PUBLIC SESSION

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Thursday, September 21, 2023
10:30 a.m.

COMMISSIONERS PRESENT:

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TRICIA BROOKS, MBA
ROBERT DUNCAN, MBA
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AGENDA PAGE

P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Welcome everyone to kicking off our work cycle for MACPAC this year.

We are going to start with a panel on appeals and denials, which is a continuation of our work. So Lesley and Amy, we'll let you take it. Welcome.

MONITORING AND OVERSIGHT OF MANAGED CARE DENIALS AND APPEALS

* MS. BASEMAN: Thank you, Melanie. Good morning, Commissioners.

Today, Amy and I are here to discuss policy options for monitoring and oversight of denials and appeals in Medicaid managed care.

We'll first start with a brief project overview. We'll then detail the key challenges of monitoring, oversight, and transparency, and present policy options designed to address these challenges.

We will then discuss some additional considerations regarding the state's role in monitoring and oversight, and lastly, touch upon next steps.

As a reminder, this work focused on three key

objectives, namely to examine whether denial and appeal processes --

[Audio feedback.]

[Pause.]

MS. BASEMAN: Okay, so to examine whether denial and appeal processes ensure access to covered and medically necessary care --

CHAIR BELLA: Hang on one second. Can everyone check their audio, please?

[Pause.]

CHAIR BELLA: Are we good? Okay, thank you.

MS. BASEMAN: So to examine whether denial and appeal processes ensure access to covered and medically necessary care, to examine how state and federal officials monitor denial and appeal processes of MCOs and to explore whether beneficiaries find the appeals process to be accessible.

While this work is closely related to evolving issues regarding prior authorization, questions around the use of prior authorization itself are outside the scope of this project. We are focused on the processes that are initiated once the denial has occurred.

In January, Amy and I presented the results of our literature review, federal policy review, and state scan, detailing the evidence regarding the first two objectives. In April, we returned with interview findings from five states and national experts.

At these meetings, Commissioners expressed concern that managed care monitoring and oversight requirements may be insufficient, and that policy options should address these inadequacies. Commissioners also indicated interest in hearing directly from beneficiaries about their experiences navigating the appeals process.

We are here today to present policy options for monitoring and oversight. Later this cycle, we will return for additional discussions on findings from our beneficiary focus groups and on policy options to improve the appeals process.

The federal government sets minimum standards for state monitoring and oversight of managed care programs, and states do have flexibility to collect and monitor additional information. However, the federal minimum standards lack critical components to determine whether MCOs are inappropriately denying care to Medicaid

beneficiaries.

Originating from findings from our federal policy review, state scan, and interviews, we have identified three key challenges in monitoring, oversight and transparency of denials and appeals in managed care. Specifically, our findings suggest that oversight requirements are incomplete in data monitoring, clinical audits, and transparency.

The current federal requirements provide only limited insight into the denial and appeal processes. There is no federal requirement for states to monitor MCO denials. While states are required to collect beneficiary appeal data, states are not required to collect information on whether a beneficiary is exercising their right to continue benefits during the appeals process. States are also not required to monitor the outcomes of any appeals to the MCO.

In our interviews, there was broad consensus that both denials and appeals outcomes are informative for monitoring and are helpful in identifying issues with beneficiary access to care. Some states voluntarily collect and monitor denial data and have used this data to

identify issues with service denials. For example, one state indicated that routine data collection and trend analysis helped to identify an issue with one MCO improperly denying non-emergency medical transportation. The state was able to work with the MCO to correct the issue for subsequent requests.

Our state scan indicated that 24 out of 41 reviewed states collect data on denials.

Additionally, reviewing appeal outcomes can provide a more complete picture of the extent to which denials are being upheld or overturned. Examining appeal outcomes can also help states understand underlying reasons for denials. During interviews, one state indicated that overturned appeals caused concern because often many other beneficiaries receive similar denials and yet do not appeal.

Federal rules do not require that states audit or examine whether MCOs are making clinically appropriate denial decisions. Regulations do require an assessment of MCO compliance with the process requirements for service authorizations and appeals through the external quality review process. These compliance checks are mandatory

activities for External Quality Review Organizations, or EQROs. But they, notably, are not assessing whether MCOs are making appropriate clinical decisions.

A recent OIG report found that 13 of 37 surveyed states regularly review the clinical appropriateness of MCO denials under prior authorization, and the results indicate that some denials were inappropriate. One interviewed state described how they perform routine spot checks and clinical reviews in areas where they have had historical issues with access.

There is no federal requirement for states to publicly report information on plan denials and appeal outcomes. As a result, little is known about the extent to which beneficiaries are denied services and the extent to which beneficiary appeals are upheld or reversed.

In our state scan, we found that 14 states publicly report data on denials or appeals. However, what is reported varies widely. States are required to report some appeal data to CMS through the Managed Care Program Annual Report, or MCPAR, and states must publish the report on state websites. However, there is no timetable by which states must publish these reports.

Some stakeholders and state officials expressed support for transparency of denials and appeals information, both as a tool for beneficiaries, as well as an accountability measure for MCOs.

I will now pass it along to Amy to discuss policy options to address these challenges.

* MS. ZETTLE: Thanks.

So now, we will turn to the policy options.

As you can see from this figure, we lay out four different policy options for your consideration today, and each ties to one of the challenges that Lesley just discussed. Together, these four policy options aim to improve the federal requirements to create a more transparent and robust system for monitoring denials and appeals.

Policy option one would have CMS improve its monitoring and oversight requirements on states by requiring that states collect and monitor data on denials and on appeal outcomes. States would be required to use this information to improve the performance of the program, and CMS would provide guidance and technical assistance to help states implement these new requirements.

As Lesley shared, our findings suggest that the minimum standards that are currently set by CMS are insufficient for ensuring that states have full insight into the denial and appeal process. In our interviews, we spoke to states who currently collect these data, going above the minimum requirements, and they shared how monitoring denial and appeal outcome data helped to identify issues and allow them to resolve these problems.

If implemented, CMS would need to update existing regulations, write guidance, and offer technical assistance. States would see an increase in their administrative activities. However, they would also now be receiving more information about managed care processes and help to improve access to care for beneficiaries. Across some states, MCOs would see an increase in the reporting requirements.

Our second policy option would have CMS require that states conduct an audit on a sample of managed care denials to determine whether or not denials were clinically appropriate. CMS would set the requirements for this process, and results would be publicly available.

Under this policy option, states would have the

flexibility to determine who would conduct these audits. For example, a state may decide to conduct these audits internally, using their own clinical staff. Or they could contract with an external third party or an External Quality Review Organization. CMS would be required to add these clinical audits as an optional task for EQROs or External Quality Review.

So clinical audits have proven to be effective at identifying inappropriate denials of care. OIG has found that states conducting these clinical audits have found cases of inappropriate denials under prior authorization. Examples included denials for drug therapies, health screenings for children, and inpatient hospital services.

Clinical audits of denials are also required in Medicare Advantage, where similarly inappropriate denials have been found. Given the higher rate of denials in Medicaid than in Medicare Advantage, audits of this nature can help ensure appropriate authorization of care in Medicaid Managed Care.

Following the OIG report examining these issues, OIG is also recommending that CMS require states conduct these audits to improve the program.

Similar to policy option one, this policy option would increase administrative burden on MCOs and states. However, some MCOs are already subject to these audits and some states are already implementing these audits.

If states elect to use an EQRO for this activity, it would be eligible for an enhanced match under our policy option.

For both policy option one and two, an increase in monitoring and oversight may help beneficiaries see improved access to medically necessary care and also see a reduction in their administrative burden. Specifically, if these audits help to reduce the number of inappropriate denials, this also reduces their need to file appeals.

Now we'll turn to our two policy options that focus on improving transparency.

Policy option three would require that CMS post all state Managed Care Program Annual Reports, or MCPARs, to the CMS website. Also, if policy option one and two are adopted, CMS would update the MCPAR template to include new data on denials, appeals, and the outcomes or findings from those clinical audits.

Currently, there is little transparency into the

MCO approval and denial process of services, limiting what we know about beneficiary access to medically necessary care. Improving transparency of these processes can bring greater oversight and accountability.

This policy option would place an additional burden on CMS to post this information and these reports and to update the templates to collect the additional information required under the regulations. This would, however, offer greater transparency to stakeholders and allow for greater analysis of the issue.

Our last policy option today focuses on ensuring that these data are accessible to beneficiaries. Under policy option four, CMS would require that states include denials and appeal data on their Quality Rating Systems, or QRS, websites.

Including denials and appeals data on the QRS websites would help improve beneficiary access to this information, which could be used to help beneficiaries select a health plan. As a reminder, these Quality Rating Systems will be set up by the states and CMS views them as a one-stop shop for beneficiaries to access information about their choices.

Given the importance of denial and appeal data in beneficiary access, these data would be publicly reported here for beneficiaries to review. Including these data would add a modest administrative burden, given that states would already be collecting this information, as proposed in the previously discussed policy options, but states would need to post it in a way that would be usable for beneficiaries.

Now we want to discuss some additional considerations. States are responsible for oversight of their managed care programs and ensuring beneficiaries have access to care. Independent of CMS action to adopt these policy options discussed today, states could improve their existing monitoring and oversight programs in a number of ways. They could update their contracts to collect denial and appeal outcomes data. They could conduct clinical audits on denials, either partnering with their EQROs or leveraging existing staff. And they could also improve transparency by posting the results of these data collected.

Additionally, states do have tools available to them to respond to performance issues that arise from

monitoring and oversight. This includes states revisiting existing policies or contract requirements to ensure that MCOs are appropriately covering and authorizing services. They also can enforce policies and contract requirements for MCOs that are denying care.

From our interviews, we heard from a number of states and they discussed the various approaches that they take to addressing these issues. And they made these decisions based on a number of specific state factors.

Lastly, we just want to call out that we did recently conduct work on external quality reviews and our findings suggested a number of compliance issues related to this topic of authorizations and appeals. We found that in 22 states there were managed care plans that were not in compliance with the authorization of services requirements currently in the regulations and 25 states had plans with compliance issues on appeals. 18 states had managed care plans that were out of compliance in both areas.

So this morning we are hoping to get your feedback on these four policy options that aim to improve monitoring, oversight, and accountability of the denial and appeals processes. If there's support for moving forward

with these policy options, we would come back with recommendation language. And since these policy options are viewed as complementary, we would combine them into one or two recommendations.

As a reminder, we will return in November with our findings from the beneficiary focus groups and our policy options on the appeals process itself. So those policy options will focus more on improving the appeals process to ensure that it's accessible and effective for beneficiaries.

With that, I will turn it back over to you, Melanie, for discussion.

CHAIR BELLA: Thank you both.

So we'll open it up to Commissioner feedback and, again, your general sentiment on moving forward with recommendations and then specific feedback on the four policy option areas up there would be helpful. And also starting out with any questions for clarification, if you have those.

Sonja, I saw you first, then Heidi.

COMMISSIONER BJORK: Thank you.

Just to get to the bottom line, I support moving

forward with all four of those policy options because they seem to get at our quest for transparency and usable data so that we can delve into more of what's going on.

I had a question about sorting out with denials, what types are administrative versus which are clinical and deal with medical necessity, because I think we will need some consistency. In order to look at the data well, we will need some consistency in definitions. Do you know much about that? Or can you speak to that yet?

MS. ZETTLE: Absolutely.

This came up quite a bit in our interviews, that some states do separate out, you know, administrative denials versus denials based on medical necessity. I will clarify that states and MCOs do appear to have different definitions for what those are. So in one state, that might be that a medical necessity denial is denied because the information was not provided to support medical necessity. In another state, that would be considered an administrative denial because a form wasn't sent in.

So I do think that that would have to be clarified by CMS in the guidance.

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: Thank you for this really informative work.

I have two questions just related to making sure I understand it correctly, and then two comments for the policy recommendations. I want to start by saying that I also support all four policy recommendations.

My first question is is this just focused on services? Or does it also include prescriptions? And does the continuation of benefits apply to both?

MS. ZETTLE: Both services and items, so drugs as well.

COMMISSIONER ALLEN: Awesome.

The second question I have is I seem to remember from prior MACPAC presentations that the appeals percentage is about 3 percent of all denials. Am I remembering that correctly?

MS. BASEMAN: We, unfortunately, do not have enough data to really definitively state that. We have data from some states to be able to put percentages around some forms of denials. But we do not have enough data to state very clearly.

COMMISSIONER ALLEN: Then I might be remembering

it from an academic paper, but I think what I remembered being struck by is that it's similar across Medicare, Medicaid, and commercial insurance. So that might be worth -- because if it is 3 percent, then that means that we're really looking only at a very small group of Advantage people who pursue the appeal process and I think that we should think of this in framing of an equity issue of who has the capacity to make it through these appeals processes when they're denied.

But my comments for thinking about our recommendations is we recommended, or at least we spoke to, random sampling of appeals for clinical appropriateness. And I'd be interested to know if it's possible to have a policy or to think about what a recommendation would look like for purposeful sampling among that? Like whether we think that there's areas that it would be more fruitful to look at populations or particular types of services instead of just a random sample of all denials.

And then the last thing is that this seems to be kind of built on a theory of change where the data will trigger state intervention. And yet, we have these EQRO findings that 18 MCOs were out of compliance with both the

appeals process and the authorization. And so I don't know if the theory of change is correct, and I wonder if it would be worth considering a policy recommendation that states set thresholds by which if so many things are denied or a certain percentage of claims are denied or a certain percentage of appeals are denied that it triggers some specific state action, whether it's just -- I'm agnostic. I'd be really interested in hearing what the ideas could be, but something to kind of close the loop from data that shows us a problem to data that indicates that states need to do something.

CHAIR BELLA: Thank you, Heidi.

Patti, then Tim, then Trisha, then Bob.

COMMISSIONER KILLINGSWORTH: So I also appreciate the excellent work.

I want to follow up question to Heidi's comment, and then I have some thoughts on the recommendations.

The follow up question is really around getting at that issue of what is compliance and what is non-compliance. And without looking specifically at the reports or data that you mentioned, do you know if compliance is defined as a single instance of non-

compliance? Or is there a threshold that's being applied?

MS. ZETTLE: It varied by state because each state defined compliance differently. So for some, it might be like a 95 percent threshold. For others it was lower, others it was higher. So we weren't able to tease that out in our analysis. So what we had to basically do was look at the public report and if it said that it was not in that first category of compliance, then we reported it as non-compliance. So in some states, that might have been -- non-compliance might have been 99 percent and in another state, non-compliant might have been much lower.

COMMISSIONER KILLINGSWORTH: That's really helpful. And it also plays into, I think, the remainder of my comments.

I also fully support the policy recommendations to improve monitoring and oversight and transparency and beneficiary experience, all of those things. I think my comments are really primarily with regard to policy options one, three, and four, all of which I support, along with policy option two.

But the comments are really more cautionary with regard to the recommendations that we will propose. And it

really relates to the interpretation of data, especially comparisons without all of the relevant context.

For example, if you think about the volume of appeals by a particular health plan or managed care organization, it's dependent in significant part on the types of services for which they choose to impose those prior authorization requirements and the larger majority of benefits aren't subject to those. So it's really not possible to look at a measure such as the number of denials per 1,000 members, for example, by health plan or even by service if you don't have the ability to take into account those nuances that really help you to understand what the data means.

So that transparency is beneficial but it's only beneficial if it's really a true and understandable picture to those who are trying to understand the data and understand what to do with it. It tells a story but the story can be misleading if we don't really understand all of the context.

The same is true for continuation of benefits data. In order to really understand if there's a problem and what to do about it, we have to understand the reasons

that continuation of benefits may not be requested. For example, one that I observed a lot in my previous role were concerns about a person being financially responsible for that benefit if the appeal was upheld. Other reasons that continuation of benefits might not be provided is, you know, if the appeal was made outside the applicable period a person might not request continuation of benefits because they know it's not available to them, or maybe because the benefits at issue weren't previously authorized. So there's just lots of reasons that we really have to understand.

Same thing for appeal outcome data. Understanding the reasons that a benefit or an appeal is overturned can tell us where the problem is in the process. If it's related to new medical information that's brought to bear in that process, that's a very different remedy than same information different decision on review.

So all of that to say that I just think when we make those recommendations, we want to include considerations that will help to put context around the data that we're making available and make sure that it can be as accurately interpreted as possible, especially in

relation to comparisons among states and health plans and as it relates to the actions that are really needed.

Thank you.

CHAIR BELLA: Thank you, Patti. Tim.

COMMISSIONER HILL: Thanks.

So first, let me associate myself with the basket of folks who support the recommendations.

Sort of following up on Patti's point, but maybe just a little bit different, on the reporting of the data I think it's going to be really important, as we write up and as we talk to CMS -- and maybe this will come out in the beneficiary focus groups -- there's a difference in my mind between collecting and reporting the data for compliance and monitoring purposes -- right -- with all of the nuances of how you report that versus reporting data and making data available to beneficiaries and their caregivers for choice purposes.

They're very different things and it's kind of the other side of the coin you're talking about. For CMS to really understand that it's not just go collect a bunch of data and put it on the website, but there's really a distinction and to really make it useful you've got to make

those distinctions.

CHAIR BELLA: Thank you, Tim. Tricia.

COMMISSIONER BROOKS: So let me start with a question and then I have a couple of comments, but I also am in favor of all of these recommendations with a little bit of a caveat.

Providers, and forgive me if I missed this in the materials, what are we hearing from providers about denials and appeals? Did we interview providers, provider groups? What are they telling us?

MS. BASEMAN: We did interview providers across the five states that we also interviewed. We heard quite a lot from the providers about the appeals process, but that was more focused on the process itself as opposed to monitoring and oversight.

COMMISSIONER BROOKS: Thank you.

And I just want to, you know, emphasize Heidi's point. Whatever that percentage is of people who file appeals, it's very low. And there are lots more people who don't file an appeal because they either don't understand it, they get something from their insurance company and they go "Well, I guess it's not covered." They just are

uninformed.

So the outcomes of appeals can be multiplied many times to illustrate the problems that exist.

So I don't think number one and number two go very far without three and four, but I would also indicate that four, on the Quality Rating System websites, these are new regs and in terms of how they have to redo them. And CMS put a tremendous amount of work into actually developing protocols of websites that states could use to build these.

But we're talking four, five, six years down the road. And as we all know, even when you have those kind of timelines, they always get pushed out. I don't know how we insert in here some urgency in this. I think CMS adding it to the annual report is really helpful to start with.

I just want to make a last point about, I just wish states would do a better job -- this is not just about what CMS can do. At one point, before the rock star Medicaid Director Ruth Kennedy left Louisiana, they were trying to put a centralized grievance and appeals process in at the state level where individuals reported their problem to the state and the state then would send it to

the managed care companies and required the managed care companies to loop back to the state with the results.

To me, that's an ideal system where the state is in control and not the managed care plan. So at some point in the future, I'd really like to look more at what states could be doing and not just what CMS is doing.

Thank you. This is good work, though. I really like it.

CHAIR BELLA: Thanks, Tricia.

Bob, then Carolyn, then Jami, then John.

VICE CHAIR DUNCAN: Thank you.

I, too, appreciate the work that's done and am in support of the four recommendations. I also like the idea of maybe narrowing the four recommendations down to a couple to make it easy.

But Amy, you said something that concerned me a little bit when you talked about with the denials and appeals process being health screening for children. Did I hear that correctly, that that was one of the items? Which leads me back to EPTSD, and medical necessity for kids.

In looking at the data, could you carve it out by population in looking at, particularly kids, that need

services outside of state boundaries, if they tend to have more denials and appeals processes to have to jump through? Is the data clear on that?

And I'm just wondering if there's trends or buckets of things that we're seeing that tend to be the hot spots for these denials and appeals?

MS. ZETTLE: Thanks. And yes, the examples you were referencing was from the OIG report. So the OIG report was actually able to -- they had two prongs. One, they actually received data from the managed care plans and kind of did their own analysis on that. And then they surveyed states. And for the states that were conducting those clinical audits, some of the examples of those inappropriate denials that came up in those audits were related to services for children and those screenings for children.

So that's the extent that we know about that, based on the public reporting from OIG.

I will say, in our state scan -- and Lesley can jump in and say more -- our methodology was to look at each state, see what they had publicly available, see what their denial rates looked like if they posted, see what their

appeals rates looked like if they posted, and just get as much information as we could.

The level of breakdown that I think you would be looking for; I can't recall a state that maybe broke it down to that level of detail.

VICE CHAIR DUNCAN: All right. Thank you, because I do appreciate the process of denials and appeals as a cost control mechanism that both the states and everybody has to have. But when I hear of things like that, I think of the long-term cost implications of things being found later versus sooner.

CHAIR BELLA: Thank you, Bob. Carolyn.

COMMISSIONER INGRAM: Thank you. And thank you for doing the work.

Did you all look at the state definitions and how the states defined denials? Or how the OIG report defined denials specifically?

MS. ZETTLE: Yes, so the way we looked at it -- well every state sort of defined their reporting differently. So some just reported on denials due to prior authorization. Some did look at like payment denials. You know, any appeal that would come in, I think, mostly used

the adverse benefit determination since that's the trigger for the appeal. So it sort of varied.

And OIG just looked at denials under prior authorization.

COMMISSIONER INGRAM: Okay, so they didn't define in the OIG report what the differences between a partial denial and a full denial? They just looked at denials? I don't believe they did, in their work, just to answer that question.

MS. ZETTLE: Yeah, they may not have.

COMMISSIONER INGRAM: So I think, getting back to -- it may have been Commissioner Killingsworth who brought this up -- but the definitions are very different if you go state to state, and even if you go organization, from health plan to health plan about how they define denial.

One managed care organization might say well, anything we do is defined as a denial if we reduce the care. But another might say well, we define denial only if we reduce all care. You could do a step-down service and offer an alternative level of care, still giving somebody a benefit, still making sure you're meeting somebody's access to care, but maybe not giving the benefit that they

particularly wanted because it's not in the benefit package that the state's defined, or it's not in the PDL that the state's defined for pharmacy.

So I think, going back to the discussion around definition, we have to be really clear about what do you define as a denial? Is that 100 percent no benefit at all? Or is it a partial denial?

And if we're going to ask states to track this and report it, and we're going to try to compare apples to apples, we have to have those definitions. So I can only be supportive of those things that we're -- of course, transparency, yes, in all of the items -- but making sure we're doing something around the definition.

Thanks.

CHAIR BELLA: Thank you. Jami, then John.

COMMISSIONER SNYDER: First of all, thank you Amy and Lesley, for doing this important work.

I am always going to look at things through an operational lens. I'm supportive, along with many of the other commissioners, in moving the policy options forward. I just think it's really important, as we do so, that we properly recognize the resource outlay for states. Both

from a cost standpoint, even with the enhanced match if they partner with their EQRO there's additional cost from a staffing standpoint. And then from a system investment standpoint.

So I just want to make sure that we're properly documenting that in the context of our process.

CHAIR BELLA: Thank you, Jami, John.

COMMISSIONER McCARTHY: Like everyone else, great work. I think it's terrific.

I can't support the recommendations that we have so far. The reason for that is we're taking incomplete evidence or data that I think we have and applying it to a big hammer to solve this problem. You know, sometimes, like I haven't read the OIG report. But back to, Bob, your question around were kids denied services?

I've worked in multiple states. I don't doubt that that happened. But it could have been a computer glitch that happened and then got caught and got fixed later on. I don't know what's behind some of those things. So we don't want to also react to things that are maybe just a one-time and it was caught and we fixed it.

The other thing is, for denials and appeals in

managed care, in every state if you go through that process on the managed care side, you can also always appeal back to the state and go through the state process. That is usually where, the places I've worked again, that you see how many times are those overturned over there.

Now I agree that that process can be burdensome. There's different ways you can do it. States have changed it. Tennessee is an example of a state, I think, that combined that process instead of having two processes. So that is also something that states take a look at, how many times are those overturned.

I want to go back to what Carolyn said. What's really important is just because a service is denied doesn't mean the person didn't get service. So that's an issue.

The other thing is the recommendation that I could possibly support is looking at either three or four, or maybe four, and starting to get some of that data out there.

We also have to think about the other side of this, though. So if you incentivize entities, whoever it is, to say hey, we're not doing denials and more people are

picking that plan, then that means other plans who are just getting autoenrollments are getting people who don't need services and we have other issues there.

So in having worked with report cards for plans, this is always an issue that you're trying to balance and how you use -- and kind of back to what Tim was saying, how you use that data is super important. To me, from a policy standpoint, there are states that you said are doing more. So to me it's more of a policy of how do you get it to start being reported and also helping states understand the direction they can go and talking to the states that haven't gone in that direction and asking them why haven't they gone in that direction.

And maybe it's more around that to say how do we help states move in that direction.

CHAIR BELLA: Thank you, John.

Dennis?

COMMISSIONER HEAPHY: I support all four recommendations.

And I do think definitions are really important, that we have a very clear definition of what a medical necessity is, what a denial is. It would be helpful -- and

maybe you're going to get into this later, but to look at who actually makes appeals, like from the perspective -- are there any demographics or any information about who makes appeals? A lot of it's just a person who's able to find a public health lawyer or some public lawyer, and they're the ones who get the appeal.

More generally, it's the complexity of the appeals process, and so maybe -- I don't know if you asked questions of beneficiaries about that, about the complexity of the appeals system and how hard it is and is there a way to get down to plain language, make recommendations for plain language or something like that for beneficiaries. But that may be further down the line.

But I think this is great.

CHAIR BELLA: Verlon?

COMMISSIONER JOHNSON: I have to say this is a really good conversation, and I really appreciate the work that you all have done.

I do support all four options, but I actually prioritized the first two, considering, though, of course, some of the comments that we had from our Commissioners about how we can make that data better.

But the other piece that I think Tricia brought up as well as I think Tim was an educational piece, and I know that we talked about in terms of the public reporting but wondering if there's a step before all of this. Is there something that we should be thinking about or hear what we can hear from the beneficiary groups to help us think about how can we make sure that beneficiaries will understand this process? And we can really get some more meaningful data that way. So I'd like to really consider that.

CHAIR BELLA: Thanks for, Verlon.

Adrienne?

COMMISSIONER McFADDEN: Yes. I too would also like to echo thank you for this great work, and like many of the Commissioners, I do think it's important to be really, very finite about what the definitions around these denials are.

My caveat is for number two with the clinical audits. I would really -- I think it's really important around those definitions that we're only auditing those cases that were truly denied for medical necessity reviews and not for lack of information or administrative denial,

so making sure that we narrow that scope.

The other policy options three and four, I think, are good starts. My equity lens would say that transparency for which beneficiaries for number four, particularly because we know not all beneficiaries are going directly to the CMS sites, and I would also like to echo Tricia's comment around the timing of having those data available.

CHAIR BELLA: John?

COMMISSIONER McCARTHY: There's one other point that I forgot to make on that one, and that is I know many states and health plans and providers have been working together to be able to have information using IT systems, AI, to link through their EMRs' systems to get past some of these things. And so it's the issue of if you need more data, is the data -- instead of even having to submit more data, the systems reach into the EMRs, pull it, and then say that's the way to go? So that's another issue.

I think on technology, we're always, as policymakers, a step behind sometimes, and so I also don't want us to make a recommendation that would slow any process that is already going on and interconnectivity.

CHAIR BELLA: Tricia, did I see your hand? Tricia, then Heidi, then I'm going to have some wrap-up comments.

COMMISSIONER BROOKS: So I do want to point out, I'm not necessarily suggesting that we add Congress's role to this recommendation, although I think it's important.

I honestly am not certain that we would see all the unwinding data that we're seeing now, had Congress not required CMS to report the data and given them the tool of an automatic reduction in FMAP for failure to report.

We have some 80 performance indicators on the books. They've been out there since 2013, and CMS is publishing regularly 10 or 12 of those. And so we can make a recommendation to CMS, and yet it could be years before we would see something. So I'm not sure that we shouldn't consider at some point what Congress's role might be in requiring reporting of the data.

CHAIR BELLA: Thank you, Tricia.

Heidi.

COMMISSIONER ALLEN: I'm glad that John brought up AI because I think that in the commercial sphere, there's really good evidence that -- and there's been some

very incredible reporting that insurers have been using AI for both denials and for appeals where medical appropriateness reviews were taking less than like 20 seconds. And I think that to think that Medicaid would not want to use tools or the MCOs might not use tools when they have a commercially insured population as well, many of them, I think would be naive. And so trying to understand how AI might affect this, I do think is a really important idea.

CHAIR BELLA: Thank you.

Could we go to slide 14, please?

So I want to echo the thanks on this work and, especially for some of our newer Commissioners, acknowledge that this is -- we have given you feedback in the past that we wanted to look at the continuum. We wanted to understand prior authorization. We want to understand denials. We want to understand appeals, and you're really taking that to heart. And I know there's prior authorization work coming out that if you want to mention, you can. You don't have to. But I want to say thank you for that.

Second, I want to reiterate the request to make

sure we're as precise on the definitions as we can be, and where we can't be, we're really clear about that, so that we don't -- the last thing we need is someone taking something out of context with a really nasty headline that doesn't actually drive this forward, because I do think we're trying to create an environment where the plans, the states, and CMS are working together to make sure beneficiaries are getting what they are entitled to get and what they are seeking to receive in cases where there is a denial.

And my question is just -- I'm really thankful that we're going to have the beneficiary work that comes back in November. I just want us to also be thinking about how we're interacting with states as we're putting these recommendations together.

Tricia, I hear the point about Congress, but I just want that these are all -- CMS should tell the states to do this, and so I want to make sure we're bringing the states along.

And what are we hearing about, for example, when they tell us they're out of compliance? Like what are we hearing? Is that because they can't do anything but the

redeterminations right now? And if they switch focus here -- and I realize this has been an issue prior to the PHE, but when states are acknowledging there are things out of compliance, understanding why and what is going to make these recommendations magically allow them to be in compliance, I think is really important. And so I would just encourage us to be getting some feedback on that front as well.

Dennis?

COMMISSIONER HEAPHY: Which states have been able to move MCOs into compliance compared to states that have not been able to do? What are the best practices with relationships to the MCOs and the states versus states where they're not able to make a headway? So are there things going on in the states that we can learn about and make recommendations on that?

CHAIR BELLA: Did you want to comment on that, Amy?

MS. ZETTLE: Yeah. I think I just wanted to highlight, because it's a good point. When we interviewed five states, they talked a lot about this and sort of different issues related to both noncompliance on the EQRO

side, which is very much related to following the rules and requirements as written and then their own internal processes where they would look at trends and help them figure out, "Oh, it looks like there might be an issue there." And we did see a range of tools that they were using from exactly those conversations of partnering with the managed care plan to say, "Oh, did you see this spike?" and then they address it.

Other states use civil monetary penalties. They publicly post that information and say, "Here's what the issue was. Here's what it was last year," and then there are the formal corrective action plans.

I think we talked about it a while ago. So just wanted to sort of reiterate that range of state-based approaches that they're using to address the various issues that come up in managing a plan.

CHAIR BELLA: That's really helpful.

You obviously, hopefully have what you need in terms of is there interest here from the Commission. I feel like this is one of those things, the deeper we get, the deeper we're going to want to go to try to understand it. So thank you for this work.

Do you need any other feedback before you can take this and bring it back to us?

MS. ZETTLE: No. Thank you. This was really helpful.

CHAIR BELLA: Well, you got us off to a great start. Thank you very much.

All right. We're going to move into Medicaid data, demographic data, and Linn is going to lead this session.

[Pause.]

CHAIR BELLA: Welcome, Linn. We'll let you take it away when you're ready.

MEDICAID DEMOGRAPHIC DATA COLLECTION

* MX. JENNINGS: Good morning, Commissioners.

Today's presentation will lay the groundwork for upcoming Commission presentations on the findings on Medicaid primary language and limited English proficiency, or LEP, sexual orientation and gender identity, or SOGI, and disability data.

This work is part of the Commission's ongoing commitment to prioritize and embed health equity in all of its work, and one of the areas that was identified as

needing attention is improving the collection of demographic information to inform policy and support efforts to advance health equity.

During the last report cycle, the Commission assessed Medicaid race and ethnicity data, and in MACPAC's March of 2023 report to Congress, the Commission recommended updating the model single streamlined application race and ethnicity questions, and developing model training and materials to encourage responses.

In addition to these recommendations, the Commission identified a need for additional work related to the collection and reporting of other demographic information, which included disability and SOGI.

So, in this work cycle, we're evaluating the availability of Medicaid, primary language, LEP, SOGI, and disability data for purposes of measuring and addressing health disparities and access to care and health outcomes.

And unlike race and ethnicity data, the collection of these data is more complicated in that there aren't federal standards for collecting these data across all federal data collection efforts, and these data characteristics aren't collected as consistently or at all

by state Medicaid programs. So the finding of this work may identify differences in the availability of these data across state Medicaid programs and indicate demographic-specific approaches that are needed in order to measure and address health disparities experienced by these populations.

So today I'll first present the definitions that we're using for these demographic data, and then I'll present on the uses of Medicaid demographic data, the availability of these data, demographic data collection priorities, and then next steps for future presentations.

So before diving into this work, it's important to have clear definitions and definitions that we are using for our purposes for this work. So for primary language, this is identifying an individual's primary spoken or written language. For LEP, identifying individuals who have difficulties reading, writing, and communicating in English. For self-reported disability, identifying individuals with disabilities. And for our purposes, these are data that are collected separately from those that are collected for purposes of determining Medicaid eligibility. And for SOGI data, identifying individuals who identify as

part of the lesbian, gay, bisexual, transgender, and queer community and sometimes also in this work identified as sexual and gender minorities, or SGM.

So Medicaid demographic data are needed for multiple purposes, both programmatic functions as well as efforts to address health disparities and equity, and so as seen in this figure for programmatic functions, this could include conducting eligibility determinations or providing translated and accessible materials. And these data can also be used to identify and assess disparities, which can include conducting research or measuring population-specific healthcare needs.

Based on our survey that we conducted with states and interviews, most state Medicaid programs are collecting the data that are needed for these programmatic functions, but efforts to identify and assess disparities with these data are still in early stages.

However, I do want to note that research findings from federal survey data do demonstrate that Medicaid provides coverage to many of these historically marginalized populations, and these populations do experience a variety of disparities in health care access,

health outcomes, and quality of care.

The Commission has expressed a particular interest in identifying whether states can assess and measure health disparities in order to ensure Medicaid beneficiaries are being equitably served by the program. So for the purposes of this work, we're focusing on the availability of these data and whether states and CMS have the tools and support they need to assess and address disparities for these specific populations.

In order to assess and measure health disparities, we also need to understand the availability of these data, and Medicaid and administrative data in federal surveys collect some of these demographic data to identify these populations, but there are limitations. Historically, federal data collection efforts have not included questions to identify all of these populations, and unlike race and ethnicity data collection, the Office of Management and Budget, or OMB, has not established federal minimum standards for collecting these data across all federal data collection efforts. However, they have released recommendations for best practices for collecting SOGI data on federal surveys, and other federal agencies

and nongovernmental organizations have developed some guidelines that are used in federal and state data collection.

Additionally, the 2011 HHS guidance for collecting sex, race, and ethnicity, primary language, and disability in population survey are guidelines that are specific to population surveys. So neither of these are specific to other federal data collection efforts.

So, in the next set of slides, I'll review the availability of these data, first in administrative data and then in population health surveys.

So state Medicaid programs typically collect demographic data on the application, and many use the HHS model, single-streamlined application. The model application includes a question on primary language but does not include questions on LEP or self-reported disability that's not related to eligibility determination or SOGI.

However, states do have the flexibility to modify the model application or develop an alternative application with CMS approval, and so states could add additional demographic questions as long as they are optional, as they

are not part of the eligibility determination.

And so this figure here displays the usability of the data that states report to T-MSIS, and CMS assesses the quality of some of these demographic measures that are submitted to T-MSIS as part of the Data Quality Atlas, or DQ Atlas. And the most recent assessment of Primary Language shows that 37 states are reporting data that are considered usable for analytical purposes, and 4 states are reporting LEP data that are usable for analytical purposes. The DQ Atlas does not assess disability, but in a MACPAC analysis of 2021, T-MSIS data, we found that 15 states are reporting valid values for over half of the beneficiary records.

And just to know what disability type means, disability elements in T-MSIS allow for the six elements that are part of the ACS-6 set of questions for identifying individuals with functional disability.

And then states, although they can collect SOGI data, there aren't any data elements in T-MSIS for reporting SOGI data, so just noted as zero.

Federal population surveys are another tool for understanding the experiences of Medicaid beneficiaries and

can also allow for looking at satisfaction and quality of care and health outcomes across many demographic groups that may not otherwise be available in administrative data.

As with administrative data, though, there are also limitations. So in a review of 13 federal population surveys, the State Health Access Data Assistance Center, SHADAC, identified which of these surveys collect each type of demographic data and also conducted a sample size analysis for those covered by Medicaid to assess whether these data could be usable for analyses.

And so as you see in this figure, the majority of surveys do collect questions on functional disability, but for the other types of data, fewer than half include questions to identify these other populations.

In terms of sample size, the majority of surveys do include -- that include these questions have sufficient sample for reporting individuals covered by Medicaid, although the ability to assess a particular measure may be limited.

I'm going into data collection priorities. Health equity has been a greater priority for the federal government, states, and other stakeholders, but many of

these efforts are still in early development and primarily focused on the expansion of data collection rather than on health disparities research and analysis.

In terms of federal priorities, advancing health equity for underserved communities is an administration-wide priority, and the Equitable Data Working Group, which was established by the Health Equity Executive Order, has recommended federal strategies to improve the collection and disaggregation of demographic data and leverage underutilized data sources to conduct meaningful disparities research.

In response to this Executive Order, CMS released a Framework for Health Equity, which focuses on the comparability of data across all agency data collection efforts in state programs, and they're exploring other data collection efforts, including for disability and SOGI data.

For the state priorities, many state governments have identified health equity as a priority for their Medicaid program, but the state strategies are primarily focused on the improvement of race and ethnicity and language data. However, there are some states that are taking steps to update their data collection and reporting

systems to allow them to prioritize the collection of other types of data, which include LEP, disability, and SOGI.

Health service researchers, advocates, and other stakeholders also use Medicaid administrative and federal survey data for a number of purposes, and many have recommended including primary language LEP, self-reported disability, and SOGI within existing demographic data collection tools, because these can support state monitoring efforts, assessment of civil rights compliance, independent research, and inform policy decisions.

So in the next three Commission meetings, I'll present on each of these demographic data types and present results from our stakeholder interviews, state survey, and federal survey review and sample size analysis.

Given the Commission's interest in these demographic data, for purposes of assessing and addressing health disparities, it would be particularly helpful to receive feedback on the direction of this work and if there are particular considerations for collecting and using these data that we should explore in these forthcoming presentations.

And I'll turn it back to you.

CHAIR BELLA: This is very clear, and I also want to say nice job. I understand that we did our own -- not we. The team, you all, did your own survey and got like a 60 percent response rate?

MX. JENNINGS: About 60 percent, yeah.

CHAIR BELLA: Very nice. Very nice. Congratulations.

Angelo.

COMMISSIONER GIARDINO: Linn, this was really informative. Thank you.

I'd be interested in understanding -- and perhaps in the December time frame -- what reassurances do we need to look into for folks to disclose, for example, SOGI information? What protections would exist if people take the risk of self-disclosing and then end up identifying themselves in a database, particularly in the current political environment where it seems like some of the civil rights protections are relinquished in certain areas of the country?

CHAIR BELLA: Okay.

MX. JENNINGS: Thank you for that. That is something that's come up in our interviews, so I can

definitely make sure to bring that back.

CHAIR BELLA: Thank you, Angelo.

Adrienne?

COMMISSIONER McFADDEN: Angelo stole my thunder a little bit, because I was going to ask the same question. Are there other models that we can look to that would provide a framework for reassurance for beneficiaries to provide these data? Because as we know, direct collection of these data are really the most reliable source.

And I would actually expand that, that sort of lens, not only to beneficiaries that are identifying as SGM but also for LEP beneficiaries, given political environments and other things going on.

COMMISSIONER ALLEN: Heidi.

Thank you, Adrienne.

COMMISSIONER ALLEN: Thank you, Linn. I'm very excited about this topic, as you know.

I wanted to point out that in prior meetings, we've talked about the streamlined application and how it's been, I think, over a decade since it's been updated, and I think that's important for motivating our work, because if it does get changed, it's likely it'll be another decade

before it gets updated again.

I know they're looking at updating it for race and ethnicity purposes, and so this is could be just a really timely opportunity for us to bring these other data collection elements to the surface as this is happening.

I think that one of the ways that you demonstrate that data can be useful is by making data useful, and so the idea that 15 states are either currently collecting SOGI data or interested in collecting SOGI data and yet T-MSIS cannot accept it, I find pretty discouraging. And I would love to know what would it take for T-MSIS to be able to accept the data. How difficult? I don't have a sense of scope of what the ask would be.

And then because I think that the December meeting on SOGI could be pretty quick if we basically say that hardly anybody's collecting it and nobody's using it, I think it would be a good opportunity to reflect on the purpose of measuring a specific population's health care needs, and I would love to hear from experts about how the data could be used to improve the way that Medicaid thinks of services for enrollees, particularly with some attention to the changing demographics of the United States by age

and SOGI, and what that means for thinking of Medicaid as a primary provider of health care for adolescents. We look at the number of maybe 3 percent of people identify as SOGI, and that may be accurate when you look at the entire population.

But if you were to look at adolescents, the number is much, much higher. And when you think of access to things like timely gender-affirming care and you think of Medicaid covering so many adolescents and you think of that we don't even know what services they need, I'm sensitive to the fact that in some states, there's prohibitions against gender-affirming care, both for Medicaid enrollees and everybody. But in a lot of states, there are no prohibitions, and some states explicitly do cover gender-affirming care. So how can they use this data to make sure they have adequate networks and contracting in place?

And so I would love to hear, if we're able to have a panel. That's the kind of conversation I'd like to have in December.

CHAIR BELLA: Thank you, Heidi.

John?

COMMISSIONER McCARTHY: Back to what Heidi was talking about, there's a couple of states, I believe, who are actually looking at this, and they're running into the issue around claims payment, because in the HIPAA requirements for claims data, you can only have male or female right now. And so that's -- it somewhat goes beyond even what we're doing here. But I think it is really important that we identify some of those barriers also on reporting this data.

I do want to say -- and I think, Heidi, you were also hitting on this on the streamlined application -- when we're asking people to apply for Medicaid, there's already so many questions and so many things. The application takes long because it's often not a Medicaid application. It's for all benefits, that we also probably need to think about in trying to collect this data, is it the best to do it right up front then, or is it later on, some other way to do it? Again, just not having a 300-page application asking a whole bunch of different things, just, again, thinking through where in the timeline, in the process to collect the super important -- I don't want people to think that I don't think this is important. It's very important

data. It's just where and how do we collect it in that process.

CHAIR BELLA: Thank you, John.

Patti?

COMMISSIONER KILLINGSWORTH: Great work and really good conversation.

I want to hone in for just a second on the data related to disability, because I think there are some things that you talked about, the significant gap between disability data that's gathered based on eligibility versus self-reported data. I think that supports that there's really a need for improved reporting of disability beyond reliance on claims information or eligibility information.

Majority of states that responded to the survey, if I read the data, said that they were not collecting or considering collecting any additional data based on disability, and then two-thirds of the T-MSIS data, self-reported, disability data is unusable. So there's a huge gap there.

I think if we look at the current questions that are being asked, they are far more likely to gather information about functional limitations and not to include

data relative to intellectual disabilities or cognitive disabilities. So as we get ready for that January presentation that's specific to disability-related data, I would love to see additional research or engagement with people who have expertise specifically as it relates to intellectual disabilities as well as conditions such Alzheimer's or related dementias, to make sure that the guidelines are sufficient to really capture that growing segment that is disproportionately represented in the dually eligible population.

And then I think we should at least consider or explore whether there is value in a recommendation that the entirety of the populations who are receiving LTSS are identified as having a disability, whether or not it's reflected by their Medicaid eligibility category. That one just seems so obvious to me, and yet we don't do that.

Thank you.

CHAIR BELLA: Thank you, Patti.

Jenny?

COMMISSIONER GERSTORFF: Thanks, Linn. I really look forward to the next conversations that we have on these topics.

For all these pieces of information, it seems like many of them can change over time. and so for states that are collecting this data, I'd be interested to understand the frequency of collecting the information, how it gets updated, if it gets updated, or if it just kind of gets carried forward.

And then also understanding if there are any limitations or -- like system limitations, operational limitations, or even application process that attributes things like limited English proficiency or primary language in the household to an entire household on an application or individually to beneficiaries.

CHAIR BELLA: That sounds familiar. Thank you, Jenny.

Dennis.

COMMISSIONER HEAPHY: Thank you.

I appreciate Patti's comments and echo them. The commonness of collecting SOGI data is really important. All these folks I know who are on PrEP, which is for HIV prevention -- and I would have never known what PrEP was, but collecting this data is extremely important.

I'm wondering if the question is, how is the data

collected? Is it just in the application for Medicaid, or is it at the provider level, at the MCO level? Where's the appropriate place to get this information, short term and long term?

And maybe, Heidi, you could answer that question to some degree or Linn, but where is the appropriate way to do this? Because this is sensitive, whether it's disability or sexual orientation or gender identity or LEP. So where's the appropriate place to get this data, or is that something we were going to look at, Linn?

MX. JENNINGS: Yeah. So it is something we've asked in our interviews, both with research experts and with states, and to understand, I think a lot of these data are collected in different places, whether it's an EHR. And they could maybe get it from a managed care plan, of some states have surveys that they ask some of these questions. I don't think there's a consensus on where it would be best.

And I think to Jenny's comment on change over time, I think we've heard a lot that asking it in multiple places is important, because often an application is kind of a one-time place that people may respond, but if you --

for determinations, if you have ex parte, you may never look at those data again, and you may never -- an individual may not go in to update. So I don't know if I have a good answer for where a best place, but I think that's a really important point to kind of think about with these data throughout this whole process is that the application is one opportunity to get information, but there may be other opportunities as well.

CHAIR BELLA: Thank you.

Adrienne and then Heidi.

COMMISSIONER McFADDEN: It just occurred to me that thinking about sort of the utilization of these data from a program administration standpoint, it would be really helpful to have -- and this is likely out of scope, but it would be really helpful to have sort of an eye towards how we can collect, in parallel, data about physicians, clinicians, and other service providers for our beneficiaries as an understanding of their ability to respond to the needs based on the demographic data that we're collecting in all of these areas.

CHAIR BELLA: I love that suggestion.

COMMISSIONER ALLEN: I wanted to mention that the

only reported -- or required reporting of SOGI data is an FQHCs. So all of the electronic health records for FQHCs have to meet an interoperability standard where they collect SOGI data, and so that doesn't mean that they do it perfectly. It doesn't mean that it's necessarily being used to target change right now, but that is something that we could look at.

And I would also like to take this opportunity to say that we did recommend that there be a Medicaid beneficiary survey, and this is a perfect example of where that could be useful because Medicare gets one, and we don't. I just want to remind everybody of that, our prior recommendations.

CHAIR BELLA: Thank you, Heidi.

Other comments?

I'm going to leave on the table -- I'm really tempted to take that one and run with it, but we'll leave that there about what Medicare gets and Medicaid doesn't for now but appreciate the point and, Adrienne, yours as well.

Other comments or questions, thoughts from Commissioners?

[No response.]

CHAIR BELLA: I think it's really exciting how you've laid it out for the next three months or next three meetings. We have high hopes for what you're going to bring back, recognizing you won't have all the answers, but really appreciate what you're teeing up for us and where we think we can make a contribution here.

So, Linn, how are you feeling about the feedback you got?

MX. JENNINGS: It's all very helpful. Gave me a lot to think about for the next presentation, so I appreciate it.

CHAIR BELLA: Okay, thank you.

Any last comments from Commissioners? And then if not, we'll go to public comment.

[No response.]

CHAIR BELLA: All right. Thank you, Linn.

We will open it up to public comment on either of the sessions that we've just had. I will remind folks if you'd like to make a comment, please use your hand icon on your computer. We'd ask that you introduce yourself and the organization you're representing, and keep your

comments to three minutes or less, please.

Arvind, go ahead.

[No response.]

CHAIR BELLA: All right. We'll just wait a second and see if we get our commenter back or if anyone else would like to make comments.

[No response.]

CHAIR BELLA: All right. Well, I will remind folks there's always an opportunity to submit comments online as well to Comments@MACPAC.gov.

Oh, great. Arvind, you're back?

PUBLIC COMMENT

* DR. GOYAL: Are you able to hear me?

CHAIR BELLA: Yes. We can hear you now. Thank you.

DR. GOYAL: Thank you very kindly.

My name is Arvind Goyal, and I'm the Medical Director for Illinois Medicaid. I wanted to make a few comments, and these will be bulleted to stay in time, but I'd be happy to answer and explain further, if necessary.

My first comment is that this is a very influential group, MACPAC. I want you to know that your

recommendations are frequently adopted, but there is usually a time lag between your reports and congressional action. I wanted to put that on the table.

The second thing I want to say is that providers and patients are really frustrated with the appeal, PA, denial process by the MCOs, and it is not unusual for us to hear that, "Hey, if I was under fee-for-service, I would not have to go through this heartburn."

Number three, I want to say that the overarching fact in the background is that MCOs save money by denials. There may be some quality opportunities as well, but the fact that there is incentive to deny worries many of us.

Number four, I want to say that the -- is there a possibility, do the Commissioners feel, that medical care can be managed appropriately, assuring high quality without PA? And I want to point out that similar legislation has been introduced in some states, including ours at one point. To my knowledge, it hasn't passed anywhere, but God knows.

I want to say that the recommendations that you put on the screen and discussed extensively at this meeting, they are lacking in real-time solutions. The

problem is that by the time these recommendations are adopted, the data is posted. Then it is acted on by the states or through CMS, et cetera. The care of a patient may already have suffered. The access may have been denied if it wasn't a claim denial. If it was a claim denial, the story may be different, but if it was prior authorization denied for a medication, for a service, for a procedure, for a hospitalization, we've got an issue. I think that transparency, the solutions need to be real time as opposed to after the fact, which is what your recommendations address.

Then I want to also say that you did talk about partial denial, and there is a term we use which is "downcoding," and that may be consistent with the partial denial that you were talking about, which is usually on the claims, or saying that you can't admit this patient to the hospital, make it an observation bed, et cetera.

The denial really needs to be addressed by proactive measures, what can be denied, what should not be denied, and what kind of explanation needs to go to the patient, the beneficiary, et cetera. I think those recommendations should be included.

The final thing that I do want to say is that in Illinois, as a result of a legislation about three years ago, we have a MCO complaint portal, and when the portal complaints come in, we classify them by the MCOs. If there are medical necessity, they go to the medical director. If there are financial issues, downcoding issues, et cetera, they may go to other subject-matter experts, if you will. However, I want to say that I can't say that it has solved the issue of prior authorization denials and timely care to all beneficiaries.

I want to stop there. I would be very interested in following up on your discussion at the subsequent meetings, as was articulated, but I'll be happy to explain anything that I've said in my comments. Thank you very much for the opportunity.

CHAIR BELLA: Arvind, thank you, first of all, for serving in the Illinois Medicaid program and for all you do and for taking the time to give us your feedback. You're welcome to submit additional comments to the email address, and then I think we know where we can find you. We may have some follow-up for you as well.

DR. GOYAL: Thank you.

CHAIR BELLA: We don't have any additional commenters at this time. So, with that, we will break for lunch. We are restarting again at 1:30 with our panel on PHE and redetermination. So we will see you all back here at 1:30 Eastern. Thank you very much.

* [Whereupon, at 11:49 a.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:32 p.m.]

CHAIR BELLA: Good afternoon, everyone. We are really excited to kick off the afternoon with a panel on our favorite subjects, and I'm going to turn it over to Martha to get us started.

PANEL DISCUSSION ON UNWINDING MEDICAID: CHALLENGES TO DATE AND WHAT'S TO COME

* MS. HEBERLEIN: Thanks, Melanie, and good afternoon, Commissioners.

So since the last time we met in April, much has happened with unwinding the continuous coverage requirement. States have begun processing renewals and disenrolling people for the first time since 2020. CMS has issued additional guidance and released the first few months of data looking at renewal outcomes and operations data.

So to give us an update on where things stand, we've gathered a panel to represent the different actors. I'm joined by individuals representing states, CMS, and beneficiaries, and today I'm joined by Kate McEvoy, who is Executive Director of the National Association of Medicaid

Directors; Allison Orris, who's Senior Fellow at the Center on Budget and Policy Priorities; and Dan Tsai, who will be joining us shortly, who is Deputy Administrator and Director at the Center for Medicaid and CHIP Services.

So, in the interest of time, I will not be reading their bios, but, Commissioners, there is more information about our speakers in your materials.

This is also going to be a moderated session. So I will begin by asking each panelist a few questions before I turn it back to Melanie to facilitate questions from the Commissioners. And then as is our practice, we will have a Commissioner-only discussion after the panel is complete.

So I will begin my questions with Kate. So, Kate, the unwinding of the continuous coverage requirement is a monumental event in Medicaid, and states and CMS have been planning for this unwinding for years. Could you describe what's going well and any unanticipated challenges?

* MS. McEVOY: Thank you so much for the privilege of joining this afternoon, and it is just such an honor to join Allison and Dan. And it is emblematic of the extraordinary partnerships that I think have characterized

our collective work during this watershed year, and that is something that has gone very, very well and is of continued benefit to the program and to people served by the program.

In addition, I think aspects that have gone well -- increase public literacy of the program and its primacy for health care coverage and also economic security for people.

I'll just go back a bit in time to say that the program performed exactly as it is intended to do when it had to scale during the pandemic but now must migrate back to confirming eligibility, which is an extremely daunting and large-scale task.

Another aspect that I think has been really good is raising collective consciousness about long-standing opportunities to smooth connections to the program and also to improve continuity of coverage. I think we have a lot that has surfaced and some tremendous consensus around the momentum and the energy needed to make that happen.

Also positive is really the transparency that has accompanied this work. I think an unprecedented level of transparency, not only around the iterations of the coverage, but use of common indicators. And I know while

that is still a work in progress, I think it's something that we should definitely remark on.

And finally, at the state level -- and I just want to say how proud I am to be representing the 56 Medicaid state and territory directors -- there is a tremendous attention at each and every interval of the stages of eligibility to promote continuity for eligible people from the ex parte process, which I think has been very well illuminated by the communications today from CMS, through other protective features such as reconsideration, and even -- and we hope that we won't come to this point, but even resumption of coverage through presumptive eligibility and other means. These are all factors in how we protect and ensure continuity.

From the standpoint of challenges, I'd start with saying that complexity and the difficulty of issue spotting and balancing among competing operational and systems priorities, this is a major challenge for states. And ex parte is just one example of that, where we saw the tremendously detailed guidance that was issued by CMS in January, did not specifically articulate the obligations around ex parte at an individual level, while it did a lot

to illuminate the broad parameters. So that continued focus on surfacing issues as we go on, I think is very important.

There are two interpretive matters that I think are active and constructive challenges. One is unpacking the procedural terminations of folks from the program, eligible, from ineligible folks, otherwise covered and not, stratification by age bands and coverage groups. These are continuing challenges in terms of what we need to learn, and it is a process of discernment.

We also really need to know more about the result and experience of members following reconsideration, so not just the stages that are being more publicly reported on, but the other means, reconsideration and others of reconnection with the program.

And finally, I think a challenge is identifying which levers will have the most influence, especially on a permanent basis, whether that is ex parte, self-help tools for address changes and understanding status of eligibility for members, call center strategies, and also community pathways and the partnerships that I think have so emblemized this process, but understanding which of those

is most probative.

So, Martha, I think that's really a capsule of where we're situated with both the positive and also the challenges.

MS. HEBERLEIN: Thanks, Kate.

And, Allison, I'm going to turn to you. From your perspective, what are some of the key areas of concern as you and your partners are monitoring state progress, and are there any positive developments coming out of the unwinding?

* MS. ORRIS: Thank you, Martha and Commissioners, for the opportunity for me to share my thoughts with you today.

I think, unfortunately, even with all of the work by CMS and the states, as Kate was talking about, to prepare for and react during unwinding, we're seeing far too many people who continue to meet eligibility requirements losing their coverage. That jeopardizes access to lifesaving health care and adds needless burdens to people's lives.

So what concerns me are the same kind of stories that all of you are reading about people who should be

easily redetermined eligible for Medicaid but who are instead needlessly losing their coverage and then having to jump through hoops to regain it.

So I want to unpack that a little, mentioning a lot of the things that Kate also touched on. As you all know, federal rules require states to attempt to renew eligibility on an ex parte basis using available data. Ex parte renewals are cost effective. They're efficient for states, and they reduce red tape and burden for enrollees. So it is a major concern, and I know it is for states and for CMS that ex parte rates are very low to begin with and that some ex parte systems are not applying federal rules properly.

That means that we're seeing too many people being asked to return paperwork. That introduces risk that the mail doesn't reach someone, that it isn't returned to the agency or isn't processed by the agency in time. And then that is what is leading to so many procedural terminations when eligibility is being terminated but not based on an actual finding of ineligibility.

Nationwide, we're seeing that procedural terminations account for more than seven in ten of all

terminations, and I think that is directly related to the low rates of ex parte renewals. Some states are well above the average of 24-ish percent that we're seeing nationwide, but there are some striking variations in ex parte rates among states that I do think is really contributing to those procedural terminations.

And then when people lose their coverage, what we're seeing is that they then have the added burden of needing to reactivate their coverage, which is adding work not just for people, but also for overburdened state eligibility workers and state systems. And all of that is leading to mounting renewal and application-processing backlogs.

So the combination of all of these factors, I think, is what's making it more difficult for people to enroll or reenroll than we would all like in this period. I think, certainly, this is really concerning in light of the already high number of people who've lost coverage and the fact that those numbers are just going to be mounting as more states continue unwinding over the next year.

As Kate was saying, I think unwinding has revealed that there have always been more procedural

terminations than we realized, and that that's contributed to the historic patterns of churn on and off of Medicaid that have impacted people's ability to keep their coverage.

So that actually all leads me to a positive, and much like Kate was saying, I think unwinding has increased awareness among policymakers and the public about how various administrative barriers prevent people with low incomes from getting and keeping their coverage.

We know that these administrative barriers need to be addressed. And I am hopeful that this opportunity and what we're seeing in unwinding is leading to momentum for states to continue the work that they're doing to address issues and for CMS to continue its oversight, its transparency around data.

We certainly know that states are working hard now to address issues, but we know that more work is needed. Some of the issues that CMS have surfaced are not the only issues that are out there impacting coverage, and I really do hope that this period will provide an opportunity to continue and scale innovative policies and practices so that we can fix low ex parte rates, fix confusing notices, and overall make the eligibility and

enrollment experience a simpler process for people who rely on Medicaid.

MS. HEBERLEIN: Thank you, Allison.

And welcome, Dan. Thank you so much for joining us on a busy day.

So I wanted to ask you a question specifically about some of the data. We know that CMS has established data reporting requirements. Some of these were made mandatory under the Consolidated Appropriations Act, and since we've met last in April, two tranches of data have been released nationally. And I was hoping you could tell us a little bit more about what the data can and can't tell us about how the unwinding process is proceeding.

* MR. TSAI: Martha, I apologize for -- I was a few minutes later that I realized I was not -- I was sitting, watching, not a panelist. And then I realized I wasn't in the right place. So all the technical things when you have in-person meetings and then you get to virtual meetings and back and forth. So I apologize for that.

But, Kate and Allison, I was able to hear almost all of what you said, so thank you.

I just want to emphasize at the outset how

important this topic is, and as Kate, I think indicated, this is really an unprecedented monumental event for us. Never before have, in the Medicaid program, have we had over 90 million people enrolled. Never before have we had this amount of time pass without states having to do eligibility renewals and for everyone to be doing that all at once. And so our focus as an administration is making sure we help people stay connected to coverage.

That's Medicaid in many cases but also marketplace for free, low-cost plans for many individuals, employer-sponsored coverage, Medicare and the like. And so that underscores every piece in continuing to build on the gains we've made over the many years the country has decreased the rate of uninsurance.

And so I think folks are probably aware of the many different pieces we are balancing, both our federal oversight and compliance responsibilities, trying to help make sure that we have a compliant process across the country with recognizing the history and where all the different states are starting from on their eligibility renewal systems and processes, as well as really trying to engage and provide new flexibilities of waivers and options

as many states have come forward with all sorts of creative proposals for how to make the process more streamlined, many of which are absolutely common sense around various things. So to your direct -- so lots of effort, big area of focus for everybody all across the board.

To your specific question around the data, I think the data has been -- the data we are tracking now, based on the CAA at the end of last year, a new statute to have us track some of these things, I think it's been incredibly illuminating. It's an unprecedented time that's giving us collectively unique insight into what's happening on the ground, and Kate and Allison, I know no one has ever seen data of this sort of being able to understand what's happening for renewals and rates of ex parte success versus procedural disenrollments and the like. And so I think that's really, really important.

The data, we will continue to update, as we have more cohorts, and the statute also requires us to be able to track where people are transitioning to, which is another really important story, but that, as you all know, takes some more time to connect to various data sources, including who's getting over successfully to employer-

sponsored coverage.

So we look forward to continuing to get out information around that as soon as it's available.

MS. HEBERLEIN: Thanks, Dan.

And, Allison, if I can turn back to you. We know that advocates have been important partners for CMS and the states in identifying issues and strategies in the unwinding process. What are your thoughts on the role that advocates play during this process and what can state and federal agencies do to support them?

MS. ORRIS: Sure. So I think that my colleagues at the Center on Budget and our partners at other national organizations and at state-based organizations have really appreciated the collaboration with CMS, with NAMD, and with individual states throughout this process.

We've developed important feedback loops and had a really open-door kind of opportunity to share information that we and our state partners are gathering about the experience that enrollees and their families are having renewing their coverage. We've been able to bring, I think, increased awareness to states and CMS about consumer experiences, and that's influenced policy responses. We've

seen things that aren't working well, and we've been able to flag them and help to dig into potential solutions that are necessary.

Even before unwinding began, CBPP and our partners supported state advocacy organizations and work that they did with their state agencies to prepare for unwinding, to adopt flexibilities, to consider messaging, to consider their notices. We emphasize the time to get it right, because states had a relatively long runway before unwinding began.

And since April, CBPP and our national partners have worked closely with state advocates to identify, investigate, and flag issues to CMS and to states. I think state-based advocates deserve a lot of credit for the important role that they play in extending eyes and ears on the ground. We know that CMS can't be everywhere all the time. So it's been really essential to have state advocates who understand eligibility and enrollment processes, highlighting issues, and giving voice to enrollees who are struggling with a complex redetermination process. So I do think that those feedback loops have been important to help bring that understanding and to help make

policy changes and operational changes, to help ease the burdens that some consumers are facing.

I think states and CMS can continue to support that work by continuing the open door that we've had -- and by we, I mean the Center on Budget but also many of our partners at the state level -- and by continuing to be committed to following up on issues that we bring them, to being transparent, both with data and with policy solutions. And I think the last thing I would say is that looking ahead, I hope that CMS will finalize its proposed rules that would bolster the role of Medicaid enrollees on Medicaid advisory committees and on beneficiary advisory groups to strengthen opportunities for consumer voices to inform policy and to share the lived experiences of people who interact with these programs so that state policymakers have insights into the impact that policies have on the people that the program serves and hear more about effective ways to communicate information about policy changes.

We know communication has been a challenge during unwinding, and I'm hopeful that in the future, there are opportunities to hear more from enrollees about that.

MS. HEBERLEIN: Thank you.

Dan, I'm going to turn back to you. You mentioned a little bit, the compliance and oversight functions of CMS, and I know that the agency has a number of tools for working with states to ensure that the CAA requirements are met, including developing mitigation plans and financial penalties. Can you describe a little bit how the agency uses specific tools in different circumstances and how you figure out what might be the most appropriate course of action?

MR. TSAI: Sure. And I think the approach we'd take and emphasize today; I would reemphasize number one. We take our oversight and compliance responsibilities incredibly seriously, which means making sure that we are engaged with states and that we're holding folks accountable to following the federal requirements as outlined in the statute. And that's really, really important.

It is also the case that as we work with states and identify where there are issues, our firm belief for -- and our goal is -- to make sure that people maintain access to health care as easily, smoothly, and quickly as possible

on the ground across 56 states and territories across the country. Part of what we are very much doing is saying when we identify an issue that is a compliance issue, we're very clear that requires having a CMS-approved way of addressing that, and that has a few important principles.

First, pausing or not initiating any more inappropriate disenrollments that are the result of some sort of issue.

Second, holding individuals harmless, meaning reinstating people, it's something that we're discovering through the process or at the outset. -- We had agreed with a range of states, when folks had identified a range of challenges they had making sure their approach is in place so that eligible people are not inappropriately disenrolled. And so that is very much the approach we've taken.

And to be clear, that states that as we identify things, there's a clear path. It helps acknowledge and give space for folks to make corrections on the ground with the really important principle of holding beneficiaries, consumers, individuals harmless, and that's really the approach we've taken with states on the ground. And that

has been effective to date.

Certainly, the enhanced federal match has been a really important part of that discussion, and as you noted, there are a range of other tools that Congress has outlined as well.

MS. HEBERLEIN: Thank you.

And, Kate, I'm going to turn to you before I turn it back over to Melanie and the Commissioners.

So, as we've seen in the recent letter that CMS sent to states regarding ex parte renewals as well as CMS expectations that states come into full compliance with renewal requirements within two years following the end of the unwinding, can you talk a little bit about more about what this work will look like and about what other challenges and changes that were instituted during the unwinding might be adopted on a more permanent basis?

MS. McEVOY: Yes. Thank you so much for the question.

I want to start with something extremely important to states and territories, and that is the really active, dynamic, applied, collaborative process with CMCS. I really want to thank Dan and all of his colleagues there

for taking a posture of elasticity, constantly examining opportunities for remedies that are surfaced at the state level and are responsive and really tailor to state systems and state needs. That has really characterized the first six months of this process.

And we also harken back to the incredible work that we mutually did during the pandemic, really getting past some of the sort of iterative, administrative, procedure-laden aspects of how the federal government and states and territories have worked in the past, and I think that has been a tremendous benefit and will continue to be.

States are also dynamically examining the data and the experience and looking for interventions that can attach over time as we learn more. The use of ex parte is a really important example, but it is a non-exclusive example of means of really increasing that pathway and the continuity to which both Dan and Allison referred. But it is one of the tools in the toolkit that I think deserves some explication.

So we have ex parte, certainly. We have the reconsideration feature, and I think that is something states are working very hard to routinize and to also

promote public literacy of. We have a lot of work on self-management tools, so tools around address changes and essentially ways of being cued to your status and eligibility systems that can originate through texting or through easy access at the member level.

And finally, those community connections to which both of my colleagues referred, really looking to solidify those, so it is not an episodic contact. It's something that we embed really on a routine basis, the feedback loops to which Allison referred.

Finally, looking at use of technology, both for triaging issues as they're emerging and then also supporting people who reasonably have complex circumstances and need additional help with, admittedly very complex processes in eligibility.

So Dan began to talk about the waivers that have been opened up to the states and territories. I think a crucial question for us -- and we're starting to really be at that vantage point -- is which are most probative at protecting people who remain eligible and ensuring effective processes that are as low burden for members as possible. So examining which of those can be embedded

permanently, I think is really a very crucial phase that we're looking at right now.

We also have a lot of aspirations around active collaboration with the systems vendors that are working at the state level. We have historically seen quite a bit of state-by-state, kind of first-dollar approaches, and in collaboration with CMCS and also the United States Digital Service, USDS, I think we all are focused on influencing scalable solutions that might be more easily replicated across states. And that ex parte effort in which all states and territories are very, very significantly and actively involved in around a remedy, that's a perfect example of a systems piece that we really want to look at in that way.

We also, leaping off what Dan said, are very excited about the new opportunities to tell the entire story of our continuum of coverage supports for people, Medicaid being a crucial linchpin -- but the marketplace and ESI are also very significant -- and really routinizing that process of knitting together those data variables annually so that we can see very clearly what patterns of migration there are and also where we may not be serving

people effectively and they're falling off coverage.

Finally, I think the most significant thing I could say to you today is really important to each and every Medicaid director in states and territories. That is embedding and means of directly hearing from members about their experience with the eligibility process.

When we met earlier this summer in Denver with all states and territories for a major summit on unwinding, we had an amazing experience hearing from the Colorado Member Experience Advisory Group, and one of its members, Samantha Fields, really left us with a message that I think rang very true to Medicaid directors across the room, and that is when we look at state data, we say that's my life that you're talking about. And we left with that very, very significant responsibility. It is the lives, as Dan said, of 93 million people at the apex of enrollment.

So thanks, Martha.

MS. HEBERLEIN: Thank you all.

I'm going to turn it over to Melanie to facilitate questions from the Commissioners.

CHAIR BELLA: First, I want to say thanks -- you are three of our favorite Medicaid champions, and to have

you all on the screen spending time with us, I don't know how to contain myself in 30 minutes for all the things I know we're going to want to ask you.

I'm going to start by carrying the ex parte thread and, Dan, start with you. September 13th was a date we all know as a deadline for states to report on what they're finding with their ex parte issues. Is there anything you can share with us at this point on what you're seeing or that would be helpful for the Commission to understand?

MR. TSAI: I think by the end of this -- we've committed to transparency around this topic, acknowledging that a lot of folks across all different parts of the system are working, working very hard around this. And so we did get responses from all the states and the territories to which this applied, and we will be posting this afternoon just a pretty straightforward summary table by state of where states identified they had an issue, which affected populations, and very rough size of impact. So that should be posted at some point this afternoon.

CHAIR BELLA: That's wonderful. Thank you.

Tricia.

COMMISSIONER BROOKS: Thank you all.

I want to start just by acknowledging that unwinding was a heavy lift, long before we found out about the ex parte problem that really lit things on fire August 30th, and it's across the board.

I know that the folks at CMCS have been working tirelessly, that folks are beginning to feel beleaguered. Kate, that's happening at the state level. I think Allison could attest to the fact that those of us who work in the policy expertise space or beneficiary advocate space, are equally working the long hours trying to take stock of what's going on and help things get better.

And, Kate, I really appreciated your comments about the three-legged stool, I'll say here, which is the states, CMS, and the stakeholder community and really appreciate that.

So, Dan, there was a Politico article this morning that indicated -- it was about the shutdown -- that indicated that CMS is asking for $37 billion to assist states with the ex parte and with the unwinding process. Can you share anything more about what you have in mind for those dollars? Some of them stay with CMCS to boost your

resources. Any of it going to the states? Can you just share any details there on that particular point?

MR. TSAI: I don't think I can comment specifically on that right now, but I appreciate the question.

COMMISSIONER BROOKS: Okay. We'll kick that can down the road a little bit, but thank you.

Also, I wanted to talk a little bit about the timeliness of the data. We still have a three-to-four-month lag before CMS is posting data. Georgetown CCF and the Kaiser Family Foundation are all posting data sooner, and we've been doing some analysis of the state data, how it compares to what CMS put out for those first two months.

And, Kate, I just want to acknowledge, I know that NAMD has been encouraging states to be transparent.

And it takes time to work kinks out of data reporting, but hopefully, now that we've had a couple of months behind us, is there any sense that we should be posting these data sooner and not waiting on that three-to-four-month lag?

MR. TSAI: Yes. More to follow on that.

COMMISSIONER BROOKS: Okay, thanks.

And one last question, Dan. Sorry to put you on the spot, because of all the breaking news today, if you guys had pushed it out till next week, I wouldn't be able to ask these questions.

So we've heard rumors along the way that -- I don't know -- half, two-thirds of states, something like that, probably have this ex parte problem, and it may not just be only kids, although it's mostly kids. In terms of the states self-attesting that they don't have the problem, does CMS have anything in mind in terms of taking a harder look at their data and doing due diligence to make sure that the state actually engaged in a thorough assessment of their systems and are accurately reporting that information?

MR. TSAI: So I'll answer from the CMS standpoint, and maybe Kate can answer from how states would think about this.

From our standpoint, we were really, really explicit and clear around the attestations, and so we have received attestations -- and again, that will be -- the summary table be posted later this afternoon.

What we always say and have said since the

beginning is we're constantly evaluating, monitoring, engage with the states, looking at what's happening. Where we see potential issues, we go dig in, and there have been examples not related to this where we previously had identified an issue of compliance with federal requirements, engaged with the states, figured out how to fix, pause, that sort of thing. So folks can expect us to continue doing that sort of activity as well.

COMMISSIONER BROOKS: And, Kate, one last comment, because you mentioned the complexity, and particularly, when we get into the non-MAGI populations, we know that they just snowball from there. One of the options that CMS has offered states has a mitigation strategy, if they have the ex parte problem, is to simply push children's renewal dates out a year, which it's not a surprise to anyone watching or in the room to hear me say I think that's a great option, because if kids are 85, 90, 95 percent of the issue here, if we push those renewal dates out and we concentrate on those more diverse populations and fixing those issues and getting the systems in place, then when the kids start rolling around again and their volume rolls around again, then maybe we're going to be in

much better shape. Any thoughts about that?

MS. McEVOY: Yes. So I first want to start by saying that states and territories are mutually very, very much concerned and interested in retention of eligibility for children. So we're entirely on the same page with that.

From the standpoint of the ex parte options, I just want to again affirm CMCS offered, as it has done throughout the unwinding process, options to states, really looking to give states and territories the opportunity to identify best fit, especially where it is primarily a systems issue. So the mutual interest is in a rapid-cycle forensic solution that will really address the problem. And Dan talked about this aspect of identification, standing down, restoration of coverage, and then remedy.

So while I absolutely hear and resonate with the comment around knitting this with the continuous eligibility that will start January 1st -- and I think we all recognize that as a substantial good for children served by the program, Medicaid being an absolute mainstay of coverage for children nationwide -- when states are examining what they can do as rapidly as possible and as

accurately as possible, the options really give them a chance to, like I said, identify the best fit. So while some states will identify that maintenance of coverage piece, there's others who are able to use other tools and strategies right now, while all are preparing to fully implement in January 1st.

And I'll just maybe go back a little bit to what Dan was saying about the systems work. When this issue first started to arise -- and this was a set of mutual discussions with the federal government that well predated the issuance of that memo -- states really actively engaged with their systems vendors. Each and every state did that so that there was the opportunity to really examine at the nuts-and-bolts level of the systems, whether the individual obligation for ex parte was being fulfilled. So that has been well over a month of staging an examination of that, to your question of kind of CMS verifying this.

And I'll just say respectfully, we're all facing significant bandwidth considerations, and I know Dan's team is also in terms of being everywhere and having that sort of omnipresent capacity. Again, I think the constructive tension for us all is balancing, moving forward as

protectively as possible for eligible people, with the detailed level of the examination of organizational processes that are not only very complex but very much heterogeneous across the country. So I think that's where states were situated working with our vendors, and again, you saw those attestations. That is the first watershed point of getting where we need to go, and that is as quick as we can be getting this issue rectified, which is exactly what's happening.

CHAIR BELLA: Thank you, Tricia.

Jami.

COMMISSIONER SNYDER: Good afternoon. Great to see you, Dan, Kate, and Allison.

So I have a question. First of all, I want to start by saying, having left my post fairly recently as a Medicaid director in Arizona, I had the opportunity to be kind of on the front end of this discussion. I really want to commend CMS and CMCS for their early engagement with states around the unwinding process.

You were, even months and months ago, well over a year ago, in fact, having individual meetings with states on a routine basis to discuss what they were doing in

preparation for unwinding.

Also, I want to commend Kate at the helm of NAMD doing such an exceptional job of facilitating learning between the states as they walk through this process, and so my question pertains actually to that.

I would love to hear from you, Kate, Allison, and Dan, about states that you feel really are demonstrating sort of best practices in terms of working with stakeholders, in terms of tapping into the sentiments of members, and in terms of leveraging technology. And when I say stakeholders, I did want to point out, I'm really interested to hear more about states that are really leveraging managed care organizations as well to connect with members that are at risk of losing coverage.

CHAIR BELLA: Who wants to go first? And I think she's saying you better say Arizona. Otherwise, you're going to be in big trouble.

COMMISSIONER SNYDER: I am not.

[Laughter.]

CHAIR BELLA: All right, Kate. You want to go first?

MS. McEVOY: Yes, I'd love to. And, Jami, thank

you so much for your leadership. Everyone is aware Jami served as an incredible national leader among directors, also was chair of the NAMD board, and I think really led the organization during the preparatory phases for unwinding, which were incredibly crucial. So, Jami, I certainly just want to affirm all that you brought to that and continue to.

So NAMD convenes affinity groups, not only of directors, but also eligibility leads, chief financial officers, communications folks, and also the deputies. That happens on a fairly weekly basis. So there is essentially a laboratory basis for direct comparison of the state's experience, rapid-cycle polling, and also identification of best practice that has emerged.

I also mentioned earlier, we have held two summits that have brought together all states and territories again for that closed-door, very candid conversation of the how of this, not just the policies, the waivers, the kind of technical advice, but the how of translating this at the more local level.

So, as you said, I think there are a myriad of examples kind of across the continuum. From the outreach

and the preparatory pieces, there are unprecedented partnerships with the community-based organizations that have a longstanding trust basis with folks, especially those who have not historically been as capably served by the eligibility process, folks who might need accommodation based on language or disability, so looking at that and, again, routinizing that so it's not a recurring phenomenon that happens on an episodic basis.

The piece around engaging with the preparatory tools, the self-help tools to which I mentioned earlier, we have many states that are pursuing those, the sort of address change pieces, the pieces around examining where you are in the process. It's been known by the kind of shorthand pizza tracker, and I would point out Colorado as an example of a state that is really leading on the technology pieces, not only from the standpoint of member tools, but also the process of automating the services and supports of call centers for the folks who really need the additional supports if they're having complexities in the process, so that piece.

I think we've also seen some major partnerships, and we are grateful to CMS for really engendering these at

the national level. So, for instance, with the YMCA, with other organizations that are seeing people in different aspects of their lives, with school systems, and the like. So looking at every opportunity to kind of touch people where they are, where they work and shop. So that this is not just a sort of static formal governmental notice process is very important.

And I think that aspect of then kind of examining kind of full and complete use of all of the levers, many states have optimized the waivers that Dan referred to. Arizona was a great example of that among its peers in terms of really looking broadly and doing what you said, what we can do to partner with the managed care organizations that have a very crucial link to members, not only from the standpoint of communications, but examining folks with complex care needs, providing care support and care management; for instance, folks served by dialysis or in cancer treatment. So there are a myriad of examples.

I just wind up by saying that I'd also greatly credit our partner, State Health and Value Strategies, Heather Howard's group at Princeton. I think it's done a phenomenal job of illuminating the best practice in ways

that are highly digestible and then enabling connections among states to translate those more broadly.

MS. ORRIS: I'll maybe jump in, and, Jami, I was going to, as I was talking about ex parte before, mention Arizona's high ex parte rates. So kudos to you and your team for that, and I know your team also has long-standing relationships with managed care organizations that have been so helpful during unwinding.

I wanted to take the piece of your question about some of the states that have been really open to working with advocates and to learning from our experiences. Just a couple of examples that come to mind, West Virginia advocates do a biweekly Medicaid unwinding task force meeting. The state Medicaid agency attends on a regular basis, I think pretty much every time, answers questions, allows for open dialogue, and that's really been, I think, essential to identifying issues and making some progress.

Kentucky is another state that just did a town hall meeting, had over a hundred people in attendance, that cabinet officials joined and answered questions that have been bubbling up during unwinding.

So I think those kind of examples of states being

open, both privately and publicly, to talking with advocates about what's working and what isn't working, is really essential.

And then I just was going to put in another plug for the data and transparency that we've all been talking about. Having the access to performance indicator data that CMS has been collecting for many years, but that was not always public, has been essential for advocates to be able to identify what operational processes are going well and which ones may not be so that we can focus our attention and energy in areas that we think have a potential for impact at the state level.

CHAIR BELLA: Dan, did you want to make any comments?

MR. TSAI: I'll take a different dive.

By the way, I'm so hungry, and I'm eating Starbursts, and they really are giving me a little bit of a kick of energy now. So this is my lunch.

I think the -- so I agree with what everyone said. I think just a different piece for a sec, because you mentioned the managed care piece. I think managed care has great potential here, and we've said with our meetings

with plans, never have the plans' interests and ours from a public payers' standpoint been more aligned.

I do think there's variation in how much plans and states with their plans are utilizing all the levers of what a plan could bring. Part of the procedural disenrollment issue that we see is certainly there are folks that are being procedurally disenrolled because they are successfully transitioning to other forms of coverage. But we also know that there are many people not fully aware of where folks are in the state in the renewal process. Did they -- when their renewal form is coming or the support that they'll need.

And I think managed care plans have a level of resourcing or should have a level of resourcing or should be willing to invest a level of resourcing for the one-to-one direct engagement to help everyone over the finish line and to also understand what is going on when we see large procedural disenrollment rates.

For plans that have a relationship with those folks, are they seeming to get over to other forms of coverage, or are there folks in that they're former members, were just not aware of what's happening, et

cetera? And so I would like to see plans more consistently using every one of those levers. That is really where plans can have value. There absolutely are plans doing incredibly creative, exciting things around all sorts of outreach in a very personal way.

I think where I would push -- and so I would say that's the best practice. Where I would push is where I see plans doing generic fairs or generic flyers and not having a sense of having chased down individuals that are enrolled in the plan and really making sure that the contact information is right, and they're seeing where they are in the process and making sure that everyone makes it through. So that I think there's more opportunity for consistency and having every plan fully be utilizing every one of those levers.

CHAIR BELLA: Thank you.

All right. While the Commissioners are gathering questions, I'll ask another one, which is it's obviously incredibly important to be kind of in the thick of it right now, watching everything that's happening. But, you know, things probably weren't perfect -- well, not probably. Things weren't perfect before the pandemic, and there will

be opportunities to improve once we get through everybody's cycle of redetermination again.

So, as a Commission, if we pull back a little bit, I'd like each of you to give us some thoughts on like where would you tell us to focus so that eligibility in the future is easier, more consumer friendly, more CMS and state friendly, and I'd like us to kind of step back and think where could the Commission add value in 2025, 2026, and beyond as we think about ways to continue to suggest program improvements.

Allison, you haven't gone first yet. You want to go first?

MS. ORRIS: Sure. I mean, I think I think about this on two levels. One is to really dig into the administrative barriers and burdens and continue to make recommendations for CMS oversight and for states to continue to prioritize some of the things we've seen that are issues, like a lack of online renewal opportunities, making sure that states continue to fix those issues, and really highlighting for the public and for policymakers, the importance of all those administrative pieces.

Then I think I think bigger about what could the

Commission do to kind of take the lessons we've learned from this experiment over the last several years with continuous eligibility. As I think Kate said at the beginning, we know that the continuous coverage provision protected people at a time when they needed it most.

States all, as of 2024, will have one year of continuous eligibility for children. States are experimenting, including Massachusetts, with continuous eligibility for adults. Some states have waivers to permit continuous eligibility for kids from zero to six in those important developmental years. Really developing the data and learning from the experience that we're seeing, both the stability that came during the pandemic, what did that mean for people's health care and financial security, and what can we learn from some of the waivers that are in effect to potentially advance continuous eligibility policies into the future is something that I think MACPAC could be particularly helpful in doing.

CHAIR BELLA: Thank you.

Kate or Dan? This is the magic wand question. Have at it.

MR. TSAI: Sure.

MS. McEVOY: So --

MR. TSAI: Go ahead, Kate.

MS. McEVOY: Okay. So three things from my standpoint, and I've already talked a little bit about this. But first, I think MACPAC has an incredibly important opportunity with its kind of research capacity and neutrality to really forensically examine which levers were most significant in this effort.

We've had unprecedented outreach and engagement that really dwarfs anything that's ever occurred for the program in my professional lifetime. We've had emphasis on continuity and consistency across states and territories, optimization of the passive renewals, which is a means of obviously reducing burdens, the pieces around scaling the automation of the process.

I do want to just talk, say briefly that with the procedural terminations, I think we are still gaining discernment about what is going to be the most important lever or levers? Even in states with higher ex parte rates, we still see some with high procedural termination rates. So there may not be a linear relationship. And we may be needing to think about knitting together protective

features at various stages of an individual's engagement with Medicaid. So I'd say that kind of which lever or aspect seems like an unbelievably well-tailored thing for a MACPAC to look at.

Second, I think that aspect that to which I spoke earlier around scaling tech solutions for states. I think in my opinion, as a former director, we have relied on a state-by-state, first-dollar approach, and that has harmed us in this effort of looking to scale things and gain consistency in a unified approach across the country. It's made it more difficult to kind of diagnose where there are issues.

And again, examining the mode and means of the kind of tech solutions for Medicaid programs, I think would be extremely important and opportunities perhaps not fully tapped historically for the federal government to exert influence there.

And finally, I think Dan talked powerfully around the opportunity for telling the whole story of the continuum of coverage options. So that's a data premise, but it's also examining how fully realized are our means of connective tissue between Medicaid, the marketplace, and

ESI. We have a number of states that are really looking at that actively, New Hampshire, New York, Pennsylvania, really the nexus. As people's economic circumstances do fluctuate over time, are we doing everything possible from an enabling standpoint, not just in Medicaid but the kind of larger sphere of how an individual can remain effectively covered?

So I think those three things would be really crucial to look at.

CHAIR BELLA: Thank you, Kate.

MR. TSAI: I think those are all great points. I think there's no doubt the silver lining of this -- there's no doubt in my mind that the Medicaid program is going to come out stronger as a result of this intensity of focus, not only on the individual eligibility processes but the overall outreach, updating contact information and all that.

I think the question is, one, how do we reduce all the things that result in the churn that we speak of, which includes ex parte and how to maximize that, which MACPAC has been looking at, which includes how to get states off a predominantly paper-based way of executing

eligibility, recognizing some people will need that, but it is still mind-boggling that sometimes the best thing everyone can say to, "When do you need to go through your renewal" is "Look out in the mail for some time in the next 12 months for when a piece of paper will come, and you have to make sure you get it and return it within 30 days." That is a really, really tough piece and all the different ways of thinking about how to structure, how to engage with individuals, and then the entire consistency and the entire set of how we go through the eligibility process. There's a lot we are all seeing and learning into what is happening on the ground.

It certainly highlights really positive things. As we've discussed, it highlights the things underneath. They're like, oh, okay, we need to figure out how to work with that, and I think that really is a different way, at a different level of granularity, than has occurred before of how CMS and states have really looked under the hood, not just with the regulatory requirements, but how is the state system actually executing upon that. And I think there are good discussions and an opportunity we have to see what is the most effective way for everybody to think about that

going forward, so you get consistency, easier, greater clarity in knowing where folks are compliant or not, and then what are all the things, the best practices, exciting pieces that folks want to do to address some of those fundamental things I mentioned.

So I hope this will lead to a renaissance over the next multiyear period of how we in the country collectively think about eligibility and the ease of maintaining and getting access to coverage through Medicaid and other programs.

CHAIR BELLA: Thank you.

Okay. We now have a lot of Commissioners, and we have five minutes left.

So Dennis, Jami, John, the clock is on.

COMMISSIONER HEAPHY: Thank you.

This question is for anyone. Dan, what's the role of ACOs in assuring that folks are maintaining Medicaid?

MR. TSAI: I think for everyone in the delivery system, health plan, ACO, individual, hospital, provider, pediatrician, but I think we want everybody making sure folks are aware and people providing as much assistance as

possible. That's our all-hands-on-deck call.

COMMISSIONER HEAPHY: But are there best practices taking place in that arena? Because we talk a lot about MCOs, but I'm wondering about ACOs in particular.

MR. TSAI: I think, in general, where people have been actually going down a list and finding people and offering one-on-one support and understanding why someone is not responding, did they just miss the mail? Did they not realize? Those things and providing direct help to get over the finish line or connecting live with resources, that seems to make much more of the difference versus whether it's an ACO, MCO, whatever. General email blasts, general mailings, general health fairs, those things are way less effective at getting folks that are falling through the cracks of actually making it through.

COMMISSIONER HEAPHY: And again, just a question, what percentage of folks with disabilities are being disenrolled for administrative reasons or are not meeting the threshold for disability status?

MR. TSAI: I don't think we have that level of granularity.

COMMISSIONER HEAPHY: It could be helpful to

understand that across the states.

MR. TSAI: Yeah.

COMMISSIONER HEAPHY: Is there anyone collecting that data or going to be collecting that data?

MR. TSAI: We will have -- as soon as the underlying T-MSIS, the full eligibility files come through, we're going to be able to see by eligibility category, by different things, what is the change in enrollment. So that will give a lot of -- you know, is this group below, above average. That will provide some, I think, more data around where to probe.

COMMISSIONER HEAPHY: But I think that's something else the Commission can look at is those categories.

CHAIR BELLA: Thank you, Dennis.

Jami, then John.

COMMISSIONER SNYDER: Very quick question for you, Dan, and perhaps you mentioned this earlier, but when do you anticipate you'll be able to provide data on individuals transitioning to other forms of coverage, whether it's marketplace or employer-sponsored insurance and the like?

MR. TSAI: We're going to start to provide the early marketplace transition data very shortly. Everyone just remember there's a long lag about these things. So you need to see that they've disenrolled, you need to get the disenrollment file at the individual person level, match it to marketplace, do all that. So there's a lag.

We're working on the employer-sponsored piece. As you can imagine, there's no data source for that. We are linking up to other data sources. They vary in quality. But we are doing our darndest. The team is working to try to find some way to connect it. That will just take a little bit more time.

CHAIR BELLA: Thank you.

John?

COMMISSIONER McCARTHY: Hey, we're three months into most state fiscal years, although there's a couple who aren't. And there's been a lot of discussion now about pausing redeterminations, putting people back on that have been taken off. Those are big costs to states going forward. So what are states saying about that and the cost side, how they're going to deal with that going forward in this fiscal year?

MR. TSAI: Kate, do you want to --

MS. McEVOY: Thank you. Yeah. John, thank you very much for that question.

All states and territories remain very strongly committed to all the remedies that we discussed, particularly around the ex parte matter, and the approach that CMS has taken, we strongly subscribe to that mitigation approach as opposed to a straight compliance approach.

That said, it does involve a shift in posture and expectations around the pace and the volume of the reconsideration process, all of which had to be forecast nearly two years ago by the fiscal folks, given the sort of timing of state budgets. So there is a substantial amount of work to really kind of reconfigure expectations and get best possible understanding of the netting effect of retaining people but also folks who are migrating off who are no longer eligible.

Like I said, I think the data that we're seeing with the procedural terminations is very hard to interpret because it's not reconciled with the reconsideration restorations or other means of coming back onto the

program.

So what I will say is we're actively in dialogue with the Medicaid CFOs. We have a very well-engaged group that we maintain as an affinity group with at NAMD. It's a work in progress, but it is a factor for states.

And I'll just wind up to say that there are a lot of states that feel that it would be very beneficial if there could be anything that Congress could do to extend the enhanced FMAP at least for an additional quarter, given the additional responsibilities that are arising with compliance.

CHAIR BELLA: Thank you.

We promise Dan a hard stop right now. I don't know if Kate and Allison also have a hard step, and, Tricia, I don't know who your question is for. But if Dan has to pop off, we will say thank you very much for all you're doing and for all your team is doing and for joining us today.

MR. TSAI: Thanks so much. Good to see you, folks.

CHAIR BELLA: Thank you.

COMMISSIONER BROOKS: Thanks, Dan.

And really, it's more of a comment, because Dan, Kate and Allison, at some point, you've sort of alluded to the collaboration across the board.

And I just want to encourage CMS to think about learning collaboratives that also include external stakeholders. Back in the late -- before 2010, there was the Maximizing Enrollment Collaborative that the RWJ Foundation sponsored that included states, advocates, policy folks, and CMS at the table. And it was the best learning collaborative I've ever been involved in, in the 30 years that I've been doing this work.

And I know that CMS does a lot of learning collaboratives, but the stakeholder community is not part of that. And we enrich the information that CMS has. As Allison pointed out, CMS can't be on the ground in every state. And so if there are any funders listening, I'd be happy to talk with you about how you could help CMS and the states and stakeholders get together to do that.

CHAIR BELLA: Well, that was a good not-so-subtle plug.

All right. I'm going to ask Kate and Allison if they have any parting words for us. You're welcome -- the

Commission is going to talk for the next 30 minutes. You're welcome to be a part of that, but we're not subjecting you to any more questions. But we will give you each a last word if you'd like to -- if there's anything else that you'd like to impress upon us or you didn't get to already say.

MS. ORRIS: Well, I'll just jump in again with thanks for taking so much time on this issue over many months.

I think the thing I would like to leave you with is that we've talked today a lot about ex parte issues. We know there are a lot of other issues that are impacting people's ability to maintain coverage. One of the commissioners talked about people with disabilities. We know that there are people with Supplemental Security Income who are having a lot of difficulty with their renewals. We know that there are people who are sending forms in and they're -- the forms aren't getting worked in time, and they're getting terminated automatically. I could go on and on. I won't.

But I think I just have a sort of plea that we continue to think together and with CMS and states about

how to triage the work that is still going to be necessary over the next year to improve the experience and just thank you all for the energy and attention to keeping a focus on this work. It's really much appreciated.

CHAIR BELLA: Thank you, Allison.

MS. McEVOY: Yeah. I share all those sentiments. Thank you very much. It's an incredible privilege to have this conversation, to continue to speak forthrightly on what needs to be remedied and improved ongoing, but also to remark on the substantial work of bringing change to this large and consequential program and all the effort and intensity that has been brought to bear this year.

I would say two things briefly. Tricia, Medicaid directors want that direct contact also. I think too often the directors can be made to seem like the other, some far distant administrator who is remote and not able to be part of that feedback loop. So we would say that that would be a mutual interest and concern is to think about ways to embed that, that learning opportunity as just being one of those.

And I would just like to take the opportunity to thank the 56 directors across this country and their teams.

The intensity of the pandemic can hardly be overstated. I had the privilege of serving as a director during the pandemic, and for those folks then to migrate to this even more intense phase of development for the program, when there are low reserves following the pandemic, significant challenges with public trust and confidence in government, and these major, major aspects of systems that are slow moving and complex and very costly to shift, I just want to thank all the Medicaid teams across the country for being so mission-focused and really never saying die. This is a dynamic effort that everyone's really giving their all to and give them great credit for what they're doing.

Thank you so much for the opportunity to be here today.

CHAIR BELLA: Well, thank you both, and thank your teams and all the people on the ground that support your teams. It is remarkable. We thank Martha and Kate and the team here for keeping us sort of abreast of all this. And when you do the collaboratives, whoever does them, we want to be at the table too. So thank you for spending time with us today. Really, really appreciate it.

Martha, thank you.

We're going to open it up now for Commissioner discussion on what we heard, where we would like to go, any questions we have, or additional exploring that we want to do.

Who would like to start us off? Jami.

COMMISSIONER SNYDER: I really thought Kate's comment about really for assessing which of the flexibilities that have been offered to states are most impactful in terms of maintaining coverage for those that remain eligible, I think that's an area of potential exploration for the Commission and something I'd definitely like to see us explore a little bit further.

CHAIR BELLA: Tricia, you're smiling.

COMMISSIONER BROOKS: I'll always have something to say.

You know, there are a huge number of lessons learned which is actually somewhat encouraging that we can go and grow from here and do a better job.

I will say, to Jami's point, AHIP has commissioned NORC to do a study trying to look at the data and which states adopted the different managed care flexibilities. And there were additional things that we

asked the state about that didn't require flexibility. This was on the 50-state survey with Kaiser this year about whether states were sharing and list in advance who's coming up for renewal, and then before they terminate them, who's looking like they're on the list for a procedural disenrollment, so you could follow up, and then after the fact, you know, sort of segmenting those of who lost because they were ineligible versus procedural for getting folks back on.

And, you know, unfortunately, some of the states that are heavy managed care-dependent didn't pick up those options, and so it will be interesting to compare some of the results there.

As big as this ex parte problem that came about on August 30th, as I said, as I'll say in the panel or the next conversation about the roundtable that we had on ex parte, this is just the tip of the iceberg. It happens to impact a lot of people, particularly kids, but there are huge opportunities for us to really harness data and use technology in a way that is going to remove some of the red tape.

And I do think we have to better understand the

communication issues. I know we know that the undercount of people reporting that they had Medicaid during the pandemic almost doubled, and it was already bad enough in terms of using the American Community Survey data to really align with administrative enrollment data. That's how you would know that the undercount is there, and it almost doubled.

And I think we're going to see additional analysis in the future that indicates a large number of people thought they were actually uninsured and they had Medicaid, and what is it that went wrong there? What is it that we could have done? We know that a number -- a lot of states paused renewals initially because they thought that the pandemic was going to turn around quickly, and then CMS really indicated you need to get started back on these doing renewals. You should not -- if you can do an ex parte, you should do an ex parte. You obviously can't turn people off if they don't respond.

So we have got to crack this conundrum about how do we effectively communicate with beneficiaries so that they know what's expected of them and what they have to do to retain their coverage.

CHAIR BELLA: Thank you, Tricia.

Other comments?

Patti.

COMMISSIONER KILLINGSWORTH: Following up on Dennis's comment earlier or question earlier, I share concerns that we don't have disability-specific data to understand the impact on populations who arguably may face some of the greatest challenges and the renewal process.

I think we know that ex parte tends to be far less utilized and in that population, and I think it would be beneficial for us to think about and look into things that states may be doing to really streamline the redetermination process for people who receive long-term services and supports, again, for people who have disabilities and I would argue not limited to people who are eligible by virtue of their disability in terms of categories, and then also understanding what states are doing with respect to outreach and assistance and the impact that that's having.

And then I think it would be good to look specifically at gaps in LTSS coverage for this population resulting from the renewal process, things that we know

could be attributed to procedural barriers and challenges and really use that as an opportunity to think about how we streamline redetermination processes for this population going forward.

CHAIR BELLA: Thank you, Patti.

Adrienne and then Heidi.

COMMISSIONER McFADDEN: So I think, in my mind, that this this whole scenario has really given us a number of different proof of concepts, and so I think, to say it a different way, that Jami said, it's really to be able to evaluate the things that have worked really well, even at a small scale in one or two states and what could sort of lend itself to policies that maybe we can suggest going forward.

The second thing that I think we still haven't touched on a lot is just technology and not just the systems that are enabling states to perform these duties, but also, it boggles my mind that I can be at work all day and hear AI about 2,000 times a day. And in something like this, which is really about an abundance of material and data that individual humans are having to mine themselves, why we're not talking more about that, and what are the

roles that AI could play in helping these things.

And then I think the last thing that is really compelling to me is I really feel like the transitions between coverage are going to be really interesting, so not only going from Medicaid to the marketplace, to potentially employer-sponsored coverage, but also the reversal of which, because we're in an economic environment where there's going to be a lot of transition back and forth. And so I would really love some information on that.

CHAIR BELLA: Thank you.

Heidi.

COMMISSIONER ALLEN: This may be obvious to everybody else and not to me, and I apologize if so, but I'm wondering what the communication is with providers about gaps when people should have been covered but they're not. So when claims are generated and the system says this person does not have Medicaid, I assume that the person would then be sent a bill. And I don't know that anybody is telling the providers that they need to reprocess claims for people who had points of care during these times of gaps, and maybe those of you who've run Medicaid programs say like, oh, yes, they rerun it, but if they don't, then

that really exposes people to some pretty significant financial costs, which they may not feel empowered to reach out to the hospital or the provider and say, "No, actually, I was covered," and really could affect their credit and have big implications for the rest of their life.

Does anybody know how that's being handled?

COMMISSIONER McCARTHY: So a couple of different things on this one. And I can't speak, Heidi, what states are doing exactly right now in doing this, but kind of, in general, on some of these different pieces. Number one, yes, when people get reinstated, those -- whether it's fee-for-service or managed care, those claims -- that goes back in. If it's a fee-for-service claim, sometimes the states decide to rerun on themselves. Sometimes letters go out or providers are contacted. Providers can resubmit those claims.

Same thing for managed care. Those claims can be resubmitted. And just so you know, often, because this is all electronic, those claims often do automatically get submitted every few months to see if it will get paid. So that's number one.

Number two is when it comes to families,

depending on which provider type it is -- so if it's a hospital, for instance, in some of the states we're talking about, they have presumptive eligibility or other things like that. They try to help people get coverage first. They usually don't go after people if they aren't high-income people, and that's an issue that comes up in there. But there's also DSH programs that can pay for claims and things like that. Again, it depends on the state and where you're at. And I know you're going to say, oh, no, they do. And I'm not saying it's in every case. I'm saying there's cases in there.

And then the third one on that one is, depending on the provider type, I think, where you have the issue that you see it most often is especially in primary care physician offices and areas like that where the person may have trouble later on trying to get services, because a claim wasn't paid or something like that. But the biggest piece on it is on the retroactive, having those claims get resubmitted and paid, and that's how it generally is done in Medicaid agencies.

CHAIR BELLA: Carolyn --

COMMISSIONER BROOKS: I think this is a heavy

lift. We haven't even talked about the impact of reinstating people on plans or on providers and how to communicate that and let people know that if they have unpaid bills, what they need to do about it or -- I mean, this is -- there's going to be this huge effect there.

COMMISSIONER INGRAM: So on this topic, what concerns me is there are some states that are retroactively reinstating people back to their original source of care, if that was managed care or they had some other type of program, and there are other states saying they're not going to do that. They're just going to reinstate them to fee-for-service. So the provider would have to then switch bills to bill fee-for-service. Then going forward, they'll put them in back into managed care, once they go through an enrollment process. Then the provider has to switch over there.

And that also is really hard, I think, for people with disabilities who are having to deal with several different aspects, whether it's meal delivery, transportation, other things, personal care that they get at their home. That type of bouncing back and forth between programs doesn't work.

So I think either making a recommendation as a Commission or asking the question, what are some of the best practices of states in terms of how they reinstated people and gave direction back to providers, that's the job of the managed care companies, frankly. And if somebody's been -- had a care plan and it was all set up and they've got all of these providers in care, it would be a total miss and a shame to have them just go back again and start all over in fee-for-service for so many months and then try to go back and get their providers switched to bill a different way.

So I think that's something we could look at in terms of best practices and explaining some of what John was just talking about as a group.

CHAIR BELLA: Yes.

COMMISSIONER ALLEN: Could it be the case that the provider would not be in fee-for-service but would be in managed care, and then the claim would not be allowed?

COMMISSIONER INGRAM: Yeah. In some states, yes. It depends on the state policy in that area.

CHAIR BELLA: Other comments?

Sonja, then Angela -- oh. No. Verlon. Sorry.

This side of the house is getting --

COMMISSIONER BJORK: All right. Are we going to be looking at state fair hearing data regarding eligibility cutoffs or perhaps bills that came in? Is that going to be available related to this?

MS. HEBERLEIN: You mean in terms of -- so there are the data -- I put in your memo -- are the data that CMS has released to date, which are current as of May. So --

COMMISSIONER BJORK: It's just very behind, right?

MS. HEBERLEIN: Yeah. I'm happy to keep bringing those.

As Tricia said, CCF puts out data pulling from state reports. Those reports -- and you correct me if I get this wrong -- are the same CMS reports -- or the same reports that the states submit to CMS.

Kaiser is also posting more recent data, but their reports are pulled both from the CMS reports and state dashboards. So there's more variability in terms of what you might be getting there. So those data include renewals, who was not renewed, who was renewed via ex parte, who was denied for or terminated for procedural

reasons.

And then there's operational data, that's like call center data. There's not claims or spending as of this point. Dan did talk a little bit about when we get T-MSIS data, and I'd have to phone-a-friend about when that's going to happen, but when we get the T-MSIS data, there will be information that's more granular, both on the eligibility side and the categories of who's in which bucket for renewals, as well as what services were provided during that time period.

There are some states that are reporting more granular data, and Kaiser, I know, puts this out -- and so does CCF -- about the number of kids. That's the breakdown I've seen. There are a handful of states that do more granular breaks, but that's not a CAA requirement, and that's not what CMS is putting out at this point in time.

But we will have more data at some point in the future to look at that.

COMMISSIONER BJORK: Okay. And I just -- I want to support Heidi's request for investigation into what beneficiary education we can do and provider education we can do and perhaps best practices. I know many states

handle things differently regarding whether people go back into fee-for-service or whether they go back into their managed care organization, but how terrible to go through first not being able to get the care, getting your care interrupted, then getting some bills for those things. And then if you didn't pay close attention, you could get sent to collections, and just the consequences are really dire for some people. And so perhaps we could look into that and maybe make some overall recommendations.

CHAIR BELLA: Thank you, Sonja.

Verlon and then Jenny.

COMMISSIONER JOHNSON: All right. Well, I just want to say to Martha, thank you. I would have been happy with just one of them for a panel. So I was very excited to see all three of them. It was very, very educational.

One of the things that I just need clarification on is -- I think Kate was talking about when she was mentioning continuous coverage, and she had called out a couple of states. And I just want to learn more about what those states are doing. I think it was New York and I think Pennsylvania, maybe another one or so.

MS. HEBERLEIN: Yeah. I'll do what I can from

memory.

COMMISSIONER JOHNSON: Okay.

MS. HEBERLEIN: So all states will need to cover kids continuously for 12 months starting January 2024. Last I looked at Tricia's survey -- and she can correct me and will -- about half of states, maybe it was like two-thirds, already do it for kids. Although it differs. Some do it for Medicaid. Some do it for CHIP. Some do it for both.

There's a handful of states -- and I want to say New York is one. Montana was one at one point in time, but I think has since dropped it -- that were doing it for adults under a waiver. So there's -- you can't do it for adults unless under waiver.

We did a recommendation that predates anybody that's currently on staff that said something along the lines about making it an option for states to pick up continuous coverage for adults rather than through a waiver, make it a state plan option, but that was 2014.

So there are a handful of states that do it through waiver, and I think that's what Allison was referring to.

COMMISSIONER JOHNSON: Okay.

MS. HEBERLEIN: And then there's the states that currently do it for kids. Everybody's going to have to do it in January for kids.

COMMISSIONER JOHNSON: Okay. That's helpful.

And then I had another question, and I just don't know the answer to this. What is a pizza tracker?

MS. HEBERLEIN: So if you order a meal and it says we're going to deliver your meal, sometimes they will send you little text alerts, like I'm preparing your meal. Oh, it's en route. Oh, here's the timing. And so there's a handful of states, and I can't tell you which ones, but I can dig in and get back to you. But the idea is that there's a tracker that will say we are processing your renewal.

COMMISSIONER JOHNSON: Gotcha.

MS. HEBERLEIN: You need to fill out these forms, the renewal form, your date is this. And so it's a way for beneficiaries to stay more on top of where their case is in the process, so that it gives them more information. And I think some of the idea behind it is also to prevent more phone calls to the call center. So it's more of like a

self-help-type thing where you get--you can access more information about your case without having to actually speak to somebody.

COMMISSIONER JOHNSON: Very helpful. Thank you.

CHAIR BELLA: Jenny.

COMMISSIONER GERSTORFF: Do we know in the T-MSIS data that we'll be getting whether there are indicators for retroactive coverage periods?

MS. HEBERLEIN: That is a very good question and one I have asked several times, and I think -- and again, I might have to phone a friend if I get this wrong, but I don't think it fully goes back because there are some states that will report back your eligibility to the date of retro, and so you can't necessarily tell if that is a retroactive period or your date of coverage period.

To my knowledge, you cannot really parse out, although perhaps there’s a flag possibly. It's been a question we've asked internally, but my understanding is you can't fully understand what's retro versus what's just your date of coverage.

CHAIR BELLA: Dennis and then Heidi.

COMMISSIONER HEAPHY: It blows my mind with the

MCOs that I think we shouldn't have any or very few procedural folks not getting their Medicaid. So I'm wondering what we could do, even bringing in some MCOs in to talk with them and say, what are the barriers? What are the challenges? How would you go about this? Because that goes to just even finding people. They have challenges anyway, and so maybe it's better understanding from them, because they really should be on the front lines of doing this. Bringing them and ask them question like, how can we do this better? How can you do it better?

CHAIR BELLA: Anecdotally, I think the plans have had quite different experiences across the states, and so it would be interesting to see what the difference is in the relationship of the plan and the state environment.

But, Martha, we do love panels. So a plug for some more panels. Yeah, as if we have time. I know.

Dennis, did you have any more comments before I go to Heidi?

COMMISSIONER HEAPHY: No. I just think we should aim for really low procedural rates, and how can we do that?

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: So I just want to point out that claims that don't get processed by Medicaid will not be in T-MSIS at all. So that's a real big gap. We won't be able to look and see that.

And I would like us to kind of think about people getting billed for care that they should have had paid for while they were not on Medicaid during that brief period, kind of the way -- like a never event, like Medicare used to pay for if somebody left a sponge inside in surgery, and then all of a sudden, they were like, you know what, we're not going to pay for never events anymore. And it changed hospital practices. It changed the delivery of care really profoundly, and I think that we really need to take a principled stance that no Medicaid enrollees should face medical debt or bills related to a time when they should have been eligible, no matter like how that -- and I don't know how you would enforce that.

But I study low-income people and their finances, and these are very precarious situations that people are living in. And it can interrupt their housing. It can interrupt their childcare, their employment. All of these things hinge on just a few dollars, and in my experience,

health care providers do go after low-income people for collections. That is -- and I have -- you know, I've studied data from the credit bureaus, and we can see that in the data that they go to collections for medical debt.

So I really would -- I don't know how to communicate and who it gets communicated to, but to say there really just needs to be some state messaging that if you have any bill whatsoever that you think you were covered for, let us know, and some way to remedy that doesn't require them to do the work.

CHAIR BELLA: Thank you, Heidi.

Tricia for the last comment. Then we're going to wrap.

COMMISSIONER BROOKS: It's just I need to correct the record for something I said earlier, and that is, I said that the Biden administration asked for $37 billion. It's is $3.7 billion for unwinding. Just wanted to make sure that I wasn't overstating what that might do.

CHAIR BELLA: Yeah, the 37 kind of threw a few of us, but, you know, thank you for that correction. And for the record, the administration has now released the information that Dan had referenced, yeah, for anyone

listening in the audience.

All right. Yes.

COMMISSIONER HEAPHY: Sorry. I think it would be helpful to hear from beneficiaries who lost continuity of care sometime next year. Is there any to get some folks in a listening group and get the information back to us? Because it really -- I think it would be helpful to know how this impacted folks.

CHAIR BELLA: Martha, I know you're coming back after the break, but we're hearing -- isn't she? Yes. Yeah, yeah.

MS. HEBERLEIN: I'm not going anywhere.

CHAIR BELLA: You look surprised.

MS. HEBERLEIN: I didn’t think there was a break.

CHAIR BELLA: Well, we're going to do public comment and a break, I think.

Obviously, like a lot of common themes coming out, looking at transitions and the coverage continuum. Looking at which flexibilities have been significant to me is the same thing as trying to figure out reducing administrative barriers and simplifying the process -- not the same but related.

Data which I know we're always anxiously awaiting whatever next release of something is going to be coming out.

And then just a reminder that Allison had at the end. It's more than just ex parte and kind of keeping an eye on all of that.

But I do encourage us. There's lots of people looking at these weeds right now, and we should be among those people. But we also, I think, do have an obligation to step back and continue to ask ourselves what is the best way that this program could run for everyone who participates in it and relies on it. So I would encourage us to keep thinking about big and long term as we look toward where the Commission might be able to make an impact on how to make this whole eligibility system better.

So do you have -- do you need anything else from us on this discussion?

[No response.]

CHAIR BELLA: I knew you were not going to say yes.

All right. We're going to take public comment on this discussion. I'll remind folks in the audience, if you

would like to make a comment, please put your hand icon up. We'll ask that you introduce yourself and the organization you represent, and we will keep comments to no longer than three minutes, please.

Yes. Thank you.

PUBLIC COMMENT

* MS. Friedman, if you want to unmute, you're welcome to make your comment.

MS. FRIEDMAN: Hello?

CHAIR BELLA: Hello. Welcome. You're welcome to make your comment.

MS. FRIEDMAN: Yes. Hi. I'm new to the program. I'm just a little bit like -- I know exactly how it works, but my name is Ms. Friedman.

I am coming from a provider's perspective. We were discussing claims that are rejected or denied within Medicaid. We are encountering an issue. I'm just -- I was just curious if MACPAC was the right place where we can discuss this issue. Like when Medicaid denies a claim, Medicaid fee-for-service, there's no appeals process in the state for Medicaid fee-for-service. Like there is -- we can resubmit the claim, but if you have to submit any

paperwork or these kind of things, there's no way we can appeal the claim if we have anything that we want to explain to Medicaid when they reject the claim, if the system rejects it.

So, as I was listening to the program, I understand that there is a need for providers to rather bill Medicaid than billing the patients, but if we don't have a way to bill Medicaid and appeal the claim, then we would not be able to bill Medicaid for that.

CHAIR BELLA: First of all, thank you for joining us.

I'm sure several people could speculate at an answer for you, but it would probably be more accurate if we could follow up with you offline and find out the state and see if we can help connect you with the right resources.

Would you be able to send us your contact information to the Comments@MACPAC.gov email address that's on the screen?

MS. FRIEDMAN: Definitely.

CHAIR BELLA: Okay.

MS. FRIEDMAN: So you want me to reach out there

with my information?

CHAIR BELLA: If you send us that and you could also share with us what state you're talking about, I think we might have a better sense of trying to connect you to the right resources.

MS. FRIEDMAN: Okay. Thank you.

CHAIR BELLA: Okay.

MS. FRIEDMAN: I really appreciate it.

CHAIR BELLA: Thank you very much.

All right. Ronnie Coleman?

MS. COLEMAN: Hi. My name's Ronnie Coleman. I'm government relations person for Benevis. We support Medicaid-focused dental offices in 13 states and D.C.

And I would just like to say that I want to give some kudos to a few states so far. Kentucky, we're really thankful for them choosing to push kids into next year for redetermination. That was one of the suggestions somebody mentioned earlier, and that's what Kentucky has put into practice.

And then Indiana and Connecticut have been helpful to us because we're able to submit complete lists of our patients across eight, nine offices per state with

their Medicaid ID numbers. And the state was able to produce a list with the individual's renewal date. So we could actually do a more focused campaign as the patient's renewal is getting close, if they had an appointment in the near -- in the vicinity. So that was very, very helpful. So kudos to them.

And so I would highly recommend if you guys have any influence to encourage more states to take that Kentucky approach.

But I'll just say that a real challenge for Medicaid-focused providers has been the fact that we're post pandemic with significant workforce challenges. Obviously, many Medicaid dental providers have extremely low show rates, and of course, most states reimbursed very poorly. This redetermination problem has been a real issue for us, because just as we thought we were improving in terms of the patients showing up and we're generating more providers to join our practices, we started seeing a significant number of people arriving at our offices or when we had to renew or sort of acknowledge their appointment two or three days in advance, that they came up coverage not effective. And so that has put a burden on

the practice that we certainly weren't expecting going into the summer.

But beyond that, I want to thank you for hosting this conversation. I think most of the states are doing the very best they can. I know they're overwhelmed. Everybody is workforce challenged. They are too. And then, of course, all the systems' challenges associated with ex parte has been just unprecedented and certainly unforeseen.

So, again, thanks for what you guys do, and those are my comments. Thanks.

CHAIR BELLA: Well, thank you for joining us, and we're always -- it's always helpful to hear from folks on the ground that are experiencing best practices, so don't be shy, please, about letting us know that. And thank you for what you're doing to individually try to help folks meet their redetermination dates.

All right. It does not appear that we have any additional comments at this time. We'll have one more chance for public comment at the end of the day.

Given that, Martha, we are actually going to take a short break before. So I'll give folks 10 minutes for a

break. 3:17, to be precise. Please come back around 3:15, 3:17, and we'll restart. Thank you.

Thank you, Martha.

* [Recess.]

CHAIR BELLA: Martha, welcome back. We are now going to talk about ex parte which I know we've touched on a little bit already today, but we'll turn it to you to lead us through the materials, and then we'll see what additional comments we may have on this issue. Thank you.

EX PARTE EXPERT ROUNDTABLE

* MS. HEBERLEIN: Great. Thank you.

So I'm going to begin today by providing some brief background on the impetus for this work before describing the roundtable itself, and then I'll review some of the key considerations that participants raised in effective ex parte renewals before discussing opportunities for improvement and some recent developments in ex parte policies.

So, as you heard from the last panel, unwinding the continuous coverage requirements is a monumental task. Given the level of effort, CMS, states, and other stakeholders have focused on ways to streamline the

process. One area of focus has been a long-standing requirement referred to ex parte renewals.

In this process, states complete redeterminations by checking available data sources prior to requesting information from the beneficiary. Rates of successful renewals using the ex parte approach vary by state and by population, and so to better understand the barriers and possible opportunities for improving the ex parte rates, MACPAC contracted with Mathematica to conduct an expert roundtable over the summer.

The roundtable was held virtually over two 3-hour sessions in late June and included participants from CMS, states, and subject-matter experts. The six states included represented diverse political affiliations and geographies as well as a number of policy factors, including differences in ex parte renewal rates, recent efforts to improve their processes, and systems integration. Subject-matter experts included beneficiary advocates, policy and program integrity experts, and information technology system vendors. In addition, MACPAC staff and two Commissioners attended the roundtable as observers.

Overall, participants agreed that improving ex parte renewals is an important goal but that there are a number of factors that complicate implementation. Furthermore, while these changes are technically possible, the issues may take time to resolve.

So, to review some of these key takeaways. When conducting ex parte renewals, states must use available information, as I said, but states have flexibility to determine which data sources they consider to be most useful, and as a result, the specific data sources used and the priority of their review varies across the states.

Roundtable participants noted that to successfully conduct ex parte renewals, states need to access a variety of data sources, and that some sources are more important for conducting ex parte renewals with certain populations than others.

Additionally, the order in which the data are reviewed vary based on what data are available as well as other policy priorities. For example, one state without a state income tax begins the ex parte process by examining Internal Revenue Service, or IRS data, but several other states noted that IRS data is less useful because they have

more recent state-level income data to tap.

Some subpopulations of Medicaid beneficiaries are also more challenging to renew via ex parte. In some cases, this is due to the additional eligibility criteria that may be more difficult to verify electronically. This is especially true for beneficiaries whose eligibility is based on age or disability, for whom asset verification presents particular challenges.

Individuals whose income is not readily verified electronically, such as those who are self-employed, those who may be shifting between eligibility categories, as well as those with medical conditions or health costs that need to be verified also face challenges.

In general, roundtable participants agreed that policy decisions, data sources, and data access challenges play a more substantial role in the success of ex parte processes rather than systems or IT issues.

Participants agreed that generally vendors can program changes requested by the state, although some changes might be easier and less expensive to make than other changes that require more extensive programming. Yet even small upgrades require time and money for planning,

development, and testing, and states have limited resources to make IT changes and upgrades, which necessitates the setting of priorities.

One of the primary system factors affecting ex parte renewals is whether the state's eligibility system is integrated with other human services programs. For example, states with integrated systems have access to updated information from an individual's Supplemental Nutrition Assistance Program, or SNAP, renewal which might streamline the process.

In states where the Medicaid eligibility system is not integrated with other programs, access to usable data can be hampered by the need to set up data use agreements as well as more limited data that might be shared and which does not provide sufficient detail to actually make the eligibility determination.

Finally, some states use fully automated data checks in which the computer programs automatically connect to electronic data sources and compare the results. And while full automation is not required to achieve a high rate of ex parte renewals, automating ex parte processing could free up staff time for other eligibility-related

tasks, such as processing renewal forms completed by beneficiaries for whom ex parte is not successful or responding to new applications.

But, on the other hand, one state participant acknowledged that with greater automation, it often takes more time to identify defects within the system than it did with manual processes where caseworkers were monitoring the process at all times.

So participants identified a number of potential opportunities for states, CMS, and IT vendors to improve the ex parte renewal process.

So, first, roundtable participants suggested that states make ex parte policies and processes, including their system logic and successful strategies and mitigation plans publicly available. They also suggested that IT vendors could better support states by sharing ex parte rules and logic publicly.

The participants who made these suggestions believe that this kind of transparency could be an important tool to helping CMS, states, and other stakeholders, such as advocates, understand the ex parte approaches and identify changes that states can make to

improve their rates.

Participants also suggested that ex parte renewal data continue to be published after the unwinding period ends, and that additional data, such as ex parte rates by eligibility category, should be shared. Participants noted that both states and CMS play a role in increasing the transparency around ex parte renewals.

Participants also suggested that states should evaluate whether their current policies and systems' configurations comply with federal and state rules and identify opportunities for improvement. For example, one participant mentioned that states should conduct a careful walkthrough of IT systems and business rules. Another suggested that states and vendors could engage beneficiaries and advocates to develop test cases to run through the system. Some participants also recommended that CMS conduct additional oversight of state ex parte processes to ensure that state systems do not conflict with federal requirements or state policies as well as to promote greater accountability for states with particularly low ex parte renewal rates.

Participants also indicated that CMS should

provide additional and clearer guidance for states. For example, a suggestion garnering significant interest was for CMS to identify the types of assets that are not likely to appreciate and notify states that they do not need to verify them annually.

Participants also requested that CMS provide additional technical assistance on topics related to ex parte, including intensive TA to states with low rates and around the use of specific data sources, such as SNAP.

Participants also indicated interest in sharing examples of successful state practices and finding opportunities for collective learning across states, which Tricia talked about during the last session. For example, CMS could host convenings that allow states to hear what others are doing and to collaborate or identify additional solutions.

Another participant suggested that vendors could sponsor or facilitate meetings for the states that they serve.

Participants also encouraged the federal government to consider making the flexibilities allowed during the unwinding period under Section 1902(e)(14)

waivers permanent. Throughout the roundtable discussions, several participants emphasized the value of these waivers, specifically with regard to asset verification, ex parte renewals for individuals with zero income, and the use of SNAP eligibility information for ex parte renewals.

So, as we know, there continues to be an intense focus on ex parte renewals and state compliance with requirements. For example, as we talked about earlier, there was the August 30th letter from CMS that was sent to states highlighting the need to conduct ex parte renewals at the individual rather than household levels. I want to note here that this issue actually was not raised at all during the roundtable and seemed to have come to light a couple of weeks later.

I also want you to know that while the data came out on which states, I have not looked at them yet, so don't ask me any specific questions, and I can get back to you if you have them.

We also know that CMS is continuing, as we heard, its monitoring efforts in this area and working with states to come into full compliance with renewal requirements, and the agency anticipates that it might provide additional

guidance or technical assistance as needed when issues are identified.

So, to be most useful to these ongoing efforts, MACPAC intends to publish an issue brief with the findings from the roundtable -- we included a draft in your materials -- in the coming weeks.

So, with that, I turn it over to you guys for comments and questions about the roundtable.

CHAIR BELLA: Thank you, Martha.

I'll start first with Verlon and Tricia, who were there, if they would like to make any comments.

COMMISSIONER JOHNSON: Yeah. I mean, I will say that that it was a very helpful session. It was really good to have a variety of stakeholders participate. I think that what we heard was -- well, we didn't hear about the August 30th issue, as you've indicated, but we did hear about other challenges and issues. Some, I think we were probably familiar with, and others were new. But it was also an opportunity, I thought, too, that folks were able to not only identify the challenges and opportunities but also some of the -- really get some answers, some real-time answers answered as well. So I thought that was really

helpful, and I'd just encourage us to have more panels like that moving forward.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So, yeah, I thought it was a great discussion, and I just need to reiterate what Martha said, that the particular issue with the multi-member households and the incorrect ex parte never came up, but we had plenty to work on before we discovered that particular issue.

I think it's helpful to point out that a number of states where they have the biggest problem in ex parte is in the non-MAGI population. Some of those folks are still maintained in old legacy-based systems that simply don't have the ability to do ex parte in the same way.

So some of the mitigation strategies that you see that states were required to pick up to be in compliance with federal rules would more often revolve around the non-MAGI populations, and so trying to get those populations into the newer systems, I think it's going to be really important in the future. And I can understand why it didn't occur at the time of ACA implementation, but it's been 10 years. So it's time to move on.

I think it was really helpful -- and I made this point in the last panel -- about having stakeholders at the table too, because there was learning back and forth between the states and CMS. A couple of issues arose that indicated that states did not understand federal policy, and there needs to be additional guidance and clarification around that. So, to that extent, I think it was really a refreshing opportunity for folks to sit at the table and share their thoughts about how things are working and how they could work if we did a better job, and I think we need to continue this going forward as a real important body of work to help move it along so that we can really get to the promise of paper-free determinations.

CHAIR BELLA: Thank you, Verlon and Tricia.

Other comments?

Heidi.

COMMISSIONER ALLEN: Thank you for this. It's super interesting, and I love the role that MACPAC played as a convener, which I think it sounds like it was really beneficial.

One area that I'm not sure who is going to take on -- and maybe this is what CMS is going to do, but the

need for determining the data hierarchies for different populations, that seems like very concrete and that we should just have one approach to doing that. If you don't have that data, then that's fine. It doesn't apply to you, but you can apply the data that you do have access to in a way that is systematic and is similar across states and is important based on the person's eligibility pathway so that it makes the most sense.

Do you know if anybody is going to do that?

MS. HEBERLEIN: It did not seem like there was an appetite for having one data hierarchy. The states and I think the rest of the stakeholders that were there recognized the need for looking at multiple data sources, but I think there was a lot of recognition of the need for the state flexibility.

That example I used about the IRS data is one, but then I think some of it also depends on the populations you cover and the data that are most relevant to them. You need your SSI data, right, and then also what you're integrated with. So I think that it would be -- I think it would be difficult to come up with a one-size-fits-all data hierarchy.

I think there have been some tools that have been put out. Kate McEvoy in the last session mentioned the State Health & Value -- [audio break].

UNIDENTIFIED SPEAKER: [Speaking off microphone.]

MS. HEBERLEIN: Thank you.

-- Strategies at Princeton, and they have done some work in thinking about what are the considerations, and I think tools like that can be particularly helpful for states and vendors as they're thinking through. But I think given the complexities, both of like the data that are available to states and the populations that they cover, I think it would be difficult to have one single hierarchy. I think it might be more fruitful to think about here are the things you need to think about when you're setting up your hierarchy and how you want to prioritize your data.

CHAIR BELLA: Other comments?

Patti.

COMMISSIONER KILLINGSWORTH: I'm going to sound a little bit like a bit of a broken record, but I do want to go back to, again, the fact that people with disabilities are far less likely to benefit from the ex parte process

and yet may face some of the greatest challenges in that renewal process.

And so I would like to see us really explore potential opportunities specific to that population, both people who receive long-term services and supports as well as people who are in disability-related eligibility categories.

CHAIR BELLA: Thank you.

Other comments?

COMMISSIONER HEAPHY: Is there anything from that roundtable that we should discuss further, or was there anything specific in that -- you come up with these great statements, and so I'm wondering if there's anything that stood out for you in the roundtable that we haven't heard yet.

COMMISSIONER JOHNSON: No. I mean, really what Tricia said about the non-MAGI population --

COMMISSIONER HEAPHY: Okay.

COMMISSIONER JOHNSON: -- the subpopulations, that really stood out for me a lot, probably more than anything. That's as profound as I can get today. I'm sorry.

COMMISSIONER HEAPHY: No, that's good. That's great.

COMMISSIONER JOHNSON: I'll do better tomorrow. Thanks.

CHAIR BELLA: Martha, were you surprised by anything you heard?

MS. HEBERLEIN: There was a couple of things that were way more weedy than I had anticipated and never had frankly thought about, which I think goes back to highlighting Tricia's point -- and Verlon said a similar comment just now -- that bringing the folks together who are the policy folks but also the people who are experiencing it on the ground and then the IT vendors -- and seeing it all together really brought up some issues that I had not heard about.

We spent a very, very, very long time talking about assets and the trouble that they pose for states because they have to have an asset verification system that's electronic, but not all assets are in there, not all banks participate, and how that is a complicated process. And I thought the conversation was -- not being a non-MAGI expert -- I thought it was very fruitful in terms of, well,

these are things you can already do under your state plan, these are things you can currently do in a waiver, and here's some additional guidance that might be helpful from CMS.

So I think there was a lot, like I thought it was a very interesting discussion and a very collaborative discussion across all the parties that were there, and there's definitely some issues that when you start to -- like we heard this -- when you start to look under the hood, there's like all sorts of things that you're like, "Oh, my gosh, I hadn't even thought of that." And that was true for me where, you know, I was chatting with colleagues who were there too, like never crossed my mind about that issue, and I think until you start really looking at the data and really looking at particular cases, those things don't come to light. And you can't think about how to fix them until you identify them.

CHAIR BELLA: I can't believe you were surprised by the weeds.

MS. HEBERLEIN: I was. It was so fun, though. I have to say.

[Laughter.]

COMMISSIONER KILLINGSWORTH: I have a question.

CHAIR BELLA: Patti.

COMMISSIONER KILLINGSWORTH: Can you identify anything that came to light as what you would sort of term low-hanging fruit, things that would be fairly easy to do but would have huge benefit for beneficiaries?

MS. HEBERLEIN: So I think the one I highlighted in my talking points about the asset verification and what is required to be verified on an annual basis, and I know in FAQ not that long ago, CMS put out some examples of what might not depreciate. But say you as a non-MAGI individual, a vehicle is one of your assets that they look at. Well, we all know that once you drive your car off the lot, it's no longer worth as much as it was when it was sitting on the lot. So, therefore, that particular asset is not going to appreciate. So why do you need to have the beneficiary try to verify the value of their car if you know it was before underneath the limit? Right? So there's certain things like that, that I think, you know -- and that was one of the things that there was a lot of support for was having more guidance around specific assets and what might appreciate and what might not appreciate and

how states could disregard those in their policies and not have to re-verify those on an annual basis, if they've already done it.

CHAIR BELLA: John.

COMMISSIONER McCARTHY: I think this is one of those areas like best practices on some of these and gathering some of that different information.

Tim and I were talking about this earlier of thinking through -- like we've gone through this whole process, and you saw different cases and things like that. If we could get those -- our suggestion to CMS would be to have test case scenarios. So when we do MMIS system certifications, those claims that were given examples have been run for years and years, and it's like every possible way you can imagine a claim can be running. It would catch those issues, but it seems like we don't have that for eligibility, and so that would be one of those examples of each one of those kind of test cases to be able to turn them over to states and say, "Hey, run these through your system. How does it work?" and just getting those down.

Martha, I agree with you, because when we implemented the system in Ohio, after the ACA, we were just

running into issues of how do we deal with this pregnant mother who has this change or this change, and we were literally in rooms going through step by step. And we didn't know if this was going to be one case that we were dealing with or 5,000 cases. But just to be able to have those, to be able say, "Hey, states, here's a list of cases," and then just add to that to verify as we go forward -- or as they go forward, I should say.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: I don't know if others have points they want to make, because I want to come back to a couple of things.

On the hierarchy issue, I actually think there's some merit at looking at a hybrid approach that for certain populations, there's a hierarchy that makes sense for that population, right? And so you would break it down that way as opposed to one size fits all.

I think the other thing that we are quite aware of -- and it gets back to the asset verification issue -- is where are states over-verifying. Sometimes states want more immigration information when there's an immigration status that is not subject to change. So that's another

particular area.

One of the things that works against us is that the federal rules actually give states the leeway to determine what data they consider to be useful. Without any criteria about -- well, you can't dismiss certain data sources that we absolutely know are useful. And I think that's another area that needs to be explored if states aren't pursuing certain data sources that could be relevant to them, or if they're saying, "Oh, that data is no good because it's six months old," then I think we have to take a harder look at that.

CHAIR BELLA: Thank you, Tricia.

Other comments?

[No response.]

CHAIR BELLA: Martha, we're reaching the end. Do you have what you need?

MS. HEBERLEIN: Yes. Thank you. And as I said, we'll hope to get this out in the next week or so, so that others can benefit from what happened at the roundtable.

CHAIR BELLA: Wonderful. Well, as I said about panels, we also love roundtables, so keep them coming. Thank you very much, and thank you again for putting that

excellent panel together earlier.

All right. I'm going to need all the Commissioners to transition their brains out of redetermination into hospital payments, and I'm going to hand it over to Bob.

VICE CHAIR DUNCAN: Thank you, Melanie.

And we've got Aaron and Rob joining us to walk us through the work that's been taking place, bring us up to speed, couple of questions, and next steps on hospital supplemental payments.

With that, I'll turn it over to Rob.

HOSPITAL SUPPLEMENTAL PAYMENT WORK PLAN

* MR. NELB: Great. Thanks so much.

All right. Good afternoon. Aaron and I are going to walk through our proposed work plan for examining hospital supplemental payments in this cycle and in the coming years.

So I'll first start by reviewing some background from our prior work about the different types of supplemental payments and their various goals, and then I'll discuss some of the newly available provider-level supplemental payment data that we plan to analyze.

As we develop this work plan, we've been guided by MACPAC's provider payment framework, which aims to think about the various statutory goals for Medicaid payments. So I'll talk about that briefly before turning it over to Aaron to walk through the specific areas of our work plan: first, better documenting the payment methods and policy goals; second, characterizing payment targeting; and third, the ultimate goal of trying to calculate overall payments to hospitals.

He'll conclude by talking about next steps of how this supplemental payment work fits in with other work we have planned this year and raising some questions for our consideration today.

All right. So first, some background. As you know, Medicaid supplemental payments are a large share of Medicaid payments to hospitals. For example, in 2021, supplemental payments accounted for more than half of fee-for-service payments to hospitals. In managed care, we also see that a large share of payments are made through directed payments. Although CMS doesn't officially categorize directed payments as a supplemental payment, we've included them in our analysis, because most of the

spending under these arrangements is for large uniform rate increases, which are similar to supplemental payments in fee-for-service.

The slides are moving themselves, which is sort of crazy.

[Laughter.]

MR. NELB: All right. I guess they didn't want me to talk about directed payments. I don't know.

All right. The other point I wanted to highlight on directed payments is just that the use of directed payments is growing rapidly, and in our most recent analysis, total spending on directed payments has more than doubled in the past few years. And according to our most recent numbers, total spending on directed payments to hospitals is actually now larger than spending on all other types of hospital supplemental payments.

All right. So one of the challenges of this work is that there's just multiple different types of Medicaid supplemental payments to hospitals and the fact that each of them are subject to different rules and are trying to address different goals. So to help make sense of it, this table lists some of the different types of payments, how

they're used, and a view about sort of the intent of the payment, at least as implied from the federal rules.

Starting at the top of the table are DSH payments, disproportionate share hospital payments, which are statutorily required payments intended to offset unpaid cost of care for Medicaid patients, which is referred to as "Medicaid shortfall," as well as unpaid cost of care for uninsured individuals.

When DSH was first added in the '80s, there wasn't any upper limit on the DSH payments that states could make, and DSH spending ended up growing very rapidly in the early '90s, before Congress established state-specific limits on DSH, known as "allotments."

The next type of payment here are UPL supplemental payments, a chance for the upper payment limit. These are fee-for-service payments intended to offset the difference between fee-for-service base rates and an estimate of what Medicare would pay. It's just kind of an illustration of how these different payments are interrelated. In the data, we saw that after DSH payments were capped in the '90s, UPL payments grew very rapidly in the late '90s and early 2000s.

Okay. Yeah. I'll keep talking through that.

Okay. So one of the limits with UPL payments is that they can only be made for services provided in fee-for-service, and so as states have moved from fee-for-service to managed care, their ability to make UPL payments has diminished. As a result, some states have sought Section 1115 demonstrations as a way to continue to make supplemental payments in managed care.

The two main types of 1115 supplemental payments are uncompensated care pool payments, which are similar to DSH, and DSRIP, delivery system reform incentive payments, which are intended to advance quality and delivery-system reform goals.

In recent years, CMS has encouraged states to move away from these 1115 supplemental payments and move into the new directed payment option, which was added in 2016. Directed payments are primarily intended to help offset Medicaid shortfall through those uniform rate increases, but some of them are also tied to quality improvement goals.

But also, I just want to point out, as we think about the different rules for these different types of

payments, that there's currently no upper limit on the amount of directed payments that a state can make, and whereas with the UPL supplemental payments, they're limited in an estimate of what Medicare would pay. CMS has recently proposed a limit on directed payments based on the average commercial rate, which is much higher than what Medicare would pay.

All right. So now that we've talked through the different types of payments, we also want to highlight the wide variation in the use of supplemental payments by state.

So this figure shows supplemental payments as a share of Medicaid benefit spending in 2021, and you can see a wide variation in the total amount of payments as well as in the mix between DSH, non-DSH supplemental payments, and directed payments.

So in 2021, hospital supplemental payments and directed payments accounted for less than 5 percent of Medicaid spending in 13 states and more than 25 percent of Medicaid spending in 6 states.

One of the challenges of our review of supplemental payments so far is that we've only had state-

level data, and to enable further analysis, the Commission has long recommended more collection of provider-level data on all types of Medicaid payments to hospitals.

Recently, the Consolidated Appropriations Act required states to begin reporting some of this provider-level data beginning October 1st, 2021. The data aren't yet publicly available, but CMS has made them available for our initial review. This includes information on payment amounts as well as some limited narrative information about payment methods and goals.

The new non-DSH supplemental payments include UPL data as well as Section 1115 supplemental payments, but they don't include information on directed payments. However, CMS has begun to collect some more information on directed payment data through its standard application form, which is referred to as a preprint, and so we've been reviewing that data as well and trying to incorporate it into our analysis.

We don't have provider-level data, but we do have information on payments by classes of providers. So we still get a bit of a sense about who's receiving the payments.

One of the added benefits of the directed payment data is that states also provide comparisons of how their managed care payments compare often to Medicare or an average commercial benchmark, which is helpful to see how all the different pieces of payments fit together.

One important piece of data that we're still missing is data on provider contributions to the non-federal share, such as provider taxes or intergovernmental transfers. A lot of these supplemental payments are financed by providers, and ideally, we'd want to have that data on provider contributions in order to calculate net payments to providers.

All right. So our ultimate goal, of course, is to use all this data to understand the extent to which Medicaid hospital payments are consistent with the statutory goals of efficiency, economy, quality, and access, and to do so, we're guided by MACPAC's provider payment framework, which is an attempt to define some of these terms and think about how they relate to each other.

So, according to the framework, we think of economy as primarily a measure of what is spent on payments and measured by things such as the payment rate, and we

think of access and quality as measures of what is obtained by the payment. And then efficiency sort of ties it all together and compares what is spent to what is obtained.

As we seek to apply the framework to different Medicaid payment policies, we, of course, aim to collect information to inform discussion about these principles. Of course, we first want to understand the methods that states are using to pay and get information about payment amounts and then compare that to various measures of outcomes related to payment.

In our work on hospital payments so far, one of the key outcomes we've been primarily looking at is the financial viability of safety net providers. This, I think, we can tie into the framework as a potential measure of access, right, since -- and, of course, just one, one measure of access, but it's important that these hospitals are there to serve the patients and then can be a source for other -- look at other measures of access in the future, such as use of care and quality.

As we plan our analyses, we always try to be informed by the feedback that you provide but also adjust our analyses based on the limits of available data.

So just for example, in our recent -- we used this framework in our recent analyses of nursing facility payments, and in that work, we really focused our analysis on looking at how payment policy related to nursing facility staffing. And that was because staffing was both an area that was highlighted as an area of importance by the Commission but also because it was one of the few areas where we had good data compared to other measures of nursing facility quality where we didn't quite have the data yet.

So, with that introduction, I'll turn it over to Aaron to talk more about the specifics of our work.

* MR. PERVIN: Great. Can you hear me?

MR. NELB: Yep.

MR. PERVIN: Okay.

We're going to go through each of our three work streams and also present some of the issues that have come up as we've conducted a preliminary analysis of the data.

So the first work stream is on documented payment methods and goals. Staff plans to update our hospital payment compendium and identify payments that appear to advance similar goals. This includes whether the payment

supports providers that serve a high share of Medicaid and uninsured patients, supports specific types of hospitals, such as rural or teaching facilities, or is meant to offset low base rates for all providers.

This information could inform the Commission's discussion about whether payments that advance similar goals might be interchangeable and therefore should be subject to similar rules.

In addition, it could inform a discussion on what the balance should be between increasing base rates versus using a supplemental payment to offset Medicaid shortfall.

Based on our preliminary analysis of the narratives. the payment narratives within the supplemental payment data, we're seeing a lot of state variation, and it's unclear the extent to which this raises federal policy concerns. On the one hand, Title 19 allows for considerable flexibility for states to design their own policies, but on the other hand, payments appear to be targeted to facilities that provide the non-federal share, which raises questions on whether the payment is meeting its statutory goals.

The second finding is that we see a lot of

supplemental payments for physicians that might be affiliated with a larger hospital system, but we can identify the states that make a substantial amount of supplemental payments to physicians. But we can't quantify the extent to which they support the larger hospital system.

The second work stream characterizes payment targeting or which hospital is prioritized to get that first supplemental payment dollar versus the last. We plan to link the new CMS data on non-DSH supplementals to our DSH dataset that we collect as part of our annual DSH report. This new data can inform discussion on how these supplemental payments are targeted and interact at the hospital level.

The Commission's position on DSH payments is that they should be targeted to hospitals that serve a high share of Medicaid and the uninsured. However, the Commission does not have a targeting principle for non-DSH supplemental payments.

So, to illustrate our analysis for all states, we've done a preliminary analysis of supplemental payments in four states, which make a mix of both DSH and non-DSH

supplementals.

We ranked hospitals and grouped them into quartiles based on their Medicaid utilization rate. Q1 is the lowest, while Q4 is the highest. We found that, by and large, most payments are targeted to high-volume Medicaid providers. However, we find that this is not uniformly true. For example, State B also sends a substantial amount of payments to relatively low-volume providers but which appear to be rural hospitals. Although these payments are not intended to support high-volume Medicaid providers, they are intended to support the rural facilities and therefore appear to advance other state policy goals. This makes it challenging to assess whether one targeting approach is superior to another.

Some areas of consideration that we've highlighted in your reading materials is that we can cut this data in a large amount of ways, including but not limited to Medicaid utilization, uncompensated care, hospital financial data such as profit margins, teaching status, geography, or even racial and ethnic makeup of the surrounding community. However, this list alone means we can cut the data in over 100 ways. So we can discuss which

analyses may be most useful.

As discussed on the previous slide, there is some variation in state targeting policies, and it's unclear if this raises federal policy concerns, since this might reflect local health system needs on the one hand but also how the payments are financed on the other.

When we last looked at DSH payments, the Commission arrived at a general principle that states should target based on Medicaid or uninsured utilization, but we did not arrive on a formal recommendation.

The third work stream is on calculating overall payment rates. As part of this work, we plan to combine supplemental payments within T-MSIS and update our previous work on the Hospital Inpatient Payment Index within fee-for-service from 2016. This time, we could potentially include both managed care and also outpatient data.

To help inform and to help us develop our methodology, we plan on convening a technical expert panel to inform our analysis. This analysis could inform how payment rates vary by state and also how they compare with other payers.

In our preliminary analysis, we looked at

directed payment preprints, which contain information on how managed care payments compare to Medicare rates among hospitals that participate in the directed payment program.

We found that payments vary widely by state, but that there's also variation within states. For example, in State A, even though the state makes a large amount of directed payments, the overall payment rates are still below Medicare. In State B, inpatient may pay over Medicare, while outpatient may pay below Medicare, which raises questions on how we should account for this within our Hospital Payment Index. In States C and D, these states both pay over Medicare rates within managed care, though State C does not tie these payments to quality, while State D ties the amount over Medicare to some measure of quality.

So for this work stream, some of the areas for consideration are how we should account for payments not strictly be intended to pay for Medicaid shortfall. For example, DSH payments are also supposed to pay for uninsured, uncompensated care, while value-based payments are meant to support quality improvement and are difficult to tie to specific Medicaid services.

This also raises questions on how we should interpret payment rates without data on provider contributions to the non-federal share. As Rob said earlier, IGT and provider taxes may reduce net payments, but this data is not publicly available at the provider level.

So to summarize our action items for today, we will present our analyses as they are ready over the next two years. The analysis of payment methods and targeting can be finished by the spring, but the payment rate analysis will not be ready until after we've convened a technical expert panel.

Our work on supplemental payments are being done alongside our DSH payment work, and we plan on returning in December with our draft DSH report and can further discuss our hospital payment work at that time.

Also, Rob is leading an analysis on barriers to collecting data on the non-federal share, and that will be presented to you all during this report cycle.

All right. So we have given you a lot of information today. We're hoping to get your feedback on our analysis, but what would be most helpful is for you all

to provide feedback on the key questions stated here. These describe how we can use the information we're collecting to determine whether payments are consistent with their statutory goals.

With that, I'll turn it over to Bob and looking forward to hearing from you all.

VICE CHAIR DUNCAN: Thank you, Aaron. Thank you, Rob, for the great work that you continue to do.

Earlier today, Dennis in the denials and appeals conversation brought up the layers of an onion. You guys are truly working through the various layers of the onion in trying to get down to what's really being paid. So thank you for that work.

So, Commissioners, any questions or thoughts on what's been proposed?

John?

COMMISSIONER McCARTHY: I think for the second and the third, I didn't quite hear, Aaron, you or Rob say this. Maybe I just missed it, but cost coverage. When being Medicaid director in two places plus setting rates, when we set hospital rates, both inpatient and outpatient, we looked at cost coverage, and that's what we were

targeting. So comparing -- I was always as a director -- it drove me crazy comparing my rates to another state's rates, because that's really -- there's no comparison there because of various reasons. So are we looking at cost coverage? Because to me, just because you're paying Medicare or above Medicare doesn't mean that it's a good rate or a bad rate. It is just that's a rate that's paid. So cost coverage, where is that falling in the analysis?

MR. NELB: Yeah. So I think as we do that payment index and get information on payment rates, we can compare it to hospital costs. Yeah. So that's something there.

Sometimes -- in the past, the Commission has raised concerns about using cos-based payment methods because hospitals may vary based on -- you know, cost may not be a measure of efficient payment, and so that's why some maybe prefer to compare to Medicare, but we do have data on hospital costs and can factor that into the analysis.

COMMISSIONER McCARTHY: I want to make it clear; I'm not saying that the payment methodology should be cost-based. It's just doing the comparison.

Thanks.

MR. NELB: Absolutely.

CHAIR BELLA: Thank you, John.

Heidi? Oh, Rhonda.

COMMISSIONER MEDOWS: Thank you. I might have gotten really old and aged out, but I thought the third bullet, interpret payment rates without data on provider contributions, don't the states know where they did the provider tax, how much they collected and where they collected it from?

MR. NELB: We are asking states this cycle and learning more. It does seem like states have the data, but it's not reported federally. So we don't have that information at our level. And I think we're going to --

COMMISSIONER MEDOWS: Have to request it from them?

MR. NELB: Yeah. It's understanding what the challenges are, both for collecting it at the state level and then for also it would be associating it for a particular provider or service. Like you may know that the hospital paid a certain tax, but then trying to figure out does that get subtracted from your inpatient rate or your

outpatient rate or some of the more specifics, we're hoping to dive into those details.

COMMISSIONER MEDOWS: I think the states know. I think it's a matter of getting the information from them in a way that they feel comfortable with sharing it. But I think they -- you know, there were a lot of people who used to breathe down my neck on a continuous basis about how much they put in and how much they should get back out, right?

And I'm going to have to agree with -- was it John? -- about when we at a state Medicaid level, we did not only look at percentage of Medicare and how much other neighboring states were paid. We did look at cost, not price. Cost. Price is completely all over the place. But that's cost. And I think people didn't really think about it. They didn't really hear about it. But as the people who had to literally open up the purse strings and pay for it, we did look at cost. For the most part, we were below the cost of actually providing the care.

VICE CHAIR DUNCAN: Thank you, Rhonda.

Heidi?

COMMISSIONER ALLEN: Thank you for this. I find

it really endlessly fascinating and confusing.

I think that the issue of provider contributions is its own really interesting and important way of thinking of payment. It's so heavily relied on by states to leverage the federal draw.

I guess I assumed that that would be available in state legislation when it's passed and that some have to be renewed at certain times, but it's not my area of expertise.

Can you go back to the slide that shows State A, B, C, and D?

MR. PERVIN: Sorry. Which one?

COMMISSIONER ALLEN: The one, the inpatient, outpatient. Yeah, that one right there.

So are these just random, A, B, C, and D, or is there a way of kind of understanding how states are bucketing in terms of how many of them are State D's and how many are state C's? You know, like not that they would have the exact percentage, but that they would have, you know -- like, for example, State B, where you have kind of this overage in inpatient and underage in outpatient or how many are, you know, balanced or then some like State, you

know, C, where you're like, wow, they're really getting a lot of money, but it's not tied to quality. Like I don't have a sense of distribution and whether these are like outliers or whether they're real distinct patterns in the data.

MR. PERVIN: Sure. I mean, that's part of the guidance is what we're hoping to hear from you on kind of the best way to group these states.

One reason we wanted to point out State D is, you know, this is an example of a state that is paying over the rates of Medicare, but at the same time, they are tying those amounts to quality.

But we could think a little bit more potentially about how we could group these.

Rob, do you have any thoughts?

MR. NELB: Well, just once we do the payment index, we'll hopefully have all 50 states and can compare.

But with the directed payments, because they are not limited based on Medicare or costs, we are seeing a number of states paying well above Medicare rates. I mean, States C and D are on the higher end of the payment spectrum, but they're not alone in that, which has been a

new phenomenon.

Historically, we've seen more states in that sort of the State A category where supplemental payments have been large but have been -- there's still been some Medicaid shortfall or uncompensated care costs. So it's been changing over time, but as we collect more data through the payment index, we'll be able to get a better sense of where other states fall.

COMMISSIONER ALLEN: Can I ask a follow-up question?

I guess one thing that I would find really helpful is kind of some meaning making around this, because the question of what is the most helpful analysis for understanding federal policy, I really like that you're talking about differentiating between what's paying for quality versus what isn't. And this is really confusing.

And one of the things that I find the most unfortunate about the way that Medicaid pays for care is that if you ask a provider, they're like we make hardly anything, and they really -- and it might be true. There's some states that like they really are making way less than Medicare, but it's often not true. It's just that the

payment is so truncated in these different segments, and they may not have the complete picture, and that Medicaid enrollees then get kind of seen as this, well, you're a draw on the system, when they're not a draw, a drain on, you know -- they're actually fully contributing as much money as populations that have a lot more political voice and concern given to them.

And so I think that kind of understanding that whole big picture of do we have evidence that Medicaid is underpaying or do we have evidence that, in some cases, Medicaid is being very generous, and how do we make meaning with that? That, to me, would be the most helpful.

VICE CHAIR DUNCAN: Thank you, Heidi.

Jenny, then Tim.

COMMISSIONER GERSTORFF: So I will first say that this is really exciting work, so I'm excited to see where this goes over the next couple of years.

Coming back to the point that you guys have made a few times, it's really hard to understand what all of this means without being able to understand what the hospitals are actually keeping and what's going back to the state.

State D, where they're paying well above Medicare, we still don't know at all how much the hospitals are keeping, so that is tough. And I don't have an answer for you, other than wish we could get that data, but wanted to highlight that.

And then I had a couple of questions on Slide 5, the table that you had there. Would gray-area payments to providers -- would that be in the DSRIP category or the state directed payments or excluded?

MR. NELB: They are not on this table. The gray-area payments are another type of payments to providers in managed care that CMS has raised questions about in its recent managed care rule, and they were ones that states were not submitting a directed payment pre-print for, and CMS is proposing that they do. But the data we have here is just drawn from the directed payment pre-print, so it doesn't include this gray area of payments.

COMMISSIONER GERSTORFF: Okay.

And then for states where they have directed payments that are really intended to continue access or support access primarily, would that checkmark go under quality improvement or another?

MR. NELB: Yeah. This is just sort of a rough categorization, right? We could think about refining these different goals and things, but there's three categories of directed payments, a minimum fee schedule or uniform rate increase, and so both of those, I think we would view them as paying for the care for Medicaid beneficiaries. And then the third category are these sort of value-based payment arrangements, which are tied to quality, but there might be some other excess goal there as well.

COMMISSIONER GERSTORFF: Sure.

And then I think it will be important to make sure that we kind of isolate directed payments that are separate payment terms versus things that go directly into the capitation rates. I think you might see different types of behavior for those different types, and then I know there are different reporting requirements and that sort of thing.

And then I was wondering if we have historical data or information on supplemental payments prior to 2016 that we could compare and see the total levels of these supplemental payments to hospitals, how that's changing over time.

MR. PERVIN: That's going to be pretty challenging for us. Provider-level information is largely just available starting in 2022. So while we do have some information at the state level, it's much harder to get provider-level information.

I guess we do have UPL demonstration data, but I don't know how far back that goes off the top of my head.

MR. NELB: Right. But, Jenny, I think you're maybe talking about just the state-level information. So we do have state-level supplemental payment data, but the challenges with -- one thing we don't have are these pass-through payments. The new directed payment authority sort of replaced -- some states are making what's called a "pass-through payment" before, and so we don't have information about whether the directed payment just replaced the pass-through or whether it was a new payment.

The Commission has recommended that CMS collect that, but we don't have that data yet.

COMMISSIONER GERSTORFF: Thank you.

VICE CHAIR DUNCAN: Yes.

CHAIR BELLA: Jenny, can you say more about the behavior or point you were making about how it would

influence behavior?

COMMISSIONER GERSTORFF: Oh, I don't know. I just think that it is a potential indicator that we might identify providers providing care differently or having different quality outcomes or different access or different utilization, possibly when they're under separate payment terms versus not. There may not be at all, but because CMS has put so much focus on those separate payment terms, there are reasons, right? So I just thought it's worth tracking.

CHAIR BELLA: And if we had this, would this make a material impact in your -- with an actuarial hat on?

COMMISSIONER GERSTORFF: It can. So, I mean, how we set the capitation rates is very different when we have to incorporate state directed payments for payments that go through the managed care plans with their claims-based payments versus when it goes more sort of in lump-sum mechanisms from the state to a check to the MCOs directly to the providers, like outside of the capitation rates. So that all can have implications in how actuaries set the rates.

VICE CHAIR DUNCAN: Thank you, Jenny. Thank you,

Melanie.

Tim?

COMMISSIONER HILL: This is great work, and to us financing geeks, it's all very exciting.

To your question on the federal policy concern, I absolutely think kind of this gestalt, and I would encourage us to think broadly. I think it's important to be thinking about hospital payments, and it's important particularly in the Medicaid context where there's so many safety nets and understanding how they're being paid and the implications of the payment amounts and sort of what that's going for.

But as I step back and think about it, I really do think there's a whole -- it's a system, right? You cannot divorce the financing of the supplemental payments and the directed payments from those payments themselves, and I worry just as we saw DSH grow, when there was no limit, and we saw supplemental payments grow before we started looking at UPL in a more directed way, we're now seeing directed payments go.

I know that CMS has put governors on those payments in terms of it's got to be value-based or it's got

to be a uniform rate increase. I worry their ability to really govern that and understand what they're really getting for those supplemental payments is unclear and subject to variability.

And so I think both for the supplemental payments and for the directed payments, I would encourage us to think it systemically and not just hospitals, right? I think nursing homes, outpatient, it is kind of broad, and whatever we can do to work with CMS or the states to figure out a standard way to collect the non-federal share -- because in many cases, we're going to be dealing with hospital associations and not the states. When we think about what these amounts are and what it looks like, it's just a very complex onion.

So I would think -- I would encourage us to think broadly, because I think Congress is going to -- they've already asked, why do they get paid so much? They're going to start asking, well, you said it's for value based -- like what are you getting for this? Until we can really kind of put a parameter around what we're getting for these payments, I think that's going to be important.

VICE CHAIR DUNCAN: Thank you, Tim.

John?

COMMISSIONER McCARTHY: I agree with what Tim said, but I want to go back to what Heidi said earlier, if we go back to that slide with the different hospitals.

I brought up costs earlier. The other thing, if we're going to be making recommendations around this, we would need the data at that kind of very specific, almost hospital level, not just at the state level on these things, because even if you look at State C there, right -- and they're above Medicare -- what they could be doing, that could be a non-expansion state, and their DSH pool isn't large enough to cover Medicaid shortfalls. And so they're trying to do that. So, again, going back to what I said earlier, they may be trying -- they may, even with those payments, only be at 85 percent of cost coverage. So they are losing 15 percent on each of those cases, and so this is very nuanced conversation on these.

But one of the things we could look at is the OBRA limits, because we know that -- they've been doing DSH audits. We know in states how far that -- what that gap is. And that gets at, a little bit, Robert, what you're saying You're getting the Medicaid shortfall in total plus

the uninsured, so that that is another nuance in there. And again, some of this is policy questions that our states are trying to figure out.

So I agree we need -- with Tim that we need to know what is being paid, but we also need to know the bigger picture of what we're paying for on these and what are the ways to finance it to try to get at some of those different pieces.

VICE CHAIR DUNCAN: Thank you, John.

I'm going to build off of that. Thinking through that process, you think about Hospital A being the largest Medicaid provider in a state. Yet it only amounts to 40 percent of their total revenue -- it's just they've got that number because they're so large -- versus a safety net hospital where they're seeing a large portion that makes up 70 percent of their revenue. And so in thinking through the mechanisms of paying, as we look through this, is there a way to decipher who and how those are?

I know you called it out, but one of the things you also said is about the financial viability. And when we look at those safety net hospitals, I think that's something we've got to make sure we're protecting.

MR. PERVIN: Yeah, absolutely. And a lot of this data, we can link to Medicare cost report data. So we do have information on a lot of costs, but we can investigate ways to bring that out a little bit more when we present it to you again.

VICE CHAIR DUNCAN: Thank you.

Heidi?

COMMISSIONER ALLEN: Are you able to observe hospital margins?

MR. PERVIN: Yes, we can observe hospital margins and can cut the margins in a couple of different ways.

VICE CHAIR DUNCAN: Jami?

COMMISSIONER SNYDER: So I just want to reiterate Tim's commentary about the quality component of some of the work that's going on under these supplemental and directed payment programs and really the importance. I think it's an important leverage point for CMS and CMCS if they really want to better track how this money is being spent and the degree to which it's contributing to overall quality improvement and cost reduction. And so to the degree that we can weigh in with recommendations in that regard, I think that would be helpful.

VICE CHAIR DUNCAN: Thank you, Jami.

Any other questions from the Commissioners?

Dennis?

COMMISSIONER HEAPHY: Readmissions keeps coming to my head. I'm wondering, is there a difference between MCOs and fee-for-service? Are there quality metrics we can look at and see whether they're actually reducing costs by improving quality?

MR. NELB: Yeah. We can start looking into some various hospital quality measures.

I think one of the challenges in doing so with this targeting is sort of, you know, it's not clear if the payment should be targeted to the hospitals that have the lowest readmission measures as a way to reward them or whether you should put more money to the state -- to the providers that have more challenges as a way to help improve it. So that's just something to think about.

As part of the payment method categorizing, we'll be looking at whether states are tying the payment to achievement of any quality goals, and I think readmissions is a common quality goal that's used. And so we can see how that comes in.

COMMISSIONER HEAPHY: The reason I raise a question is because if MCOs should -- like seem the larger systems perspective. MCOs should assuring that there are lower readmissions, so it's not just on the hospital. So is there a difference between the populations that are covered by MCOs and those that are not, if that makes sense?

MR. PERVIN: Yeah, I think we could think through different ways that we could look at quality -- I mean, we can hospital-specific quality, and then we could also potentially look at different measures of quality for payers. That could be something that we could ask the technical expert panel about is what would be the best ways to tie that together.

We are a little bit limited in terms of the quality measures that we have access to. So we don't really have access to a lot. It would be challenging, but we can incorporate that into some of the discussions that we're going to have with the technical expert panel about like how to incorporate quality into this analysis.

COMMISSIONER HEAPHY: Thanks.

VICE CHAIR DUNCAN: I'd be remiss -- I appreciate

Dennis's comments on readmission. I think that's something important to look at, but in a pediatric hospital, readmissions are purposeful, because kids don't need to stay in the hospital beyond a certain time. It's better to discharge and then bring them back for their appropriate surgery. So I just want to make sure that as we have that conversation on quality that we differentiate the care by the population.

COMMISSIONER HEAPHY: Do folks go back to the community, or do they go to a long-term nursing facility? You probably can't get that data, but that's the type of stuff that's important.

VICE CHAIR DUNCAN: Yes, Rhonda.

COMMISSIONER MEDOWS: So, gentlemen, I'm going to stick my nose into your business. Would it be any easier to pick three or four states to drill down on some of the questions that we got and having the state and their particular provider community lean in? And you can give them anonymous names if you want, fruits, vegetables, letters of the alphabet, whatever you'd like, but just to get an idea about how much of it is value-based care, how much of it is quality, how much of it is specialty

specific, right? And maybe that would be one way to add a little bit more depth to the information, because I'm looking at all that you've done, and I'm thinking, one, you're probably not getting paid enough. Two, you probably need a raise. But three, it's like nailing Jell-O to the wall, right, because there's just so many different aspects of it, and every scene is completely different. But maybe three or four would be good examples.

And we know that that does not include -- does not describe the entire universe, but it kind of gives you a little bit of a flavor, right? Maybe?

MR. NELB: Yeah, that's a good suggestion. We can take it back. I think especially with the non-federal share data that we're missing, maybe there's a way we might be able to get some information in a handful of states just to help illustrate how much that really affects the analysis.

VICE CHAIR DUNCAN: Thank you, Rhonda. I appreciate you recognizing the work that's been done and the digging and the Jell-O that they're working through. I'm hoping it's a good flavor, cherry or grape, in the process.

Any other questions from the Commissioners?

[No response.]

VICE CHAIR DUNCAN: Gentlemen, do you think you've got enough information moving forward?

MR. PERVIN: I think you've given us plenty to think about, yeah. Thank you.

VICE CHAIR DUNCAN: Thank you. We look forward to the next report.

So, Aaron, you're fortunate. You get to step away, but, Rob, you get to stay, and we'll wait for Drew to join you. We'll get into the latest on nursing home.

[Pause.]

VICE CHAIR DUNCAN: Welcome, Drew.

REVIEW OF PROPOSED RULE ON NURSING FACILITY STAFFING AND PAYMENT TRANSPARENCY

* MR. GERBER: Good afternoon. Rob and I are happy to wrap up the day today by reviewing for the Commission the recently published Notice of Proposed Rulemaking on nursing facility staffing and payment transparency. We'll provide a summary of what the proposed rule includes and highlight potential areas for the Commission to comment.

To start, I'll review some background about the

current state of nursing facility staffing levels as well as MACPAC's prior work on the topic.

Then I'll walk through the proposed nursing facility staffing standards before handing it over to Rob to discuss the provisions on Medicaid payment transparency and where staff feels the Commission may want to comment regarding our prior recommendations or to provide technical comments.

To begin with some background, when we are talking about nursing facility staffing, the focus largely rests on direct care staff, which centers around registered nurses, or RNs, licensed practical nurses, or LPNs, and certified nurse aides, or CNAs. As we found in our own review of the literature, higher staffing hours per resident day, or HPRD, a common measure of staffing, has long been associated with better health outcomes for patients.

Analyses that MACPAC conducted for a nursing facility staffing issue brief last year as well as for our most recent chapter to Congress found that facilities that serve a higher share of Medicaid-covered nursing facility residents typically have lower staffing levels than other

facilities, which given the makeup of the Medicaid population may contribute to health disparities.

Our analyses also found staffing levels vary widely by state, which we'll touch on in a moment.

CMS currently requires nursing facilities to have RNs or LPNs available 24 hours a day, an RN available at least 8 consecutive hours a day, and a full-time director of nursing position, and all these requirements calculate out to about a 0.3 hours per resident day staffing requirement when looking at a 100-bed facility.

To talk about some of our prior work, MACPAC has conducted several projects examining this topic culminating in our chapter recommendations earlier this year. In 2021, MACPAC reviewed state policies to improve nursing facility staffing levels, which include state minimum staffing standards. Our review found that 38 states and the District of Columbia have state standards that exceed that existing federal requirements, and 11 states and the District of Columbia have standards greater than three hours per resident day.

This March, the Commission developed a set of principles for assessing nursing facility payment policy

and made two recommendations. The Commission recommended greater transparency of Medicaid nursing facility payments, costs, as well as ownership and financial information, and recommended that states be required to conduct assessments of their Medicaid nursing facility payments relative to costs, quality outcomes, and health disparities.

Now that we've talked a bit about where nursing facility staffing currently stands, let's discuss what led to this proposed rule and the standards it seeks to set.

As a reminder, President Biden announced in March 2022 that CMS, in the wake of the COVID-19 pandemic, would propose new minimum staffing standards that would be based upon a new staffing study, which was an update to a previous study completed by CMS in 2001.

That April, CMS issued a request for information on establishing these mandatory minimum staffing standards to which MACPAC provided some technical comments based upon our prior work.

By June of this year, CMS had completed its staffing study, which in part examined the potential effects of various new standards for staffing at different standards, and then the proposed rule was published just

earlier this month. And comments will be due November 6.

I'll talk through the standards themselves. The minimum staffing standards include three components. First, the proposed rule would set a minimum standard of 0.55 hours per resident day for RNs and 2.45 hours per resident day for CNAs. At this time, CMS does not propose setting a specific minimum standard for LPNs and is not currently proposing what would be a total staffing level for all staff.

Second, the proposed rule would require at least one RN be on-site for 24 hours a day, which differs from the existing requirement, which allows for an RN or an LPN to be on-site for 24 hours a day.

And finally, third, CMS proposes enhanced facility assessments requiring facilities to conduct annual assessments of staffing needs, and this provision is intended to encourage higher staffing levels for facilities with higher patient acuity.

In the rationale for these proposed staffing standards, CMS points to statistically significant improvements in quality and safety for residents that was found in its companion staffing study. If the new

standards were to go into effect, CMS estimates that 75 percent of facilities would need to increase their staffing to comply with the requirements. This would come at an estimated cost of $40.6 billion over 10 years.

Digging into that a bit deeper, Medicaid's estimated share of costs are put at $26.9 billion over 10 years, which they estimate would be about $11.1 billion in state funding and $15.7 billion in federal. However, it's important to note that the specific effects on each state will vary depending on whether states change their payment rates. Currently, in the proposed rule, there's no requirement that states change payment rates or payment methods.

CMS also estimates that there'd be $2.5 billion in savings to Medicare over 10 years due to reduced hospital use.

I'll hand it over to Rob now to review the payment transparency provisions of the rule as well as potential areas where the Commission may want to comment.

* MR. NELB: Thanks, Drew.

In addition to the new staffing requirements, the rule also proposes to require states to report annually on

the share of Medicaid payments spent on compensation for direct care workers and support staff and to report this information at the facility level. The requirement would be effective four years after the rule is finalized.

This requirement would apply both to nursing facilities and intermediate care facilities for individuals with intellectual disabilities. ICFs are not subject to the new minimum staffing requirements.

What's proposed to be reported is this sort of ratio of amount spent on staffing to overall Medicaid payment rates. So that the denominator there, the payments are defined to include both base payments as well as supplemental payments, payments in managed care as well as managed care directed payments and beneficiary contributions to their share of costs.

The analysis would exclude payments for which Medicaid is not the primary payer. For example, for a patient dually eligible for Medicare and Medicaid, the initial portion of their nursing facility stay is typically covered by Medicare, and that would be excluded from this analysis.

On the numerator side, the workers are defined to

include some of those direct care workers that we discussed before, the RNs, LPNs, CNAs, but would also include therapists, social workers, other activity staff, as well as support staff who help maintain the physical environment of the facility, like a janitor or those who help support other services such as food workers. This definition of workers is similar to the definition used in CMS's recent HCBS rule, but unlike that rule, CMS is not proposing a minimum payment requirement of what facilities would need to spend on these staff.

Okay. So now that we've reviewed the rule, let's discuss some potential areas for comments. First, the Commission could support efforts to improve Medicaid payment transparency and use the opportunity to reiterate the Commission's prior recommendation and note some additional steps CMS could take to build on the transparency requirements proposed to meet the full level of transparency that the Commission recommended.

For example, MACPAC recommended that CMS make payment rates publicly available and not just information on the share of payments spent on staffing.

Second, to better understand payments, the

Commission also recommended data on provider contributions to the non-federal share necessary to calculate net payments to providers.

Third, it would be most helpful if states could collect and report data on all costs of care for Medicaid-covered residents, not just the staffing costs. We could still report the staffing costs separately. So you could calculate this ratio, but by having information on all costs, we could also use this data to assess the extent to which Medicaid payments were adequate to cover the costs of efficient and economically operated facilities.

And finally, the Commission's recommendation also called for assessment of quality outcomes and health disparities in addition to payment rates, and this information would help policymakers understand whether the staffing costs reported represent staffing that's adequate to meet beneficiaries' needs.

The Commission has not made formal recommendations on staffing standards, but we can offer some technical comments for CMS based on our prior analyses.

For example, in the proposed rule, CMS has asked

questions about whether staffing standards should be adjusted for patient acuity, and so we can share some of the findings from our recent acuity analyses.

We can also share information on state payment methods to inform considerations about how states might be affected by the increased nursing facility staffing costs.

Finally, we can discuss some of just the technical challenges with determining staffing costs for Medicaid-covered residents based on our prior analyses. So one of the challenges, especially in a nursing facility, is where the staff are serving multiple patients, not just Medicaid. There were just some technical issues with trying to decide how much of someone's time was actually spent on a Medicaid-covered resident.

That concludes our presentation for today. If you're interested in commenting, we'll work on drafting a letter to reflect the Commissioner discussion and submit it before the deadline, November 6. Thanks.

VICE CHAIR DUNCAN: Thank you, Rob. Thank you, Drew.

All right? Thoughts, comments from the Commissioners?

Okay. You start.

CHAIR BELLA: I think we should comment, yes, and I think it would be helpful to hear if there are any Commissioners that don't feel we should comment. And then we can get comments on specific next steps.

VICE CHAIR DUNCAN: Thank you, Melanie.

So while others think, I've got a couple of questions one.

One, again, the transparency that we recommended in March 2023, I think we've got to hold true to, because it's really difficult if you don't have full transparency of where the dollars are going and what is being effective or not.

The other question you raised was around the staffing and staffing to acuity. I've never run a nursing home, but I know in a hospital, we staff to acuity. I can only imagine if you're in a nursing home and there's someone with higher needs and you've got a nurse trying to spend time taking care of that, then there are other residents of that nursing home not receiving the appropriate care that they should be receiving. So I do think that's something that needs to be addressed and

looked at on evidence, based on what evidence shows us in a nursing home, how staffing should be aligned.

Angelo?

COMMISSIONER GIARDINO: As a pediatrician, I tend not to think in nursing homes, but I thought your briefing material was really informative. And I too believe we should comment.

I think it was your previous slide. I think in the comments, we should really reiterate the things that we've said and provide the background.

And I really do feel that the Medicaid support should over time be going more and more towards running the facility well and making sure that the right number of people are there to take care of the Medicaid enrollees. Fundamentally, I think the more comprehensive view that you've proposed, where we have to understand how much of the Medicaid dollar is being spent to pay the real estate trust that owns the ground underneath the nursing home, which is investor owned -- I think that's really important, because my suspicion is that there's a whole industry that is making a ton of money on Medicaid-serving nursing homes. And I think tax dollars should go towards making the

facility run efficiently and paying the staff to take care of the enrollees, and I would really feel like we should keep keying in on that.

And then in terms of the staffing issues, fundamentally, I believe in some kind of standard that you have to meet. I just don't know if that's our expertise and if our work has really been in that area.

Thank you.

VICE CHAIR DUNCAN: Thank you, Angelo.

Tim?

COMMISSIONER HILL: Just a question. I get the rule itself as in that cluster. I was interested that they identified a savings to Medicare from the increased staffing. Did they say anything about Medicaid, and if you're going to have a higher staff on the Medicaid side, is that going to lead to any savings? Clearly not going to offset, but did they talk about Medicaid savings at all?

MR. NELB: Yeah, no Medicaid savings.

I think one of the other benefits of having more staff, it could also help where people get discharged into the community. But that is more for people who are having that sort of short-term nursing, skilled nursing after a

hospital stay. So most of the benefits go to Medicare rather than Medicaid.

And then as Drew mentioned, there's a lot of increased costs, which may be attributable to Medicaid-covered residents, and so for a state that currently pays nursing facilities based on costs, if they don't change their payment method, they would end up increasing payments.

Yeah, it's unclear how state Medicaid programs will be affected.

VICE CHAIR DUNCAN: Thank you.

Melanie?

CHAIR BELLA: It's like Tim and I are on the same brainwave here.

So I'm struggling with how to think about the increased Medicaid cost and frustrated that, once again, like that we're seeing an accrual to the Medicare program at a cost to the Medicaid program, and I don't know what we say about that. At any given time, there's a million duals in nursing homes, right? This is real. So improving the quality of care and having more people that are able to not bounce in and out of hospitals, it's very, very important.

This financial misalignment between Medicaid and Medicare, it's just another example. Perhaps we can find our way to call that out. Perhaps we could ask NAMD, how are the states feeling about this? Are they not too worried about it because they're not required to do it? There shouldn't be a lot of public pressure to do it, I would imagine, right? But I don't have anything to say, except can we think about how we might shine -- continue to shine light on areas where we cost shift from Medicare to Medicaid, even if it's good policy for people that need better care.

And. Jami, maybe I'll put you on the spot. You're fresh out of sea. How would you think about this?

COMMISSIONER SNYDER: [Speaking off microphone.]

VICE CHAIR DUNCAN: Thank you, Melanie.

Any other questions or comments from the Commissioners?

Rhonda?

COMMISSIONER MEDOWS: Only if you need another vote for making the staffing ratio be associated with acuity. That's another vote for, and then a little side note is that payment is based on acuity already. So maybe

that money should go to actually fund the staffing.

MR. NELB: Maybe just a clarification on the acuity. So they used acuity information when coming up with their staffing study and developing this minimum staffing standard, but the minimum itself is uniform for all facilities and not just for acuity. And they're asking questions about whether to do that or not.

We know Medicaid-covered residents actually tend to have lower acuity than other residents. It's interesting. If you did adjust for acuity, maybe it would result in a lower standard for a high Medicaid facility.

The way that they're getting at acuity is those enhanced facility assessments. The minimum is sort of uniform for everyone, but then trying to have a higher limit for facilities with a higher acuity -- and so that's the way they're getting at that.

But yeah, points well taken, and at least for now, in terms of a technical comment, we plan to share the data we've done on acuity. As sort of the challenges of calculating that, there's been some new methods that have been used and all that.

And we have information as well about the extent

to which states are paying based on acuity, but yeah, it's a little complicated for the dynamics of Medicaid-covered residents in a nursing home, how they compare to others. That's just something to be aware of.

VICE CHAIR DUNCAN: Thank you for that clarification and explanation.

John.

COMMISSIONER McCARTHY: Melanie, back to what you were saying, I'm torn on this one too of whether to comment or not comment from the standpoint of if the costs do get raised to Medicaid and states have to implement that and have an increased cost, that means something else doesn't get done or some other provider doesn't get an -- it's not unlimited dollars. And so I have had many, many fights, discussions, whatever you want to call it, with nursing facilities in improving quality in these areas. But your question was should we comment or not, and I guess as a Commissioner, it's hard for me to say should we comment or not when I don't know what the comments are yet. So that's a little bit of it.

But I am concerned, again, with the cost shift that you're talking about and what doesn't get done if this

gets funded.

VICE CHAIR DUNCAN: Thank you, John. Point well taken.

Yes, Jami.

COMMISSIONER SNYDER: Yeah. And I would argue that I think it's incumbent upon us to comment.

VICE CHAIR DUNCAN: Yeah. Thank you.

COMMISSIONER HEAPHY: I think we need to comment and iterate the points that were made previously, ask why they were not considered.

And then adjusted for quality is important, and finding out where the money is actually going is -- where is that money going? Because I think the reduction in hospitalization rates, it should be -- like you said, the turnarounds, all those, and the duals in the nursing home, it just -- yeah, we definitely have to comment. Yeah, because the conditions in nursing homes are abysmal, and somehow, we have to really get at the cause of that. We're not able to get at that right now.

VICE CHAIR DUNCAN: Thank you, Dennis.

Any other comments?

COMMISSIONER HEAPHY: So, Rob, how do we get to

the actual cost? Because you alluded to before -- or someone had felt what the ground that these nursing homes are sitting on and all that sort of stuff. How can we put more pressure on CMS to get to the actual costs?

MR. NELB: Yeah. So, I mean, our recommendation would call for information about all costs of care for the facility, and we can cite some of our work in the chapter. So it includes staffing costs as well as the real estate and other overhead at the facility.

There are some set standards that are used on Medicare cost reports that we can cite, but then there's also been some efforts to better capture information on what's called "related party transactions" with those real estate investment trusts or others, and we can highlight that as well, so hopefully more guidance. It's one of the things where states actually have more of the data than the federal government has. Since this is the proposed state reporting requirement, there may be a way to make sure that we're getting the complete data here.

COMMISSIONER HEAPHY: I think it's the state is going to be paying the bill.

MR. NELB: Well, I guess states can -- they often

require their own state cost report, which can include more detailed information than is maybe on a Medicare cost report, and so that's a tool that could be used.

VICE CHAIR DUNCAN: All right. There's no other comments. Drew, Rob, thank you very much. Appreciate the due diligence. Did you get what you needed from us?

MR. NELB: Yes. Thank you so much.

VICE CHAIR DUNCAN: Okay. We look forward to the comments and feedback at our next meeting.

All right. Now we go to public session. So if anybody out in the public would like to make a comment, please raise your hand, and remember the three-minute limit.

PUBLIC COMMENT

* [No response.]

VICE CHAIR DUNCAN: Going once, twice, three times. Seeing no public comments, I'll turn it back over to our Chairwoman.

CHAIR BELLA: Thank you, Bob.

All right. Any last comments or questions from Commissioners?

[No response.]

CHAIR BELLA: Well, new folks, you survived day one. Hopefully, you're coming back tomorrow. Tomorrow we'll start a public meeting at 9:30, and we have three sessions.

Thank you very much, everybody, for being so engaged. Thank you to Kate, and thank you to the team, also accommodating some curveballs today with some exciting CMS announcements. So thank you all, and we'll see you here tomorrow morning. Have a great night.

* [Whereupon, at 4:51 p.m., the meeting was recessed, to reconvene at 9:30 a.m., Friday, September 22, 2023.]

PUBLIC MEETING

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

Friday, September 22, 2023
9:31 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
HEIDI L. ALLEN, PHD, MSW, Vice Chair
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
ROBERT DUNCAN, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
VERLON JOHNSON, MPA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
RHONDA M. MEDOWS, MD
JAMI SNYDER, MA
KATHY WENO, DDS, JD

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:31 a.m.]

CHAIR BELLA: Good morning, welcome to day two of our September meeting.

We are going to get started talking about school-based behavioral health services for students.

If all commissioners could make sure that their audio is correct on their computers, that would be great.

And then, Audrey and Melinda, we'll turn it over to you. Welcome.

SCHOOL-BASED BEHAVIORAL HEALTH SERVICES FOR STUDENTS ENROLLED IN MEDICAID

* MS. NUAMAH: Good morning, Commissioners.

Today Melinda and I will be discussing school-based services, which are services delivered in schools by providers who are employed by a school or local education agency.

In 2014, a CMS policy change opened the door for states to expand coverage of school-based behavioral health and other health services to students enrolled in Medicaid.

Given this opportunity, MACPAC contracted with Aurrera Health Group to examine how states and schools are

providing behavioral health services to students enrolled in Medicaid and to identify considerations for doing so. This entailed conducting stakeholder interviews in the months leading up to the release of new federal guidance last spring.

In this session, we'll provide background information on school-based services as a foundation for the November meeting. We'll come back in November to discuss findings from those interviews and to provide more detail about recent federal guidance and activities.

I'll start today's session with an overview of school-based services and discuss key concepts relating to financing and payment for school-based services. Then Melinda will discuss select factors affecting billing and claiming, highlight recent federal actions to expand access to school-based services and share next steps for the Commission's work.

Just to note, while many of the topics we'll cover are relevant to school-based services generally, they also play a role in specifically shaping access to behavioral health services. We welcome feedback on whether certain concepts require further explanation or

clarification, as well as your views on whether there are topics that warrant particular attention from the Commission.

We generally think of school-based services falling into two categories: services provided to students with disabilities, and those provided to students without disabilities. The Individuals with Disabilities Education Act, or IDEA, requires public schools to provide students with disabilities education and health care related services, such as speech or physical therapy, that support their ability to learn. These services must be documented in a student's Individualized Education Plan, or IEP, or for children under three, their Individualized Family Service Plan, or IFSP.

Medicaid is a primary payer for services included in an IEP or IFSP. However, local education agencies, or LEAs, are generally not required to participate in Medicaid. Under IDEA, LEAs are required to provide necessary services identified in an IEP regardless of whether Medicaid funding is available.

Prior to 2014, the free care rule prohibited states from paying for services that are available to all

students without charge to the beneficiary unless the services are part of a student's IEP or IFSP. CMS, however, reversed the free care rule in 2014. Over the last decade, states have had the option to cover school-based services for Medicaid eligible children without disabilities.

Since then, 22 states have amended their state plans or otherwise expanded coverage of school-based services under the free care policy reversal. As you can see from this map, 17 of the 22 states expanded coverage for all medically necessary services while the remaining states cover a more limited set of services, often including behavioral health care. In many cases, the primary motivation for these expansions was to improve access to services, particularly behavioral health care, and to obtain Medicaid payment for services that were already being provided to students enrolled in Medicaid without an IEP or IFSP. Coverage of school-based services varies by state and the types of behavioral health services provided in schools can include psychological testing and evaluation, individual and group therapy, and behavioral health crisis services.

As with other Medicaid expenditures, states receive federal matching dollars for their expenditures on school-based services. State approaches to financing the non-federal share of expenditures for school-based services have implications for how they reimburse LEAs for those services. In most states, LEAs contribute 100 percent of the non-federal share for Medicaid school-based services through either certified public expenditures, or CPEs, or intergovernmental transfers, which allow states to claim federal matching funds. CPEs are the most commonly used approach for financing the non-federal share for school-based services.

When using CPEs, the state Medicaid agency can pass on all or some portion of federal funds to the LEAs. States are not required to pay the federal share associated to CPEs back to providers, though CMS encourages them to do so, and we have limited insight into how states are directing those funds.

States using CPEs are required to pay school-based providers using a complicated cost-based reimbursement methodology based on incurred costs. Under this commonly used approach, states make interim payments

to LEAs throughout the year and later reconcile those payments to incurred costs.

The random moment time study, or RMTS, is a key feature of the cost-based reimbursement methodology in many states. At a high level, RMTS is used to determine the amount of time that employees spend on covered health care services and allowable administrative activities. When an RMTS is conducted, school employees are randomly selected and must document all of the work that they do during a specific randomly select time.

Citing federal audit findings, CMS encourages states not to notify participants until the exact time of their assigned random moment and recommends that participants complete the random moment activity documentation immediately, though some flexibility may be permitted in some circumstances.

Now I'll pass it along to Melinda to complete the rest of the presentation.

* MS. BECKER ROACH: Thanks, Audrey, and good morning, Commissioners.

I'm going to spend some time now talking about select issues affecting billing and claiming for school-

based services.

States have flexibility to determine the types of providers that can bill Medicaid for school-based services. This includes the ability to cover services furnished by providers whose qualifications and scope of practice may differ from those of providers working in non-school-based settings. For instance, state Medicaid programs can cover counseling services provided by school psychologists or school social workers who are not licensed by the state to provide care outside of a school setting.

To be eligible for Medicaid reimbursement, school-based providers must document that the services provided to enrolled students meet the state's definition of medical necessity. This can be documented in a number of ways, including in an IEP or, for students without an IEP, an individualized health plan containing the required information.

Claims for school-based services generally must list an ordering, referring, or prescribing provider whose state licensed and enrolled in Medicaid. Because of this federal requirement, as well as medical necessity requirements in some states, schools often have to wait for

an order or referral from a child's primary care or other licensed provider before providing care.

Medicaid third-party liability rules apply to school-based services. Medicaid is generally the payer of last resort, meaning that state Medicaid agencies must take steps to identify and recover payments from third parties, such as other payers or federal programs that are legally liable to pay for services provided to enrollees.

For school-based services provided outside of an IEP, schools must first seek payment from any liable third parties before billing Medicaid. For services in a student's IEP, Medicaid pays first. States can obtain federal waivers that shift the burden of seeking third party payment from the school to the Medicaid agency, though CMS notes that these waivers are rare.

Schools must comply with multiple federal rules that safeguard student information. Medicaid rules do not require schools to obtain parental consent before exchanging a student's information for billing purposes. However, under IDEA and the Family Educational Rights and Privacy Act, or FERPA, schools generally cannot disclose personally identifiable information to the state Medicaid

agency for billing purposes without a parent's prior written consent. For children with disabilities, IDEA regulations additionally require schools to obtain parental consent before billing Medicaid the first time to pay for IDEA services.

The Bipartisan Safer Communities Act prompted a number of recent administrative actions related to schools. In May, CMS released comprehensive new guidance on Medicaid services and administrative claiming in schools. Released in consultation with the U.S. Department of Education, the guide clarifies existing guidance and provides new flexibilities. Following the release of that guidance, CMS and the Department of Education launched a technical assistance center which will host stakeholder calls and develop additional resources for states and schools as required by the Bipartisan Safer Communities Act.

The law also provides $50 million to HHS to award grants to states to implement or expand school-based services. Those grant awards are expected next summer.

Audrey and I will return at the Commission's November meeting to discuss key issues that emerged during stakeholder interviews and the extent to which they appear

to be addressed through the new federal guidance. That's when we'll take a deeper dive into some of the new flexibilities and requirements that are outlined in that guidance.

At that meeting, we'll also provide any available updates on additional guidance or support that may be forthcoming from the technical assistance center.

As Audrey noted, today's presentation was meant to lay a foundation for the November meeting. During your discussion this morning, it would be helpful to know if there are particular questions commissioners would like us to be prepared to address at that meeting.

Finally, as a complement to this work on school-based services, and as part of the commission's broader efforts to understand how children access behavioral health care, MACPAC is currently engaged with Aurrera Health Group to examine considerations for providing behavioral health services through school-based health centers. We expect to publish findings from that work next summer.

That concludes our presentation. Thank you, and we look forward to your questions.

CHAIR BELLA: Thank you very much.

Bob.

VICE CHAIR DUNCAN: First of all, thank you for taking on this work. I'm excited. It really, to me, goes to providing the right care at the right time at the right place with the right type of provider.

I have a history of working in school health in Tennessee, Wisconsin, and now with Connecticut. So as you embark on this work, I'd be interested to know because, as you described, a lot of this has to go through the school systems themselves. And as we all know, particularly in the behavioral health world, the workforce is very difficult. Schools hiring and finding the workforce, providing the talent and the training that they need, and the resiliency pieces for them, from what I hear from schools is extremely tough.

So what are the options for schools to contract with other providers who have the expertise to do this type of work?

And then the second is, when you talk about the billing and the parental consent as you're providing care, in my past experience, there's been time where parental involvement needs to be had. And that becomes very

difficult, as you highlighted. So what and how schools are working through to get those questions answered?

And then the next is, as CMS looks at this, are they looking at their fellow agency, the CDC's Whole School, Whole Community, Whole Child framework around school health?

Thank you.

CHAIR BELLA: Did you want to respond to any of those, or just take them back?

MS. BECKER ROACH: I appreciate those comments, Bob, and I just wanted to note that we will, in November, be talking about workforce issues and parental consent in more detail as far as the findings from our stakeholder interviews.

VICE CHAIR DUNCAN: Thank you.

CHAIR BELLA: I want to acknowledge; Bob was supposed to be leading this session so I will give him cleanup. He will come in and summarize where we landed, since I messed that part up.

Jami and then John.

COMMISSIONER SNYDER: Audrey, Melinda, I just really want to express my appreciation for the work that

you're doing in this area. I think it's so critical, in terms of expanding access to behavioral health services for children in our delivery system.

One of the issues that I ran into as a Medicaid Director in two states now as really some concern on the part of schools with the school-based claiming program around the complexity of participating in the program. So I guess I would like to learn more about sort of schools' perception of participation in the program through the work that you're doing and any sort of regulatory changes that could potentially be made to reduce the level of complexity.

I know a lot of schools -- for instance in Arizona -- elected, rather than participating in the school-based claiming program, to co-locate services on campus or to established school-based health centers because it was just easier, from an administrative standpoint. So I would really like us to kind of dig into what that means for schools and how we might be able to reduce the overall administrative burden.

CHAIR BELLA: Thank you, Jami. John?

COMMISSIONER McCARTHY: Going down those paths,

the questions I have, of having been audited and lived through this here in D.C., and had a big payback, the first question is back when you were talking about payment, if you could get into the question of what is reasonable expenses. Because even when you use a CPE, you can't just say "oh, our social worker makes $2.5 million a year" and then claim that. So there's still an aspect of reasonableness that has to be in there. What is that level? What does that look like? Because that's one of those barriers that Jami is talking about.

The second is how then, when it comes to payment, staff costs are compared to contractual costs? That's back to what Bob was talking about. Because in CPEs, you can claim for staff costs differently than you claim for contractual costs because you don't necessarily need to do a time study in contractual costs because of the 100 percent Medicaid. So there's an issue with that. Is that how it's handled? Again, this is in the details of the payment.

And lastly, how is Medicaid dealing with the issue of duplication of services, especially things like PT/OT? When children need those, they should be getting

them where they need it most. And so you run into these issues of if the kid is in school most of the day, should they also be getting PT/OT outside of school?

I'm not talking about summer, when it's clear, but when they're in school how do we deal with -- should we even deal with the duplication of services?

CHAIR BELLA: Thank you, John.

Patti and then Tricia and then Carolyn.

COMMISSIONER KILLINGSWORTH: First of all, let me just echo the thank you. I appreciate looking into this topic. I think it's so important.

I would like to better understand the treatment modalities that are used. I know there's a range of ways that services can be provided. But any data that's available around sort of the predominant delivery model.

And then in particular, the efficacy of the approach, any data about outcomes relative to other models of behavioral health care. So the school-based health centers or other private health care providers, I just want to be sure that as we're expanding access, that we're doing it in a way that's producing the outcomes that we really want to see for kids.

Thank you.

CHAIR BELLA: Thank you, Patti. Tricia?

COMMISSIONER BROOKS: So this builds on Patti's comment a little bit, and that is that, you know, it's disappointing that we're only at 22 states that have picked up the free care rule. And what can we do to examine the experience, even if it's on a case study basis, that could really demonstrate, it builds on the outcomes, that this is really a wonderful way to get behavioral health services to kids that need it, particularly in light of the mental health crisis among youth in the country?

CHAIR BELLA: Thank you, Tricia. Carolyn?

COMMISSIONER INGRAM: Thanks. I feel your pain in doing this. My first job in Medicaid was actually creating Medicaid in the schools program for New Mexico and then launching the fun time study that all the schools got to do. So I do have a couple of things that I think would be helpful to dive into.

The schools I worked with always complained about trying to balance the medical necessity requirements that we had under Medicaid back with the requirements under IDEA for educationally required benefits. And I'm curious,

again going to this issue of trying to get rid of some of the complexities of the program, if there's been any solutions to that? Or if there are things that we can make, in terms of recommendation, to make that a little bit easier for schools.

The other question I had is if you looked yet into what managed care companies are doing to coordinate back and coordinating the care with school-based services? Whether it's in the Medicaid, in the school's program where they're getting OT/PT/speech, as John was mentioning, to avoid the duplication. But also to look at how they're putting together the plan of care, providing wrap around care around whole-person care. And what are some good models there that maybe could be shared? Or are there lessons learned that we could suggest in some of the policy decisionmaking that are better examples of how to do whole person care and coordination back with managed care companies in the schools.

CHAIR BELLA: Thank you, Carolyn. Sonja?

COMMISSIONER BJORK: Thanks.

I'm hoping you can also keep an eye on some of the experiments that are going on. For example, in

California, the Youth Behavioral Health Initiative, where there's going to be an all-payer fee schedule so that the schools can just bill one entity no matter what insurance the child has, and see how those work out and if there's any learnings from that.

MS. BECKER ROACH: California was actually one of our five study states, so we will be coming back with information about some of their initiatives.

CHAIR BELLA: Thank you, Sonja. Dennis?

COMMISSIONER HEAPHY: A couple of things. One is how do we de-silo the school system from the whole health needs of folks? And why isn't the IEP part of someone's care plan? I think it's just common sense that it should be part of that care plan.

There are concerns I've heard from parents about there's equipment that children need for educational purposes, but they can't bring it home because it's for the school, like a communication aid.

Or the medical necessity guidelines require the child to have proficiency in the ability to use a piece of equipment but they won't be able to develop that proficiency without using that piece of equipment first.

And the difference between medical necessity and developmental milestones, I think are things that others are trying to get to. But how do we look at children as whole people, reaching developmental milestones, and take this on in a real full way.

So right now, break down the silo between the systems because kids with complex care needs are really being left behind and their families are really struggling with this stuff, as well as the schools.

CHAIR BELLA: Just for my own education, where is the prohibition on bringing things home? Where does that come from?

COMMISSIONER HEAPHY: If a piece of equipment was purchased by the school for use for the child in the school, then that's what it was for.

CHAIR BELLA: Got it.

COMMISSIONER HEAPHY: And so --

CHAIR BELLA: I'm smiling when you said these things are common sense. Yes, everything you just said seems very common sense.

Heidi.

COMMISSIONER HEAPHY: Sorry --

CHAIR BELLA: No, go ahead Dennis.

COMMISSIONER HEAPHY: I was just going to say, from what I've seen, it disproportionately negatively impacts folks of color and folks from different cultural backgrounds because they don't know their rights. They don't understand the system. And where other folks might be able to actually -- it depends on the school district, too. That's part of the challenges, how to make sure there's equity across school districts because it doesn't seem to be the case, that there is equity.

CHAIR BELLA: Thank you.

Heidi, and then Rhonda.

COMMISSIONER ALLEN: So there was a study that came out recently from the University of Chicago about basically seeking care and receiving care, and it showed that the vast majority of adolescents who tried to seek behavioral health couldn't get it. So from what I hear about this, I think this is not just a Medicaid problem. This is a larger problem and schools seem like a potential place for the solution, but Medicaid shouldn't be the only payer in this environment.

It seems like people with private insurance

should be able to use mental health services in the school, as well, for their kids. And that by doing so, it would make the Medicaid financial situation better because there would be multiple payers and there would be more infrastructure and economies of scale.

So I know that we don't have any domain over what ESI does, but we do have the wonderful ability to frame a problem and talk about Medicaid's place in that problem. And I think we can speak about all of the issues around Medicaid. But I would love it if we could also say, you know, by Medicaid engaging with other payers in these collaboratives that this would not only help Medicaid but would really be beneficial to lots of kids who are having difficulty accessing behavioral health providers because many behavioral health providers don't take any insurance. And so this would be a place where a really big difference could be made.

CHAIR BELLA: Thank you, Heidi. Rhonda?

COMMISSIONER MEDOWS: So piggybacking on what you were just saying, it kind of ties into my question. I simply can't remember, are the clinical social workers, therapists, et cetera, in the school, are they in network

for the managed care organizations?

MS. BECKER ROACH: I think it depends on the state and the circumstance. Typically, school-based services are carved out of managed care. And of the states that we interviewed, and we'll talk more about that next time, but I think all but one had carved out school-based services.

COMMISSIONER MEDOWS: Because that might be a way to kind of build the behavioral health network itself, right, with mid-levels by pulling in the people that are in the school system. And then whether or not they take commercial or not is another boon for them. But that would be one way to kind of pull it together a little bit tighter.

So if you had a regular fee-for-service or a special funds that are funding school-based care, is it an annual -- probably an annual budget amount, right, that goes to them? But if it was going through the managed care network, in addition to or instead of, that might actually kind of solve two problems a little bit. Because they need a network, right? They do need a formal network?

I don't know. Let me think about that more. But

that's something to kind of think about, whether or not that's an option. We are so deficient in behavioral health that it's criminal, right?

But if there was a way to do that and if there was a way for the managed care organizations who are also looking at ways to build their pipeline for people in their network to be able to be taken care of, that might be a way for them to actually invest in that a little bit.

Do you kind of get what I'm saying? Okay.

It's okay, I'm not talking about creative financing. I'm talking about network building and access. Okay? Thanks.

CHAIR BELLA: Thank you, Rhonda. Verlon.

COMMISSIONER JOHNSON: I just want to echo what everyone else said. I really appreciate the study. I mean, it really addressed some health equity issues as well as some educational equity, as well, when we think about keeping kids in school and getting these services. So again, a lot of what everyone else said I echo, as well.

But I'm just curious, for the stakeholder interviews, are we just looking at states at this point and schools? Or will you be drawing in the parents and

students, as well, into the conversation?

MS. BECKER ROACH: We conducted a series of interviews last spring with state Medicaid and education agency officials, as well as representatives from school districts and beneficiary advocates in select states.

COMMISSIONER JOHNSON: Okay, perfect.

MS. BECKER ROACH: And a national stakeholder, as well. Did I miss anybody?

COMMISSIONER JOHNSON: Thank you.

And then one last thing, the BCSA, I know that doesn't start until the summer of 2024. But I would love to learn more about that, too, as they go along their process.

CHAIR BELLA: Other comments or questions?

[No response.]

CHAIR BELLA: Well, you came with a few things. You're leaving with many things. That's a good sign of our interest.

Do you have what you need from us at this point?

MS. BECKER ROACH: I think we do. I think a lot of the Commissioner's comments tie to some of the findings we'll be coming back with in November. And where they

don't, we'll be doing some additional digging.

So thank you.

CHAIR BELLA: Well, really important work. We look forward to having it come back in November and continuing on. Thank you very much.

Audrey, I think you're staying with us. Is that right? Lucky you. Excellent. Well, we'll transition into talking about Medical Care Advisory Committees.

ENGAGING BENEFICIARIES THROUGH MEDICAL CARE ADVISORY COMMITTEES (MCACs)

* MS. NUAMAH: All right. Yes. Hello again.

Beneficiaries have much to offer in the development, implementation, and evaluation of Medicaid policies, and because of this, the Commission has previously discussed the importance of beneficiary engagement as a strategy to advance health equity.

For example, in January 2022, MACPAC staff convened a panel of experts to discuss federal, state, and health plan approaches to beneficiary engagement, and then in our June 2022 chapter about Medicaid's role in advancing health equity, the Commission signaled that more research should be done to learn about current state practices for

engaging beneficiaries from historically marginalized communities.

So in order to continue this work, MACPAC staff examined how states are using their medical care advisory committees, or MCACs, as a strategy for beneficiary engagement.

Federal rules require each state Medicaid agency to establish an MCAC that consists of various stakeholders, including beneficiaries or consumer group representatives, to advise the agency on health and medical care services.

States have adopted varied approaches to structuring and running their MCACs, and due to a prior lack of federal guidance, CMS recently proposed a rule on ensuring access to Medicaid services that also revises the current MCAC regulations.

Historically, there has been little information collected about state implementation or the use of MCACs in bringing the beneficiary voice to Medicaid programs. MACPAC contracted with RTI International to examine how states use MCACs to engage beneficiaries, particularly those from historically marginalized communities, to inform programs, policies, and operations.

So this session will begin with a background on the federal statute and regulations related to MCACs, an overview of state Medicaid beneficiary engagement practices, and recent proposed federal actions to implement changes to the federal regulations.

Then I will share findings from our work with RTI about state approaches and challenges to MCAC beneficiary recruitment and engagement and how CMS plans to address certain challenges in the proposed rule.

Lastly, staff would welcome feedback on these findings and whether Commission would like for staff to come back with policy options in November on any particular topic raised today.

Federal regulations describe requirements for the appointment and composition of committee membership on MCACs. These include physicians and health professionals who work with the Medicaid population, members of consumer groups that include beneficiaries, and the director of public welfare department or the public health department.

The regulations also touch on committee participation requirements and the support the committee can receive from the Medicaid agency, such as staff

assistance and financial arrangements. Federal financial participation is available at 50 percent for the committee's activities.

As a health equity strategy, policymakers can engage with beneficiaries to develop a deeper understanding of the issues that affect their access and use of the Medicaid programs. They can co-create appropriate solutions and identify potential unintended consequences that would negatively affect the people served by the program.

Research shows that meaningful beneficiary engagement consists of established trust between the agency and the beneficiaries, dedicated resources to support participation and engagement, and a continued and sustainable bidirectional feedback loop. These efforts take time and require a dedicated effort.

However, beneficiaries often cite barriers to participation. These include feelings of intimidation in participating, they doubt that their feedback will be used and heard, and logistical challenges to attending meetings. State Medicaid agencies are beginning to develop strategies to address these concerns, such as including the MCAC in

earlier policy development discussions and offering hybrid meeting options.

This past spring, CMS released a Notice of Proposed Rulemaking, or an NPRM, that would change federal MCAC rules. First, it would rename MCACs to "Medicaid advisory committees," or MACs. It would expand the scope of topics to be addressed outside of just health and medical care services. It would establish a beneficiary advisory group, also called a "BAG," as a beneficiary-only subcommittee to these MACs, and require state agencies to publicly post information related to MAC and BAG activities.

The purpose of these changes is to increase the two-way communication between state and Medicaid agencies and stakeholders and promote transparency and accountability.

The Commission's comments on the NPRM express general support of the newly proposed MAC as a lever to advance health equity. It is unclear when CMS will issue a final rule or release the future guidance that they indicated they would release on meaningful beneficiary engagement.

As previously stated, MACPAC contracted with RTI to learn more about MCACs. RTI conducted a policy scan of state statute and regulations as well as publicly available information for all 50 states and the District of Columbia to understand rules for MCACs.

We also conducted stakeholder interviews with six states: Kentucky, Maryland, Nebraska, North Carolina, Oregon, and Virginia. The stakeholders consisted of state Medicaid officials, beneficiaries, consumer group representatives, who all participate in MCAC meetings. We explored the barriers to beneficiary participation in providing input, approaches to overcome these barriers, and additional insights for potential policy consideration.

As a note, all these interviews were conducted prior to the release of the proposed rule.

Given the limited federal guidance thus far, our analysis found that there are substantial variation in how states have implemented MCACs with respect to beneficiary and consumer group membership and meeting participation requirements.

While federal rules require beneficiary membership, it does not specifically speak to the diversity

of those beneficiaries. However, the Commission has previously commented on the importance of diverse representation of Medicaid beneficiaries in participating in policymaking discussions. So we explored state approaches to meaningfully engaging beneficiaries, particularly those from historically marginalized backgrounds.

We found that few states have requirements for diverse representation, and when they do, these requirements are fairly narrow, such as including persons with disabilities, older adults, or Tribal representation on MCACs.

The NPRM encourages states to consider diverse representation as part of their member selection of Medicaid beneficiaries, but it does not mandate it.

The analysis of publicly available membership lists found that there were beneficiary vacancies in the majority of states. The states we interviewed did note that they have difficulties finding beneficiaries to participate. One recruitment approach is to recruit beneficiaries that serve on other state advisory committees or on managed care organization beneficiary communities.

Medicaid officials noted that while this is a useful strategy, it can also put a burden on beneficiaries as oftentimes multiple agencies and committees are seeking the same beneficiaries for input.

Additionally, some beneficiaries and state officials interviewed described the MCAC application as a long, complex, and overly formal process, similar to a job application. CMS defers to states on how they develop their MCAC application. The NPRM does indicate that additional guidance on recruitment strategies is forthcoming. However, there has been no federal guidance or technical assistance on how to recruit and retain members from historically marginalized groups.

Also, during the interviews, some states expressed difficulty in finding beneficiaries who are willing to participate in a multi-year commitment. The proposed rule states that the MAC and BAG members must serve a specific length of time determined by each state, and that after committee and advisory group members complete their term, the state will appoint new members to ensure that membership rotates continuously.

Interviews also cited that inconvenient meeting

times and location are additional barriers to participation, but noted that with the rise of hybrid and virtual meetings, after the COVID-19 pandemic, has increased their participation in these meetings.

Beneficiaries and consumer group members across all of our interviews indicated they had experienced that the Medicaid agency staff does listen to their input on Medicaid policy and program topics, but some were uncertain whether their feedback led to real change. Others noted that state Medicaid agency staff do not always provide timely responses to questions or follow through on requested information to committee members.

In our interviews, beneficiaries expressed feeling more qualified to participate in MCAC discussions on topics that directly apply to their lived experience and felt less comfortable discussing more technical topics.

Some interviews identified examples of supports that might be helpful in increasing their participation, such as including beneficiaries in the agenda setting for MCAC meetings, providing background information for agenda items, and hosting pre-meeting Q&A sessions to help increase their understanding of these more complex policy

topics.

State officials recognize that meaningful efforts to strengthen their relationship between the Medicaid agency and beneficiary is time and labor intensive and noted that states face difficulty balancing this investment with other priorities.

When asked what would be most helpful in terms of improving state engagement with beneficiaries, state officials suggested technical assistance or a learning collaborative with other states to see how they are running their MCAC programs. The NPRM suggests more guidance will be released with best practices for meaningful beneficiary engagement.

Most states offer MCAC members at least one type of support to incentivize beneficiary participation at MCACs. These may include financial stipends, reimbursement for travel expenses, or childcare, but in speaking to beneficiaries, most were either unaware of these supports or the support was underutilized. Beneficiaries mentioned, for example, not accepting the stipends because they fear that it might affect their Medicaid eligibility or status with other entitlement programs.

State Medicaid officials ask for more clarification from CMS as to whether gift cards were an appropriate form of reimbursement as well as what is the appropriate amount for financial stipends.

The NPRM does not change the current rules about these financial arrangements. CMS has not indicated whether there will be further guidance about how states can offer financial support without affecting beneficiaries' eligibility.

Some states reported more robust consumer engagement and participation when they had beneficiary-only subcommittees. However, subcommittees may also experience similar challenges to beneficiary engagement, such as lack of advanced knowledge in advanced briefings, imbalanced ratio of Medicaid staff to beneficiaries, and time commitment, especially if a member has to participate in both the subcommittee meetings as well as MCAC meetings.

The NPRM, as I previously said, would mandate each state establish a beneficiary advisory group, consisting of beneficiaries, family members of beneficiaries, or their caretakers. While beneficiary-only subcommittees have some benefits, CMS and states should be

aware of current challenges with subcommittee structure and membership, as it may inform how states create these BAGs.

States may require additional technical assistance in creating BAGs to ensure consistency and meaningful beneficiary engagement.

Commission reactions to the findings of this analysis would be much appreciated. We are looking for Commissioner feedback on the level of interest on moving policy options forward.

Since there was a lot of information presented to you all today, here are some questions to guide the discussion. Depending on your feedback and level of interest, staff could return in November with policy options for the Commission to consider.

Thank you.

CHAIR BELLA: Audrey, I'd first like to recommend that we find some other acronym than BAG, which I know is not your choice, but I can't help but cringe every time I hear that.

Heidi, you want to kick us off?

COMMISSIONER ALLEN: I do, because I may be the only person in this room who's a former Medicaid advisory

committee director. Am I? Anybody else?

[No response.]

COMMISSIONER ALLEN: I never get to be this. You guys are always like, "Well, as a former Medicaid director," and I'm always like, "Well, I was never that". But I am a former Medicaid advisory committee director. I did that for many years, and so I have a lot of thoughts.

I really appreciate this work. I think that this is so squarely in the focus of beneficiary voice that we've been talking about over the last couple years, and this is an existing, tangible, statutorily required effort that I think could definitely be leveraged for the purpose of beneficiary voice.

I did a cursory search of Medicaid advisory committee websites, and only about half of them -- did not they even say, "if you are interested in being a member, click on this link, send an application". The other half, it's a complete mystery how you would ever be on it. And so I think that really requiring states to make very clear on the Medicaid advisory committee website, how you can apply to be a member would be very helpful.

I have a presence on Twitter and I've multiple

times had family members reach out to me about their Medicaid program, and one of the first things I like to refer them to is the Medicaid advisory committee. And for people that are really interested in advocacy, I suggest serving.

And I tried to help somebody find out how they would apply one time. I can't remember the state. Maybe I shouldn't even say if I do, but I could not myself figure out how they would apply. I emailed the person on the website. I didn't get a response. I went through the governor's office. I didn't get a response. And so I think that it's not as difficult as maybe they think. It might be difficult if they're sitting around a room trying to think of somebody, but it's not as difficult if you find out people who have something to say about Medicaid and invite them in.

The other thing is I really feel like the Medicaid directors need to be closely tied to these and not just to make a report to come in and say this is what we're doing but to think about substantive areas to bring to them, ready to receive feedback, and for them to attend those meetings, especially if there are going to be BAGs of

just beneficiaries to really show that the state cares about what they have to say.

And the last thing that I wanted to say is that public comment is also a really important way to get beneficiary voice, and I would like us to look at that, because every Medicaid advisory committee holds 15 minutes at the end of every meeting for people to make comments. And I'm wondering if states are making the hybrid meetings available to the public or not, and if call centers are giving people information about how they can attend these meetings and provide comment. When you have these really complicated cases or advocacy organizations, is anybody saying, "You know what? Why don't you go talk to the Medicaid advisory committee about this, because this is a really important issue that you're experiencing"? Just like how do we close the circle for this audience and for people who are participating to be able to bring that forward. I think public comment is a really important tool.

And we certainly listen, for those of you who are out there. We certainly listen to the public comment that comes in here.

CHAIR BELLA: Heidi, do you have any more concrete suggestions on the recruitment or the application process, other than make it easier?

COMMISSIONER ALLEN: Well, I mean, obviously, just put it on your website. If you would like to be a member of the Medicaid advisory council, email this person, or here's an application and send it here. Like I said, about half the states do not have any information on that.

And then I definitely think things like reimbursement, that's always come up. That was coming up when I was leading this committee many, many -- you know, a decade ago, people were saying, "Well, all of the other invested people on the committee are paid through their jobs to be here, and I'm not." Obviously, I think you capture it well in the report that meetings are oftentimes held during the day or in times where people can't come. So I think all of those are real challenges, and I'm wondering if CMS is going to have some guidance on that.

But I think that even just making it easy when people are interested would be a really -- that's like a concrete step forward.

CHAIR BELLA: Thank you.

Rhonda, then Carolyn, then Adrienne, then Tricia.

COMMISSIONER MEDOWS: So I think the recruitment pieces need to be improved, but I also think before you can go and recruit, you've got to make the process easier.

I've got to tell you, it's a little bit terrifying when I think about what we're asking people to fill out on an application. What do they need to know? What qualifications do they need to be on this? What is it that they're filling out that they need to -- like their name, whether or not they're Medicaid enrolled, what program they're in? What else do they need to be able to be on the commission?

COMMISSIONER ALLEN: I think that's usually it. I think it's usually --

COMMISSIONER MEDOWS: So it's not a job application?

MS. NUAMAH: Well, it depends. For some states, they do ask, "Oh, do you have a criminal background?" similar to a job application, like really getting into some of the weeds. And then other states just ask, "Are you a Medicaid member, and why would you like to serve on this committee?" And they found that, oh, yeah, when they have

the more simple application, they are able to get more people in. But some of them, they do require like a whole long process, and that's because a lot of the times, these committee members are appointed by the governor. So I think they wanted to have a little bit more of this background information.

COMMISSIONER MEDOWS: I think if we want their opinion, we got to make it as easy as possible for them to participate. I get concerned when we talk about multi-year commitment for people who have to do renewals every year. They're not necessarily going to be on Medicaid for multiple years. So I think that's not realistic.

I think the terms that are offered for them, you have to give them an opportunity to renew as long as they stay in the Medicaid program itself, if that's what you're looking for, a beneficiary.

If you're looking for a former beneficiary that's not doing something else, that's a different position on that committee.

I think that I get a little bit concerned about the whole idea of the taking off time in the middle of the workday when there are people who are trying to work and

can't do that. I think it's basically you're excluding a whole category of working people, particularly working parents, who may want to be on the commission. So how do you flex that? Right?

And then when you're talking about the part about the diversity of the beneficiary representation, we get into our habits. We're creatures of habit. We know four people who we use for every commission and every advisory council, and we don't talk to anybody else. But it should be that there should be some consumer advocacy groups out there who can help us identify beneficiaries who would be willing and interested.

And sometimes you need a bridge. Sometimes it can't be the state person that's asking, "Will you be on my advisory council?" Sometimes it's got to be a friend of a friend that does that for you. Does that make sense to you?

Heidi, I wasn't on this thing that you were on, but I'm a former Medicaid beneficiary, and I can tell you that if my parents were trying to keep a job, take care of their kids, they wanted to have a voice. These are things that would make it a little bit more likely that they would

want to be a part of something that influences their health care. Does that make sense?

CHAIR BELLA: Thank you, Rhonda.

Carolyn?

COMMISSIONER INGRAM: Yeah. So I used to chair a Medicaid advisory committee, and I'm now running a health plan and have also those types of folks participating in our activities. And I think there's a couple of things that we've learned over the years that are helpful.

One, I think there are some states that do reimburse for travel and mileage. I don't know if you've met with those yet, but maybe we can help link you up to how they pay for it. It's not a huge amount of money. I come from a very rural, diverse state. So it's hard for people to travel those long hours to actually come in person. So there are states like that, that will pay for reimbursement and mileage. It doesn't cost the Medicaid program that much to do that to get folks there.

Of course, now with everything, the way it's changed, we have centers where we're setting up Teams meetings so people can join in different centers, and if they don't have the electronic capability, they can come to

a center and get the Wi-Fi and join there so they don't actually have to travel those long distances. So I think there's ideas that we can give you in terms of that.

The other, there's also other compensation that can be given besides just money, but sometimes people like to attend these events because they're having a hard time with services. And if you offer ability to have a breakout session time where vendors are available, like managed care companies or durable medical equipment (DME) companies, other people to help -- or staff to help them with their problems and issues, maybe they're more likely to come and participate if they can also get help with other things.

Giving a topic, I think somebody suggested here -- Heidi -- for people to actually have meaningful contribution towards. So if they get to help design some of the value-added benefits or what the design of some of the program services are going to look like, I think there's more desire to help show up instead of just coming and being talked at.

Obviously, having meetings at different times of the day helps address the issue if people can't take off during work hours. I know we used to do that some.

And then the other group I just want to call out that's worth mentioning or talking to is Groundworks Ohio. They have a center for family voice that the foundation that I run actually helped fund part of, and they go out and actually help families understand about these processes and how to join them and how to be a voice in your health care, how to be a voice at the table for policymakers and kind of do training. So it might be worth talking to them a little bit about what was their experience.

They've done lots of focus groups. They've gotten people throughout the state of Ohio invested and contributing and have a really great system and program going on, I think, that they're trying to build out, not just in the metropolitan areas, you know, where John lives -- I'm just kidding -- but out regionally around the state. So they might be a good -- another resource for us to just interview.

Thank you.

CHAIR BELLA: Thank you, Carolyn.

Adrienne?

COMMISSIONER McFADDEN: So I think after hearing my colleagues, this is a bit of an echo, but I'll say it a

different way.

I think when we talk about sort of the composition and diversity of these councils, I think there's a bit of a selection bias for not only those that we continually tap on the shoulder to ask for their volunteerism, but there is a tendency by certain types of beneficiaries to want to volunteer for these committees.

Although it's not my favorite thing in the world, I wonder if there are things that we can learn from things like jury duty and how we are selecting peers to be able to contribute and also have a composition that is more reflective of the full sort of membership pool.

The second piece of the jury duty thing is that jury duty does give some compensation or like a daily rate for the time spent, and so there is reimbursement for travel and for their time. If there's a policy that could maybe mirror, the same way we do things like jury duty, that would be really interesting to look at.

Then I think, Carolyn, you brought it up, what I was going to say is the hybrid meetings are really great. I think we have to think about our beneficiaries in rural areas and thinking about having partnerships where there

are centers that can provide the actual environment and the technology for individuals to participate.

I think this will be especially important as we think about the -- I'll call them B-A-G's, because I don't want to call it a "BAG" -- the B-A-G's so that we can have a sort of diverse geographic as well as sort of demographic representation on these.

CHAIR BELLA: On this, Carolyn? Okay. Go ahead. Then Tricia, then Patti.

COMMISSIONER INGRAM: Sorry. One more thing that you brought up that we forgot to talk about or add, but for folks who speak different languages, having somebody or have other ways of communicating, having ways to accommodate that. Again, it doesn't really cost that much money to have those. I know we had that available when I ran the Medicaid advisory committee to bring in translation services for people who have other native languages, whether it's Spanish or other Native American languages or signing. Other kinds of capabilities for people who have other ways of communicating is helpful.

And that's why I think sometimes the virtual environment and having Teams available with translation is

a good way to accommodate some of those other things. Again, I think there's some best practices out there pretty easily we can get for you.

CHAIR BELLA: Tricia.

COMMISSIONER BROOKS: Just quickly, because it hits on some of the comments already made.

I liked what Carolyn had to say about a hybrid model where they have hubs, because we know that broadband access is a problem. Language access equally. I'd written that down.

You mentioned Groundwork Ohio. There are other groups that have parent advisory councils, at least children's advocacy groups, and that could be a great opportunity to pull folks in.

And then on the application, has anyone thought about doing an interview rather than having somebody pull up and fill out a form or a paper document? It seems to me that that might be a good way to start a dialogue where the person can also ask questions and get answers to really figure out whether they want to be part of it.

CHAIR BELLA: Patti, then Dennis, then Jami, then Heidi.

COMMISSIONER KILLINGSWORTH: An important topic that we all care a lot about. Audrey, thank you for your work. Lots of great comments that I think have a lot of potential value in terms of increasing participation.

From a policy perspective, though, just stepping back, we're in this interesting period where there's a proposed rule that will, in some ways, change the policy and result in additional guidance from CMS. So I'm struggling a little bit just with the timing of when we need to weigh in. Do we need to give that an opportunity to play out, see what guidance CMS issues, watch that, see the impact that it has, and then potentially from a policy perspective, step into it. I'm not recommending that. It's more of a question than it is a statement.

The other thing I would just say from a policy perspective that I would find interesting is there's been no discussion really of how the managed care rule requirements around advisory committees related to managed care relate back to these broader sort of Medicaid committees, and it seems to me there ought to be representation from people who are in managed care states who are participating in those groups also participating in

that broader Medicaid advisory committee, not a part of the current requirements but something that maybe we could think about.

EXECUTIVE DIRECTOR MASSEY: So, Patti, regarding your first question, we have really good and strong momentum on the MCAC work that Audrey has been leading. So I think that we can continue to see where that goes if there is an appetite for policy options and potentially recommendations to HHS or to Congress.

I think the rule is -- the proposed rule, rather, is helpful to the extent that it shows us what CMS is thinking in terms of their proposed policy, but the administration has different routes that they can take to ultimately finalize -- or not -- components of the rule.

So given the uncertainty of where that policy may land, I think that we acknowledge it, and we consider it in the context of other debates and conversations that we're having. But it does not preclude the Commission from moving forward with our work.

CHAIR BELLA: It's a good clarification, Patti. Thank you for raising it.

Dennis.

COMMISSIONER HEAPHY: A lot of thoughts. This is not a policy, but just a culture shift that needs to take place. This work is so intimidating for people. I plead with people all the time to participate in different communities around the state.

And there's also the sense of rather than -- the state expects people to come to them, rather than the state going out to the community. And I'm thinking specifically of minority populations and folks whose voices just are never heard, and the state really needs to -- states really need to develop trust with those communities.

I think one of the ways to build trust is to go out to those communities and let them help shape the agendas, because when the agenda comes from the top down, then people are less likely to buy in because they don't think they're going to be heard.

And the idea of the advisory committee, the BAG, B-A-G, we're very concerned about that because we want to see measurable impact, and advisory committees tend to have less impact than committees that shape policy, and advisory committees can be more easily ignored. So how do we ensure that there's actually going to be measurable impact that

makes it worth people's time?

I appreciate all the comments about time and reimbursement for folks, but the other piece of this is ongoing education of people throughout the entire process. So that once somebody decides to join a committee, that there's an onboarding process, and that onboarding process is just not a one-shot deal, but it's actually an ongoing process, even like a buddy system, to help folks.

I think it's getting trust from the community and letting the community shape the agenda, because until community is able to shape the agenda, then the trust is not going to be there.

I say that just from personal experience being on a committee in Massachusetts where we really do a tremendous amount of work with the state, and we define the agenda, and we work with the state, with MCOs, a tremendous amount of work that we wouldn't be able to do if we were not the ones -- access to data, access to information in a timely manner, and that real sense of equal partnership as opposed to being beneficiaries at the table requesting the state to do something from a beneficence model, but it's actually all this working together at the table as having a

common goal.

That, I think is key. So maybe even -- I don't know if that's a recommendation, but how to move this away from a Medicaid office-centric model to a more co-created model, I think, like how can we do that? So it's really -- I think that's really what gets buy-in.

CHAIR BELLA: That's your OneCare Implementation Council?

COMMISSIONER HEAPHY: Yeah.

CHAIR BELLA: Yep. Well, that could be something Audrey looks at if she hasn't already. All right. Thank you, Dennis.

Jami, then Heidi, and maybe Kathy, if your hand is up or down. Great.

Jami.

COMMISSIONER SNYDER: Dennis, I think you captured it perfectly.

I think it's important when we think about beneficiary participation, it's not about just having beneficiaries or historically marginalized populations at the table. It's ensuring that their contribution is meaningful.

Dennis, you kind of pointed to a couple of components or a couple of ways in which we can ensure that beneficiaries are participating in a meaningful manner, and, Audrey, you mentioned this in your presentation as well, having beneficiaries at the table in the development of the agenda so we're ensuring that the issues of individuals with lived experience are elevated within the discussion.

That pre-meeting, I found to be really, really helpful historically, meeting with beneficiaries before the meeting to walk through the agenda, to walk through any complexities. A lot of the topics we talk about are pretty technical in nature, and to answer any questions in advance has been really helpful to the discussion ultimately so that folks really around the table can participate in a meaningful manner.

CHAIR BELLA: Thank you, Jami.

Heidi?

COMMISSIONER ALLEN: I think that everything I was going to say has been well said, except I will just add that Virginia is a good example of having a very easy way to let the state know on their website that you'd be

interested in being a Medicaid advisory committee member, just your name and phone number and address. So if we're looking for good examples, that's one.

Oh, I was going to say sometimes make in your rules to say exactly who you want to have, who must be represented, the same way as we do with MACPAC. It says in statute how many different types of people need to be on there. I think that would be a very good way to ensure that states know when they're not getting people that they need on there and make a concerted effort to do so.

COMMISSIONER HEAPHY: Yeah. That's good.

CHAIR BELLA: Yeah. I was just going to make one comment on that. The state that I got to do this in is very specific about who's in it, but it also is very dominated by provider associations. So Dennis's point about having a meaningful voice, there's no way, that that voice is very much drowned out and feels more like a check, I guess, and so your point resonates with me quite a lot, Dennis.

So, Heidi, I think we can be prescriptive about it, but how do we balance out the meaningfulness of what, I think, is the intent behind all of this is?

COMMISSIONER ALLEN: I mean, I think that's why they're recommending the B-A-G. Yeah, because of that issue, and that's been a well-known issue is that you get a bunch of provider voices, and it's really hard to be heard and intimidating.

But even within the B-A-G's, if they say, we want somebody who's a dual eligible and we want -- you know, and like really making sure that they call out the specific folks that they want to have at the table, that they want to have the race and ethnicity and that is reflected in the state, those kind of important characteristics, that I do think that that sets parameters for state employees to work around when they're making these committees.

CHAIR BELLA: Dennis, you had another point. Then Kathy, then Adrienne.

COMMISSIONER HEAPHY: Just that having organizations represent beneficiaries is not the way to go with the provider piece that you were saying, because that doesn't work.

I can send information about what's being done in Massachusetts. Massachusetts contracting with, we believe, a couple of CBOs to actually go out into the communities,

to better understand what the communities want and what would drive folks to actually want to be part of the MAC in the state.

CHAIR BELLA: Thank you.

Kathy?

COMMISSIONER WENO: Hello. I think pretty much the turn of the conversation between Dennis and Heidi and Melanie has pretty much taken my comments as well.

I've sat on so many of these. I can't count, but it always seems to be a provider group issue, especially among -- if they're a dental group, for example, we get the dental association and a lot of the managed care reps from the dental portion of the group. If the true point of this group is to get beneficiary input, it's not happening. So looking at the content of these groups is probably just as important as looking at how they're formed.

CHAIR BELLA: Thank you, Kathy.

Adrienne, then John, then Tim, then Rhonda.

COMMISSIONER McFADDEN: Kathy, you read my mind. I was going to say I think there are two opportunities potentially. One is to be able to be prescriptive about, in general forums, what is going considered in these

meetings, and so having dedicated time for provider issues and then dedicated time for beneficiary issues, I think would be one way.

The second thing is if the B-A-G's are going to certainly be something that are pursued, I think it would be helpful maybe to establish co-leadership of the actual committee with representation from the B-A-G being like a co-chair of the M-A-C or a vice chair or something. And so that could formalize having the voice be at the table and being respected.

CHAIR BELLA: Thank you.

John?

COMMISSIONER McCARTHY: I just want to say all the input is great. I will tell you -- and I know you've been on some of these -- this is really hard to do, and having done it in two states, it is extremely challenging and needs to be changed. And I think, Adrienne, you hit one of the pieces of like how do you get that.

I want to hit on three other different pieces, and that is, Heidi, to your point of just being on a website, there are still states that don't have their MCAC on the website at all. Or if it's on there, it's like

2022, not even like how do you apply, but literally it's not on there. So I think from a policy standpoint, having to be on a website and easy to find -- that's the other thing is Medicaid agencies are really good at saying it's on the website, and it's 21 pages down. How do you -- what does that mean? Does it have to have its own website? That type of an issue, so from a policy standpoint.

The other one -- and I think we've hit on it a couple of times -- is they're also supposed to have bylaws, which should be on there. So this gets back to some of the questions of who should be on the committee, what are the terms, how do -- like those bylaws, I think, should be a requirement and be on a website at least, if not other places.

Lastly, I think this is the biggest issue from a policy question is we can say all these things, CMS can do it, but what is their enforcement mechanism? The only enforcement mechanism right now in statute and CFR is take away all your FMAP, which is like no state is going to lose 100 percent of their FMAP because they're not doing the committees correctly. So it's back to, from a policy standpoint, is there an enforcement mechanism that needs to

be discussed or thought about, and how do you do this?

MS. NUAMAH: Melanie, can I jump in here to address Heidi and John's most recent point?

So the NPRM does have statements about this, because they really are trying to enforce this transparency piece. So they do have in there that states need to publish the recruitment application, all the bylaws, to your point.

But, John, I think you're really touching on something that was missing in the NPRM: how are they going to hold the states accountable to this? That's not in there right now. So that is something that we can consider.

But I did want to say that the NPRM is really trying to push more of this transparency piece.

CHAIR BELLA: Thank you, Audrey.

Tim?

COMMISSIONER HILL: I just think the work is terrific and important. I don't know that I have a ton to add, having never been on MCAC or run one, but I do have a methods question, if it's kind of right to bring up here, reflecting on this presentation as well as the last

presentation.

Our policy analysis is kind of strict policy analysis, and I'm wondering if we ever engaged in any kind of elements of engaging beneficiaries or others using human-centered design principles or journey mapping to give a different flavor to policymakers about what these policies mean, like having an understanding. On the school-based services conversation, it's just how complicated it is for a beneficiary to interact with that system, or in this case, how complicated it is for a beneficiary to interact and try and understand. Whether it's here or -- I don't know if this is the right place to do it, but to have that methods conversation about, is there another way to think about doing our policy analysis around some of these issues?

CHAIR BELLA: Thank you, Tim.

Rhonda.

COMMISSIONER MEDOWS: I just wanted to piggyback on to when we were talking about doing the outreach to the beneficiaries. Having the website up and having people be referred to it is great. I think it would be also helpful that we go to meet them where they are, and you can do that

through the eligibility enrollment point of service, that they know that there's something out there they could participate in. They could apply to it.

I think if they don't know about it, it will never just be go to a website. It just won't. So I think having something like that.

I know that when we've done something, when we try to do outreach to try to get beneficiary feedback in the past, we've actually gone to them, and they are not shy, by the way in the enrollment office, just letting you know that. People will tell you all kinds of things.

The second point is when we do decide who's going to be serving, which beneficiary is going to be serving, they're going to need a little bit of extra support before the first meeting, not just for the onboarding but to kind of understand what the topics are going to be, so they don't walk in cold.

So if you're going to talk about school-based care or you're going to talk about access to mental health or you're going to talk about how hard is it to get your renewal or something along those lines, they do need to be helped along with a coordinator or somebody before the

meeting starts. Otherwise they get on the call or in virtual or in person, and there's a bunch of people just going like this, right? I'm willing to bet you a Hershey bar with almonds that if they kind of know what the topic is and they have something to say, that they will say it.

CHAIR BELLA: Thank you, Rhonda.

Sonja?

COMMISSIONER BJORK: Thanks.

It sounds like we have come up with so many recommendations for best practices, and so I think that might be a great thing to pull together.

One thing I heard that I would like more information about is why people would be asked if they have a criminal background in the application process. If you really want people with lived experience, that really could turn off a lot of people from even filling it out.

The final thing I wanted to mention is that our health plan does have a consumer advisory committee, and one of the members got selected for the state. They don't call it the "BAG," but for the statewide committee. And we're all so proud of him, and when he comes to our meetings, he has a part on the agenda where he lets us know

what's going on at the state. And that kind of back-and-forth is really helpful.

CHAIR BELLA: That's great. Thank you, Sonja.

Other comments or questions?

[No response.]

CHAIR BELLA: Audrey, I mean, I think the answer to everything is yes, as usual, right? I hope that are some concrete things that you can take from this and then also some sort of additional policy areas or future areas of interest that we might be able to continue to build on, on this work. Do you have what you need?

MS. NUAMAH: Yeah, I think so. So yeah, we'll probably come back in November with more like fleshed out, but this was really helpful. Thank you all.

CHAIR BELLA: Well, thank you very much. We'll look forward to that in November.

We are running a little bit ahead and so we're going to take a ten-minute break just to give people a chance to move around a little bit. We'll come back at 10:55 Eastern time, please. Thank you very much.

* [Recess.]

CHAIR BELLA: All right. Welcome back,

everybody.

Kirstin, you have cleanup. Welcome. We are excited to hear from you on MSP, and we'll let you take it away.

MEDICARE SAVINGS PROGRAMS: ELIGIBILITY AND ENROLLMENT

* MS. BLOM: Great. Thanks, Melanie, and thanks, everyone. This is our last session of the day and of our first meeting of the cycle, so thanks for bearing with me.

We're here to talk about the Medicare savings programs and go over some eligibility and enrollment topics. This topic is pretty timely because just this week, as I think Kate mentioned at some point earlier, CMS finalized the streamlining eligibility and enrollment rule, a portion of it, but the portion that includes the MSPs. Several of those provisions have now been finalized.

So, with the MSPs kind of back in the news, there's sort of renewed awareness, I think, among policymakers of the role that these programs play in access to care, and it seemed like a good time for us to try to refresh a little bit on this topic since the Commission has done some work on this, going back a number of years.

For our session today, I'll provide an overview of the programs, talk about our prior work, go over some policy changes that have occurred since we last looked into this issue, and then discuss next steps.

So the MSPs are administered by the states. There are four different types, and anyone enrolled in these is considered dually eligible. The MSPs provide Medicaid assistance with Medicare premiums and cost sharing, and although payment policies are just one factor, one of several factors that could affect access, MACPAC has found that as the Medicaid contribution to Medicare cost sharing increases, beneficiaries are more likely to use certain outpatient services, which has been the impetus for the Commission's ongoing interest in this area.

The QMB and the SLMB programs, the first two on this list, are fairly similar. They're both entitlements and both cover Medicare Part B premiums and cost sharing. However, the QMB program, the qualified Medicare beneficiary program, offers the most comprehensive coverage and enrolls the most people.

Lower down the list, the qualifying individual program, or QI, is a little bit of a different -- an

anomalous program in this group. It is fully federally funded. Funding is provided to states through a capped federal allotment. States receive 100 percent match for that program, up to the amount of that allotment, and this program used to be reauthorized every year. Some of you probably remember that, but since 2015, it's been made permanent with permanent funding.

And then lastly on this list, I'll just mention this briefly, the QDWI program. This is a very small program. It was designed for just a subset of people who actually don't qualify for premium-free Part A, and so this program is meant to help them with their Part A premiums. Hardly anyone qualifies for this because, as you know, most people don't pay for Part A. So this program is not typically the topic of research.

Okay. So each MSP has different eligibility and enrollments -- or eligibility criteria and benefits, and you can see from this table that the QMB program, again, the one that's the largest, so we'll keep our focus there, is split into two Medicaid eligibility pathways. Beneficiaries can be either QMB-only or QMB-plus, depending on whether they are eligible for full Medicaid benefits.

So people eligible for an MSP and full Medicaid benefits are considered full benefit duals. That's the QMB-plus group. And then people eligible only for the MSPs, that is, only for assistance with Medicare premiums and cost sharing, are considered to be partial benefit duals, and that's the QMB-only group.

As you can see, the QMB enrollees must have incomes at or below 100 percent of the federal poverty level and meet criteria for asset limits, as shown on this table.

As I mentioned, the QMB program offers the most comprehensive set of benefits for any of the MSPs. You can see them listed here, but basically, Medicare Part A premiums for anyone who needs that, but primarily Part B as well as all of the Medicare co-insurance, deductibles, and co-payments.

You can see that the SLMB program right below the QMB is structured in a similar way with a partial-benefit and a full-benefit pathway, and eligibility for this program, income eligibility, starts where QMB eligibility ends. And it goes up to 120 percent. Benefits are similar to the QMB program in that it covers Part B premiums and

cost sharing.

The QI program -- sorry -- lastly on this list -- covers the Part B premium for people with incomes up to 135 percent, and again, we won't talk too much about QDWI.

As I mentioned, states determine eligibility for these programs. Federal standards exist, but states have the authority under Section 1902(r)(2) of the Social Security Act to be more generous. They can expand eligibility by using less restrictive methodologies than the federal standards for income and for assets, and a number of states do that.

The Medicare Part D program has a low-income subsidy to offer subsidized Part D premiums to low-income Medicare beneficiaries. That program is administered by the Social Security Administration, and I'm talking about the Part D LIS program because it is very similar to the MSPs. It provides similar benefits to the people and to similar people who have similar income and asset levels. And, as a result, efforts have been made to align the eligibility criteria between these two programs in order to facilitate enrollment in both of them.

An automatic eligibility link exists between the

two. So anyone eligible for the MSPs is also eligible for LIS. That is not true in the other direction, though. People eligible for LIS are not automatically eligible for the MSPs.

As I have mentioned, states have the option, though, to align their methodologies with those of the LIS program to facilitate enrollment into the MSPs but not all states have done that.

Without that, there are slight differences between the programs in terms of some types of income and assets that are counted for determining MSP eligibility, but not for LIS.

In terms of enrollment, there's about 10 million duals enrolled in the MSPs in 2020. Almost all of them were in either the QMB or the SLMB programs, with the vast majority, just over 8 million, enrolled in QMB.

Between the QMB-plus and QMB-only, the majority of people, 6.5 million, were in the QMB-plus program, and this kind of illustrates why these two programs are an area of focus.

So in terms of who is enrolled in these programs and who's benefitting from the Medicare -- the Medicaid

assistance with Medicare premiums and cost sharing, residents of urban areas are the primary enrollees of MSPs, and that's where most duals tend to live. And compared to Medicare beneficiaries who are not duals, MSP enrollees are more likely to be younger, to be Black or Hispanic, and to be female.

So this table provides a more detailed look at enrollment in both of the QMB and SLMB programs, but let's focus on the QMB-plus program, which is several -- like it's sort of in the middle of the table, because that's where most people are.

So, notably, while MSP enrollees are split about 37 percent under age 65, and 63 over age 65, if you look at the non-dual column at the end of the table, most non-dual Medicare beneficiaries are in that older age bracket. So that kind of gives you a sense of the varying ages between people who are -- duals who are in the MSPs and non-dual regular sort of Medicare beneficiaries.

In terms of race and ethnicity, as I mentioned, QMB-plus enrollees are more likely to be Black or Hispanic. People who fall into one of those two groupings make up about 40 percent of QMB-plus enrollees but only represent

about 14 percent of non-dual Medicare beneficiaries.

As I mentioned at the outset, over the years, MACPAC has really developed a body of work in this policy area with a focus on increasing enrollment. So our most recent work was in June 2020, the June report. We made recommendations designed to improve participation in the MSPs, and that work was -- those recommendations were built on a study that we did under contract with the Urban Institute to estimate participation rates in the MSPs. So that study, which was conducted in 2017, found that in the QMB and SLMB programs, enrollment was only about 50 percent of eligible individuals for the period of study. So the period of study -- so this analysis was based on survey data in part, and the period of study was late, sort of 2009, 2010.

Because of the relatively low levels of participation that we found with that study, we worked and did some additional research to develop some recommendations aimed at improving that, and a potential pathway that emerged was to achieve greater alignment with the Part D LIS program, because as I said, similar populations, similar types of benefits. So our

recommendations really were focused on getting -- trying to encourage states to use the same income and asset methodologies that the SSA uses when it's determining eligibility for LIS. It included things like defining income, assets, and household size in the same way as SSA.

The reason for that is that the states receive what is called "leads data" from the Social Security Administration on a daily basis, and states are able to use that. So that data is eligibility information that the SSA has collected for purposes of determining LIS eligibility. States receive that on a daily basis and can use it if they want to initiate the application for the MSPs.

To the extent that state eligibility criteria is already aligned with LIS, that makes using that data a lot more effective. The requirements, just for a little bit of background, that SSA provide this data, goes all the way back to the MIPPA legislation in 2008. That legislation also provided outreach dollars to help bring people into the programs, make them aware of the MSPs by providing funding to SHIPs, AAAs, and ADRCs.

Since we last talked about this, a number of policy changes have occurred that affect these programs.

Like I said, in what was a proposed rule -- but when I pulled these slides together, but it's now a final rule -- CMS made a number of regulatory changes designed to streamline enrollment into these programs. They are now requiring that states use the leads data as the application for the MSPs and to determine eligibility.

And to make this easier, CMS made a couple of fixes, like defining the family of the size involved as at least those individuals included in the LIS definition. States have the option to add more people, but under prior law, it was a little bit of a Wild West situation with states having that -- defining that in different ways.

Also, states are now going to be required to accept self-attestation of certain income and assets, such as burial funds, interest and dividend income, and other things that were being treated differently between LIS and the MSPs and making the exchange of data a little bit more difficult.

There's also been a piece of legislation I just want to flag, which is the Inflation Reduction Act, which created a little bit of an additional misalignment by expanding eligibility for the full LIS subsidy, up to 150

percent. If you remember back in the prior slides, the QI program goes up to 135, and that was the place where you could get the full subsidy in the LIS. That 135 mark was common across the two. Now LIS is going to be at 150, sort of creating a little bit of an additional gap there.

And then, in addition to those two regulatory and legislative changes, I wanted to just talk briefly about a few changes in the landscape that have occurred that I think are relevant to participation in the MSPs, and as a reminder, the data we used last time when we estimated participation was from 2009-2010 time-frame. And since then, a number of things have happened. The Affordable Care Act was enacted, and over the years, most states have chosen to expand to the new adult group.

It's reasonable to assume that in states that have demonstrated a propensity to provide coverage to people who are eligible, there may have been a commensurate effort to enroll new adults into the MSPs as they aged into Medicare, thereby perhaps increasing participation in these programs.

Also, the growth in Medicare Advantage has been exponential over the last 10 years. From 2011 to 2022, the

number of eligible Medicare beneficiaries enrolled in MA has increased from 26 to 49 percent, according to MedPAC. MA plans have an incentive to make sure their members are getting assistance with their Medicare premiums and cost sharing, another change which has likely increased participation.

Finally, as I've noted, states have the option to make their eligibility criteria more generous than the federal standards, and states have made some changes. Some states have gotten rid of asset limits. Some states have increased the income levels, including big states like New York, which accounts for 9 percent of all duals. Other states like California, which has 13 percent of duals, have announced that they're going to be eliminating assets in the next year.

So all of this kind of adds up to wanting to take a refresh, take another look at this, and think about some potential next steps. So we're planning to gather more information through interviews to try to better understand where enrollment and participation are today, especially relative to where it was when we last looked at this and arrived at that sort of 50 percent figure, as well as

understanding the role of federal funding for outreach.

We're also planning to try to talk to one or two states to understand how they view the MSPs and how they might be working to facilitate enrollment in their states, given their particular circumstances, especially now that this rule is has been finalized.

Depending on what we find, we'll come back to the Commission with potential policy options. As part of our work to identify those policy options, we are hoping to leverage our prior work -- planning to leverage, I should say, our prior work with the Urban Institute to conduct a follow-on analysis of enrollment in the MSPs over the last 10 years, broken out by some of the demographics that I presented. So we can see how those trends might have changed over time and what we might be able to infer about participation from those trends today.

So we're hoping to use today's meeting to clarify any questions that you guys might have about this slightly weedy topic and then gauge your interest in further discussion of MSP policy issues at subsequent meetings.

That concludes my presentation. I'll turn it back to you, Melanie.

CHAIR BELLA: Well, it won't surprise you to hear that I'm thrilled that we're taking another look at this.

With that, I will have John kick it off.

COMMISSIONER McCARTHY: I love these topics. This is the stuff that I lived for as Medicaid director.

In D.C., we had expanded up to 300 percent FPL for QMB, and one of the things that I saw then in going to Ohio where there wasn't an expansion of this, the issue you run into around the federal poverty level is the same across all of the contiguous 48 states. Yet we know in some places it's higher costs; in some places, lesser costs. In D.C., all of D.C. was high cost. So it was easy to make that change, but in a state like Ohio where you have urban areas and rural areas, it's a differentiation in there, and so making that change has a different type of impact.

One of the things that I would like to see us take a look at is when you do this change, you have to do it through a state plan amendment, and it has to be statewide. So is there a way you could look at it maybe not doing it statewide, if that makes sense?

The other one is -- and this is a super technical

piece, and I can't remember exactly where this ended up, but there's an issue where when inflation is zero and the Social Security benefit doesn't go up, people's Part B premiums don't go up. And I'm getting this off a little bit, but the state gets burdened because they still have to pay something around the higher premiums. So this was in the last year of me being in Ohio where we were dealing with this issue. So while everyone on Medicare is protected, the states aren't protected from that increase, and so it was a budgetary issue too. So that's, again, in a bigger policy question: Why do states face that? And if that's changed, Patti is looking at me like that may have changed, but okay. But that's one of those --

CHAIR BELLA: That's a Part B issue, though, and more so than like this? You're talking about the benes were held harmless --

COMMISSIONER McCARTHY: Right, but the states weren't.

CHAIR BELLA: -- and then the state had the price tag.

COMMISSIONER McCARTHY: Yes.

CHAIR BELLA: Yeah.

COMMISSIONER WENO: Yes. So that's a barrier, then, to states using this, because you have that price tag when that happens, which it doesn't happen all the time.

CHAIR BELLA: And your comment about could you do partial state would be on maybe increasing income or assets in Cleveland and not Akron.

COMMISSIONER McCARTHY: Correct. If you had urban areas and you're looking at areas of like it is high cost in this area, but not in this area, could I pick five counties or whatever it is, because there's a cost differential.

Again, just trying to think of those things that I was running into of --

CHAIR BELLA: Yep.

COMMISSIONER McCARTHY: This is an amazing program. It's helped a lot of seniors that I've worked with, and so it's like how do you make it work best in the program.

CHAIR BELLA: Other comments?

Patti, surely, you have a comment.

COMMISSIONER KILLINGSWORTH: First, I would say that I really am anxious to see the updated enrollment data

and to see if we've made progress and if that progress is consistent or if there's significant variation in the progress based on expansion states versus non-expansion states. It's clearly a really important issue to make sure that people who are eligible are enrolled, especially in light of the additional costs or beneficiary protections really related to costs that are part of the QMB program for dual eligibles.

I fully support, obviously, continuing to press into this issue and identifying ways that we can both educate people about the availability but also make those processes more "automatic" for lack of a better term. There are a lot of people who would not apply for Medicaid for a variety of reasons, but they would apply for help paying their Medicare premiums if they knew that that was available to them. And they don't often know that it's available to them.

CHAIR BELLA: Thank you, Patti.

Dennis, any comments?

COMMISSIONER HEAPHY: I was thinking about the Medicare Advantage, the growth in the folks. It's a fantastic thing, but I'm just concerned about the folks

that aren't in MA plans, and how do you get the word out to them in a more robust manner? So just like pondering it, actually. It just seems that MA plans are not the solution for everybody, but yeah. That's where I am, talking about folks who are not in MA plans.

CHAIR BELLA: Other comments?

Verlon.

COMMISSIONER JOHNSON: So I'll just echo again that this is a great program, and the reason why I'm in Medicaid. I was in Medicare for several years and then learned more about the QMB/SLMB program and said, "Hey, that Medicaid is a pretty interesting program. I want to transition over," so definitely a supporter.

I did have a question around the Urban Institute and the work that was done there. Will we have enough updates or data around that for them to update the study that they were able to do back in -- was it 2020?

MS. BLOM: Yeah. It was 2017, they did that work.

COMMISSIONER JOHNSON: Oh, 2017, okay.

MS. BLOM: And the answer is we're trying to think of ways to mitigate the data issues there. The work

that they did was actually really labor intensive, and they were marrying survey data with administrative data to try to get at the eligible not-enrolled population.

So this time, I think what we're hoping to do is use the administrative data as the first phase and kind of look at where enrollment is now and how it's changed over time to see what we can kind of learn from that, what we can glean about participation --

COMMISSIONER JOHNSON: Okay.

MS. BLOM: -- and then perhaps in a second phase, if we feel like it would be useful, delve into kind of that survey-based side of things and think about the eligible side.

COMMISSIONER JOHNSON: That's great. Thank you.

CHAIR BELLA: John.

COMMISSIONER McCARTHY: One more issue we dealt with and using the "leads" data to do automatic enrollments, you still have to take beneficiary choice into consideration, and this was something then that we were working through issues, because we got some people who did not -- even though they're qualified, did not want to be enrolled. Automatically enrolled them. They want to be

disenrolled. The issues with that, especially if it's months after the fact, because then are you going backwards? And then there's an issue of now they got to pay all those premiums, and so it's back to how to -- if you're moving in that direction, if a state decides to move in that direction or something, how do you do communications? I think we talked about it a little earlier. How do you do communications? How do you work through those policy implications that come through that?

And then second part is I know in the past there were some questions around the impact if a person had picked a Part D plan and they liked that Part D plan for whatever and then they got put on the LIS, that's a different -- they get disenrolled from the current Part D plan and moved to a different one sometimes. That sometimes cause some issues with their prescriptions. So it's just I'm curious on that one, if that's still an issue. I don't know if it's still an issue, but it's something to let us know if it is or isn't.

MS. BLOM: On the Medicaid side, was the concern -- the reason for disenrollment, people didn't want to be on Medicaid or --

COMMISSIONER McCARTHY: That is correct. People did not want to -- yes. I'll just say that.

CHAIR BELLA: So, Kirstin, on the rule, just the portion of the rule, do you see that as -- I mean, it's directionally where we were going. Do you see this -- our work will continue to build on that and continue to make sure states understand the additional tools they could be leveraging? Is that how you're thinking of that?

MS. BLOM: Yeah. I think they've largely addressed the recommendation that we made about things like household size. The rule takes care of that.

I think there's one area with burial funds that I think seems like we could potentially say something there since I think state treatment of that -- the rule is requiring self-attestation, but states -- it's not changing the fact that states are able to require that that money be set aside in order to not be counted, which is a little bit different than how LIS does it. So there's still sort of a wrinkle there.

Then there's the issue as well of the funding for outreach that I think we could -- I think we talked about that in our last chapter. We could potentially think about

that.

Then the enrollment, the data side, I think, is an area we can contribute. I know that there was a lot of happiness on the part of the duals office with the study that we had done back in 2017 with Urban, and although it's difficult to reproduce that, I think we could inform the discussion with some data, especially over time, on where enrollment is, because I do think we can learn over time. It does seem like enrollment has probably increased for a number of reasons over those data we used in 2017. It's just that we don't know that from the data. So I'm hopeful we can put some meat on those bones.

CHAIR BELLA: And how long will that take? What's your timing that you're thinking about on the data side?

MS. BLOM: I'm hoping that I can come back later this fall with some information. That's a little bit TBD right now. I think about maybe the Urban Institute is listening to this session, but I'm hopeful that later this year, early next year time frame is doable.

CHAIR BELLA: All right.

Dennis.

COMMISSIONER HEAPHY: With the MA plans, do people realize that this is a right that they have, and it's not something that's being given by the MA plan?

MS. BLOM: I'm not sure, Dennis. That's a good question.

COMMISSIONER HEAPHY: Because the spike in MA plan enrollment, the people should know that they have a right to this and that does not come with just being in an MA plan. It's important.

CHAIR BELLA: Thank you, Dennis.

Are there any other comments or questions?

Kirstin, I would just ask that we're always keeping a pulse on where the states are on some of this and understanding what the barriers are, and I'm afraid as new folks come in, these are not acronyms commonly used, so QMB, SLMB, QI, QDWI, I'm not even sure how many people are fluent in that language. So we can be continuing, I think, to provide education on that too. It's really important.

CHAIR BELLA: All right. Do you have what you need?

MS. BLOM: Yes. Thank you, guys. Thanks for the discussion.

CHAIR BELLA: So we'll see you back this fall with more work in this area. Thank you very much.

All right. We're going to take public comment on the three sessions from this morning. So we will welcome anyone in the public who would like to make a comment. Please raise your hand and introduce yourself and the organization you represent, and we ask that comments be kept to three minutes or less. We'll open that up now.

Great. All right, Wendell. If you would like to unmute, you're welcome to make a comment.

PUBLIC COMMENT

* MR. PRIMUS: Well, thank you. I'm Wendell Primus. I'm a visiting fellow at the Brookings Institute, and for the last 18 years, before I retired, I was the senior policy advisor to Nancy Pelosi, Speaker Nancy Pelosi.

I would just say a couple things quickly. One is that I've done a study comparing what ACA people pay versus what low-income elderly pay with the same income and the same family size, and you have over 3 million elderly paying the full Part B premium. And that's $164.90 a month, almost $2,000 a year. And the ACA beneficiary below 150

percent of poverty pays nothing.

And you have -- when we did this study using CPS, you have 18 million elderly paying substantially more than ACA beneficiaries, again, with the same income, the same family size, and now, again, Medicare has a higher actuarial value than a silver plan on ACA.

I would say the MA plans do lower the Part D premium for many people, but my understanding is that MA plans almost do nothing in terms of the Part B premium.

So I think you should seriously consider administrating the MSPs through the Social Security Administration, just like we administer right now, higher premiums for higher-income elderly. I think it could be done, and I think we're going to issue an issue brief on that subject.

So I think those are my comments. Thank you very much.

CHAIR BELLA: Thank you very much for joining us, and we'll keep an eye out for that issue brief. Thank you, Wendell.

Other comments?

[No response.]

CHAIR BELLA: All right. I think that's a wrap on these three sessions. We have reached the end. So I'll ask Commissioners if there are any additional comments or questions from any of you before we adjourn.

Sonja.

COMMISSIONER BJORK: Thank you. It was such a great discussion yesterday about the unwinding process, and some of us had concerns about the impact on beneficiaries of a possible period of ineligibility that they might go through, through mistakes or problems with the ex parte process. And I just wanted us to keep track of that concern and raise it when we can, that we really want to look out for the beneficiaries and not have them face billing problems from any services that they receive during a period they might be ineligible.

And that happens during normal times, but because we're talking about millions of people going through the process, we see that it might really become an issue for a lot of people.

CHAIR BELLA: Thank you, Sonja. Tricia.

COMMISSIONER BROOKS: So building on that, we have to continue to examine how we do a better job of

detecting these kind of problems in advance, and we heard from Kate McEvoy on the state reaction and, wow, we've done readiness testing and we haven't detected it in the past. And I think there are a number of ways that we can do that.

One is through looking the lens of PERM, the Payment Error Rate Measurement program. I know that people would say, "Well, wow, that's after the fact." Yeah. Well, it's been 10 years after the fact that these rules have been in place, and perhaps we could have caught it if we were looking at negative determinations.

Secondly, it's just in the system readiness. Obviously, we did not do as thorough a job as we might have been able to do had we looked at it.

I think the third area that's really come up on the unwinding is that we need more timely, disaggregated data in order to make informed decisions about policy and implementation, and right now, when you have a three-to-four-month lag in an environment that's moving as quickly as it is in the unwinding, that's not timely enough to really detect problems and nip them in the bud.

CHAIR BELLA: Thank you, Tricia.

Heidi.

COMMISSIONER ALLEN: So thinking of prospectively how we could perhaps protect Medicaid beneficiaries better for these periods of time where they experience uninsurance, whether it's because of a mistake that was made, like we've seen happen recently or for other reasons, can we look at programs that might exist in the Medicare program to protect people for a period of time after they disenroll for claims if they reestablish enrollment?

Medicare experts, my understanding is that there is some program that if they disenroll, but then they reenroll within six months, they have this kind of umbrella coverage. And something like that might be a really important tool to protect Medicaid enrollees who are also churning, which we know is a very significant issue.

CHAIR BELLA: I think you might be talking about deeming for duals and D-SNPs. Yeah. Just for the record, it's pretty -- it's not a be-all, end-all sort of solution, but understand the point to look for if there are other -- aspects in other programs that provide protections to beneficiaries, understand that point.

COMMISSIONER HEAPHY: I think protecting continuity of care is really crucial. So how do we do that

with MCOs to make sure folks don't lose their Medicaid benefits for populations that do cycle on and off Medicaid because of income changes on a regular basis? Is there a way to preserve their continuity of care within the MCO, have the MCO picking them up for a month just to maintain that continuity of care? Because they know the person is going to be back on Medicaid the next month, because there was such churn there with folks' income going up and down.

CHAIR BELLA: So, obviously, all of this is sort of hot on the heels of what came out yesterday and what we've learned, and so I know Kate and the team will be absorbing and asking a lot of questions, talking to CMS, talking to the state Medicaid directors. I can assure you that will all happen, and we will share and continue to discuss in our future meetings. But I appreciate those comments.

Is there anything else?

Angelo.

COMMISSIONER GIARDINO: I guess I just wanted to make sure that as we look at some of the issues related to unwinding, looking at the CMS statement that came out yesterday, as I looked at that table of all the different

issues, it did seem to me just in a cursory way that children were inordinately affected by some of the processes. So I'd love to keep an eye on proportionally how many kids are being harmed in this process. It just seems to me that one way to do that, since the age is in every IT system on earth, you could put the kids towards the end of the unwinding if they're disproportionately affected until you get the systems working. So I'd love to see data on that and if that would be a way of perhaps providing some additional support to protect the children in the Medicaid program, since it seems to me they are disproportionately being affected by the current unwinding processes.

CHAIR BELLA: Thank you.

Other questions or comments?

[No response.]

CHAIR BELLA: All right. Well, then we are adjourned. Congratulations to our newest Commissioners for completing your first meeting. See, it's not nearly as bad as anyone might tell you, and we will look forward to seeing everyone in November. Thank you very much -- and to Kate and the wonderful team behind me.

* [Whereupon, at 11:32 a.m., the meeting was adjourned.]