In addition to codifying the CAA, the rule also proposes other technical changes to CMS' oversight of DSH policy. These changes are very similar to policies that CMS has previously proposed, which the Commission has also previously commented on. The Commission may decide to reiterate some of these comments it has already made previously.

So the rule broadly changes -- the rule makes broad changes to how Medicaid shortfall is calculated. So as a reminder, DSH payments to hospitals are limited by uncompensated care. This is the sum of unpaid costs of care for the uninsured and Medicaid shortfall, which is the difference of costs of care for Medicaid-eligible beneficiaries and the payments the hospital receives for those services.

Over the last few years, since around 2018, lawsuits have challenged how Medicaid shortfall is

calculated for patients with third-party coverage, and for context, this is a fairly large population. In 2017, we estimated that 18.4 million beneficiaries have third-party coverage, with 11.5 also having Medicare and 8.5 million also having private insurance.

So between 2010 and 2022, there have been two different definitions of shortfall that have been in effect. The first is CMS' 2010 policy, which calculates shortfall by taking costs and subtracting all payments a hospital receives for Medicaid-eligible beneficiaries. The second definition was the policy that took effect in 2018, after the District Court of D.C. vacated CMS' policy because the DSH statute did not explicitly mention third-party payments. However, this ruling was eventually overturned on appeal, and CMS officially reverted to its 2010 policy in 2021.

In 2019, MACPAC recommended that calculations of shortfall should only include beneficiaries for whom Medicaid is the primary payer. This was done because of the initial effects the court ruling was having on hospital finances.

So this table visualizes the different

definitions of Medicaid shortfall. On the top row is CMS' 2010 policy, and as you can see, Medicaid payments and things like private insurance payments or Medicare payments, these payments would be used in shortfall calculations in addition to payments and costs for individuals who only have Medicaid coverage.

Now, under the policy set under the D.C. district court ruling, Medicaid payments are included, but now private insurance or Medicare payments or other third-party payments would no longer be included in shortfall calculations. Under the Commission's recommendation, those covered by a third-party are completely removed from the shortfall equation. None of their costs are included, and also none of their payments are included.

In our June 2019 chapter, we looked at the effects that each of these policies had on different hospitals. The CMS 2010 policy disadvantaged children's hospitals and other hospitals with beneficiaries with private coverage because private insurance generally pays higher than Medicaid costs. Conversely, the 2010 policy benefitted hospitals with large numbers of those who are dually eligible for Medicare and Medicaid because Medicare

pays around 90 percent of costs of services.

So in 2020, CAA implemented a shortfall definition that was consistent with MACPAC's recommendation, but provided an exception for hospitals that see large numbers of beneficiaries who are dually eligible for Medicare and Medicaid. For these hospitals, the limit for DSH payments is the higher of CMS' 2010 policy or MACPAC's recommended policy.

Okay. Now that you all are experts on the varying definitions of Medicaid shortfall, we're going to look at an overview of the rule and also look at potential areas for comment.

So the first proposed change is codifying CAA's calculation of shortfall. CMS is going to use the most recent cost report data to determine which hospitals are eligible for the DSH limit exception. The public would be notified of which hospitals meet the exception before October of each year. However, in spite of this new definition of shortfall, CMS is not proposing any changes to how data on shortfall is collected on Medicaid DSH audits.

The second proposed change is around recoupment

of DSH overpayments. So according to a DSH audit that we used, the most recent DSH report, 422 DSH hospitals received a total of $1 billion in excess of their limit. So we estimate that overpayments, these DSH overpayments, made up almost 6 percent of all DSH payments in that year. CMS proposes to require auditors to estimate overpayments on their audits to facilitate efforts for states and CMS to recoup DSH overpayments. Generally, after these audits are filed, overpayments are then redistributed to other hospitals within a state.

The third proposed change is on the DSH allotment reduction methodology. The current methodology applies smaller reductions to states that target DSH payments to high-volume Medicaid hospitals or hospitals with high levels of uncompensated care. Data on both of these factors are collected through DSH audits.

In addition, states that use DSH funding for coverage expansions under Section 1115 waivers in 2009 are exempt from this methodology. However, this exception no longer has any practical effect because these waivers are no longer in effect, and CMS proposes removing this requirement.

However, states such as California and Massachusetts still use DSH funding in their demonstration for supplemental payments, and because these states do not submit DSH audits, the DSH targeting components of the reduction methodology will use the average uncompensated care factor and average Medicaid volume factor that is used for other states.

The final proposed change is that CMS proposes to post both CHIP and also DSH allotments on CMS' website instead of the Federal Register since the process of posting on the Federal Register is often time-consuming and also administratively burdensome. CMS also proposes to remove the requirements that final allotments are posted by April 1st, a deadline that CMS has failed to meet previously.

So, in summary, we proposed a few areas of comment. The first area of comment is around reiterating the Commission's desire for data transparency. The Commission may suggest to CMS that shortfall be reported separately for patients with third-party coverage among these excepted hospitals. This would give policymakers the ability to better understand the effects of Medicaid

payment policy on uncompensated care for all hospitals and for the excepted hospitals.

The three other recommendations would be reiterating previous comments on other proposed rules. This includes requiring states to resubmit audits showing which hospitals have received these redistributed DSH overpayments. Another would be using provider-level data to determine how supplemental payments are targeted under DSH-funded Section 1115 demonstrations, and then also requesting that CMS post allotments by April 1st to help states prior to the start of their fiscal year.

With that, I'll turn it over to you all for questions and comments.

CHAIR BELLA: Thank you, Aaron. Would you like to comment? Would you like us to comment?

MR. PERVIN: I think it might be nice to comment, yeah. The new Medicaid shortfall definition is interesting and is pertinent, and, you know, we would like to have data on how that exception works, so that might be one area where you could all comment.

CHAIR BELLA: It feels like this is someplace that we should comment, but let's take the temperature of

the rest of the Commissioners. Who wants -- Bob, do you want to get us started?

COMMISSIONER DUNCAN: I have a question in trying to understand --

CHAIR BELLA: Is your mic on?

COMMISSIONER DUNCAN: My mic's on. Thank you. I had a question trying to understand the new policy. A lot of it makes sense, but when I think of children, particularly those in the SSI that have both Medicaid and a private insurance, some of those kinds with special health care needs, their private insurers will not pick up some of those services and where they rely on Medicaid. And so what impact does that have on the providers providing that service? And then what impact would that have on the hospitals caring for those patients?

MR. PERVIN: Sure. So in the instances where private insurance is paying over cost, that creates what's called the "Medicaid longfall," and that would decrease the DSH limit for these children's hospitals. However, under the proposed rule, since these children no longer have Medicaid as their primary coverage, they would not be included in the shortfall calculation, and so, therefore,

that hospital's DSH limit would be unaffected by these individuals where primary coverage is provided through a third party.

COMMISSIONER DUNCAN: Thank you.

CHAIR BELLA: I never had "longfall" before. Bill, are you up?

COMMISSIONER SCANLON: I think commenting is of significant value, and the two themes are transparency and timeliness. And I think both of them are something that we've emphasized in the past and we should continue to emphasize, that CMS has put this out there sort of having support for both of those areas is helpful to them as well as more generally.

CHAIR BELLA: This is your chance. Anything else you want to say We're not going to have DSH tomorrow.

COMMISSIONER SCANLON: Well, we're going to vote on it tomorrow.

[Laughter.]

COMMISSIONER SCANLON: No, nothing more on this.

CHAIR BELLA: Okay. Thank you, Bill. Fred and then Darin.

COMMISSIONER CERISE: Thanks, Aaron. Can you

talk a little bit more about the first notes? I'm still trying to figure that one out, so the exception hospitals, the 3 percent or so. So would that recommendation or that potential point of those hospitals reporting separately, that sounds like some extra reporting that would be specific to that group that claims that exception? Is that correct?

MR. PERVIN: Yes, so it might be easy if I go back to -- oh, there we go. Yes, so right now on DSH audits, Medicaid shortfall is not reported separately for different kinds of patients. It's all kind of reported on a single line. And so what we would be proposing is that DSH audits are changed to report both the shortfall for the Medicaid-only population, and then for these excepted hospitals, they would need to also report on shortfall for individuals with third-party coverage. So you are correct that these excepted hospitals would have additional reporting requirements.

COMMISSIONER CERISE: And that would be -- if you were going to claim the exception, then you would have that responsibility to report if you did not think you were in that group, like most places would not, that wouldn't be an

added burden for them?

MR. PERVIN: So it would only apply to hospitals that are part of that exception, and those hospitals would be notified in advance of the state fiscal plan year. So it's going to be posted theoretically before October of every year, so before those DSH audits are filed, so hospitals will know whether or not they meet that exception.

COMMISSIONER CERISE: That would be interesting to see. I agree.

COMMISSIONER GORDON: Can you describe that timeline again? They would be notified in October prior to the year that will be audited?

MR. PERVIN: Yeah, so -- no, so it's -- they are notified -- I might need to check the timeline specifically again, but my understanding is they would be notified using most recent cost report data, and so they would be notified the October before DSH payments for that fiscal year starts flowing. So they would be notified before the state plan fiscal year that the DSH payment is for.

COMMISSIONER GORDON: I'm just trying to think that through from -- and this is maybe for others here that

live this daily. But I'm just trying to think from the hospital's perspective, you know, is that giving them sufficient time to be able to adjust their systems, to be able to report that information, you know, before -- this is where I always get a little concerned when we do some of the audits, and I'm guilty of it, so that's why I have the concern. We do audits and we would introduce new audit criteria or new reporting criteria at a time when it's impossible for the entities we're doing it to to have adjusted their systems and processes to comply, so then, therefore, they look like they're noncompliant. So if I'm telling them in October that starting January 1, they have to be reporting things differently because that year I'm going to be looking at this break down differently, I -- again, I'm not a hospital administrator, never have been, and probably never will be. But it just seems like that may create some challenges.

MR. PERVIN: That's a good point. Can I come back -- I'd like to review kind of the timeline of when these things would be implemented, and then we c d--

COMMISSIONER GORDON: Nothing is ever easy with DSH, so yeah. And, yes, I do think -- I mean, I think we

have to comment seeing that we have commented on DSH ad nauseam. It would be awkward for us not to speak up and give some feedback here. So thank you.

CHAIR BELLA: May I ask just a clarifying question? On these two sub-bullets, the excepted hospitals are the top 3 percent or are there other hospitals that can also be excepted?

MR. PERVIN: No, it would be the top -- it's two different top 3 percents. So one is the top 3 percent in terms of the number of inpatient days for Medicare Part A beneficiaries who are also eligible for SSI. And then it's also the top 3 percent in terms of the share of inpatient days for Medicare Part A and SSI. But it's only those two -- only those two factors make you eligible for the exception.

CHAIR BELLA: And we think that's good policy?

MR. PERVIN: So that was not part of our recommendations previously. This exception was put in by Congress, partially to provide additional support or make sure the DSH limit for hospitals that see a large number of duals don't see that DSH limit go down. We have not weighed in on whether or not that exception is good policy.

CHAIR BELLA: But that exception is out of line with how we viewed duals with regard to definition of Medicaid shortfall, right? Or am I thinking about that wrong?

MR. PERVIN: Sorry. Can you ask that question again?

CHAIR BELLA: Bill, what do you think about this?

COMMISSIONER SCANLON: I'm not sure, honestly. I mean, it sounds like it's trying to make a -- create enough room that you'll have more hospitals included by employing both criteria.

CHAIR BELLA: So is this better for duals or better for hospitals, or possibly both?

MR. PERVIN: Possibly both. It's better for hospitals that serve a large number of duals because they'll be able to claim a higher DSH limit than they would if they weren't eligible for this exception.

COMMISSIONER CERISE: And is that presumably because their Medicare reimbursement is going to be well below their costs?

MR. PERVIN: Yes.

CHAIR BELLA: Thank you. Verlon and then Angelo.

COMMISSIONER JOHNSON: I think I have a pretty simple question. When we look back at the recommendation to post on the web, I think that makes a lot of sense. But I guess I'm confused by the acknowledgment that they'd rather go past April 1st, and then, of course, I think our comment is that we would rather them stick with that date. Was there a reason besides the idea that the Federal Register would take a lot more time for them to go past that date?

MR. PERVIN: So our recommendation for our DSH allotment reductions, we're trying to provide DSH allotments -- finalize DSH allotments on a more timely basis. Basically, CMS has failed to meet that deadline previously in the past, and so the assumption is that under this rule, because they don't need to post the allotments on the Federal Register, that it would reduce the administrative burden for CMS to post them.

We're also of the opinion that removing the requirement to compare Medicaid spending to final DSH allotments, you know, separately as part of the chapter, that would also help CMS post those allotments on a more timely basis.

COMMISSIONER JOHNSON: So we could actually again stick with the April 1st date. Is that correct?

MR. PERVIN: Yeah, we would hope that -- yes.

COMMISSIONER JOHNSON: Okay. Perfect. Thank you.

CHAIR BELLA: Angelo?

COMMISSIONER GIARDINO: Aaron, on this slide you commented that there was federal courts involved. Are any of our recommendations at odds with what the appeals court decided?

MR. PERVIN: No. Our recommendations are not at odds with what the appeals court decided. The D.C. District -- the district court of appeals ended up overturning that original 2018 ruling, so once that occurred, CMS reverted to its prior policy. And, no, we have not been in conflict with those rulings.

COMMISSIONER GIARDINO: Okay. Thank you.

CHAIR BELLA: Other Commissioners?

[No response.]

CHAIR BELLA: Anyone who spoke will be asked to review the letter, and if there are any other volunteers who would like to review the letter, we need to get this

turned around fairly quickly. That's right, Aaron?

MR. PERVIN: Yeah, comments are due on April 25th.

CHAIR BELLA: Excellent. Do we have any other Commissioners who would like to make a comment on this or ask any questions? Do you have the direction you need as far as like what areas we would like to comment on?

MR. PERVIN: Yeah, it sounds like we're definitely in favor of reiterating prior Commission comments. I need to get more information back to Darin and the rest of you on kind of the timeline for when that exception and when hospitals are notified whether or not they're eligible for the exception. But, yeah, we can get that to you forthwith.

CHAIR BELLA: Okay, great. Dennis, it looks like you have a comment?

COMMISSIONER HEAPHY: I'm wondering, are you satisfied with the metrics they're using across the hospitals and they're deploying transparency? Are all states reporting the same data the same way? Is that a fair way to do it? What are your thoughts on that?

MR. PERVIN: Yeah, so right now, the way -- right

now all states are reporting Medicaid shortfall in the same way. Once this goes into effect, states will continue to report Medicaid shortfall in the same way, but excepted hospitals would be reporting a different kind of shortfall compared to other hospitals. And one of the reasons why I think there's value in commenting and making sure that shortfall for at least the Medicaid-only population is presented in the same way across states is that we'd be able to compare appropriately across states and also appropriately across hospitals.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Any other comments?

[No response.]

CHAIR BELLA: No, Rhonda is good, Dennis is good. Okay.

Aaron, a small subset of us will look forward to reviewing the draft letter next week. Thank you very much for your work on this.

We will now open it up to public comments before we adjourn for the day, so we welcome folks in the audience to raise your hand if you would like to make a comment and introduce yourself and the organization you represent. And

we ask that you keep your comments to three minutes or less, please.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Nobody wants to comment on our DSH adventures, I guess.

All right. Well, we that, thank you to Kate and the team. Thank you to the Commissioners. We'll be back tomorrow starting at 10:00 a.m., and we'll start with taking a vote on the DSH recommendations that we discussed first thing this morning.

Thank you very much. See you all tomorrow. We're adjourned.

* [Whereupon, at 3:30 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, April 14, 2023.]

PUBLIC MEETING

Ronald Reagan Building and International Trade Center
Hemisphere A
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, April 14, 2023
10:01 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
KISHA DAVIS, MD, MPH, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
MARTHA CARTER, DHSC, MBA, APRN, CNM
FREDERICK CERISE, MD, MPH
ROBERT DUNCAN, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DARIN GORDON
DENNIS HEAPHY, MPH, MED, MDIV
VERLON JOHNSON, MPA
RHONDA M. MEDOWS, MD
WILLIAM SCANLON, PHD
KATHY WENO, DDS, JD

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:01 a.m.]

CHAIR BELLA: Good morning. Welcome to Day 2 of our April MACPAC meeting. We are going to start this morning with taking a vote on our recommendation related to DSH.

Aaron is going to lead us through that, and then we will take the vote.

Welcome. Thank you.

VOTE ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* MR. PERVIN: Thank you.

Okay. So we're just going to be voting on the recommendations that we presented yesterday, and this is a recommendation for automatic adjustments for Medicaid disproportionate share hospital allotments.

So Recommendation 1.1: In order to reduce the wide variation in state disproportionate share hospital allotments based on historical spending, Congress should revise Section 1923 of the Social Security Act to require the Secretary of Health and Human Services to develop a methodology to distribute reductions in a way that

gradually improves the relationship between total state and federal DSH funding and the number of non-elderly, low-income individuals in the state after adjusting for differences in hospital costs in different geographic areas.

Recommendation No. 2: Congress should amend 1923 of the Social Security Act to ensure that total state and federal disproportionate share hospital funding is not affected by changes in the federal medical assistance percentage.

Our third recommendation is that Congress should amend the Social Security Act to provide an automatic Medicaid countercyclical financing model using the prototype developed by the U.S. Government Accountability Office as the basis. The Commission recommends that this policy change should also include an eligibility maintenance of effort requirement for the period covered by an automatic countercyclical financing adjustment, an upper bound of 100 percent on adjusted matching rates, an increase in federal disproportionate share hospital allotments so that total available DSH funding does not change as a result of changes to the federal medical

assistance percentage, and also an exclusion of the countercyclical FMAP from non-DSH spending that is otherwise capped or have allotments, for example, territories and other services and populations that receive special matching rates, for example, for the new adult group.

And then our last, Recommendation No. 4: To provide states and hospitals with greater certainty about available disproportionate share allotments in a timely manner, Congress should amend Section 1923 of the Social Security Act to remove the requirement that Centers for Medicare and Medicaid Services compare DSH allotments to total state Medicaid assistance expenditures in a given year before finalizing DSH allotments for that year.

And with that, I turn it back over to you.

CHAIR BELLA: Thank you, Aaron.

Any questions or comments from the Commissioners before we go to vote?

[No response.]

CHAIR BELLA: No? Okay.

I'll do my spiel. On January 19th, the MACPAC Conflict of Interest Committee, chaired by Kisha, met by

conference call and determined that for the purpose of our vote today under the particularly, directly, predictably, and significantly standard that governs our deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest related to the recommendation under consideration.

EXECUTIVE DIRECTOR MASSEY: Okay. So we will take one vote on the package of four recommendations. As a reminder, Commissioners, you can vote yes, no, or abstain.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Martha Carter?

COMMISSIONER CARTER: Yes.

EXECUTIVE DIRECTOR MASSEY: Fred Cerise?

COMMISSIONER CERISE: Yes.

EXECUTIVE DIRECTOR MASSEY: Kisha Davis?

VICE CHAIR DAVIS: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

COMMISSIONER DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jennifer Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Darin Gordon?

COMMISSIONER GORDON: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

[No response.]

EXECUTIVE DIRECTOR MASSEY: Not present.

Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: William Scanlon?

COMMISSIONER SCANLON: Yes.

EXECUTIVE DIRECTOR MASSEY: Katherine Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. Votes tally, 15 yeses, one not present.

CHAIR BELLA: Aaron, thank you.

MR. PERVIN: Thank you.

CHAIR BELLA: We are going to go into our next session, but in the couple minutes that we have, I want to publicly acknowledge that five of our Commissioners are rolling off their six years of service today. So that was the last votes they will ever -- well, maybe not ever. Maybe you can be reappointed again. I have no idea. But we want to publicly acknowledge the work of Martha, Fred, Bill, Darin, and Kisha, and thank them for six amazing years of service and dedication, and we hope that they will be on the other side in future meetings continuing to advise us. So thank you all very much for your service.

And now I'm going to turn it over -- am I doing this one? Okay. I'm doing this one. So welcome, Tamara and Asmaa. Please take it away. We're rolling to HCBS services. Thank you.

ACCESS TO HOME- AND COMMUNITY-BASED SERVICES

* MS. HUSON: Great. Good morning, Commissioners.

So today, Asmaa and I will present an overview of the draft chapter on access to home- and community-based services for the June report to Congress.

Here you can see an outline for the chapter. We start off with some background on Medicaid coverage of HCBS, followed by the discussion of access barriers mapped to MACPAC's access framework, and we finished with a discussion of next steps for the work.

This chapter draws on multiple streams of work, including stakeholder interviews, a roundtable, an environmental scan, and two panels. All of this work highlighted the numerous challenges that beneficiaries face trying to access HCBS and the administrative complexity for states of administering these programs.

In terms of next steps, the Commission is committed to exploring ways to expand access to HCBS and working towards identifying policy levers that meet that goal.

As you know, Medicaid is the primary payer for LTSS, which includes both institutional care and HCBS. Medicaid beneficiaries who use LTSS are a diverse group spanning all ages with varied cognitive and physical disabilities. People often receive services for years or even decades.

To be determined eligible for Medicaid,

individuals generally must fit into a specific eligibility category and meet certain income thresholds. To qualify for LTSS, they must meet additional standards, such as asset tests and functional criteria that are based on an individual's physical or cognitive status.

There are multiple Medicaid eligibility pathways for LTSS. States are required to cover beneficiaries who receive Supplemental Security Income through the mandatory SSI-related pathway. All states also choose to cover individuals through one or more optional pathways, and you can find a table of the most common eligibility pathways for LTSS users in the draft chapter.

Once an individual is determined eligible for Medicaid, they're entitled to the full range of covered services in the state. HCBS are optional services, but all states choose to cover them. Some states provide HCBS through an amendment to their state plan, such as through Section 1915(i), but most HCBS are provided via Section 1915(c) and Section 1115 waivers.

Variation exists in terms of benefits offered by state as well as by how benefits are delivered, the types of services covered, population served, and eligibility

criteria. States often use different terminology to refer to the same or similar services. In response to states' unique approaches, researchers developed the HCBS taxonomy, which is a uniform classification system comprised of 18 service categories.

So, for example, one HCBS taxonomy category is home-based services, and this includes services such as home-based habilitation, home health aide, personal care, companion, homemaker, and chore services.

So MACPAC conducted an environmental scan last summer in which we reviewed Section 1915(c) and Section 1115 waiver documents and Section 1915(i) and 1915(k) state plan authorities for all 50 states and D.C. We mapped the services offered under each authority by state and by population. And just for a point of reference, the seven population groupings we used are aged; individuals with intellectual disabilities or developmental disabilities, also called ID/DD; individuals with physical or other disabilities; individuals with brain injury; individuals with mental illness or serious emotional disturbance; individuals with HIV/AIDS; and lastly, individuals who are medically fragile or technology dependent.

And overall, based on our scan, we found that caregiver support and home-based services are the most commonly provided services, and the least common are rent and food expenses for live-in caregivers and also participant training.

So this slide here provides a high-level summary of the results of our environmental scan, including the total number of waivers and authorities we reviewed as well as the number of states using those authorities by each of the seven populations I just listed.

This table particularly includes Section 1915(c) waivers, Section 1115 demonstration waivers, and Section 1915(i) state plan authority. There is a separate table in the chapter appendix for Section 1915(k) state plan authority. The chapter appendix also provides the count by HCBS taxonomy category as well.

And based on our review of Sections 1915(c), 1115, and 1915(i), we found certain commonalities among states in terms of the target groups they select for HCBS and the services they provide. All states and D.C. provide HCBS for individuals with ID/DD or autism as well as for the aged population. Forty-nine states also provide HCBS

to individuals with physical or other disabilities. About half the states offer HCBS to individuals with brain injury, mental illness, or those who are medically fragile or technology dependent, and 10 states offer HCBS targeted specifically to individuals with HIV/AIDS.

And then a little background on spending. So nationally, since fiscal year 2013, spending on HCBS as a proportion of total LTSS expenditures has exceeded spending on institutional care. However, in some states and for some HCBS populations, spending on institutional care exceeds spending on HCBS.

So in 2019, HCBS expenditures as a share of total Medicaid LTSS reached 58.6 percent, and in 29 states and D.C., HCBS made up 50 percent or more of the total LTSS spending, but among all states, rebalancing ratios ranged from 83 percent to 33 percent.

And the figure on this slide shows fiscal year 2018 data on HCBS spending by population type, and this data is from a Mathematica report, as indicated in the source notes. And based on this data in 2018, almost one-third or $16.7 billion of LTSS expenditures for older adults and people with physical and other disabilities was

for HCBS.

In contrast, for people with ID/DD, which includes autism spectrum disorder, about 79 percent or $18.3 billion of their LTSS spending was for HCBS. And for individuals with behavioral health conditions, it was just over 49 percent. And finally, for other populations, which includes individuals who are medically fragile or technology dependent, have HIV/AIDS, brain injury, or belong to multiple subgroups, HCBS expenditures totaled $11.4 billion.

And now I'll turn it over to Asmaa to walk through the rest of the chapter.

* MS. ALBAROUDI: Great. Thanks, Tamara, and good morning, Commissioners.

Today I'd like to spend the remainder of our time describing findings from our research on access to HCBS in two areas, barriers for beneficiaries and state challenges in administering HCBS programs mapped to MACPAC's HCBS access framework.

In its June 2022 report to Congress on Medicaid and CHIP, the Commission discussed a new Medicaid access monitoring framework with three key domains of access. For

purposes of analyzing access to HCBS for Medicaid beneficiaries, we mapped our findings to these three domains and added an additional category, administrative complexity, to capture the challenges that states face in operating their HCBS programs.

Provider availability and accessibility looks to capture things such as potential access to providers and services as well as worker availability.

The use of services domain of the access framework measures realized access by examining use of services.

Next, beneficiary perceptions and experiences of care is focused on barriers to accessing care, experiences with care, and beneficiaries' knowledge and understanding of available benefits.

And administrative complexity examines state administrative burden in managing multiple HCBS programs, often under different waivers or state plan options, implications of system complexity on beneficiaries, as well as state capacity and resources.

HCBS providers include several types of workers, direct care workers, direct support professionals, as well

as independent providers who tend to be low-income women and people of color. We have heard repeatedly in our work that limited provider capacity and direct care worker shortages are key barriers to increasing access to HCBS.

Providers do not have workers available or the budget to meet population needs in states.

State officials mentioned limitations related to HCBS provider expertise and capacity generally, and in particular, when serving persons with ID/DD and behavioral health needs.

These workforce shortages limit the ability of Medicaid programs to serve more people in the community. Further, a lack of HCBS funding coupled with limited provider capacity creates challenges for states to provide a person-centered approach to HCBS delivery, and the COVID-19 pandemic exacerbated these challenges.

ARPA provided a temporary increase in the federal medical assistance percentage, or FMAP, for state Medicaid programs to support the infrastructure for HCBS. States are using ARPA funds on activities that enhance, expand, or strengthen HCBS, such as initiatives to increase provider payment rates.

Thirty-three states and the District of Columbia have ARPA-funded initiatives to plan for or implement changes in payment policies such as increasing payments to workers, implementing monetary incentives, and conducting studies on new rate structures. For example, Maine used ARPA funds to provide bonuses to direct care workers and their immediate supervisors in 2021.

In an emergency, Section 1915(c) waivers can be modified with a submission of an Appendix K. Every state with a Section 1915(c) waiver program submitted an Appendix K during the public health emergency requesting flexibilities to bolster HCBS delivery and reimbursement. Some of these flexibilities include increasing provider payment rates. While Appendix K flexibilities are set to expire six months after the end of the public health emergency, states have the option to make some flexibilities permanent through their Section 1915(c).

Next is use of services. States are allowed to set caps on enrollment in a Section 1915(c) waiver and to establish waiting lists when demand exceeds the waiver's approved capacity. Wait times differ across HCBS populations, across states, and even within states across

waivers. States are using ARPA funding to expand services for beneficiaries, including efforts to reduce waiting lists. Six states -- Alabama, California, New Mexico, North Carolina, Tennessee, and Texas -- are proposing to eliminate or reduce waiting lists by adding a total of over 17,000 waiver slots.

Another area we explored related to utilization was disparities. Our findings point to disparities in HCBS access across a range of factors, including by HCBS subpopulation, by race and ethnicity, geographic location, as well as age. For example, one study found that Medicaid HCBS spending is lowest for dually eligible Black males with multiple sclerosis as compared to white males with MS who had the highest HCBS spending.

Another study found that among people with Alzheimer's disease and related dementias, higher HCBS expenditure was linked to a lower probability of institutional care for white individuals and not for Black individuals. However, we heard that it is challenging to identify the extent to which these disparities occur given the lack of available data, particularly related to data on race and ethnicity. More information and data are

necessary to better identify inequities in HCBS access and is an area for future Commission exploration.

Next is beneficiary perceptions and experiences of care. Consumers face knowledge gaps regarding available HCBS supports in the community. Several stakeholders shared that people who are eligible for HCBS can encounter confusing information about options available and how to access them.

One source of information for beneficiaries is the information and referral/assistance network, which includes a range of entities responsible for making available and coordinating services for persons with a disability, older adults, and caretakers. Some of the primary functions for I&R/A specialists include identification and referral to available services in the community and information sharing. Entities involved in these networks include but are not limited to 211 centers -- area agencies on aging, 211 centers, centers for independent living, as well as aging and disability resource centers.

Each entity also offers different services ranging from providing a referral to essential supports to

options counseling. Services provided through I&R/A entities may also be operated through a no wrong door system in which state and local agencies coordinate to create a simplified process for people to access information, determine their eligibility, and provide one-on-one counseling on LTSS options.

One key issue is lack of training for and high turnover rates among information counselors, which are partly driven by low wages, similar to the HCBS workforce challenges. Some states have used ARPA funding to improve the availability for HCBS information for individuals by allocating funding specifically to their state's no wrong door system.

States are operating with limited capacity and resources, and state administrative staffing shortages may hinder efforts to establish more robust HCBS systems. Through our work, we heard that states can experience challenges, given the complexity associated with administering HCBS waiver programs.

States may provide HCBS via different waiver and state plan authorities. Their decision regarding their administrative approach can be driven by varying reporting

and renewal requirements, which can consume state resources. For example, states are subject to different requirements, such as for reporting for different waiver and state plan authorities. However, compared to HCBS state plan options, waivers give states enhanced flexibilities that may justify additional reporting requirements.

Through interviews with stakeholders and panels of experts, we identified various suggestions to streamline HCBS administration. They include aligning reporting requirements and renewal processes for waivers with those required for state plan options to decrease administrative requirements, and rethinking the design of HCBS programs to better align with beneficiary needs. For example, through use of ARPA funds, Minnesota launched a Waiver Reimagine Advisory Committee, which is supporting the second phase of the state's efforts to consolidate its four disability waiver programs, each associated with varying diagnoses and populations served, into two waivers with one set of eligibility requirements.

National experts and federal officials said that some income and resource eligibility criteria can deter

individuals from applying for home- and community-based services. In particular, we heard feedback on the medically needy pathway. Recent CMS rulemaking looks to address the institutional bias in the medically needy pathway by accounting for the projected expenses of individuals receiving HCBS when determining Medicaid eligibility for a given budget period. The proposed rule's intended to decrease Medicaid churn among institutionalized beneficiaries, decrease state administrative costs because of a projected decline in Medicaid churn, and improve outcomes with continuity of care.

Another area MACPAC explored was the concept of a core benefit as a mechanism to expand access to HCBS. MACPAC convened a roundtable in December of 2021 to discuss ways to streamline the HCBS benefit and increase access to community-based care where stakeholders also discussed the concept of a core benefit. To flesh out the roundtable discussion, we included questions on the core benefit in the interviews the Centers for Health Care Strategies conducted in 2020.

Overall interviewee responses were mixed on the idea of establishing a core benefit and its potential to

streamline access to HCBS. Interviewee considerations to operationalize a core benefit included workforce availability, the need for increased federal financial support, state capacity to enhance current infrastructure to accommodate new enrollees, and time to initiate the benefit.

Given the current challenges states are facing, including the unwinding of the continuous coverage requirement established under the public health emergency, and implementation of initiatives in state ARPA spending plans, introducing a core benefit, whether optional or mandatory, would be a significant change to the HCBS system.

MACPAC is committed to engaging in research and analysis to minimize barriers to HCBS access through exploration of a range of policy areas, not limited to the core benefit.

To summarize our chapter findings, beneficiaries may face challenges trying to access HCBS, given limited availability of providers and services, a lack of information and awareness of HCBS options, difficulties in navigating complex eligibility requirements, as well as

lengthy eligibility determinations that delay access to care, and waiver enrollment caps and waiting lists that may limit access to services.

States also encounter obstacles administering HCBS programs, primarily limited to staff capacity, worker shortages, and managing various authorities.

The Commission is committed to exploring ways to expand access to HCBS. In the coming year, we will work to identify policies that drive towards a more streamlined HCBS delivery system with increased access for beneficiaries and reduced administrative burden for states.

Using the HCBS access framework as a guide, we plan to explore a range of policy levers, including HCBS payment policies in response to workforce shortages, HCBS authority requirements and potential opportunities for streamlining, ARPA spending plan implementation, disparities in HCBS access, and eligibility policies.

Thank you for your time today and, we welcome any feedback the Commission may have on the draft chapter.

CHAIR BELLA: Thank you very much.

We'll open it up to Commissioners. Darin?

COMMISSIONER GORDON: Thank you for the chapter.

A lot of good information in here.

I think, as you go forward -- obviously I won't be a part of the Commission then. So this is just a suggestion. When you look at -- and I've seen this in a variety of companies that provide HCBS services -- we talked about the direct care workers, and you did talk about support, "direct support workers," I think is what they were referred to in here. I do think looking broadly at what's required to provide the services, not just the direct care workers. I think that's an obvious thing, but I think seeing also there's challenges with folks that do scheduling, that do training, that do oversight and compliance, and all those things are necessary and important.

Also, as you think about reimbursement going forward, you know, I think we've all had different experiences with care workers. I think one of the challenges -- and as we think about it in the context of folks being discharged directly from hospitals, for example -- is, you know, the way these direct care workers are paid for, it's fee-for-service. They don't have direct care workers sitting waiting for people who may need services.

And so there is a gap there between when they identify an individual who needs services, and then they have to go out and recruit someone and train them and do the background requirements for them. So there's a gap there, and so thinking about reimbursement more broadly and thinking about how, you know, you can think about HCBS, is there a way to build some kind of level of capacity, different ways to think about reimbursement, so you can reduce or eliminate some of that gap so that it is a more useful tool as part of -- you know, as you're thinking about discharge planning, you know, sending them home with these services?

The administrative capacity, well, you talked about it like the multiple authorities of waivers. I'm glad you brought that up. I mean, we had a personal experience with that, and I think it's not only true in managing the different programs, the different reporting, the different calls with CMS when you have multiple waivers, it was also an issue from a compliance perspective for us because you had all these different dates that different reports were supposed to be done and different updates to CMS would be done. And it's just hard -- you know, that's a hard thing to manage, and it wasn't because

of incompetency. It was unnecessarily complex waivers, and we did it to ourselves. We had too many waivers.

So I really appreciate the thought about streamlining because I get the requirement that would expect, you know, that states have to be accountable to CMS for what they're doing in these waivers and provide all that information. That's a given.

I do think there needs to be a pathway to make that easier so that that limited staff is working on, you know, other program enhancements, on their own oversight and compliance of, whether it's the health plans or the provider networks are working with, you know, area agencies on aging or sister agencies, so making sure that the amount of time isn't being consumed by a limited workforce just on pushing paper but allowing them the opportunity to do the other great work that's necessary to serve the populations that they oversee.

Thank you.

CHAIR BELLA: Thank you, Darin.

Martha?

COMMISSIONER CARTER: Thank you for this chapter.

To echo, I think, some of what Darin has said, I

was struck by the dizzying number of waivers and state authorities that constitute this program, and, you know, that translates to administrative burden and cost.

At the same time, you know, beneficiaries or potential beneficiaries are met with a dizzying array of what's possible for them, and I really urge us to think about this in terms of a whole-person care. The people who need these services are more than the sum of their waiver eligibilities.

We did see the example of at least one state that's trying to merge some of their waiver programs, and I think that's a goal. That should be a goal -- is to try to reduce the cost and the administrative burden and improve -- or decrease the complexity, improve the access by somehow looking at people as whole people and what they need. And it's a little shift from core benefit. It's like whole person. What does this person need?

Thank you.

CHAIR BELLA: Thank you, Martha.

Other comments? Heidi and then Dennis.

COMMISSIONER ALLEN: I really appreciated the chapter. I thought it covered so much, so well. I feel

like every time I read it, I relearn everything.

One thing that I thought, because it's always such an important thing to drive home how much it's cheaper to provide home- and community-based services and institutional care, and it also aligns with beneficiary preferences. In Figure 4.1 and in the part of the chapter where you talk about how costs are being redistributed across populations and you see that for people who are older and have disabilities and it's still at a higher institutional rate than home- and community-based services, I think just putting -- you could put a little bar there and see how many enrollees that represents. So I think that what you'll see is that the cost, which is on the bar, is high, and you see it towards institutional care, but that probably represents fewer people being served. And so just some way to put like a per-enrollee cost or per number of enrollees served for that amount of money, I think would be really helpful to kind of -- just another opportunity to kind of continually drive home.

We're always talking in MACPAC about, you know, where we can save money in the program and for things that we might be excited about having Medicaid do in the future,

and this is just such an obvious place where money savings are possible that I always want to make sure that we're highlighting that.

CHAIR BELLA: Thank you Heidi.

Dennis?

COMMISSIONER HEAPHY: I appreciate what Heidi just said about the per-person cost.

I also think it would be really helpful to root HCBS in a historical context of how it developed, because HCBS developed actually out of the civil rights movement, with folks with disabilities. And so HCBS is not just a medical service. It's actually about providing services to folks to help them realize their civil rights, and so I think that piece of it is really critical, and yet it's not part of the conversation. When we have, it becomes automatically like just a medical service. Much of what's provided by HCBS providers is non-medical services and support people in the community, so things like consumer choice, control, risk, those sorts of things.

I also think -- and this is something that is a mix of populations that receive HCBS is always so broad and the waivers are so different based on age of onset of the

disability, the diagnosis, rather than looking at -- rather than looking at the specific needs of the individual, the person-centered needs of the individual, and how might a movement away from diagnosis, a person-centered approach looks at ADL and IADL needs versus age of onset or type of disability might shape or reshape how dollars are spent, because there's so many waivers available for folks who are under 18. And then they sort of disappear for folks with onset, and then there's some that reappear when folks turn -- over 65. And so is there a way to look at HCBS more holistically, looking at the services required, instead of the diagnosis?

And I can share more with you, but I think it is important to contextualize HCBS within a larger framework of civil rights for onset and the ADA, that somehow the chapter has to be foundational.

And I think the last thing I'll say is that consumer voice in shaping HCBS is really important. Consumer voice is critically important, and family voice is very important. Also, we need to make sure that the voice of folks that are underrepresented are included with African American, LatinX, and other non-English-speaking

populations, and also populations and folks with substance disorder or mental health diagnosis, that those voices can also be underrepresented in the conversation about HCBS, because, in our society, there's such a moralization of substance use disorder, moralization of mental health, that I think it's important to again look at it and say how we ensure the voices of these populations are part of the conversation, and again, in particular, looking at racial and ethnic populations and how we make sure that those underrepresented voices are elevated in the conversation, because we really don't know what the gaps are.

And what little information is out there, it shows that there are disparities, and so I think that's -- yeah, that that's what I have to say for now, but thank you. Thanks for the chapter.

CHAIR BELLA: Thank you, Dennis.

Bill?

COMMISSIONER SCANLON: Yeah. I wanted to echo the sentiments that Dennis has just provided because I've long felt that we really misunderstand LTSS when we talk about it in medical terms. It's not about sort of curing a disease or maintaining sort of a certain status. It's

about how individuals with disabilities live their lives, and when we use words like "need" and "diagnosis," we get trapped into the medical frame mentality or framework.

And I think we really need to recognize preferences are the key here. It's how an individual wants to live their life with a disability, and as Dennis pointed out, age makes a huge difference. The expectations for someone at different stages of life with respect to age and a disability are incredibly different, and we need to be thinking about how do we appropriately support those variations.

This is something that I think is an incredible challenge in terms of a public program deciding sort of what is it that in terms of preferences that we need to recognize and support.

CHAIR BELLA: Thank you, Bill.

Other comments?

[No response.]

CHAIR BELLA: Well, I too would like to say thank you for the chapter and for the work. My request would be that we continue to be as concrete as possible when we're looking for ways to reduce administrative burden,

simplification, access for beneficiaries, and all of those categories, making it easier for people who are eligible and need the services, making it easier for states, making it easier on the workforce side, because I really feel like it's time for us in the next cycle to be making recommendations in this area. So to do so, we're going to need to be really concrete, drawing from all the work you've done and all the folks you've talked to.

I guess my request is kind of thinking ahead next year. I think it's aligned with where you guys would like to go. We'd really like to see us coming back with recommendations in these areas that pull together best practices, and I think those were going to be most successful if we can be very concrete about what those are and how we think it will solve these issues that ultimately will result in greater access for folks to get care at home or in the community.

Okay. You obviously got some good input. You see this is an area of great interest for us. Anything else either of you need?

MS. ALBAROUDI: I don't think so. Thank you so much.

CHAIR BELLA: Okay. Thank you very much.

I'll turn it over to Kisha to take us home.

VICE CHAIR DAVIS: All right. Our last panel of the day. I invite Lesley and Amy to come join us to talk about denials and appeals in managed care. They did an extensive set of interview findings that they're going to share with us today.

DENIALS AND APPEALS IN MANAGED CARE: INTERVIEW FINDINGS

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

Today Amy and I will discuss ongoing work related to denials and appeals in Medicaid managed care.

We'll start with a brief reminder of our project work plan and timeline. We'll then give a condensed refresher on the relevant federal Medicaid requirements, both for managed care plans and states, regarding denials and appeals. Lastly, we will detail our key findings and discuss next steps in our work.

This work covers three main policy questions listed here. Namely, how do denial and appeal processes ensure that beneficiaries have access to medically

necessary care? How do states and CMS monitor and oversee denials and appeals in managed care? And do beneficiaries find the appeals process to be accessible?

In January, Amy and I presented the findings of our literature review, federal policy review, and state scan to help answer these first two policy questions. Today we will discuss the findings from our state and stakeholder interviews pertaining to the same two policy questions.

We've contracted with Mathematica to conduct beneficiary focus groups in order to better understand the last policy question regarding the accessibility of the appeals process. We will return in September with those findings.

In January, Amy and I detailed the relevant federal Medicaid requirements for states and managed care plans. The following slides represent a condensed overview to serve as a reminder of these requirements.

Federal rules allow managed care plans to limit or deny services to beneficiaries based on medical necessity or utilization management tools, including prior authorization. MCOs may apply these medical necessity

criteria to ensure that beneficiaries are receiving care that is covered, appropriate, and necessary.

Federal rules do place some restrictions around these tools. At a high level, services must be no less than the amount, duration, and scope for the same services offered under fee-for-service, and MCOs cannot arbitrarily deny a service based solely on illness.

When an MCO denies care, they must provide a notice explaining the denial to the beneficiary. Following a denial, beneficiaries have a right, written in statute, to appeal that decision with the managed care plan. If a previously authorized service is reduced or terminated, beneficiaries have a right to request to continue to receive services throughout the appeals and state fair hearing processes.

MCOs must maintain an internal system for reviewing appeals and issuing decisions. Federal rules detail the requirements for both the service authorization and appeals processes, including on timelines, specifics on the process, and areas for state flexibility.

For example, under federal rules, MCOs must resolve appeals in no more than 30 days. However, states

may impose shorter review time frames if they choose.

This graphic displays the appeals process at a high level. The process starts when a service is denied and the beneficiary receives the denial notice from the MCO. The beneficiary then has up to 60 days to appeal this denial, and they can file the appeal either orally or in writing. The MCO has up to 30 days to review the appeal or 72 hours in urgent cases. The MCO must ensure that the person reviewing the appeal is different from the individual who first denied the service, and they must have the relevant clinical expertise.

Then the beneficiary is notified of the plan decision. If the MCO reverses the decision, they must authorize that service within 72 hours. If the MCO upholds the denial, the beneficiary can choose to request a state fair hearing, and they have up to 90 days to request this hearing. The state schedules the hearing, and a final decision must be given within 90 days.

The federal requirements around monitoring and oversight are roughly split into responsibilities for three parties: states, external quality review organizations, and the federal government.

States are required to collect and monitor data related to appeals. These data are submitted by plans to the state at regular intervals. Notably, states are not required to monitor denials or the reasons for denial.

States contract with external quality review organizations to conduct oversight of managed care plans. These reviews are largely focused on compliance with federal requirements, although some states contract their EQRO to perform optional activities, such as a focused report on denials.

CMS now collects appeals annually through the Managed Care Program Annual Report, or MCPAR. The reporting template includes the number and type of appeals, the service type of appeals, the number of state fair hearings and their outcomes, and the number of external medical reviews. The MCPAR template excludes any reporting on the outcome of appeals.

I'll now pass it along to Amy to review our study approach, interview findings, and next steps.

* MS. ZETTLE: Thanks, Lesley.

So for this interview project, we had two main objectives. First was to understand whether denial and

appeals processes ensure beneficiary access to covered medically necessary care, and secondly, we wanted to examine how state and federal officials monitor these processes.

We conducted over 25 interviews and spoke with Medicaid officials across five states. Using the information from our state scan, we selected states with a range of monitoring approaches. We spoke with some states that had detailed reporting requirements related to denials and with one state that currently does not require reporting on denials. Three of the states publicly report information related to denials and appeals and two did not.

In addition, we interviewed MCOs, providers, beneficiary groups, EQROs, national experts, and officials at CMS.

We tried to gather a range of perspectives across each of the stakeholder groups. So, for example, we spoke with a nonprofit community health plan, and we also spoke with national for-profit plans. We spoke with individual providers. We also spoke with large hospital systems.

So our interview findings focus on three major areas: the denial process, the appeals process, and then

the efforts to oversee these processes.

So first, we'll start with authorization denials and their notices. As Lesley explained, when an MCO denies a service or limits a service, they must notify the beneficiary of that decision. In our interviews, beneficiary advocates and providers shared that the notices can be lengthy and lack some critical information. The MCOs we interviewed shared that these notices can be challenging to draft at the appropriate reading level, especially since MCOs are often required to include regulatory citations. And while the notices must include the reason for the denial, many stakeholders were concerned that the reasons were not detailed. For example, notices may say that the denial is due to lack of medical necessity without explaining why that request doesn't meet that specific standard to determine medical necessity.

Relatedly, many interviewees shared that a common reason for denials is that the request is missing supporting documentation. So in order to demonstrate medical necessity, clinical information needs to be provided, and without that required documentation, the MCO may deny for lack of medical necessity.

Lastly, we heard from many stakeholders that the time frame for denial can be lengthy, up to 14 days for an MCO to make the decision. These stakeholders noted that this timeline ultimately delays the ability for that beneficiary to appeal, leaving the beneficiary without services for longer than necessary.

MCOs had mixed views on the timeline to authorize services. Some thought that they could meet shorter timelines if needed, and in fact, across many states, they do. And others thought that too short of a timeline could lead to more denials.

Now we'll share findings on the appeals process, which are focused around three discrete areas. First, generally, stakeholders thought that the time given for beneficiaries to file an appeal, 60 days, was appropriate. However, there was concern that the timeline for a beneficiary to request a continuation of benefits may not be sufficient.

So if a beneficiary was previously authorized services and then they are terminated, reduced, or suspended, that beneficiary can request to continue receiving those services throughout the appeals process.

For example a child with special health needs could receive a denial letter that their private-duty nursing hours are being reduced from, let's say, 40 hours. While the parents appeal this denial, they can continue to receive their private-duty nursing at that level as they go through the process to appeal.

However, beneficiaries must file this request within 10 days or by the time the service authorization expires. Beneficiary advocates shared that by the time the beneficiary receives and opens the mail, they're often well into that 10-day window to request the services.

Next, we heard about the important role of external support in the appeals process. First, across all interviews, there was broad agreement that providers play a key role in this process. They also receive the denial notice, and they can help beneficiaries either by filing on their behalf for an appeal or providing that additional support and clinical documentation.

In addition, beneficiaries may seek help from disease groups, legal advocacy groups, or family members who can help them navigate this process.

Lastly, some stakeholders expressed concern about

potential conflicts of interest with MCOs handling appeals. For some stakeholders, it was their perception that beneficiaries may be intimidated to initiate an appeal with the same organization that had denied their initial request. Several stakeholders also provided examples of managed care service representatives dissuading beneficiaries from filing an appeal or requesting a continuation of benefits.

In one state, a nurse practitioner employed by the state Medicaid agency is involved throughout the appeals process, and this may bring some impartiality to the appeal.

MCO interviewees shared that they hold extensive staff trainings to ensure internal consistency in handling appeals, and that they also closely monitor trends to identify potential compliance issues and address them.

So next, we'll share some key findings on monitoring and oversight of denials and appeals. First, we learned that states monitor denials and appeals to identify potential access issues. So states noted that some level of denials are going to be appropriate, and it's going to show that the MCO is appropriately denying medical services

that maybe aren't covered or weren't medically necessary in the first place. But by monitoring denials, it allows them to look for any changes from the trends that could signal a potential issue, and then they can address it.

Another state discussed how they closely examine appeal outcomes. They emphasized that they investigate all overturned appeals to determine if there was an issue up front with the authorization process that resulted in the inappropriate denial. This state indicates that the overturned appeals really cause concern for them because often many beneficiaries may be receiving similar denials but not appealing to get the service.

And as a reminder, states that are monitoring denial trends are not required to do so by federal rules. They're electing to do so as part of their overall monitoring process.

And in our state scan, which we presented on in January, we showed that about half of the states are currently looking at denials.

Similarly, while states are required to collect and monitor appeals data, they do not have to specifically look at that appeal outcome, so whether an appeal was

overturned or not, though some do elect to do so.

While some states are looking at denial trends, there are limited examples of states that are actually auditing a denial to see whether it was clinically appropriate. In our interviews, states did express interest in moving toward this type of audit in addition to their existing monitoring efforts around reviewing trends and relying on the compliance reviews from the EQROs.

We also asked about efforts to monitor whether beneficiaries are exercising their right to request the continuation of benefits while they're appealing a denial, and there were not any specific efforts shared to monitor this. Some states did indicate that they have regular conversations with beneficiaries and advocates, and this hasn't come up as a concern.

Lastly, states had mixed views on the value of publicly reporting data related to denials and appeals. As we shared in January, there's limited public reporting on denials and appeals in Medicaid managed care, and the states that do report this information, it tends to vary pretty significantly in what they're reporting and how they report it.

So some states viewed public reporting as an important tool in transparency for the beneficiaries and also in accountability for their managed care program and for their organizations. Another state official thought that the public data is largely being unused or viewed by beneficiaries.

So next, we are continuing our work on this topic, and over the next few months, we will be working to conduct focus groups with beneficiaries who have experienced a denial and have appealed.

So the goal of these focus groups is really to better understand the experience of a beneficiary in navigating the appeals process, and we expect that these conversations will offer additional insights but also offer greater nuance to some of the findings that we presented here today.

We will present the findings of these focus groups in the fall, and we'll also share draft policy options that will build off of the findings from the state scan, the interviews, and the focus groups. And this is all working toward a March 2024 chapter.

So for today's discussion, we look forward to

hearing your feedback on this work and would appreciate your input if there are specific areas where you would like to see work done on policy options for the fall.

We will leave this slide up, which is a summary of the interview findings, and hopefully, it will help guide the conversation. And I'll turn it back over to you, Kisha.

VICE CHAIR DAVIS: All right. Thank you both. Thank you especially for the extensive, in-depth interviews, really looking at the breadth and depth of that, and we look forward to hearing from the beneficiary experience back in the fall -- or the rest of the Commission does.

One thing just to kind of guide our thoughts, they're looking for us to help kind of narrow the field. So rather than saying we want to focus on all of these things, which is what we tend to say, if there are some of these policy areas that we think need to have special emphasis or one more than another or a certain order that we might want to take them in.

And I will turn to Heidi first for comments.

COMMISSIONER ALLEN: Right after you told me I'm

supposed to narrow. I want somebody else to go first so that that could have been forgotten by me by the time it came to me.

So I have a couple of things, that I think this work is so important, and I'm really glad that we're taking a systematic approach to thinking about it.

And one of the things that I've been thinking through is how different Medicaid is in private insurance in terms of who's on the hook for care that has been provided but is determined to not be medically necessary or denied, and in the case of Medicaid, I think that's the provider. In the case of private insurance, I think it's the consumer. And so I think that considering the provider's perspective on this is really important, since this may be a significant reason why providers don't want to work with Medicaid is if they end up providing care that they're not reimbursed for, and so I'm wondering if there's a way that we can think about that.

ProPublica produced a report on March 23rd that I think is really important for us to be thinking about when we're thinking about denials and appeals, and that's that Cigna was using an AI algorithm to do mass denials. They

gave an example of one provider in one month denying 60,586 procedures, and that physicians were able to make these denials without ever opening the case. And they were spending, on average, 1.2 seconds per denial. Medicaid managed care does not operate in a vacuum, and I would be very interested to know if managed care companies and Medicaid are using any of these automated processes, because we know that appeals are only 2 percent -- or less than 2 percent, I think. So that just tells me that if we just focus on appeals, we're really going to be missing a huge part of what's happening, and that we really do need to be thinking carefully about denials.

Medicaid recipients, the way that I imagine this playing out -- and I'd be interested to learn more, but I imagine that the provider who was providing the care is like, "Okay. Well, I'm no longer going to provide the care," but the consumer is not at all empowered to try to go through the process of the appeals and to get the information that they would need to provide that. And I'm not sure how often the providers are doing that on their behalf or why providers don't do that on their behalf, and so I'd be really interested in learning that specifically.

VICE CHAIR DAVIS: Thank you, Heidi.

Darin, then Martha, then Sonja. I've also got Angelo and Tricia.

COMMISSIONER GORDON: Yeah, narrowing is going to be a bit of a challenge, and part of that -- I think one of the comments that Heidi was making is similar to my thought process -- is I think you have to understand the prior authorization process before you jump into denials, because I do think understanding really how that works, I think, is going to be a benefit to everyone as they're looking at this.

But also, if I were to narrow, I'd look at the monitoring and oversight aspect of it, and I would look at it more broadly than some of the feedback you all received. So look at some of the accreditation agencies and what they do, and NCQA being one of those, looking at utilization management, and certifications where they do look at are you following clinical evidence and making these decisions. Are the people making the decisions at the right level? In other words, are you having a specialist review something that they're best suited to be reviewing versus having someone that may be a general practitioner reviewing it?

I think understanding that, I think, will give a clearer picture, because I do think if you say, well, they didn't use their EQRO to do this, that they may have another source or an avenue in which they're leaning on that to give them some confidence and how that process is playing out and being followed. But again, just front end, helping everyone understand how that process really works and then looking at oversight and in a broader context than just EQROs in states.

Thank you.

VICE CHAIR DAVIS: Thank you, Darin.

Martha?

COMMISSIONER CARTER: As my colleagues have said, narrowing is a little bit of a challenge here.

Two points. One is the amount of clinician time that is taken up in dealing with some of these appeals and sometimes even the prior auth, and that translates to less availability just to provide patient care. That's not only the backend staff, the billing staff, the whole cadre of people you have that are doing prior auths, but then when it gets to the point that the clinician has to get involved, it's taken away from patient care. So I think

that's a problem, and I don't have a solution. But I think we need to highlight that.

The other comment is just to comment and again just to sort of point it out that some of these prior auths are denied because there's a step process that has to happen, but because of our fragmented system, that step process actually already happened in a different MCO, in a different -- you know, they were uninsured, whatever. Whatever clinical step had to happen, it actually has happened, but there's this whole process of proving that it happened. And I know that was something that we had to go through in my health center. Again, it's just waste and cost, and so sort of teasing out what's really important in this prior auth process and what is just extraneous duplication and waste and further fragmentation of our system and figuring out how to separate those and keep the good and move away from the bad.

Thanks.

VICE CHAIR DAVIS: Thank you Martha.

Sonja?

COMMISSIONER BJORK: Thank you. I wanted to emphasize Darin's point about looking at NCQA because many

managed care organizations have that accreditation or are seeking it, and in California, it's a requirement now for all of the Medi-Cal managed care plans. They have very specific instructions about, for example, the denial letters.

I'll just read what the requirement is, "as appropriately written, notification includes a complete explanation of the grounds for the denial in language that a layperson would understand." My goodness, is that challenging? Because everyone's balancing trying to use layperson language at a certain reading level but also give the specificity that is required in order to truly explain what happened, and then in addition, the regulatory language that is required.

So at the health plan I work at, we had to have a lot of practice sessions with the physicians, because they'll write their explanation and then the lay people have to look at it and say, "But that's still not simple enough," and so we had to have a lot of education and training to get staff in the habit of writing in that way.

So I'm curious if an agency has NCQA accreditation, if you did any comparison to those that

don't, and did the notices indeed turn out to be better if they're trying to live up to the NCQA accreditation. So I'm just wondering if that makes a difference.

And then regarding monitoring and oversight, if an agency gets NCQA accreditation, they have to have a very intense audit every three years, or more frequently if they didn't do very well, and that's on top of an annual audit by the state agency. So that's two chances to take samples of denials and look into the cases and see if they were done well and according to all of the rules.

And then, finally, I wanted to bring up a challenge about members who have dual coverage. Sometimes that adds a whole other level of complexity and really hard, hard things for the members to understand whether it was Medicare or whether they have some kind of partial commercial coverage that does or doesn't cover the item at hand.

So an example is DME. A commercial agency may have issued a denial or they took their time or they went through their process. Then it comes to the payer of last resort, Medi-Cal, and it starts over. You need evidence that the primary insurance did their job and went through

the UM process. So that, I'm sure, is very baffling to the customer who's waiting and frustrating. They call one insurance agency, "Oh yes, we're in process." They call the other, their Medi-Cal managed care plan. So that's where care coordination staff can step in and help. So if there's possibility of looking into best practices about that, I think that would be helpful.

Thank you.

MS. ZETTLE: And I can answer the second question about denial notices and whether they had NCQA accreditation. I believe most of the states that we looked at required NCQA accreditation. We were only able to gather a small sample of actual redacted denial notices. We are hoping that in the focus group process that maybe people will feel comfortable sharing that.

We have model notices, of course, but it is different when you actually see the template filled out, and it makes its way to the individuals.

So we weren't able to do a comparison of if it was NCQA-accredited and whether it was -- and I don't even know if we would really have the expertise to determine whether or not it was appropriate or not or well done.

But I did just want to note that EQROs do also look at that as well. NCQA does too. And the specifications or requirements, we were looking through them the other day. It's a little different, but they both -- so in every state, that should be happening. So I just wanted to clarify that.

The other thing that NCQA in our understanding of looking through their documents and interviews we've had with EQROs and them and everyone, the clinical appropriateness, so whether or not the denial up front was clinically appropriate based on the guidelines used, is not something that is being done across the board. So either from the EQRO or in the accreditation process, it's something that folks are interested in, but it isn't something that is being done through that process. So I just wanted to clarify that too.

COMMISSIONER BJORK: And I also wanted to mention how important strict language and interpreter requirements are. It can be hard to get a document translated into a not-very-common language, but it has to happen, because otherwise the person will have no idea what is going on. So I think that it's very good to have those be clear,

clearly stated, not just in the languages of the most commonly -- or the most commonly spoken languages, but even for ones that are uncommon, having a system ready to get those translated and still be timely.

VICE CHAIR DAVIS: Thank you, Sonja.

Angelo?

COMMISSIONER GIARDINO: Thank you. This was really important work.

A couple comments I would make. I guess I'd love to learn a little bit more around the value of not being transparent. So what is the programmatic value to a program not reporting on denials and appeals? From a quality improvement perspective, if there's something important, you measure it, and you also measure the balancing measure. So if you're denying and then appealing, the overturn rate, that to me seems fundamentally important to do, and I can't think of a good reason not, for an MCO not to say how many denials they have and then how many of those denials are appealed and then how many are overturned. That one to me, I think there's more work to be done at the value of not reporting denials and appeals.

And then, of course, all denials and appeals aren't the same. So there's really different processes around benefit denials versus medical necessity, and I think we should really be precise on that, because if it's a benefit denial, it's a benefit denial. So you didn't have coverage for that as opposed to a medical necessity thing where you might.

And then just to pick up on Martha's point, we talk a lot about the beneficiaries doing the appeal process, but the provider is part of this almost always. And those letters of medical necessity are two to three pages sometimes, and they require the submission of evidence. You have to kind of do a PubMed search and download an article and send it to the medical director at the MCO. So we should be looking at the burden to the provider, which is uncompensated.

And then I guess I would like to just highlight that all the MCOs I've ever worked with have a retroactive denial process that I think we should look into, because that's a backend way of clawing dollars back after the care has been delivered. And I don't think we should ignore the burden to providers of retroactive or retrospective denial,

and that is part of the UM process.

And then, finally, If there are any ways of doing an analysis around the ownership of the plan -- so I can just -- I'll just be clear about my bias. Provider-sponsored HMOs tend to deny less and overturn appeals more, and investor-owned plans tend to deny a lot and not overturn appeals a lot. Now, that's my bias. So data could counter that, and then I might change my mind if there's evidence.

But I think ownership is something that really speaks to why you need transparency, because states have different approaches to who they contract with, and the provider-sponsored plans tend to have a much more beneficiary-centric approach to care.

So I just throw those out there. Thank you.

VICE CHAIR DAVIS: Thanks, Angelo.

Tricia?

COMMISSIONER BROOKS: I just want to get something up here.

I want to agree with Darin here. We need to go upstream before we get to the denial piece, and of course, there was a proposed rule on prior authorization, and

that's going to be finalized soon. So it's going to be interesting to see what impact that had.

The Kaiser Family Foundation did an examination -- pardon me while I try to get this back up so I can get it right -- of Medicare Advantage, and they found that only 11 percent of 2 million prior authorization denials were appealed, and the vast majority of 2 percent were overturned, which suggests that perhaps they shouldn't have been denied to begin with. So I think we have to be really mindful of are we setting up a system that just is creating administrative barriers to getting care,

But I do believe that we need more data. We do need denial numbers, not just appeal numbers. We need the appeal outcomes as well so that we really do have a sense of the significance of the problem.

It also seems like we should do more work to identify the extent to which standardized denial notices across all plans in a state will help, help providers in particular, help beneficiaries understand as well as whether there are standardized medical necessity definitions, because if a provider has -- is a provider for eight plans and they all have a different definition of

medical necessity, it makes it extremely difficult for the provider to determine, because the provider is not sitting there going, oh, you're in Cigna, oh, you're in whatever other plan you're in. And I have to think differently about how I prepare this information so I can get the prior authorization.

So I really think we've got to go upstream before we start to focus just in on the denials, because I don't know that we'll get where we need to get in the long run.

VICE CHAIR DAVIS: Thank you, Tricia.

We've got Jenny, then Dennis, Kathy, and then Fred.

COMMISSIONER GERSTORFF: So I want to carry forward the theme that Heidi and Darin and Tricia mentioned as far as the tools that MCOs are using for prior authorization and things that are leading to denials. I think we know that MCOs rely on all kinds of different tools that contribute to these decisions that are using predictive analytics, machine learning algorithms, and there's been a lot of research in the bias that is inherent in a lot of those tools.

Dr. Ziad Obermeyer has done a lot of research in

particular that I think bringing that into the conversation, understanding maybe what NCQA might be doing with that research team, and if there's anything that -- any kind of tools or reporting that would be useful to states on understanding specifically which tools are being used by plans and how they've been assessed for bias that might be inherent in them or how companies are working to correct for that bias.

VICE CHAIR DAVIS: Thank you, Jenny.

Dennis.

[Pause.]

VICE CHAIR DAVIS: We can't hear you, Dennis.

Is he unmuted?

COMMISSIONER HEAPHY: I'm sorry.

I want to just echo some of the things that were said and say that if an MCO is using automated proprietary processes in making decisions, that by virtue being proprietary, the beneficiary or the provider don't have access to the information they need to actually mount an adequate and appropriate appeal. And so the whole proprietary automated piece of it really is so filled with conflict that something needs to be done about.

In addition to -- we need -- we definitely need more monitoring, oversight by state Medicaid offices. I think there's got to be some way of helping them, the officers strengthen their ability to actually provide the oversight that they need of the MCOs.

In Massachusetts for dual eligibles, we worked with the state implementation counselor. It's basically the consumer counselor works with the state and plans, created a letter, a simplified, unified letter to support plain language in denials and approvals. And so I'd recommend looking at that. It's actually with CMS right now, and CMS is getting feedback to see whether this is something other states can use as well.

There's other things I want to say too, but I think what -- so much of what Angelo said was just so spot -- was just so spot on, and I think I said this earlier. With using diagnosis rather than need as a criteria and deny people who actually can benefit from medically necessary service or piece of DME, that we need to really look at how diagnosis is being used and may actually harm people and lead to increased cost than if they had been provided the service, it would have reduced cost and

improve the person's quality of life.

And that's it. So thanks.

VICE CHAIR DAVIS: Thank you, Dennis.

We'll go to Fred.

COMMISSIONER CERISE: Most of my comments, Angelo did a good job with.

I would just -- so I think the monitoring and public reporting is a good thing. The fact that half the states monitor that, it seems that there's a real opportunity there.

I would just caution on that, that we have to be clear or as clear as possible on what metrics we choose and we choose to publish, because different people will interpret that differently. I've met with legislators who think denials is a good thing because you're managing the population, and so if you're not having denials, then you're not managing costs, which there's some truth to that. But what's the right amount of denials? Who knows? But reporting that in some standardized fashion, so volume would be important and then the other percent appealed and the percent overturned and to try to paint a picture if there are games being played.

Plans may automate their denials. Then the providers are going to automate their appeals, and we all can escalate automation, and not a penny of that is going to taking care of patients, and so I would just be -- try to be careful in the metrics that we would recommend, that they really as accurately as possible can point you to if there's a problem.

And then all of this speaks to the need for a better payment system. This is ridiculous. The hoops we go through to try to manage costs and more value-based or population-based payments where you can calculate what a population ought to cost and have the providers do that and get away from these individual payment decisions and challenges is just such a much better place to be, but I know that's beyond the scope of this discussion.

VICE CHAIR DAVIS: Thank you, Fred.

Go ahead, Darin.

COMMISSIONER GORDON: I just want to broaden our thinking a little bit on denials as being only something -- the cost down, because some of the denials we've seen -- and I've seen this, personal experience, with family members. Actually, the recommendation was that the

evidence was for a more costly intervention than what was actually being proposed.

So I think we can't always assume that the denial is only because we're trying to say we want you to save money, because it is based on what the latest medical evidence is, and I've seen them. I had that experience in Tennessee.

So I think we just need to understand that it -- and I don't want to just paint it in a singular context. Let's just have a broader thinking about denials, maybe more than just a utilization control to not spend money. I don't think that's a fair and accurate way to view these.

VICE CHAIR DAVIS: Thank you, Darin.

So I think we maybe weren't so successful in narrowing the field. We failed. We failed at that.

Go ahead, Heidi.

And, Dennis, is your hand still up from before? Did you have an additional comment?

COMMISSIONER HEAPHY: I have another comment.

VICE CHAIR DAVIS: Okay. I'll put you after Heidi.

COMMISSIONER ALLEN: So I just kind of wanted to

respond to that because I think that I don't -- I mean, do we believe that it's the role of managed care to say, no, I'm going to deny this because I think it should be a more expensive -- like are they really -- is that an appropriate oversight to have somebody who doesn't know the patient and is only looking at a claim to say I'm going to deny it? And is there any evidence to suggest that they would be then responding with, no, we think you should do this more intensive or expensive -- I mean, I just don't know that I've ever heard of that happening.

COMMISSIONER GORDON: That's why I'm saying look at that because I've had the personal experience and I've seen the data.

So I do think if we -- this goes back to why we're going to go upstream and look at what is the process here for doing prior authorization, and what is it that they're looking at? They are looking at the latest evidence.

I was in federal court talking about this very issue about there was good evidence back then that the latest medical evidence doesn't make it to the physician, frontline physician, and get into practice, as we all think

it does or that we would hope that it does.

One of the things that prior authorization is required to is based -- and all our denials had tied back to what is the evidence, what are you denying, and what are you saying in turn should be covered if you're saying this isn't the thing that the medical evidence supports.

I don't know if everyone has that level of sophistication and how they've done that, but as Bob knows, we went through decades of litigation to improve that whole system, make sure that it is based on something that is credible, that we can audit it. Now we see it, and we did see them suggesting things because the medical evidence said it wasn't the appropriate thing.

So I just think we got to be careful to default and just assume, do a little digging, look at the process. What is that based on? And I think that will help make a more informed policy recommendation, to the extent the Commission gets there.

VICE CHAIR DAVIS: Thank you both.

We'll go back to you, Dennis.

COMMISSIONER HEAPHY: Well, I think we look a lot at -- we look at a lot of denials, and we look at a lot of

approvals, but don't spend enough time looking at modifications, because a lot of plans can post that they've got the highest approval rate or low denial rates. And yet if you look and see, access to services are actually being trimmed down when there's like personal care attendant services. With people's personal care attendant services, it says on the letter approved. But you flip the page, and it says it's been modified. So the person sees that it was approved, and then actually when you look at underneath the surface, it was actually modified. A lot of the same thing with a lot of other services. The medical equipment, same thing where, yes, we're happy to say that you've been approved for the piece of equipment you requested, but actually, aspects of that DME were not approved. They're actually denied as part of a modification. But when one looks at the document, it's been approved. That's a really big issue.

In terms of transparency, this is also in terms of consumer choice and looking at different plans if they want, they may want to join. They're being able look at the approval -- or actually, not approval -- look at the overturning of appeals is really helpful. So if a plan has

got a high percentage of overturn of appeals, then that may actually determine whether or not the person wants to join that plan, because it may mean that a plan that has much lower level of overturn of appeals is actually -- potentially more straightforward with how they actually make the approval process.

So I do think from a transparency perspective and enabling beneficiaries to make informed choice, which MCOs they join, that it's important that have transparency in these areas.

VICE CHAIR DAVIS: Thank you, Dennis. Very important comments.

Just as we wrap, I did -- we pulled on a lot of threads, but I think there was a lot of support for monitoring and oversight in that process as a way that we can really explore a little bit deeper.

One thing I'll add for the Commission to explore and information to bring back, I do think it's important for us to better understand this prior authorization process, to understand how is it that we got here, what are the benefits to it. As a physician in that relationship with a patient, that I was often frustrated by prior

authorizations and the hoops, as Fred said, the hoops that we had to jump through to take care of patients.

But each system is created to create the outcomes that it has, and so we've gotten here for a certain reason. And I think before we tear down the process, we need to understand a little bit more of how it is that we got here. What are the benefits of prior authorization? How is it really curbing costs as we are looking at creating that additional oversight for the program?

So we've given you a lot. I hate to ask. Is there anything else that you need from the Commission?

MS. BASEMAN: No. This was helpful.

Are you good?

VICE CHAIR DAVIS: Oh, Sonja.

COMMISSIONER BJORK: How does the work that we're doing right now dovetail with the rule that's about to be released? Are you just going to -- I know it's like context, but what about the timing of our work compared to the rule?

MS. ZETTLE: The interoperability and prior auth rule?

COMMISSIONER BJORK: Yes.

MS. ZETTLE: Yeah. So that was released -- the proposal was released in late December. So that does sort of focus more on the upstream. That's more about timelines related to prior auth -- actually to back up, the bulk of that rule is the platform and the systems around prior authorization, which is definitely not something that we are touching on in this project.

Where there is overlap is kind of two areas, where one is they do propose that based on kind of requiring these new systems, that then that should allow for a shorter authorization period. So instead of 14 days, it should be 7 days. And again, this is a proposal.

The second area where I think there's some overlap with some of our findings was that under that rule, payers, so not just Medicaid MCOs but all payers, or the payers in the exchanges, plans, and MA plans and MCOs, will need to post publicly on their websites, the denial rates. These are really aggregate levels, so not by service. So it's a little different than I think what we've been looking at when thinking about denial rates. But there is a transparency requirement there too.

So a little bit of overlap, but I would say more

on the margins. It was a pretty hefty rule.

VICE CHAIR DAVIS: Yeah, Martha.

COMMISSIONER CARTER: In that proposed rule, there was a creation, I think, of a gold card -- is that the term? -- where providers who had a consistent high level of approval of their prior auth requests got streamlined approvals. It would be interesting to dig into that just a little bit, talk to -- I think that's been in effect somewhere, because I think I heard -- yeah? Yeah. So just sort -- how's that working? I don't know if the rest of the Commission is interested in that, but I would be. I'll listen in.

VICE CHAIR DAVIS: You'll listen in for that meeting?

Rhonda put some comments on the chat, but I'd actually encourage you to speak those out loud so we have them for the record.

COMMISSIONER MEDOWS: I apologize. I don't have enough bandwidth apparently for audio and visual. All I put in the chat was my support for looking into prior auth, what it's doing, what it's able to achieve, and where it may be either a benefit or a barrier.

And then for the appeals process, looking further into that as well and monitoring it and distinguishing between the types of appeals, whether denials occur because there's a lack of documentation, a lack of follow-up evidence, or missing data as opposed to a clinical dispute between the provider taking care of the patient and the health plan medical director, that type of thing.

And then I think it's also important to look at the overturn rates for the same.

So kind of what I think partially what Darin was talking about, but overall a really interesting area to dig further into. So thanks.

VICE CHAIR DAVIS: Thank you, Rhonda.

One last look?

[No response.]

VICE CHAIR DAVIS: All right. Thank you, Lesley and Amy.

I think we'll go to public comment.

CHAIR BELLA: Never have we had such an exciting Friday last session, so thank you both.

We're going to open it up to public comments. I see at least one hand. Just to remind folks who would like

to speak, please introduce yourself, who you represent, and limit your comments to three minutes or less, please.

I see Charles. You should be good to go, Charles.

PUBLIC COMMENT

* MR. BRUNER: Well, thank you very much.

I'm Charles Bruner, and for the last six years, I have managed a Child Health Transformation Initiative funded by the Robert Wood Johnson Foundation. It involves a network of 45 national health and child health and advocacy organizations and a 50-member child health equity leadership group.

We came to three major conclusions of particular relevance to MACPAC. First, the child health system can contribute to rectifying health inequities in improving population of health but only if the health system places its major emphasis upon children and their healthy development.

Second, there is a legion of evidence-based practices that have shown the value of doing so. These involve more preventive, developmental, whole-child life course, and relational primary health care, and are

recognized nationally as what should become the standard of care in the AAP principles of a pediatric medical home, in Bright Futures, and in the Medicaid EPSDT benefit. However, these are not now being financed and diffused by the health care system to become the standard of care.

Third, while Medicaid and CHIP represent the primary health care payer for children and serve three-quarters of all children most vulnerable to poor health outcomes, Medicaid in most states simply does not recognize the value of nor support such evidence-based practices in its financing. Medicaid and its coverage of children must lead in doing so if the health system is to fulfill its roles in health equity, population health, and value-based care.

To elaborate just a little on the current situation, children represent over half the population on Medicaid and CHIP, and children are the most diverse and most vulnerable part of the population from a health equity perspective. They represent, however, only about 20 percent of all Medicaid spending. Most of the current attention on health care reforms and on Medicaid, particularly in the so-called "value-based payment

systems," fundamentally is about cost containment and health cost reduction and focuses primarily upon adults and persons with existing infirmities and disabilities.

The population with the greatest potential to improve health and rectify health inequities is the child population, and they require a value-based investment approach and not a value-confined cost containment one.

In 2022, MACPAC presented an important message to Congress on the need for Medicaid and CHIP to address issues of health equity, but this only touched upon the role of child health, as the paper I provided describes. MACPAC can play an important role to advance health equity in population health through Medicaid in developing a follow-up, child-specific health equity chapter in a report to Congress, and I recommend that MACPAC do so.

Thank you.

CHAIR BELLA: Charles, thank you for your comments and for sharing the paper. It was circulated to the Commissioners.

Anyone else who would like to comment today?

[No response.]

CHAIR BELLA: Any last words from Commissioners?

[No response.]

CHAIR BELLA: Kate, anything?

EXECUTIVE DIRECTOR MASSEY: No.

CHAIR BELLA: Well, it's always hard at the last meeting when we know that some folks have satisfied their term. I just want to say thank you again to Darin, Bill, Fred, Kisha, and Martha for your service. Even if you won't be back, you say you will be back. It's in your blood.

And thank you, everybody. Thank you to the MACPAC team. We are adjourned. Thank you all.

* [Whereupon, at 11:39 a.m., the meeting was adjourned.]