PUBLIC SESSION

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COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: All right. Good morning, everyone. Welcome to the November meeting of MACPAC. We are going to get started with the continuation of our work on managed care appeals, and welcome, Lesley and Amy. I'll turn it over to you.

IMPROVING THE MANAGED CARE APPEALS PROCESS

* MS. BASEMAN: Thank you, Melanie, and good morning, Commissioners.

Today Amy and I are here to discuss policy options for the appeals process in Medicaid managed care.

We'll first start with a brief project overview. We will then quickly walk through the methodology for the recently convened beneficiary focus groups. Next, we'll detail the key challenges with the appeals process and present policy options designed to address these challenges. Lastly, we will touch upon next steps.

As a reminder, this work focused on three key objectives, as indicated here on the slide. Today's presentation will focus on policy options for the appeals process. We will return in January for a vote on

recommendations and a presentation of the draft chapter. The chapter will appear in the March report to Congress.

We briefly want to walk through the methodology for our beneficiary focus groups. We contracted with Mathematica to conduct these focus groups. Mathematica conducted four focus groups and two individual interviews, totaling 22 beneficiaries and caregivers. Participants were eligible for our focus groups if they had appealed a managed care denial within the last three years. Mathematica mostly relied upon legal aid organizations and state ombudsman offices to assist with recruitment.

Key findings identified from this study reflect only the experience of those who were recruited and participated. We do not know the extent to which these findings apply to individuals who do not seek out assistance from legal aid or ombudsman offices. However, the focus group findings echoed many of the findings from our roughly 30 interviews.

This table displays some key features of the focus group participants. In total, we heard from 22 beneficiaries and caregivers across eight states. Most participants were caregivers for parents or children, and

most were appealing a denial in home health aide or nursing hours. One interview was conducted in Spanish, with all remaining interviews and focus groups conducted in English.

The evidence we collected suggested three key challenges with the appeals process. While we emphasize input from focus group participants in these next several slides, we want to flag for Commissioners that these challenges arose from multiple streams of evidence collection, including interviews with states and stakeholders, a state scan of publicly available data, and a federal policy review.

The first key challenge from our research was a lack of trust and general frustration with the appeals process. Most focus group participants did not have a positive experience with their MCO. Many reached out to member services representatives and felt that these individuals were some combination of unknowledgeable and unhelpful.

In our interviews, providers and beneficiary advocates shared that communicating with the MCO can be a frustrating experience. Some even provided examples of being dissuaded from filing an appeal.

Many focus group participants also felt powerless against the MCO. Some indicated that the power imbalance was intimidating, even comparing it to a David versus Goliath scenario.

Lastly, focus group participants who had never filed an appeal before had high expectations to win their appeal, whereas those who had filed multiple appeals before had far lower expectations. These quotes further illustrate this issue of frustration and lack of trust.

Regarding member services representatives, one focus group participant indicated that there's a large gap in that knowledge and ability to be helpful. Another participant felt that the MCO's goal was to get them to give up on their appeal.

The second key challenge from our research was around access barriers to continuation of benefits. As a reminder, continuation of benefits is designed as a beneficiary protection for continuity of care. If an MCO terminates, suspends, or reduces a previously authorized service, beneficiaries have a right to continue receiving services at the previously authorized level while the appeal is pending. Beneficiaries have 10 days from the

date of the denial notice to request this continuation. MCOs are allowed to recover the costs associated with services provided while an appeal is pending if repayment for services is consistent with the state's usual policy on recoveries.

We found that access barriers for continuation of benefits fall into three categories: awareness, timelines, and repayment. Focus group participants were generally unaware of their right to continue receiving services. Some indicated that they only learned of this right once they obtained legal representation. Interviewed beneficiary advocates, including legal aid societies, indicated that the timeline to request continuation of benefits is too short. Focus group participants expressed that delivery of notices is often delayed, so 10 days from the date of the denial notice can sometimes happen before the beneficiary even receives the notice.

Lastly, interviewed beneficiary advocates shared that the threat of repayment dissuades beneficiaries from requesting to continue services. This quote further illustrates the issue of awareness for continuation of benefits.

The final key issue from our research pertained to the challenging and burdensome nature of the appeals process. First, focus group participants shared that denial notices often arrive late, if at all, and can be hard to parse. This finding was corroborated by our interviews in which beneficiary advocates and providers shared the same issues with denial notices. Additionally, interviewed MCOs indicated that it is challenging to write denial notices at the appropriate reading level, given requirements to include both clinical and legal language.

Second, focus group participants shared that the appeals process itself is incredibly time consuming, making it difficult to manage. Beneficiaries or their caregivers often have to spend hours on the phone with the MCO to understand the denial and what is required to pursue an appeal. They then spend more hours on the phone with their providers to obtain the required clinical documentation. This finding was echoed by interviewed providers who shared that they also spend hours on these tasks for their patients.

Lastly, external support, including from providers, community organizations, and ombudsman offices,

is critical for navigating the appeals process. Nearly all focus group participants sought out assistance from legal aid or their state ombudsman office in pursuing their appeal. Interviewed beneficiary advocates and providers suggested that knowledge of available external support can even influence a beneficiary's decision to appeal.

One caregiver participant expressed that they often measure their days in terms of the number of phone calls they had to make that day regarding the appeal. Another caregiver participant expressed frustration at the process, indicating that the wheels turn very slowly and that the process is both terrible and exasperating.

I'll now turn it over to Amy to present our policy options and next steps.

* MS. ZETTLE: Thanks, Lesley.

So today we're going to present four policy options for your consideration. As you can see from this figure, each policy option seeks to address a specific challenge that was uncovered during the stakeholder interviews from earlier this year and then the focus groups from this summer. Together, these policy options aim to make the appeals process more accessible to beneficiaries

and to help ensure that beneficiaries have access to medically necessary care.

Our first policy option would modify existing regulations to require that states establish an independent external medical review. This is currently an option for states, and 14 states have taken up this option.

This external medical review occurs following an internal appeal, which has been upheld by the MCO. Current rulemaking specifies that beneficiaries would need to initiate this external review. However, this policy option we're discussing today would allow states the discretion to set up the independent review either automatically or at the beneficiary's election. An automatic review would be more similar to how Medicare Advantage sets up its external medical review.

And similar to current rulemaking, this policy option would not extend any timeframes for the state fair hearing process.

Our interviews and focus group findings showed that there was both distrust with the current system and perceptions of conflicts of interest. Requiring that states establish an external medical review conducted by

clinical experts of upheld denials would bring greater independence to the process and improve trust among beneficiaries. In states that have external medical review, the OIG reported that external medical reviewers overturned 46 percent of denials in favor of the beneficiary. As a result, those beneficiaries gained access to medically necessary care of previously denied appeals.

In addition to offering beneficiaries an independent clinical review of their appeal, states and plans can use this as a tool for performance improvement. For example, a high overturn rate of a specific service by an independent clinical reviewer may indicate that improvements need to be made to the authorization process and to better ensure appropriate access and reduce inappropriate denials.

As for the effects of this policy, this option is expected to have the most significant financial and administrative burden on states. The cost will vary depending on how states elect to set up the reviews and whether they would be automatic, but we will work with CBO to get an estimate on that.

Among all our policy options today, this policy option would likely have the most direct impact on improving access to care, and we should note that OIG did make a similar recommendation to CMS earlier this year, but they did recommend that that review process happen automatically and across all states.

Okay. Policy Option 2 seeks to address the challenges related to continuation of benefits that Lesley just walked through. This policy option would require that CMS issue rulemaking to extend the deadline available to beneficiaries to file for continuation of benefits as well as require monitoring and oversight of this protection.

In addition, CMS would issue guidance on continuation of benefits to improve awareness and clarify policies regarding potential repayment of services delivered.

Our research indicated that accessing continuation of benefits were a challenge for those three reasons: tight beneficiary timelines, lack of awareness, and the threat of repayment.

In addition, you heard from us last session that there's no federal requirement to monitor whether

beneficiaries are using or exercising this benefit. So together, rulemaking would give beneficiaries more than 10 days to apply, and it would also require that states monitor the use to see whether it is accessible for beneficiaries.

The guidance would offer states model language to improve the notices and clarify that recruitment can happen only in states where this is allowable under fee-for-service. The effects of this policy would create some administrative burden on CMS to both issue guidance and regulations and then on states to implement those regulations.

Our third policy option would direct CMS to issue guidance detailing the various tools and approaches that states could take to support beneficiaries as they navigate the appeals process. This should include tools for improving the denial notice, reiterating the requirements on MCOs to provide beneficiary support, and indicating areas where Medicaid funding could be used to support external entities.

Publicly available data suggests that few beneficiaries appeal denials, and we heard from

beneficiaries and interviewees that the process can be challenging, burdensome, and require external support.

The challenging nature can begin with that initial denial notice. Beneficiaries found that the denial notices do not always articulate a clear reason for the denial, and interviewees from MCOs acknowledge that drafting such a rationale can be challenging.

So the goal here would be to have some guidance from CMS to really help states and MCOs improve that notice and help better support beneficiaries. This policy option would create some administrative burden on CMS to issue the guidance, and if the appeals process is more accessible through these supports that states may choose to implement, more beneficiaries could see improved access to care.

Our last option would update federal rules to require that MCOs provide beneficiaries with the choice of receiving these denial notices electronically. Current federal rules require that MCOs send written denial notices by mail. Our findings suggest that written notices delivered by mail can be inadequate for some beneficiaries. Beneficiaries cited that the notices can be delayed or not arrive, and beneficiary advocates and stakeholders widely

supported having additional modes of communication available for this denial notice.

This policy option would align delivery requirements with those already in place on the states with regard to eligibility notices, and under this policy option, CMS would be required to go through the rulemaking and comment period process.

States would be required to implement this regulation, updating their managed care contracts, and MCOs would be required to offer this to beneficiaries.

Managed care plans would then implement the requirements, and beneficiaries would then have the choice to access this critical information electronically.

We're looking forward to hearing from you all and your feedback on these four policy options. It would be helpful to hear which of these policy options you would like to advance for the March report to Congress and if you'd like to see any changes to the policy options that we would bring back in recommendation form in January.

And I will turn next to this slide to kind of refresh your memory on the various policy options.

CHAIR BELLA: Thank you, Amy and Lesley.

We're going to do this a little bit different than we usually do. I'm going to go by recommendation and try to take feedback, and then we'll talk about it as a whole. And I'm going to start with Recommendation 4, because I actually think they're sort of easiest to hardest as we get going, so trying to sort of clear the air on ones that feel a bit easier.

But just to set the stage, there has been pretty widespread interest from Commissioners in pursuing this. The intent would be to have the discussion today to provide feedback. This would come back to us in January for a vote for inclusion in the March report.

So if we could go specifically to the slide for Recommendation 4. Any comments or questions or concerns on Recommendation Policy Option 4?

Patti and then Tricia.

COMMISSIONER KILLINGSWORTH: First of all, thank you both for the incredibly good work on this topic. It's a lot of information, but it's really, really insightful.

I do support Policy Option 4 in providing enrollees with an option to receive notices in an electronic format. I think it would significantly expedite

access to that information, make sure that there's sufficient time to request continuation of benefits, and mitigate some of the challenges that have been discussed with respect to mailing addresses.

I do think it should reflect the state's ability to then require the appropriate information to support electronic communication, if that's the preference of the enrollee. So it will be important that the state has access to that information, that it is updated as it changes for the enrollee, just as mailing addresses need to be updated so that they can ensure that they can deliver that information to them in a timely way.

I think that we should look carefully at whether duplicative mailed notices would then be required if someone opts to receive their information electronically. My tendency is to think that we don't need to do duplicative processes. We honor the preference of the enrollee. I know that there are Commissioners who feel otherwise. So maybe a look a little bit deeper into the value of duplicate mailings plus electronic communication would be really helpful.

And then I have some thoughts about how this

interplays with another recommendation, and I'll hold it until we get to that.

CHAIR BELLA: Thank you.

Tricia?

COMMISSIONER BROOKS: So I definitely support giving the option for electronic notices, but I think there has to be more caveats and that plans would be required to assess the open rate or the kickback rate. And if it hasn't been opened in a certain number of days or it gets sent back as undeliverable, that a written notice must get sent.

I agree that doing a duplicative -- I don't know. You know, we have tons of emails and texts and notices going out on unwinding, and we still see people not taking action. So I'm not sure that I think you should be spending the extra money to do both at the same time, but there needs to be a way to backfill.

CHAIR BELLA: Thank you.

Heidi and then Rhonda.

COMMISSIONER ALLEN: So first, I just want to say that I really appreciated the focus group with the beneficiaries, and while I was reading it, I could feel my

anxiety and sense of overwhelm like being triggered. I could see -- I just felt how a beneficiary must experience this, navigating this process, and I thought that it was very telling that it was mainly caregivers that participated, because imagine doing that while you're sick. So imagine doing this if you don't have a caregiver and you're your own caregiver. You're navigating a health condition and trying to navigate a bureaucracy, and how difficult that must be. And so I felt like bringing that voice in was really important.

And I love that we're doing this right now, and that we've been building to do this work, and there's actual concern about this in the Senate and the House, and that they want to know how to fix this. So I think it's really timely as well.

In terms of Policy Option 4, I am a survey researcher. I've spent the last 15 years trying to find Medicaid enrollees and get them to respond to me, and best practices in trying to collect data or get Medicaid enrollees to respond to you is to use every single mode at your disposal.

And I would say that this is a high-stakes

communication, much re-enrollment, and people do change phone numbers. They do change addresses. They do change emails occasionally. But you do as much as possible and hope that one of them reaches.

I don't think of it as duplicative. I think of it as absolutely necessary, because none of those communication strategies on their own are -- you know, don't come with issues of like too much email or email filters or you're not home and you don't get the mail. If you try to do as much as possible, then I feel like what that is is due diligence for the Medicaid program to show that they really are trying to reach the participant.

That's it for me.

CHAIR BELLA: Thanks, Heidi.

Rhonda and then Dennis.

COMMISSIONER MEDOWS: I was going to speak in support of and in favor of Policy Option 4, providing the option for electronic notices, and also speak in agreement with what Tricia mentioned about it being actively monitored in terms of open rates, responses, et cetera.

I would say that it may be that there is another way to try to address whether or not there should be email

or snail mail following electronic notices or not, and it may be allowing beneficiaries to opt out if they truly don't want mail.

CHAIR BELLA: Thank you.

Adrienne, then Verlon. And I thought this was going to be the easy one, guys. Okay.

COMMISSIONER McFADDEN: I just want to echo and thank you again for all the extensive work on this. It was very informative.

I am particularly fond of this policy option. So I'm definitely supportive of it. I think, one, it allows beneficiaries to receive communications in the way that they want to and also lays a foundation for more equitable communications, particularly around language access and other needs as well. And so I would just like to echo my support.

CHAIR BELLA: Thank you.

Dennis, I'm sorry. I skipped you.

COMMISSIONER HEAPHY: That's okay. I wouldn't let you forget.

I want to echo Heidi's points about people needing multiple forms of access to communication.

People's phone numbers in this population change quite frequently. People run out of minutes. People's addresses change quite frequently, and so the more options people have to get access to information, more likely they're going to follow through. And so I would love to see this changed to all the formats, if possible, but I would go with No. 4 as a minimum standard.

CHAIR BELLA: Thank you, Dennis.

Verlon?

COMMISSIONER JOHNSON: So I totally agree with Heidi and others who have spoken about this. I think it's important to have the different modes.

I would actually say to make sure that beneficiaries have an option to have all of them, if they want to get mail, if they want to get email.

I have a real-live situation that just happened. I was actually helping out a family member who I'm a caregiver for. And they received a mailed notice that was ignored. I have access to their email, and I received the email notice. So I think in terms of even for caregivers, I think that could be really helpful. So I would support it.

I understand the need for -- you know, the concerns about duplication and all of that, but we need to make sure they're getting what they need when they need it as soon as possible.

Thank you.

CHAIR BELLA: Jami.

COMMISSIONER SNYDER: I was just going to echo the sentiments of Verlon and others. I think multiple modes of communication are really important, and I think we've really learned that through unwinding. And we talk a lot about carrying on the lessons from unwinding into the future, and I think this is a great example and definitely support the recommendation.

CHAIR BELLA: And I would just remind us all, the recommendations are at a fairly high level. So we are raising some issues that can be further discussed in the chapter, some issues that may need to make it into the recommendation, but some issues that can be left to CMS or the states without sort of taking away our ability to make a recommendation, so just thinking about that.

All right. Let's go to Recommendation 3. I'm going to make a bet that no one is going to argue against

making things simpler and easier to understand, but I'll open this one up for comments or factors that you want to be considered in the chapter alongside the recommendation.

I can't see. Patti, is that your hand?

[No response.]

CHAIR BELLA: Heidi and Tim and Carolyn.

COMMISSIONER ALLEN: So I would love if we could include either -- if it's possible to formulate a recommendation. It may not be, but to state that the letters need to speak to exactly what is needed. So that was something that came up in the -- you know, there's this concern about how difficult it is to communicate complex medical information, complex Medicaid policy in these letters, and I think that that is true. And I definitely read that the variation, how some states are required to include regulatory language and that makes it even more confusing. But it feels like there should be an effort made to say, in bold, pulled out of the text, this is specifically what we need from you, like either your diagnosis doesn't match this treatment or we need a letter from your doctor, or your doctor needs to send us these forms. Those things seem like that they could be made

simply and could be called out.

This idea of -- I was just really struck by the beneficiary who was like, "Well, I had a doctor tell me I need this. Like, how could you tell me it's not medically necessary?" That is such a confusing thing for people, and this process represents a whole long chain of realized access. People got the appointment. They went and saw a provider, and the provider is like, "I'm going to do these labs, and I'm going to do this physical exam, and I'm going to do these imaging, and then we're going to come up with this treatment." And so all along the way. we've invested time and energy, and then at the last second, they get a notice that says it's medically unnecessary. I'm like, what are they supposed to do with that?

And that's kind of my concern with the fair hearing and why I think so few people do it is like, how would you navigate that to create your own witnesses in this hearing? Like, it doesn't make any sense to the average person. It doesn't make sense to me when my health insurance does that to me. I'm like, I don't know what you mean.

So just something like we recommend that there

should be a clear and concise sentence that says this is what the beneficiary needs in order to get this treatment, like a letter from the doctor, a different diagnosis, a form that needs to be sent in. That's what I would hope for, if possible.

CHAIR BELLA: Thank you, Heidi.

Tim and then Carolyn.

COMMISSIONER HILL: Yeah. I sort of second the notion on the complexity of the forms and somehow making it easier.

I'm struck by all the recommendations, and they all have a lot to be said for them, that many ways we're taking a complex process. So we're fixing that complex process by adding more process to it, which sometimes that's like your only lever that you can pull.

But I'm wondering -- and I know this is dueling policy things going on, but as CMS thinks about their rating system for managed care plans, if there's a way to build into that process or for the Commission to speak to building into that process, some sort of assessment here, whether it's, you know, secret shoppers or analysis of data that's coming out on the appeals process and how clear

those issues are for beneficiaries to build into the rating system, some sense of how plans are doing on this, because guidance is great. But it just feels like the same hammer that we always use is like issue more guidance, and is there another lever that we can pull? And is that lever the rating system?

CHAIR BELLA: Thank you, Tim.

Carolyn.

COMMISSIONER INGRAM: Thanks for the work on this.

One question I had was, did we look at the requirements that managed care companies are in many states required to have ombudsman folks that are external to the company helping beneficiaries?

MS. ZETTLE: Yeah. The five states that we talked to, I believe one of the states discussed that, though the managed care plan we spoke to, I don't recall it coming up. But yeah, there does seem to be a number of external supports that vary certainly by state and by health plan.

COMMISSIONER INGRAM: Okay. Thanks.

I can support this statement of Option 3, of

course, because everybody wants things to be simpler, as Melanie pointed out. One of the great, fun things I get to do in my job is try to do grade leveling on notices that go out to clients, and it is very difficult, as they've stated, to put everything in there and try to meet grade level.

I would almost ask, then, that CMS, also in our response, provide some tools to the states. While we as companies all have these tools, the states -- and a lot of them don't have any kind of training or staff. They spend hours trying to review something, because remember before these go out, the state reviews them. Managed care companies can't send out any of these notices to folks without the states approving them. So they don't really have sometimes the best skills at doing that. They may not have a person like Heidi in their state to turn to get help. They may not have a legal advocacy group. And that's how some of the notices become so complicated, frankly.

So maybe tools back to states that they'd be able to see something. Whether it's language that is provided or tools around grade leveling or some other format that we

can try to think of, I think that would be helpful to add.

Thanks.

CHAIR BELLA: Thank you, Carolyn.

Sonja, then Rhonda, then Patti.

COMMISSIONER BJORK: Thank you.

So NCQA does have some guidance about notices, meaning that there has to be a section in the notice where it is written, in as common language as possible, the medical reason or the exact reason for the denial. And still, the notices are just awful. They're so complicated because they have the regulatory citations in there, and because they do often have a lot of technical knowledge. And as was stated, that's what's required.

So I think that our recommendation could even include something about flexibility, because what I envision is, what if there was an extra page that said things like regular people speak? You know, a friendly page that says this is what is needed, additional records from your doctor. Everyone can understand that.

But as is stated, it has to get approved by the state. So health plans and states just can't go rogue sending out flowery notices. The format of such a thing

would still have to be approved, but I think a separate page, even, that just says things, how regular people talk. And then the official notice that has all the regulatory citations and the medical jargon and things like that, that is also important, because if the person brings it to their legal aid attorney, they want to know what was the basis. And so it could meet both goals, I think, by just pulling out one separate part that's customer friendly.

CHAIR BELLA: Thank you, Sonja.

Rhonda?

COMMISSIONER MEDOWS: I would love just to be able to see that simplified language that you just described. I think that would be fantastic.

I am bilingual. I speak English and bureaucracy, and I can tell you that these forms are incredibly complex, and they're terrifying when you get them. You got to work your way through paragraph to paragraph.

I think even if you added in simplified language, if they have to see the clinical statement first and the legal statement first from the health plan, I worry that maybe the simplified language, it needs to be there, but I think they need a navigator to translate that into a way

that they understand it.

And so the person who was mentioning, you know, are there ombudsmen already, please don't hate me if I just say this quite plainly, but I think the ombudsman or the navigator should be with the state and not with the health plan. I think some of the comments that came in, even though that small sample set that Mathematica looked at, was issues on trust and concerns about conflict of interest. I think if there was a choice between a third-party objective entity like legal aid, the state which has its own challenges sometimes with having people believe and trust in it. But I think having the health plan have an ombudsman, I don't know that they would trust that. That would kind of make me as a consumer, as a beneficiary, want to look for somebody, a third party to help me translate a denial.

That's all I wanted to say is that I think sometimes a navigator needs to be there along with the simplified language to help them actually understand truly what is necessary in order to respond to the denial.

CHAIR BELLA: Thank you, Rhonda.

Patti and then Dennis and then John, and then we

need to keep moving. So we have about 10 minutes left for the other two.

COMMISSIONER KILLINGSWORTH: Okay. I support the recommendation.

I will say that it might be beneficial, Lesley and Amy, to just look further at how beneficiary support systems that are required under 438.71 have been operationalized by states, primarily for MLTSS, but I think relative in terms of just the availability of support and assistance throughout that process.

And then maybe include awareness and experience of beneficiaries in using those systems and opportunities to maybe build off of those or further strengthen those or just think about the role that they play in improving access to the appeals process.

Thanks.

CHAIR BELLA: Thank you, Patti.

Dennis and then John.

COMMISSIONER HEAPHY: Two things. One is Massachusetts, actually beneficiaries' plans and the state did work together to create a plain language cover sheet. You might want to look at it. It was for the dual

eligibles, the dual eligible plan. And it contains a contact person at the plan and the information to contact my ombudsman and state, and so it contains both those things. It's just very plain language, and all the legal language comes after that.

I think what's also really confusing -- I don't know how to get to this -- is beneficiary received notices that say you have been approved for your request, and then they get to page 2, and it says we've modified your request. And that's really a denial, and to make sure the modifications of services are recognized as denials, and the cover page says what it says, we denied this piece of your request for this reason, because a lot of folks just get confused because the wheelchair, they thought they're going to receive is not the wheelchair they receive. The cover page says it was approved, but the next page says that they've not approved X, Y, and Z pieces for that wheelchair. That's critically important to address that as well.

CHAIR BELLA: Thank you, Dennis. That's a great suggestion to look at the plain language cover sheet.

John?

COMMISSIONER McCARTHY: One of the other things I think when you talk about this one is just when you get the notice, what is in there around the criteria that are used to make the approval or denial? I think that's one of the issues many states deal with. In D.C., when I was Medicaid director here, that was something we worked on quite a bit was making it very clear what the criteria is, because I think that's where we run into a lot of problems. So if there's something else in here -- you need to be able to point to something that says here's your criteria.

CHAIR BELLA: Thank you, John.

Thank you all. We're going to move to Recommendation 2. This is about continuation of benefits. Comments from Commissioners? Patti.

COMMISSIONER KILLINGSWORTH: So I do support CMS issuing guidance around continuation of benefits. I do think it's really important that beneficiaries, states, and key stakeholders are engaged in crafting that guidance. I think model language would be really helpful.

I also think that there should be expectations around monitoring and oversight as it relates to this beneficiary protection. I think that could occur and

oftentimes does occur as part of EQRO or accreditation reviews. NCQA was mentioned earlier.

I do think we need to thoughtfully consider whether there is a need to, sort of across the board, extend the time frame if the primary issue is related to timely receipt of a mailed notice, which could be mitigated by the Policy Option 4. So an alternative might be to simply add additional days for receipt of mail to the 10-day time frame when mailed notices are the preferred option.

CHAIR BELLA: Thank you, Patti.

Just having been in a state with -- I'm trying to think through how difficult that might be to operationalize and kind of keep track of that, and obviously, it also depends on if the state is having mail plus electronic and all of those things.

COMMISSIONER KILLINGSWORTH: I can only tell you that in Tennessee, we do add mail time, but we add it across the board. Of course, everything is done in writing right now. So I can't tell you if -- exactly how the state would go about making those adjustments if there were options available. It could be complex, and of course, the

default could always be to add the mail time across the board rather than trying to hone in on those situations where it's appropriate.

But appeal systems and the IT systems that support appeal processes can be pretty easily programmed to set those dates in accordance with certain rules that you would put in place.

CHAIR BELLA: Okay, thank you. I mean, certainly, these are things we can tease out in the relationships among the various options and choices that are either required or optional for states and for individuals.

Anybody else have comments on 2 before we move to Policy Option 1?

Dennis.

COMMISSIONER HEAPHY: It's important to note the beneficiaries about payment, repayment issues, because it would seem to me that -- and I know this is not one of the options, but something to look into -- is whether or not beneficiaries should be permitted to continue that service without the threat of repayment until the decision has been made, because if they're in network and they're doing

everything that's supposed to be done, then it would make sense for them not to have to repay for those services until the decision has been made, because you're not going to get -- it's impacting the number of folks who make appeals, and so it's a barrier to making appeals for a significant portion of folks. I'd like to see us do more research to find out how the impact -- let's say states that do require repayment or the states that do require repayment, and there's differences in appeal rates between those states or perceptions of beneficiaries in terms of the process itself.

CHAIR BELLA: Thank you, Dennis.

Jami?

COMMISSIONER SNYDER: Just one quick note. I'm supportive of the policy option, but I think we need to continue to attend to the need for awareness and ensuring the individuals are aware of their opportunity to continue benefits during the process. I think that's a big piece of the equation. Many folks in the system just aren't aware of that option, and so I just want to make sure that we attend to that as well.

CHAIR BELLA: Thanks, Jami.

Heidi. And then we'll move to Option 1.

COMMISSIONER ALLEN: I couldn't totally hear what Dennis was saying over here, but regarding holding patients harmless, these are very low-income people. I would very much support a policy that says beneficiaries should always be held harmless from continuation-of-benefits process. There should be under no circumstances that they have a provider tell them that they need something, they go through their legal right to appeal, and then they're given a bill for continuing treatment while they go through the legal process. It seems like it's being used as a tool of total suppression for the appeals process, because people are just -- or continuation of benefits -- are just like, "I can't -- I don't want to have this happen to me."

And so I don't know how many of my fellow Commissioners would support adding that as a recommendation, but it sounds like in practice, most states aren't doing it. And so it's even more egregious that the threat of it is being used to suppress action when it's not even necessarily a policy. So the actual impact of the policy would just be simply easing beneficiaries' minds that doesn't necessarily change what most states are doing.

MS. ZETTLE: Can I just to that point -- could I respond quickly?

CHAIR BELLA: Yes.

MS. ZETTLE: I think we covered this back in the spring. I don't think we touched on it in great detail here, if at all, but in our interviews across the board, states, beneficiary advocates -- I mean, no one could point to an example of where repayment was actually pursued. And so the clarification is that really this is only in cases where the state does this already for fee-for-service. So it seems like there's maybe clarity is needed around that, but just wanted to echo that.

CHAIR BELLA: Yeah.

MS. ZETTLE: We found no instance of repayment actually being pursued -- or recoupment. Sorry.

CHAIR BELLA: I want to table this one, because it's a pretty big one, I think, and it doesn't mean we can't come back to it. But we need to get to Policy Option 1 as well. So let's move to that and then figure out, Heidi, how we address this either now or it's -- none of this work is ever one and done, right? We've started down a road here.

Okay. Let's go to Policy Option 1. We're obviously going to run overtime.

Bob.

COMMISSIONER DUNCAN: Thank you again. Appreciate the work done.

I'm in favor of Option 1. I was terrified to hear that almost 50 percent were overturned. That means 50 percent of the population not receiving the services they should be receiving.

And so I'd also be interested to know in those states that currently have -- you mentioned 14 -- this, if you saw a better -- from lack of trust or intimidation, if they felt better about the process because of the external review or not. But I'm in favor of No. 1.

CHAIR BELLA: John, then Patti.

COMMISSIONER McCARTHY: I don't support Option No. 1 for a number of reasons. One is states can already do it, right? So 14 states have decided to do it.

CHAIR BELLA: Can you guys please put this slide on No. 1? I'm sorry.

Please go ahead, John. Thank you.

COMMISSIONER McCARTHY: Fourteen states already

do it. It's an option. If states want to do it, they can do it. In the OIG report, it actually talks about one state was in the process of adding it. Three more states were in the process of adding it. So you should leave it up to state to do it.

But there's a lot of different ways that individuals, whether it be providers or individuals in the programs, they can go to their legislatures to push their states to do these things, go to the governor's office and move in that direction.

The other part of it is, on the external quality review, who makes up the group to do it? So you can have issues in both directions around it.

And then lastly, you're looking at the OIG report. It doesn't seem to be a political issue at all. It's both red and blue states were choosing to do this, and so for me, this one seems like we're going too far on it and states can do it, and they can make that choice.

CHAIR BELLA: Thank you, John.

Patti?

COMMISSIONER KILLINGSWORTH: So I do support the availability of the independent external medical review

process.

I don't disagree with you, John. There are lots of ways for people to provide feedback or to express concerns, but I think there is value in a clinical review that is performed by an appropriately qualified medical professional and who is neutral to the process.

I do think that it should be available upon request, not automatic, maybe except in limited circumstances, and that could include certain types of critically important service, maybe when denials for a service or a category of services or even in the aggregate for a particular health plan reach a certain threshold or at the election of the state. And I think it would go a long way in really -- that kind of flexibility would help to manage the administrative burden and cost if it were not completely automatic.

I do think that states should have the ability to integrate that review as a part of their state fair hearing process, not sort of completely stand alone, just so that it flows seamlessly, again, making sure that it's done by an independent, qualified entity.

I do think it's important that the data from that

process is collected, reported, monitored, and actually used by health plans, states, and CMS to identify potential issues with denials or access to care.

And I think the cost concerns, which are very real, could be mitigated by offering an enhanced match to help cover the cost of the external review, so essentially, the federal government could bear the larger share of making that beneficiary protection available.

CHAIR BELLA: That will go over really well, Patti.

All right. Heidi and then Carolyn and then Verlon.

And I will just like to say to Commissioners, we don't have a score on this yet. I think there are different opinions on whether the score for the administrative piece would be material or relatively small relative to the Medicaid budget. CBO would provide that score as part of the next stage if this advances.

Heidi and then Carolyn.

COMMISSIONER ALLEN: So I support everything that Patti said. I think you framed that beautifully, though I would make it automatic to line up with Medicare Advantage.

I think that the more alignment we have in processes across our different health care -- major health care systems, the easier patients can navigate it, because complexity is the enemy of access.

And so I would love it if we could have CBO also produce a cost for what it would be if it were automatic, just so we can know the degree of what we're discussing. And if we can't do automatic, I would certainly support having the -- not automatic unless we find these areas where there's concern and then making it automatic.

And I like the idea of actually tying it to the star rating too.

CHAIR BELLA: Carolyn. And then I know I missed a hand over here. So if folks -- oh, no, I missed Verlon. Sorry. Carolyn and then Verlon.

COMMISSIONER INGRAM: All right. Thank you.

I can't support Policy Option No. 1 in the way it's written currently. I think, actually, Heidi, something you just said rings true with me. Complexity is the enemy of access.

I think the way we've put this or established this is just going to make the system more complex, more

confusing to consumers to use. They have a right already to have a third-party review, a physician, a separate physician review their appeal inside the managed care company. They then have a right to go to a fair hearing. Adding in this additional layer, I think is just going to confuse consumers.

I like some of Patti's suggestions. I think there's some ways that we can still do this and maybe weave it into the state fair hearings process because the state -- again, the states don't have those clinical physicians available to do that. So maybe there's some way to weave it into that process.

So thank you for doing the work, but I can't support this piece, the way we've written it. Thanks.

CHAIR BELLA: Thank you, Carolyn.

Verlon and then Jami.

COMMISSIONER JOHNSON: All right. Thank you.

I echo everyone else, and thank you for doing this work. It's very helpful and definitely had some feelings around it that I think others have indicated too as I read through the materials.

I'm usually the first one to -- or one of the

first ones, because there's a lot of us here, who really look at things that have a lot of administrative burden or financial burden as an issue. But for this one, I have to say I fully support it.

When we think about the research that we've read and we see that lower-income individuals are less likely to appeal and more likely assume that it's going to be upheld, that's a huge health and health equity issue. And so I do like the fact that it could be an automatic process but do agree that we need to get more numbers around what that looks like.

I love the fact that it's clinical as well, but echoing Bob's point, 46 percent of those who have used this, have seen that it's been overturned, is a significant number that I think is worth really looking at.

And the other fact is that this is the most direct, which means that we can make a huge impact, a lot quicker than some of the other recommendations that we have.

I still support all the other recommendations but really want to look into this. So the CBO numbers are going to be important. I think addressing some of the

great points that the Commission's brought up around being automatic, looking at the committee makeup and things like that is going to be important. But it's one that I really want to explore a little bit more.

Thank you.

CHAIR BELLA: Thank you, Verlon.

Jami and then Dennis.

COMMISSIONER SNYDER: Yeah. Lesley, Amy, just really appreciate your work on this, your continued work on this issue.

Unfortunately, I can't support the policy option. I feel like there's an opportunity in lieu of establishing an external medical review process for enhanced monitoring and oversight in states and enhanced transparency, kind of going back to something that Tim mentioned earlier on in our conversation related to one of the other policy options in terms of transparency with state's quality rating systems and really shedding light on overturn rates and rates of upholding denials among managed care organizations, I think would be equally beneficial.

CHAIR BELLA: Thank you, Jami.

Dennis?

COMMISSIONER HEAPHY: Yeah. I agree with what Heidi and Verlon and others have said and also regarding the star rating, and I think we need to look at how the level of distrust beneficiaries have of the managed care plan, and that there needs to be that option of having an independent, conflict-free external review available to people, because so many people say, why am I going to go back to a plan that just told me no? And that's why -- that might be perhaps why so many folks don't do it.

So I'm just tired of hearing other beneficiaries say I'm not going to bother doing this because it's just -- why am I going to go out to the plan when they told me they just rejected what I requested? And so having this independent conflict-free piece is, I think, essential.

Thanks. Thanks for your work.

CHAIR BELLA: Thank you, Dennis.

Before I wrap this up with some comments, anyone have any other comments from Commissioners?

[No response.]

CHAIR BELLA: Okay. Well, thank you for this engagement. Obviously, there's a lot of interest and some really good perspectives on how we could go forward.

Heidi, I'm going to suggest on what you raised that it sounds like Policy Option 2 is going to move forward, and I think there are things we could try to learn once communication is clear. I understand the point about oftentimes it's a deterrent to even filing the appeal if it's the threat of repayment, but I would like to suggest that we talk about that issue in the chapter, we figure out some way of monitoring the effect that what we tried to do on Policy Option 2 has, and we could always bring that back.

I think it's difficult to introduce that at this stage, but I'll give you a chance to think about that, and we can come back to that before we break from this meeting over the next two days.

On this one, we were planning to take this forward as a bundle of recommendations. Doesn't mean that we have to do that. It sounds like there may be reason to separate the recommendations when we bring them back in January for a vote.

But what's going to happen now is all this feedback will be taken into account. These four policy options will come back to us. They will come back to us

with a score, and we will discuss them again in January for inclusion in the March report.

But does anyone have any other comments or questions?

[No response.]

CHAIR BELLA: I'm not even going to ask Lesley and Amy if they got what they need because I think they got quite a lot.

MS. ZETTLE: We're good.

CHAIR BELLA: Heidi.

COMMISSIONER ALLEN: I just want to ask, do we have to be in consensus to bring something for a vote, or can we have a vote where we know some people are going to vote no, but we think that the majority of people will vote yes?

CHAIR BELLA: No, we don't -- actually, we don't want to be looking like we're puppets and only bringing things that everybody agrees to. We can tell from Policy Option 1, which is why we're probably going to have to split these recommendations out, we're not going to have a unanimous vote, but it is coming back. All four of them are coming back, and people will have the choice to vote

their vote on each of them. And we'll see how that goes. Does that answer your question?

[No response.]

CHAIR BELLA: Okay. I'm not saying I want you all -- I'm not saying I want 9-8 votes on everything, but yes, I am saying we are very supportive of healthy discourse and dissension and Commissioners voting the way they feel.

All right. Thank you, Lesley and Amy. This is wonderful work, and we are going to switch. Bob, I'm going to hand it to you.

COMMISSIONER McCARTHY: Thank you, Madam Chairwoman.

Next, we have Linn coming up to bring us back up. Remember in September, we talked about collecting demographics from the beneficiaries so that we can understand the services and things needed, and today Linn is going to bring forth our Medicaid primary language and limited English proficiency and the collection of that data.

So with that, Linn, welcome.

MEDICAID PRIMARY LANGUAGE AND LIMITED ENGLISH

PROFICIENCY DATA COLLECTION

* MX. JENNINGS: Great. Good morning, Commissioners.

In September, I presented an overview of our evaluation of 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.

To inform our work, we completed a literature review and a federal survey assessment, fielded an online survey of state Medicaid programs, and conducted 22 structured interviews with federal officials from HHS, CMS, and state Medicaid programs, research experts, and beneficiary advocates, representing individuals requiring language services, individuals with disabilities, and sexual and gender minorities. And so today's presentation will focus on the findings related to primary language and limited English proficiency data collection.

So I'll start by reviewing the definitions that we're using for primary language and LEP, and then I'll present an overview of health disparities experienced by those with language service needs and the modes of Medicaid

language data collection, which include the application and federal surveys. And then I'll present considerations for collecting language data and next steps for this work.

Primary language and LEP are two components of language data, and they have distinct purposes to ensure individuals have adequate language access and for measuring health disparities. And when these data are not collected, data related to health care experiences and service needs can't be disaggregated between those who have experienced -- or have LEP and those without, and this can lead to incomplete and inaccurate understanding of the needs of these populations.

And so primary language identifies the language that is most often used in the home or in someone's everyday life, and it's often used as a proxy for determining whether someone may have language service needs.

LEP identifies the English proficiency of individuals who report having a primary language or preferred language other than English, and when this information is self-reported, individuals can specify their proficiency with English, which can provide more

information about the type of services that they might require.

When language data are collected, they can be used to measure health disparities experienced by individuals who don't speak English and those with LEP, and research findings indicate that individuals with LEP are more likely than those without LEP to experience barriers during the enrollment and redetermination processes and are more likely to lose their benefits. They're also more likely to report poor health outcomes and are more likely to have difficulties with scheduling appointments and understanding their diagnosis and treatment.

There are many factors that contribute to these disparate outcomes, including that they are more likely to have difficulties communicating with providers, and this can result in an incomplete documentation of medical history, misunderstanding of patients' symptoms, misdiagnosing patients, and other potential medical errors.

Medicaid language data can be collected in a number of ways, including on the Medicaid application and in federal surveys, and each of these modes can provide different types of information about individuals with

language service needs.

And so language data that are collected on the application can provide Medicaid beneficiary-level information about spoken languages, and this can inform the state about the beneficiary language service needs and health disparities.

Most states use the HHS model single-streamlined application, which includes an optional question for the head of household about preference or preferred language, if it's not English, and the model application does not include a question about LEP.

And given this, almost all Medicaid programs collect primary language on the application, and a few programs do collect LEP.

States can also report both of these types of data to T-MSIS, and CMS assesses the quality of these data as part of the DQ Atlas. And the most recent data quality assessment of primary language indicates that 37 Medicaid programs report primary language that are usable for analyses, and four states report LEP data that are usable for analyses.

Federal survey data can provide stakeholders with

population-level information that can be disaggregated to identify Medicaid-covered individuals and those with language service needs. Surveys can provide additional insights regarding experiences with accessing and using health care services, including reasons for delayed care, satisfaction with providers, and quality of care.

In a review of 13 federal population surveys, the State Health Access Data Assistance Center, or SHADAC, identified six surveys that ask at least one question on primary language and five surveys that ask a question about LEP. SHADAC also conducted a sample size analysis and found that all the surveys that include these questions have a sufficient sample for reporting about individuals covered by Medicaid, but the ability to assess particular measures may be limited.

And so drawing from our literature review and our survey of Medicaid programs and stakeholder interviews, we identified several factors, which are shown in this figure for the Commission to consider regarding collecting language data for purposes of measuring and addressing health disparities, and these considerations align with many of those raised by the Commission's prior

recommendations regarding the collection of Medicaid race and ethnicity data and some additional considerations that were raised at the September meeting. And so we'll review all of these in the following slides.

The state Medicaid programs can use these data for multiple purposes, and one of those is to ensure language access. Title VI of the Civil Rights Act requires all federal agencies and programs receiving federal financial assistance to ensure language access to individuals with LEP. These requirements were also extended by the Executive Order, improving access to services for persons with limited English proficiency, and in section 1557 of the ACA, and these that were extended to apply to health programs administered by executive agencies, including state Medicaid programs.

And therefore, state Medicaid programs are required to provide at no cost to applicants and beneficiaries, program information in both paper and electronic formats that are accessible to individuals with LEP and via oral interpretation.

In MACPAC's survey of Medicaid programs, states reported that language data are most exclusively used for

these programmatic purposes, and the data that are currently collected are often sufficient for identifying beneficiary language needs.

Language data, though, can also be used for research purposes, and states reported that they don't currently use their primary language data for this purpose, but there is some interest from states to consider other uses. However, in the interviews, they did report that they were unsure of how to use these data for non-programmatic purposes.

Regarding the state and beneficiary burden, states reported challenges with updating the application in state data systems, and so regarding the application updates, these can be resource and time intensive because they require making updates to both the online and paper application. They require conducting testing of new questions and translating these questions to multiple languages.

For integrated systems, the updates also have to align with multiple program application requirements and may require approval by multiple programs.

Applications are often also long, and states

reported concerns that additional questions may further burden the applicants.

Regarding the data system, states reported challenges with updating these systems, which are used to store and report Medicaid eligibility and enrollment data to T-MSIS, and for example, if a new element or data elements are added to the application, these new fields also have to be added to the data system. And these data elements need to be stored either in a way that align with T-MSIS or need to be reformatted to be able to be reported properly.

An interviewed state shared that although these system updates are common, there are administrative costs with them, and the updates may be more burdensome for states with older systems than those with newer.

There are also some data quality considerations. Self-reported data are considered the best method for collecting information that reflects an individual's identity, and if these data are not reported -- if the data are reported by someone else, identities may be underreported or misidentified since someone else's perceptions may not align with how someone would self-

report.

Language characteristics can also change over time, and individuals may want opportunities to update this information. Research experts noted that language data should be collected anytime other demographic data are collected, and that collecting these types of data multiple times allow individuals more opportunities to update changes to their English proficiency, and this could affect their language service needs as well.

Data collection methods should also allow for data to be generalizable to the Medicaid population, and this should be inclusive of those with LEP and those who do not speak English, and so if the data collection process doesn't include translation or interpreter services in the respondent's primary language, it can prevent individuals from filling out the survey or the administrative form or from providing accurate information, and therefore, the data that are collected may not be representative of the full Medicaid population.

Regarding data privacy, the data collection and reporting process has to comply with HIPAA and other applicable federal and state laws to ensure data privacy

and to protect individuals from discrimination.

When collecting language data, it can be also important to include information about how the data can and cannot be used, and this provides individuals with assurance that their data are secure and won't be used to harm them and won't be used inappropriately during the eligibility determination. Additionally, this can also improve response rates and the accuracy of information that individuals voluntarily provide.

And so at the next two Commission meetings, I'll present on SOGI data and then on disability data collection, and it would be helpful to receive Commissioner feedback on the considerations presented today and whether there are other factors we should be considering with this work.

And I'll put up this slide as a reference, and I'll turn it back.

COMMISSIONER DUNCAN: Thank you, Linn. I appreciate that.

As I was listening to you, tying back to the last conversation around communication, how these interact, making sure things are simplified and our beneficiaries can

understand.

So with that, Patti, I see your hand first.

COMMISSIONER KILLINGSWORTH: Thank you, Linn. This is really helpful work, and I especially want to focus on the administrative burden components of the considerations.

It seems to me that collecting the LEP data along with primary language would be very beneficial. You've made a really good case for that, not just in making sure that we're providing appropriate language assistance, but really in being able to measure and address inequities that can result from access to care issues that are related to language.

So when we think about burden, it seems that the administrative burden across the 50 states and U.S. territories in testing language and translation and approval processes could be minimized if CMS were to take the lead in developing, testing, and translating model language for those applications and then waiving additional approvals of application revisions for states to incorporate that model language. So just sort of an across the board, it's okay to modify your applications to include

this model language.

I think when we think about burden from the enrollee's perspective, we could mitigate -- it would be mitigated, really, by the fact that the LEP question wouldn't even apply if your primary language is English. And for people whose primary language is other than English, It seems that any additional burden in answering those questions is probably secondary to making sure that they're getting materials to help improve their access to care.

I do think when we think about systems impact and reprogramming those systems that CMS could require that approval of enhanced match for new systems would require the collection of LEP data. Maybe down the road we can talk about that relative to data to address other health disparities, but then also making enhanced match available to support modifications to existing systems to get to achieve the collection of that data over time.

COMMISSIONER McCARTHY: Thank you, Patti.

Did I see your hand, Jami?

[No response.]

COMMISSIONER McCARTHY: Okay. Heidi. Okay. I

knew I saw something on the left here.

COMMISSIONER ALLEN: Thank you.

Patti, I agree with everything that you said on this.

I want to bring the health services researcher perspective to this, which is that the surveys are great. It's great that they have enough Medicaid sample, but it is a fact that when you're trying to then look at sub-access or anything else, the numbers fall apart. And so really the only way to think of limited English proficiency as a health disparities' population and understand if they're experiencing disparities would be through the universal collection in an application and being able to integrate it into T-MSIS.

Only then would you be able to see if there's differences in utilization and quality, costs, and outcomes. That's just never going to be something that survey research is going to be able to do when you're looking at a population that's a smaller sample. So I just want to point that out.

COMMISSIONER DUNCAN: Adrienne?

COMMISSIONER McFADDEN: I agree with the points

that have been made, and I just want to do an extra sort of soapbox from my own past, which is I've done language needs assessments for states and things like that. I do feel like some of the existing surveys that exist out there fall short, because we talk about spoken language, but we don't talk about your ability to read or write the language. And I think that's also very important to survey as well.

COMMISSIONER DUNCAN: Thank you, Adrienne.

Rhonda.

COMMISSIONER MEDOWS: I'm just going to say ditto to all that's been said and speak in support of the recommendations that are listed here.

COMMISSIONER DUNCAN: Tim.

COMMISSIONER HILL: This is great work, and my comments are going to add to it, maybe.

I'm all on board with the collection and trying to figure out a way, whether it's through surveys or through T-MSIS to make sure we get the data, but I just keep coming back to a comment that we made last time, which really the disparities occur at the service provision level, right? It's the providers who have to interact and deal with folks and care for people who have limited

English proficiency, and how do we go that next step? We're going to collect, we're going to analyze, but what are we going to do in the delivery systems for either the managed care plans or from the fee-for-service providers to be sure that people with that limited proficiency are getting connected to care delivery that meets their needs? So if you could figure that out, perfect.

COMMISSIONER DUNCAN: Thank you, Tim. I appreciate that.

That was a question I was going to have. Feedback I've gotten from our September session from those is the burden -- we talked about the burden on the states and the burden on the beneficiaries, but the burden on the providers in asking some of the questions, both what they already perceived to know, but some of this other, particularly when dealing with the pediatric population. And so I think it would be interesting to get some of their feedback.

Any other comments?

COMMISSIONER HEAPHY: I have a question.

COMMISSIONER DUNCAN: Sure, Dennis.

COMMISSIONER HEAPHY: Are you including folks who

use ASL as well in this, American Sign Language, or is that a separate population?

MX. JENNINGS: I think it's come up in some of the like language access -- language service needs that -- it comes up in some of that, but it hasn't been the specific focus of, I guess, on primary language and LEP. And that would be, I guess, kind of an additional piece of that.

COMMISSIONER HEAPHY: Yeah. I'd recommend us looking at that access, folks who use ASL for communication, because it's one of the most -- the highest requested languages in hospital settings and other settings.

COMMISSIONER DUNCAN: Thank you, Dennis. A great point.

Anyone else?

CHAIR BELLA: I'll just say I appreciate -- I really like the way we're chunking this out in the various segments, and for the Commissioners, the intent is to get through these three sessions and then possibly be moving on a recommendation path for the June report, just to reiterate that context.

COMMISSIONER DUNCAN: Linn, do you feel like you got everything you need for the next steps?

MX. JENNINGS: Yeah. Thank you. That was very helpful.

COMMISSIONER DUNCAN: Well, thank you.

So, Madam Chairwoman, I caught us up on time.

CHAIR BELLA: Well, you tell Bob to make up time, and he does that and then some.

Thank you, Linn. Thank you, Bob.

We're going to open it up for public comment now on either of the two topics we've discussed this morning.

So a reminder to folks watching, if you'd like to make a comment, please use your hand icon. Introduce yourself and the organization you're representing, and we ask that you keep your comments to three minutes or less. We'll open that up now.

Mara, it looks like you can unmute and make your comment, please.

PUBLIC COMMENT

* MS. YOUDELMAN: Great. Can you hear me, just to double-check?

CHAIR BELLA: Yes, we can hear you. Thank you.

MS. YOUDELMAN: Awesome. Good morning. My name is Mara Youdelman. I work at the National Health Law Program, where I'm the managing director for Federal Advocacy. And I've been working on language access issues for my entire couple of decades at the National Health Law Program.

So just really briefly commenting on the last presentation, I would love to suggest a couple other considerations for the issues related to collecting language data. As someone mentioned, a lot of the issue happens sort of downstream from the application process at the provider level. I think collecting language access data, limited English proficiency data at the application stage would allow some of those downstream users to have information in advance for planning purposes so that they know what languages they might encounter as well as for having appropriate language services on staff. So the information collected comprehensively on the Medicaid application could be transmitted to manage care organizations, hospitals, clinics, et cetera.

Regarding standards for collecting language data, the Institute of Medicine a number of years ago did collect

-- sorry -- did research on the best ways to collect language data, including as well as race and ethnicity. So I would suggest looking at that, because you might not have to reinvent the wheel.

And then also another downstream benefit of collecting language data is preventing discrimination. Medicaid agencies themselves are subject to Civil Rights laws, including Title VI and Section 1557 of the Affordable Care Act, and so ensuring that they have the appropriate data to ensure that their programs and activities don't discriminate is another important reason to collect language data.

So I would just add those to the discussion, and thank you very much for considering this and other aspects of demographic data collection, which we think are important for all populations served by Medicaid.

CHAIR BELLA: Thank you, Mara, for your comments and for joining us.

Arvind? Arvind, you're welcome to comment.

MR. GOYAL: God bless. Thank you. My name is Arvind Goyal. I'm the Medicaid medical director for Illinois and delighted to hear your discussion on improving

the managed care appeals process. I think the staff has done a great job assembling the information they did.

But I would like to suggest that there be a separate track or maybe a combined track getting feedback from the providers, maybe the hospitals, the nursing homes, the physicians who are getting burnt out at a very fast speed and partly because of prior authorization denials and payment denials. So that's one point I wanted to make.

A second point I wanted to make is when the appeals are overturned and the information that was provided today, 46 percent of being overturned on appeal -- so I think the Commission should recommend some sort of penalty for those denials, at least to compensate in some token way, if not a substantial way to compensate for the time that the beneficiaries and possibly providers would take appealing those types of adverse decisions that shouldn't have occurred in the first place.

Those are the two comments I wanted to make, and I appreciate the time you gave me.

CHAIR BELLA: Thank you, Arvind, and thank you for continuing to dial in and participate in the meetings.

MR. GOYAL: Yes. Thank you.

CHAIR BELLA: Anyone else like to make a comment in the audience?

[No response.]

CHAIR BELLA: All right. Any other comments or questions or feedback from Commissioners?

[No response.]

CHAIR BELLA: No? Everyone is looking around to see because everyone wants lunch.

All right. We're going to take a break for lunch. We're going to come back at one o'clock Eastern time with a panel on continuing our work on the PHE and the unwinding, and we're going to hear some strategies from a couple of states and how some health plans have been getting involved as well.

So thank you all for this morning. We'll see you back here at one o'clock.

* [Whereupon, at 11:48 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: All right. Welcome back, everyone. Hope you all enjoyed lunch.

Martha, we are thrilled for this session. You know how much we love panels, and so we will let you take it away.

UNWINDING THE CONTINUOUS COVERAGE REQUIREMENT IN MEDICAID: STATE AND MANAGED CARE PLAN STRATEGIES

* MS. HEBERLEIN: Okay. Thank you.

So this afternoon, we are going to have another panel, as Melanie just noted. So in September, the Commissioners will remember that you heard directly from a panel representing multiple stakeholder perspectives, including CMS, states, and beneficiary advocates. So to continue the discussion on how the unwinding is proceeding, we have pulled together a panel of state Medicaid agency representatives and managed care plan association representative to share some additional thoughts.

So today I will be joined by Amir Bassiri, who is the Deputy Commissioner of the Office of New York Insurance Programs and Medicaid Director in the New York State

Department of Health; Cora Steinmetz, who is the Medicaid Director for the Indiana Family and Social Services Administration; and Stephanie Myers, State Affairs Director, Medicaid Health Plans of America.

So in the interest of time, I will not read their bios, but, Commissioners, there's more information about each of the speakers in your materials.

And similar to last month, this will be a moderated session. So I'm going to be asking the panelists a few questions before turning it back to Melanie to facilitate questions from the Commissioners, and then we will have a chance to have a Commissioner-only discussion after that.

So to begin with the states, thank you all for joining us.

Now that we're about halfway through the unwinding, although some states are further ahead than others, I was wondering if you could tell us a little bit about any adjustments you have made in the process, whether the data you are collecting informed these changes, and the effect that they have had on renewals and procedural disenrollment rates.

So, Amir, can I ask you to start?

* MR. BASSIRI: Yes. And nice to be with the panel.

We in New York are only a third of the way through. We started a little bit later, and we're taking the full 14 months, started with June and will be done in May of '24.

In terms of what we've done and how we've pivoted on approaches based on data, we initially were planning for using (e)(14) waivers or some of the federal flexibilities under the CAA for our legacy system, and the legacy system is for our non-MAGI, aged, blind, and disabled populations where we still have Medicaid administered by our local counties.

As we did that and we were doing that to be in compliance with ex parte requirements, we did see an opportunity to apply some of those flexibilities to our modern system, which is an integrated marketplace, which has been very critical to retaining eligibility and coverage in public health insurance programs across CHIP, Medicaid, our Basic Health Program, and the qualified health plans under the ACA. And we have seen that having

some of those flexibilities in both systems has been very, very impactful to increasing our renewal rates and our ex parte rates. So that has been something that when we were planning, we had not necessarily planned for that we quickly pivoted on. Some of those changes to the modern system haven't yet taken effect, like the 100 percent FPL and a couple of other changes. So those have been very impactful, and we are pleased with our renewal rates, which are hovering around 77 percent for Medicaid and CHIP.

Additionally, I think one thing is the text thing, which has been incredibly impactful, reaching members, working with our health plans, but something New York did prior to the ACA was our facilitated enrollment and our assisters, enrollment assisters, which we maintained post-ACA under our 1115 waiver. And we have a unique circumstance in New York where our health plans can be facilitated enrollers.

There are protections in place for members to preserve member choice and meet federal rules, but that has been an incredibly valuable tool. And we've learned that 80 percent of our members go through the renewal process from the assister program. That is unique to New York.

That coupled with our integrated marketplace, which has Medicaid within the marketplace, not separate, has really facilitated coverage transitions when people who may not be Medicaid-eligible but may be eligible for other public health insurance or their child may be eligible for CHIP.

We did have and identified an issue on inappropriate ex parte renewals within our modern system, and we have created a manual workaround process for that. But we were inappropriately disenrolling about 20,000 people each month.

We've, since that's been identified, fixed that. We have a manual process for that and the system fix that's going in place in January.

But overall, I think we've been very, very keen on looking at our data, stratifying all of the data by race, ethnicity, gender, language spoken to continue to refine and improve our continuous monitoring of renewal rates by population.

MS. HEBERLEIN: Great. Thank you.

Cora, can you please share your view from Indiana?

* MS. STEINMETZ: Certainly. Thanks for having me today.

A few months into our unwind activity, Indiana has now just completed month 7 of our 12-month unwind period with data reflected through month 6, since we've just closed the month of October.

A few months into our unwind activity, we launched a public-facing dashboard that we are really proud of, and was incredibly stakeholder informed. So we have ongoing large group stakeholder meetings about every six weeks, and those started well before the unwind period began in Indiana.

We also have sort of a targeted group of stakeholders that we work very closely with which represent provider groups, of course, the hospital association, our FQHC and community health center associations, the minority health coalition here in the state and our Covering Kids and Families group. Those partners really are the boots on the ground assisting with outreach efforts, and they were very clear with us that if we could make as much data public as possible, that would really inform their ability to get out and reach as many Medicaid members as possible

to make sure they were aware of redetermination activities.

And so our dashboard really started as the CMS report that is required to be submitted, and then we expanded upon that. Similarly to New York, we're looking very closely at demographic data, including age, race, dually eligible status across each of our Medicaid programs and delivery systems, and then the dashboard allows users to drill down to the county level which has allowed partners to really target their efforts to areas where perhaps we are seeing higher rates of procedural disenrollments or individuals not responding to initial communications from the Medicaid entity.

It also is directly informing how we as the state are targeting our marketing activity and communication and outreach. One example of this is that our dashboard data reflected that the particular program with the largest procedural disenrollment was our Healthy Indiana Plan, which is our expansion population, adult Hoosiers.

And so we have now pivoted our messaging to really target family advocates, to encourage family advocates to reach out to friends and family members who are Medicaid members to make sure that they know what to

do.

We also have our messaging now really reiterating parents should take action, even if they no longer qualify, because their children may remain eligible, even if the parents do not.

Additionally, we've looked at this data to make sure that the talent that we're recruiting for our marketing efforts is reflective of the population that we're trying to reach out to, and so we're very pleased with the use of the dashboard, both for our internal approach as well as how our partners have taken on sort of the side-by-side effort to reach as many individuals as possible.

MS. HEBERLEIN: Thank you.

So turning to you, Stephanie, managed care plans have played a fairly active role in some states as they unwind. Could you describe some of the activities they've taken on and highlight approaches that were effective in supporting state unwinding efforts?

* MS. MYERS: Sure. And first, I want to say thank you for having MHPA on the panel today. It's truly an honor to be here and share the great work our MCOs are

doing during the unwinding.

So our MCOs are working hard to help ensure that their members are able to get through the redetermination process and maintain health care coverage, whether that's Medicaid, the exchange, employer-sponsored insurance.

So some of the stuff that they're doing is, first, they're doing direct outreach to their members. This is phone, mail, text, and kind of like what Amir said, they're also finding that texting is highly successful as well in terms of getting outreach to those members and getting in touch with them.

The majority of our members are also working with community-based organizations and providers on the ground to make sure that their information is getting out there and we're getting outreach as wide as possible.

About half of our member MCOs are also working with different retail businesses on the ground, and some have even done a few paid advertisements as well, and others are working with schools and employers and also working with other MCOs in their state.

And just to point to a couple of specific ways that our MCOs are working with the unwinding, we have a

member partnering with FQHCs, federally qualified health centers, to engage their Medicaid patients. The MCO provided the FQHCs with health navigator grants to increase outreach activities through the redetermination period and also while building the FQHCs outreach capacity over the long term.

Another member is leveraging their ongoing partnership with a network of over 100 food pantries in the state of Kentucky, serving rural communities across the state. The MCO has placed outreach team members at these locations and have added redetermination education and support to the health literacy classes they were already conducting at these sites.

A member MCO in Pennsylvania leverages their member resource centers located throughout the state in high-traffic areas to provide in-person support on utilizing their plan, research insurance coverage options, and navigating insurance. Known as Connect Centers, they are currently assisting members and nonmembers alike with the paperwork needed to reapply for Medicaid.

And then in Hawaii, the MCOs together fund what's called the "Community Health Advisory Partnership," or CHAP

for short, to leverage existing relationships with community-based organizations and community health centers led by -- leveraging existing relationships. And what this does is they serve Pacific Islanders, COFA migrants, recent immigrants, LEP communities, unhoused individuals, and young and single mothers. So that CHAP outreach activity includes recruiting and activating trusted local influencers in language, collateral, coordinated social media, town halls, webinars, and community events.

And then, as an example of paid advertisement -- I don't know if this was exactly paid or not, but we've had an MCO do almost like an on-air interview with one of the local news organizations that talked about unwinding. It was funny because it's actually in my market. So I got to see this live on TV. So that's just kind of unique and in the creative ways that our MCOs are reaching their members and trying to make sure that they're getting through the redetermination process.

MS. HEBERLEIN: Thank you.

So turning back to the states, Cora, we know that reaching Medicaid beneficiaries has always been a challenge. Could you describe some of the more innovative

approaches that Indiana took to connect with folks?

MS. STEINMETZ: Sure. Happy to do so.

So a few different areas, one being that we really leveraged other state agency connections that were strengthened or forged during the pandemic period, and so we really embraced sort of a whole-of-government response to getting the word out, because we know that our Medicaid members are served by many other state agency programs, and they really have great connection points and are trusted entities in communities as well across the state of Indiana.

For example, we work with our Department of Workforce Development to put materials in WorkOne Centers across the state and in community college-shared areas. We equipped emergency responders with information who frequently are providing community paramedicine or other types of in-the-community care for our members.

We also made sure that our Department of Child Services' individual caseworkers as well as local office directors had the information that they could share with families that they were interacting with in the child welfare space.

Our local health departments through our Indiana Department of Health house many WIC clinics throughout the state, and so we ensured that they were engaged with flyers and communication for individuals who are visiting the WIC clinics.

In Indiana, our Early Intervention Program for children, birth to age three, is called the "First Steps program." So families that have children with developmental delays, the First Steps providers were equipped and ready to help them complete redetermination paperwork.

School-based services are also an incredibly important part and expanding part of our Indiana Medicaid program. So we worked with our Department of Education to leverage their resources with school superintendents and school principals as well as clinics and school nurses.

And then in regards to doing everything we could to ensure we had the most up-to-date information for our Medicaid members, we collaborated with the Indiana Bureau of Motor Vehicles and located 80,000 addresses that were different for Medicaid members than what was registered with the Bureau of Motor Vehicles and provided direct

outreach via postcard to those mismatched addresses to try to address that.

As others have noted, we also connected closely with food banks across Indiana. Our pharmacists association and national and local pharmacists were an incredibly important part of our outreach and continue to be so as well as mental health clinics.

And really throughout this, all of these various partners that we're incredibly appreciative have partnered with us to get the information out. We've really tried to make sure that we have a consistent message across all of the various entities so that Medicaid members are hearing sort of this drumbeat from the ground level about what action is needed to be taken, and if they find themselves disenrolled, how they can obtain other coverage, or if they remain eligible for Medicaid, how we can reenroll them as quickly as possible to ensure that they have health care coverage.

In addition, we are using traditional outreach. We've also found text messaging and emailing to be incredibly useful tools. We have really taken that to a new level that Indiana Medicaid had previously not used.

Our MCOs, managed care organization partners, have been incredibly helpful as well in their outreach efforts, again, making sure that we have a consistent message.

And so in Indiana, if an individual was up for a redetermination and not in an ex parte category, we made five to seven different contact attempts just from internal state resources to reach out to them in addition to what they might be seeing in their community from our partners.

MS. HEBERLEIN: Thanks.

Amir, you talked a little bit or alluded a little bit to the text messaging work in New York. Could you talk more about that and some of the other outreach efforts your state has taken on?

MR. BASSIRI: Absolutely. The text messaging work has been incredibly powerful and illuminating. What we have done is focused on, for the members that we have information all up to date on and who are going through the manual renewal process, we did some targeted text messaging and sort of a one-survey text response, which was really targeted towards identifying the reason for which they did not complete their renewal.

And as we've done that each and every month, we've seen both the response rates and hit rates increase, and then correspondingly, we've seen the increase of the people who were texted go and complete their renewal after opening the text, and that has increased each and every month that we've done it.

We've been capturing a lot of that information and looking at demographics that we have available, whether it's age or race and ethnicity. We do see it being particularly impactful for members who are between the ages of 19 and 34, which is where we actually have seen lower renewal rates than some of our other cohorts, understandably so, but that has been where we've focused. And we will continue doing some of our one-survey texting. It has been incredibly powerful and we hope it's here to stay permanently.

The emailing has also been a strong outreach tool. A lot of the things Cora mentioned with our other state agency partners, working with providers, pharmacies, FQHCs, and having open-dialogue, joint meetings routinely with our consumer advocates and our health plans has helped break through some issues and logjams throughout the

process, whether it's data sharing or up-to-date renewal information and renewal dates has been very, very impactful.

One other comment I'll make that hasn't been said yet with regards to outreach is we have tasked our call center to do direct outreach to individuals who failed to come back for renewal. Similar to what Cora said with the five or seven touch points, it's not all state staff, but we're doing something similar and employing our vendors and call centers to directly outreach to members who fall in that category. And it has resulted in those individuals coming back and being reinstated as they go through the process.

MS. HEBERLEIN: Thank you.

So turning back to Stephanie, has MPHA -- sorry. MHPA. I get my acronyms backwards -- and any of the states that you work with -- are you guys considering the role that plans may play in the future? Amir alluded to some of the 1902(e)(14) waivers and the flexibilities there. Have you been thinking at all about what can continue and what barriers might need to be addressed before you guys can continue some of your work?

MS. MYERS: Sure. Thank you, Martha.

Yeah. As a matter of fact, that's some of the work that we're doing right now is really talking with our member MCOs to see -- you know, now that we're seven months in, what are we seeing that's working? What do they want to see continue? What might not be working so well? So those are a lot of the discussions that we're having right now, actually, so very timely.

I'll just go through a few of the points that our MCOs are definitely wanting to see continue, and, you know, first things first, the continued flexibility to conduct outreach via text, right? I think all of us on here have talked about how successful it's been during the redetermination unwinding process, and that's definitely something our MCOs want to see continue, because it has been successful in making that touch point with the member and getting them through the redetermination process.

But another thing that they would like to see continue is the ability to help members fill out the redetermination forms. So right now, states have the ability to do that through the (e)(14) waivers. We would love to see that continue because that's another way that

we can be helpful to make sure that the members are filling out the paperwork, hopefully, appropriately so there doesn't have to be as much back and forth between the eligibility determination agency and the member, so that they can successfully get through that process.

Another thing -- and I think Amir kind of alluded to it -- is the ability for the MCOs to not only help to fill out the form but to collect the signature, almost be like the assisters that they are in New York but maybe a little bit different in other states. But we would really like to have that ability so that we -- the MCOs -- can make sure that form is making it to the state and making it into that process so that it doesn't somehow fall through the cracks in between the conversation and getting it to the state agency.

And then lastly, we would like the flexibility to outreach to members during the reconsideration period. So if they are terminated from the rolls, to be able to make that outreach to them and say, "Hey, we saw that you were disenrolled. Did you get your paperwork? Did you have any trouble sending it in?" or "Do you have other coverage?" so that we can make sure that nobody's falling through the

cracks and becoming uninsured.

MS. HEBERLEIN: Thanks. And I was hoping I could pitch that same question back to the states even though I didn't prepare you for that in advance.

I don't know. Who wants to start with -- what would you like to hold on to after this is done?

MR. BASSIRI: Happy to jump in to this wish-list question. Our wish list is the (e)(14) flexibilities be permanent and remain in place post unwind.

MS. STEINMETZ: And I think from the Indiana perspective, we would echo that sentiment as well. We have adopted more than a dozen of the flexibilities and have really felt that they've been integral to the outreach. Many of the ones that involve the MCOs have been deployed here and really yielded great returns. So we'd love to see those made permanent.

MS. HEBERLEIN: Melanie, I'm going to turn it back to you for the Commissioner questions.

Thank you all.

CHAIR BELLA: Well, first, thank you to the panelists. We love panels. So we're going to have some questions.

But I actually -- I'm embarrassed to ask this question, but how long are the flexibilities? So they go to 14 months to states that might -- do they just basically travel with the amount of time that the state is taking?

MS. HEBERLEIN: I think that's right. I think they're tied to the end of the unwinding, but I'd have to go back and look at the specific language -- because they're waived with their -- you know, it's based on the inability to process the MAGI and non-MAGI determinations correctly. And so I believe they are tied to the end of the state's unwinding period, but I'd want to go back and reread that and make sure that's right.

And Tricia is sort of nodding, but I think she's thinking too.

CHAIR BELLA: I see Amir nodding. I guess for Amir and Cora, what MACPAC is trying to do constantly during this whole PHE and unwind and restart is figure out do we have anything unique to say that would support these efforts, and so really, we're not an advocacy organization. We're not a monitoring organization, but we are here to look at access, and we are here to support states and Congress and the agency.

So we like hearing kind of your wish list. It's really helpful, and so that just a little bit of grounding, Martha, to see where we might need to go from that will be something I imagine that we're going to want to talk about.

All right. I'm going to open it up. So we have the panelists for about a half an hour to ask them questions.

Carolyn, we'll start with you.

COMMISSIONER INGRAM: Hi. Thank you. Thanks for joining us. I'm Carolyn Ingram. Nice to see you all today.

One of the questions I had was about folks who are on Medicare and Medicaid. In the flexibilities you have, what work have you seen that works well in terms of being able to keep those folks on? We know a lot of them who are on Medicaid and Medicare at the same time usually are for a certain reason related to a disability, and the chances are that's probably not going to go away. So I'm just wondering about what outreach methods you found to be most effective at keeping them enrolled.

MS. STEINMETZ: I'm happy to jump in here a little bit, Amir, if you don't mind.

MR. BASSIRI: No, go ahead.

MS. STEINMETZ: I think for us, those individuals are really typically pretty well connected with their providers, whatever type of provider that is, if it's a home- and community-based service provider, their nursing facility, hospital or their primary care physician. So I think what has been really effective, especially in the dually eligible population who are -- those 65 and older. The texting and email, although we see that increasing as individuals age, is not at the same response rates, perhaps, that we've seen with the younger population, particularly in our expansion age population. So I think really leveraging the provider community has been very effective for us with that population.

I would also add that I think there's a fair amount of overlap in the ex parte redeterminations that happen for those groups here as opposed to other areas of our programming.

MR. BASSIRI: And I will say in New York, at least, we sort of looked at it in two cohorts, those that have aged into dual eligible status during the unwind and who may or may not need long-term services and supports,

but for those don't, we've been -- we have an (e)(14) waiver and have been working on keeping them in our more modern integrated marketplace so that they don't have to be disenrolled and go through the local districts to be determined eligible for long-term services and supports.

And one thing we did to get in front of that last year was align the income eligibility level for all adults to be aligned with MAGI under ACA, the 138 FPL, to create some smooth or less clunky transitions when someone does age into Medicare.

It previously had been that the income eligibility dropped from 138 to 87 percent of FPL, and so we brought that up. We made that investment during the PHE, and it has helped those transitions tremendously.

CHAIR BELLA: Thank you.

Stephanie, anything you want to share specific to duals that you've heard from your plans? If not, we don't want to put you on the spot.

MS. MYERS: We actually haven't heard anything specific in terms of the dual eligible population itself. It's been more global in terms of what's been working and what hasn't, and really that direct outreach has been

what's been mostly successful.

CHAIR BELLA: Great. Thank you.

Jenny and then Jami and then Tricia.

COMMISSIONER GERSTORFF: Thank you all for being here.

Just a question on some of the data. So it seems like the best chance we have for some of these flexibilities to become permanent is going to be improvement in evidence-based outcomes, and I was just wondering what kind of standardized metrics or outcomes your states might be looking at and collecting data on that we can use to support that request.

CHAIR BELLA: Amir, would you like to go first?

MR. BASSIRI: I can take a shot. It's a great question, and like Cora mentioned in Indiana, we have been trying to be very transparent with our renewals and status. We have a PHE dashboard. It tracks more than just Medicaid and CHIP renewals.

But by looking more deeply at race, ethnicity, and other health equity measures, including income, we are hoping we can demonstrate that the (e)(14) waivers are not only helpful at retaining coverage for eligible

individuals, but also that they are specifically targeting and improving renewal rates for underserved populations and underserved communities.

So we're trying to use our data to kind of make some of those cases. We are also, as part of our flexibilities, leveraging the SNAP eligibility, SSI eligibility, to auto-enroll or make the renewals a little more seamless and hit those ex parte renewal rates.

So we're taking a range of different actions, but we don't have a clear-cut sort of research study in place that would say by the end of the demonstration, this is what we accomplished and this is why it should be permanent. We're looking at it holistically but from a health equity lens.

MS. STEINMETZ: I would sort of echo that from the Indiana standpoint.

I think it's challenging also. We don't have great -- we don't have an ability, I would say, right now to identify which specific waiver was really effective for a particular member and the reason that we were able to reach them. That's just not how we are necessarily tracking from our renewal outcome standpoint.

But I think we will have the ability at -- probably demonstrated now, but especially as we move into the second half of our unwind period, we'll really be just showing the importance of tracking a little more detail around what a procedural termination is or disenrollment is and how that sort of is the same as or different than maybe pre-pandemic or pre-continuous eligibility times.

CHAIR BELLA: Thank you.

Jenny is our actuary extraordinaire, so always thinking about -- have you seen anything yet from any other states, Jenny?

[No response.]

CHAIR BELLA: No? That's a great question.

Jami and then Tricia.

COMMISSIONER SNYDER: Good afternoon. I want to just start by thanking all three of you for being here. I know this is an incredibly busy time in particular for Amir and Cora. So if you're taking one hour out of your work week to spend with us, I just really appreciate it. And thank you for your creativity in ensuring that you're connecting with members so that if they remain eligible, they're remaining enrolled.

So I'm curious. At a point like this, in the history of the program, I think it's equally important to critically evaluate what hasn't worked well. So I'm curious, in particular, for Cora and Amir, what's been your sort of biggest point of frustration or biggest pain point in this process?

MR. BASSIRI: Do you want to go first, Cora, or do you want me to go first?

MS. STEINMETZ: The first thing that comes to mind is just the unprecedented volume, which hopefully we wouldn't be in a situation like that again where we could -- but just I would say maybe two things with that in terms of the volume of redetermination work. It was also extremely challenging in the planning stages not knowing when this would begin, and so trying to staff up accordingly, be at the call center, the individuals who were going to process the redeterminations, it was really -- it was challenging to be in an ongoing standby situation quarter after quarter, as we sort of had extensions of the public health emergency – which were unavoidable. But that created some challenges, in terms of activating our boots on the ground sort of partner stakeholders, because every

quarter we would do the preparation. And I think after so long, you kind of become numb to the same message of it might be coming, it might be coming. And then it wasn't. Okay, it's really coming this time, and we really need to be ready to flip the switch and to do so in a meaningful way that didn't feel rushed. So I think balancing those at the outset was a large challenge. I think we've navigated it well and are pleased with the outreach that we have ended up with but certainly, certainly a challenge.

MR. BASSIRI: I would echo that and add on to some of the timing challenges in that the rules of the road were essentially established on December 27th with respect to what CMS was going to be held accountable for and what states would be held accountable for. So this uncertainty in planning was exacerbated by the fact that we had four months to comply with a new set of rules and requirements that we probably could have better managed if we had known a year prior and avoided some of the issues that required system modifications that take time. And it did make this probably harder than it needed to be.

Another pain point for New York is just the fact that we do have our non-MAGI population going through the

local districts for their Medicaid administration, and it is hard. We have 58 localities. Each has different capability and sophistication. Everyone is struggling with staffing and having the knowledge expertise to process some of the more complex Medicaid applications.

And getting data has not been seamless. We normally are getting the non-MAGI data from the districts a little bit later than we're submitting information to CMS. So we're always trying to bring together these three eligibility systems and the information from them at one time to report accurately, and that has been a pain point.

CHAIR BELLA: Thank you.

Tricia.

COMMISSIONER BROOKS: Good afternoon, everyone. Thank you for joining us.

I have two questions, and they're very different. We've talked a little bit about what you thought worked well and what hasn't worked well, but what was missing? Are there other flexibilities that you would have liked to have seen made available to states that wasn't?

And I can start with an example to get the --

[Laughter.]

COMMISSIONER BROOKS: Just we heard from a lot of providers that they are not able to assist with remote renewals, because the only way they can do that is to become an authorized rep. And that's a little scary for both the provider as well as the beneficiary. So that's one of the flexibilities I would have liked to have seen, but I'm curious if you've come across other things to say, oh no, we can't do that, but boy, would we love to.

CHAIR BELLA: Stephanie, this is just fair game for you on behalf of the plans also to chime in. So I called on Amir first last time. So, Cora, do you want to start us off?

MS. STEINMETZ: Yeah. I think that that's a great example, and maybe along similar lines is we had requests from providers to provide listings of Medicaid members so that they could do their own outreach. And so, of course, there's a lot of privacy issues that you run into in that regard that are very -- those protections are there for a very important reason.

But I think we struggled a bit in navigating some of those circumstances, particularly for large providers

like hospital systems, for example, who wanted that information. And so I think, in retrospect, there may have been ways that we -- and we did end up working with certain providers in that. So I don't want to say that we left it on the table, but I think it's something that we probably would have approached a little different from the outset if we knew that there would have been requests for specific -- not just demographic data, specific member information so that we could really equip partners to do direct outreach that weren't the MCOs particularly in our populations that are not in a managed care product. So that might be one example.

MR. BASSIRI: I think Cora hit on the example I was going to mention for New York with respect to providers seeking information to directly support members that may be receiving ongoing care at their facility.

The other was with respect to -- there were some (e)(14) waivers that CMS had put out initially. They then added new ones later in the process once unwinding began -- the zero income or 100 percent FPL. It would have been nice to have those sooner, only because of the system builds that are required to effectuate those, and for us,

that's multiple eligibility systems.

One thing that I have requested was to halt procedural disenrollments for our ABD or our non-MAGI population under the assumption that there is nothing necessarily -- or there's very few circumstances in which someone would lose their eligibility if they are in certain categories, non-MAGI categories. And we were at the time having a very difficult time aligning and demonstrating the SNAP auto-renewal with that SNAP with our legacy system.

So I was asking if we don't need to disenroll procedurally anybody, just let us not do it. We couldn't get that approval at the time. I think there's some willingness that CMS is willing to hear us out on that now. That would have been nice to have, only because we're very just concerned with our local districts, their capacity managing them with our state staff. We don't want anyone to fall through the cracks, and for that population, we know they are, by all means -- they are eligible, so they shouldn't be disenrolled, unless they're voluntarily disenrolling.

CHAIR BELLA: Stephanie, did you want to add something?

MS. MYERS: I'll just add a little bit here. And, Tricia, that's a great question, to be honest with you. I'm definitely going to take that back to my members and pick their brains about things that they think, you know, are outside of what's already been available.

But I do just want to touch on that. If anything, we would have liked to have seen the (e)(14) that allowed MCOs to aid members in filling out the applications come out a little bit sooner, so we could have gotten in there quicker than what was allowed. And we would love to see some of the states, more states take that up, but understanding that it wasn't released until later, that that might be why only seven states so far have taken up that particular waiver. But I just want to make that point there that we would have liked to have seen some of that happen a little bit sooner, understanding that hindsight is 20-20 in this situation.

COMMISSIONER BROOKS: Thank you for that.

My next question has to do with children and transitions between Medicaid and CHIP. Somehow the concept of seamless, coordinated transitions between Medicaid and CHIP embedded in the ACA's principles didn't actually make

it into reg in the way that I think they could have been. So the guidance is requiring states to send pre-populated forms when a child's -- when the ex parte shows that the child is eligible for CHIP but not eligible for Medicaid. So they still send the pre-pop. If it's not returned, they have a choice as to whether they terminate coverage or whether they choose to rely on that reliable data from the ex parte source and go ahead and put them into CHIP. And I think that's a shortcoming in our current regulatory structure.

But I'm just curious how those transitions are working in both of your states, because you do have separate CHIP programs.

MR. BASSIRI: Yes. I can start for New York. We have seen of all our programs, the CHIP renewal rates being the highest, and generally, in terms of program transition, we've seen people who were in CHIP prior to renewal, about 84 percent of them are remaining in CHIP, and about 14 percent are moving to Medicaid. And those that are the opposite circumstance, Medicaid, in Medicaid prior to renewal, about 5 percent are going over to CHIP. And then we have 8 percent going to our Basic Health Program and the

remainder primarily remaining in Medicaid.

So we have been fortunate to have the integrated marketplace, and we can do some of these coverage transitions pretty seamlessly. And in the process of the renewal, and it has been a very strong asset for us to keep people covered.

We did have the ex parte, the renewal issue. It was slightly more nuanced than the national issue on income. We do income correctly. It was really related to documentation. But outside of that, we've seen the coverage transitions play out somewhat as we expected based on what we know about the historical transitions between those two programs.

MS. STEINMETZ: And it's a great question. I don't know the answer off of the top of my head regarding how we treat the transition directly from Medicaid to CHIP, although I know that our eligibility team is monitoring that closely along with all sorts of transitions between different forms of coverage, because there are other examples of that across our various programs as well in addition to just Medicaid and CHIP.

But we have been, working to do everything

possible to increase our number of ex parte redeterminations, and we were fortunate to be a state that already performed our ex parte renewals at the individual level rather than the household level. So we didn't have to make changes in that regard.

But I'd be happy to follow up with that specific information on the Medicaid and CHIP piece, because that is an area of interest certainly among stakeholders here in Indiana as well.

COMMISSIONER BROOKS: [Speaking off microphone.]

I'm so sorry, guys. You didn't hear any of that.

I was saying that both of your states are showing gains in CHIP, and that's not true in every state. Some states are actually seeing declines in CHIP as well as Medicaid.

But a follow-up for you, Stephanie, is, have you heard anything from the plans about these transitions? Are there concerns that are bubbling up from them about that?

MS. MYERS: I haven't heard anything specific to CHIP, the CHIP program specifically. I know that our members are concerned about children being disenrolled from the program, and that's something that they've been

watching closely, but not specific to CHIP itself.

Some of our states, the CHIP is procured separately sometimes, but in a lot of states, it's procured the same. So it's almost seamless, depending on how the state sends over that data. But I do know that our plans are concerned and watching very closely the numbers of children that are staying enrolled.

COMMISSIONER BROOKS: Thank you for that.

And for the record, the (e)(14)s are good through the unwinding period.

MS. HEBERLEIN: Thank you, Tricia.

CHAIR BELLA: Thank you, Tricia.

Dennis and then Sonja and then John.

COMMISSIONER HEAPHY: Thank you.

From the beneficiary perspective, are you hearing anything from beneficiaries about glitches they're experiencing in the system? I can just tell you in my state, people are receiving contradictory information. I know someone who received two letters saying that they were no longer eligible for Medicaid and then a couple of weeks later received a letter from the state saying they were eligible. They would -- the Medicaid would be renewed. At

the same time, they received a letter from the MCO saying that their Medicaid was in jeopardy. And so are you seeing that in your states at all or anything different that's creating a barrier for beneficiaries?

MR. BASSIRI: We have not seen the kind of issues like the one you're describing. However, there was one issue with our non-MAGI population, because we didn't have our SNAP solutions systematically in place until actually October. Renewal dates were pushed out, and there was a circumstance where that renewal date and the information in our systems was not getting appropriately adjusted. And members ended up getting two letters, one which said they missed a renewal date, the other one that gave them the new renewal date, but not necessarily as concerning as some of the examples you shared about someone being at risk. It was really just specific to the date in which their renewal would take place.

COMMISSIONER HEAPHY: Thank you.

Indiana?

MS. STEINMETZ: I'm not familiar with any sort of overarching concern like that. We have heard from specific individuals, of course, around confusion or maybe

individual one-off errors in terms of processing.

And then I think also we continue to look at broadly, how can we make sure that we're providing information in the most plain language possible. I think that's something that many states struggle with. This is very technical information, and so I think we do continue to think about what do we need to do to make sure that the information is as understandable as possible for members and beneficiaries, and that they have the resources that they need to understand what is being asked of them from a redetermination standpoint. So that's an area that even beyond the unwind period, we'll continue to pay close attention to through member advisory information that we seek.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Thank you.

Sonja?

COMMISSIONER BJORK: Thank you.

I was wondering if any of you knew of special strategies or efforts to reach Native American or Native Alaskan members, or was it part of just the overall strategy? Perhaps reaching out to tribal health centers?

In California, it's been a slow, slow process with some of the tribal members renewing Medi-Cal because some of them already can get care at their local -- at the clinic that they go to. And so the motivation to go and take care of governmental paperwork wasn't as strong, but they do -- it's really important that they do their renewals. It's important for the tribal health center and for them to have all the benefits that they're eligible for.

MR. BASSIRI: That's a great question. Similar to California, New York -- our Native American population and tribal members who are enrolled do prefer to use the clinics, whether they're enrolled in Medicaid or not. But for those that are, some of the nations here specifically to -- and for which do have the largest health programming, they've actually been wonderful partners. And we've worked directly with the nations, both with our public health and Medicaid offices to make sure they have access to all the information and just giving them a direct line to our eligibility staff to the extent they need any special handling or attention on issues.

But it has been slow, similar to what you described in California.

MS. STEINMETZ: I know we work closely with individuals on this particular issue, and ethnicity is one of the particular demographics that we can drill down into the data.

I don't think we've seen any outlying data in that regard, but it is something that we continue to monitor for any disparities broadly across various populations in Indiana.

CHAIR BELLA: Sonja, anything else?

COMMISSIONER BJORK: No, thank you.

CHAIR BELLA: Okay. Thank you.

John?

COMMISSIONER McCARTHY: Like everyone else, I just want to say thank you for your hard work and taking time out to talk to us.

Having been a former Medicaid director, I think you guys are all most worried about people getting the services that they need, especially if they're eligible.

So, Amir, I'll start with this question with you and then go over to Cora, since, Amir, you've been Medicaid director longer. But looking at the process that you've been going through, two different questions. Number one,

have you seen fair hearings, an increase in fair hearings on the eligibility side? So that's one. And then number two, I'm assuming you're also probably watching utilization. Have you seen big changes in utilization or things that might worry you about people not getting services they need?

MR. BASSIRI: Two great questions, John.

I'll start with fair hearings. So we have not seen a massive increase in eligibility-related fair hearings. We do have somewhat in our -- for the integrated marketplace, we do have an appeals team. They sort of try and troubleshoot transitioned individuals to other forms of coverage that they're eligible for if they're not eligible for Medicaid, and that has worked relatively well.

We do have a large number of fair hearings and a backlog that we're working through, but they're specific to cases that were either continuing cases from PHE time periods for services, not really related to eligibility, but we are working and do need to do more work on addressing the backlog and shoring up some of the appeals process moving forward. It has been challenging for us to find and hire ALJs and work with our disability office to

process those fair hearings timely. But fortunately, there have not been an increase due to eligibility-related fair hearing requests.

In terms of utilization, we do monitor that very closely. We have during the unwind as well. A lot of the individuals that we moved into fee-for-service that had third-party coverage obviously are not and were not accessing services, so they likely had ESI. They've been moved to ESI.

There haven't been massive changes to utilization thus far. We don't have any assumption that people aren't accessing or getting access to services, but we are not seeing the big swing in utilization along with the downward trend on enrollment.

Our health plans are very vocal in making sure that we are assessing the acuity of the population that is enrolled. We feel confident that our projections in the trend is right, but that's something we're monitoring very, very closely on an ongoing basis.

I hope that answers your questions.

MS. STEINMETZ: And I would echo around the utilization piece what Amir shared.

So we similarly have not seen big shifts in utilization, and what we've heard from providers so far is that they're not seeing major changes in their payer mix. And so we've asked to stay in close contact with them because, certainly, if we see an increase in the uninsured population seeking care, that will be another outside indicator of what that means from a broader health policy context in our state.

So we'll continue to monitor, because we do realize that it's a little bit of a lagging indicator, especially for healthy populations who may not be seeking health care services right away.

On the fair hearing side, we have not seen an uptick, more than what we would expect, and we don't have any hearings that have gone past 90 days. So we've been able to manage that, but again, we're continuing to monitor it because we know that that could shift really pretty rapidly. So we're pleased with where we are right now on the fair hearings piece, but we'll continue to work closely with our office of administrative law proceedings to make sure that we can react quickly if that situation changes.

CHAIR BELLA: I thought you were going to ask if

they wanted to federalize the eligibility system, John.

COMMISSIONER McCARTHY: Future. In the future.

[Laughter.]

CHAIR BELLA: All right. In the couple minutes we have left -- you all have given us kind of your wish list and your thoughts -- we'll just do like a speed around. Anything else you want this Commission to hear from you? I mean, obviously, the door is always open if you think of something after you leave, but anything else that you would leave us with today as we continue to do work in this area?

MS. STEINMETZ: I, I would just share that I'm fortunate enough to be the spokesperson here for this, but there is a massive team behind me that doesn't get the credit anywhere close to what they deserve. So really, eligibility is performed at the state level in Indiana, but it is through a sister division, and so the Division of Family Resources has really undertaken the bulk of this effort, the Medicaid team more from a policy standpoint, my eligibility staff, and the communications team within our Family and Social Services Administration. I would be remiss if I didn't remark on their incredible efforts.

So I appreciate you taking the time to review this information and hear from the state perspective, because we've really tried to take a thoughtful and transparent approach throughout, and I'm just appreciative of the opportunity to share the good work of the team with you all today.

MR. BASSIRI: Yeah. I'll go ahead and echo that and just say thank you to you all. We appreciate your interest and learning more about what's worked, what hasn't worked. It would be a failure if we come out of this with the same old standards and processes we had in place prior to the public health emergency. I think we've learned a lot about what churn really is, what it means, what's needed, what's not needed.

There's a lot more we can do to maintain program integrity and maintain underlying intent of the program, and so anything that the panel needs to better understand the impacts of some of these changes, I think we're -- all of us are very interested in providing that, knowing that there have been some meaningful changes that have resulted in good progress towards meeting our mission, so thank you.

CHAIR BELLA: Thank you.

Stephanie, any final words?

MS. MYERS: Sure. So first, I just want to thank you for having us on this panel and wanting to hear the MCO perspective in terms of what's happening in the unwinding. The MCOs are grateful for all the hard work that their state partners, the state agencies are doing in this unprecedented time. And as always, they are -- you know, the MCOs are here to help in any way possible and make sure that Medicaid beneficiaries are getting through the process and maintaining their coverage.

CHAIR BELLA: Well, thank you. Martha, thank you, and thank you all and the teams behind you, who I know will not see this on transcript and hear you thanking them or hear me thanking them, but I would really appreciate that work. And honestly, if anything comes up, they want to make sure that the state's view that this Commission is made aware of, please don't hesitate to let us know. Thank you all again very much.

MS. STEINMETZ: Thank you.

CHAIR BELLA: All right. So we're going to open it up to Commissioner discussion. Who would like to start us off? Jami.

COMMISSIONER SNYDER: Yeah. Just a quick comment in follow up to the three panelists' suggestion that what they'd like to see continued is the continuation of the 1902 waivers -- or the (e)(14) flexibilities, rather.

Many of you may know this already, but CMS has posted a really nifty map on their website illustrating the degree to which each of the respective states have taken advantage of the (e)(14) waivers ,and it really falls along a continuum. And it's not neatly tied to the politics of states either.

I think Tennessee has employed the highest number, largest number of (e-)(14) waivers at 15. But states are all along this spectrum. So it's just something I think we should think about as we think about MACPAC's role and the importance of these (e)(14) flexibilities and ensuring that individuals that remain eligible remain enrolled, whether we want to weigh in along those lines as well, because clearly there's disparity in terms of opportunity given whether states have decided to take advantage of some of those flexibilities.

CHAIR BELLA: And do we know what's been holding states -- I mean, capacity is obviously an issue. But do

you mean like the clock is running out to get some of the states to take some of these things up? So you're thinking about more in the permanent realm and then helping states that might not be doing it today also take it up if it's made more permanent.

COMMISSIONER SNYDER: Yeah. So just really kind of digging in and finding out what the barriers are to states taking advantage of the flexibilities and what we can do to support them.

MS. HEBERLEIN: So, Melanie, if I can just jump in, because we heard a little bit from the ex parte roundtable that some of the flexibilities -- and we heard a little bit from the panel today -- that the timing wasn't quite right, and the systems builds to execute them and then roll them back when the flexibility ended, was too big of a lift for them to take it on. And it wasn't necessarily the policy -- or that they didn't want to pursue it, but that it was a time and systems-build constraint. And that's maybe not true for all of them, but we definitely heard that from the roundtable.

CHAIR BELLA: Yeah, that makes a lot of sense. Thank you, Martha.

Patti and then Tricia.

COMMISSIONER KILLINGSWORTH: So in addition to that, I think one of the things that I would find particularly helpful would be summaries of the publicly reported updates, you know, kind of on unwinding progress and outcomes, where states are developing their own individual dashboards, but putting that together in a concise and meaningful way that really helps us look at the impacts on access.

And then to the extent that you could surface any insights from that data that could highlight potential access concerns that the Commission should discuss, that would be particularly helpful.

Today was really good because we got to talk with at least a couple of states, but my sense is that there's -- if we talked with 48 more states, we'd get 48 more ideas about things that they have learned. And if we talked with health plans and stakeholders, we'd get even more ideas.

So what are those particular things that are working? I was intrigued by the text messaging conversation. It's certainly been our experience that health plans can play a very significant role, but other

things either that are currently -- have been permitted and have been found to be particularly valuable or other kinds of flexibilities or adjustments that might be needed to mitigate concerns as we move forward.

CHAIR BELLA: Thanks, Patti.

Tricia?

COMMISSIONER BROOKS: So just building a little on what Jami was saying about the (e)(14)s, I know that CMS is very interested in hearing from stakeholders on what is working, what do you want to retain, but they also have to determine if they have the legal authority to allow those as state plan options without a statutory change, because the temporary flexibilities live under different rules, and they're only temporary. So that is going to be a little bit of a heavy lift, I think, for CMS to come out of the gate at the end of the unwinding and say, oh, here's a new set of options that you have.

The other point I wanted to make is that all of the unwinding data reporting requirements end in June. Unfortunately, it was a date certain established under the Consolidated Appropriations Act, and I think we've always talked at MACPAC about the importance of being data driven.

And we've seen different types of renewal data that we've never seen before that has been extremely helpful in illuminating all of the procedural barriers that there are in Medicaid.

And I'd like for us to, at some point, explore more on the data reporting side, not just the unwinding renewal data, but all those performance indicators that I keep harping on, that there are 80-something of them and we see eight or nine of them published by CMS. And they've been on the books for 10 years.

Data is not useful unless it's timely and unless we use it to make program improvements, and I'm not sure we're maximizing the opportunities there.

CHAIR BELLA: Thank you, Tricia.

On your first point, presumably CMS is evaluating all of those things.

COMMISSIONER BROOKS: They are, but they've asked for help from the stakeholder community. I think the legal services organizations, in particular, are trying to take a hard look at that. Some of the lawyers on our team are looking at that as well. I just think they need help, because, as we all know, they're bandwidth is problematic,

and they may be facing another shutdown.

MS. HEBERLEIN: Yeah. And, Melanie, they've also asked for data to show what works and what doesn't work, to Heidi's point earlier, I think it was -- no -- or Jenny's point. Sorry. This side of the room is difficult to see. So they're definitely trying to think through what they can make permanent, but I think it's both a legal perspective but also making the case based on what actually works and what the effect has been. So they've definitely been asking those sorts of questions.

CHAIR BELLA: And is Congress looking at those things also? Do we know?

COMMISSIONER BROOKS: I don't know for sure. I mean, I know, you know, certainly what some of the staffers think are really important, and it's on their radar as well. But I haven't heard specifics on that.

CHAIR BELLA: Other comments?

[No response.]

CHAIR BELLA: I guess tying to what Tricia -- I mean, this is kind of the theme, but Amir said -- I think he used the word it'd be a real shame if we go back, if we don't, you know, use any of this to make the whole process

better. And so as the Commission, continuing to think about where we weigh in on how to make that process better, because as we all have discussed, ex parte was a problem before COVID. The complexity of the system was a problem before COVID.

And so, Martha, I guess I would say if you had a magic wand, what do you want to continue to bring back to us?

MS. HEBERLEIN: Well, I love sitting up here and having this discussion with you. I do think from a data perspective, I think that is something that I struggle with a little bit is to understand what has worked and what we want to keep going forward. And when we've asked that question in our routine calls with folks, I don't know that everybody is there yet and everybody's thinking about it yet. I think it's, you know, especially since the ex parte issues surfaced, I think that has sucked a lot of air out of the room a little bit, and they've been trying to put that fire out. And I think that there are conversations beginning about, well, what has worked and what do we want to keep on?

I think that there's probably a lot of things

that are harder to roll back, and I would think things like texting that are sort of built into the routine operations now where we send out multiple notices, we try four or five phone calls, all of these things, like some of that that has been maybe more routinized and might continue just from inertia.

And then I think there's other things like some of the 1902(e)(14) flexibilities where we would need to find a legal way to keep going with those. And then there's other things. I'm sure there are more issues in ex parte that we just haven't figured out yet, and I think there's other things, like Tricia, where we've talked about screen and enroll, where there's an SMD letter from 2000, and why is that not working the way we thought it was?

So I think there's some other things that the PHE -- like as we've been processing all of these renewals that have raised long-standing issues, that I think I would agree with Amir that it's not just don't go back, but what can we learn, and where did the issues -- where did issues get pointed out that we haven't yet resolved?

COMMISSIONER HEAPHY: And I'm -- I'm sorry.

CHAIR BELLA: Go ahead. Dennis and then Jami and

then Heidi.

COMMISSIONER HEAPHY: Jami, I think you pointed to the website, right? And I'm on the website now, and I'm just -- 270 total waivers were approved, and then there are hundreds of multiple types of waivers that were approved, so figuring out which one of those are the ones to focus on is a tough job, but I think it's important too to figure out, okay, of all these total waivers approved, the types of waivers, which are the ones that had the greatest impact?

CHAIR BELLA: Jami?

Thank you, Dennis.

COMMISSIONER SNYDER: Yeah. And along those same lines, I think a starting point might be just to look at which of the flexibilities that have been offered to states would require a statutory change versus those that we could employ without some sort of statutory revision.

CHAIR BELLA: Heidi?

COMMISSIONER ALLEN: Following up on that thought, I think that this is a good example of work that MACPAC could contract out for research, that we would be uniquely positioned to be helpful to make happen versus

like an outside health services researcher like myself, because it requires a lot of really nuanced understanding of all the different Medicaid programs and their eligibility and then how they prioritize populations for redetermination.

And I think that when I look at this Excel spreadsheet that you can get from the CMS website, kind of near the map, it's all a bunch of zeros and ones, a variation, which in normal health services research, we're like, yes, like you can do like causal studies with these kinds of things. It could be really great, but I think the researchers would be really hampered by the insider information that they would need to have about the decisions that states made in terms of how they prioritize and how they reported numbers and what numbers can you trust and what are the outcomes.

But I think that if MACPAC were in charge of -- or not in charge, but leading a collaboration with a research organization so they could bring that insider knowledge to the use of the analysis, I think it would be really successful. And if we started with the flexibilities that do not require any legislative changes,

then I think that we could have a really neat analysis to say these are the things that were really powerful and helpful and that should continue, and meanwhile, we could keep our eye on what might -- how we could help change the things that people feel like really work, but we can't quite -- but a longer process.

CHAIR BELLA: Thank you, Heidi.

Martha, you're definitely hearing consensus around, I think, that area of -- based on what we have, what should stay, what requires statutory change, what doesn't, what do we know, what can we collect.

And, John, I was half joking, but keeping an eye on things like what does the future of eligibility and Medicaid look like?

And, Tim, the point you made about we're throwing all this money at systems in every single state and in multiple counties across states, how do we do better?

I won't be here while you all figure that out, but I'll be watching, like some of our former Commissioners are watching today.

All right. Anything else?

Tricia.

COMMISSIONER BROOKS: Yeah. When mentioning SNAP, it just reminded me. We need to impose from the federal government, the idea that they need to look at how do you create seamlessness across public programs, because states with the integrated eligibility systems have talked about how difficult this has been to coordinate SNAP and Medicaid, and then there are states like New Mexico has a real mess right now in terms of SNAP, and they're saying we need to get people food before we necessarily step in and do the health care. And we just need to align these rules more at the federal level to make it easier for states to administer the programs.

CHAIR BELLA: No problem. No problem at all. This is recommended across the agencies. Have at it, Martha.

MS. HEBERLEIN: Yes.

COMMISSIONER HILL: Can I just ask on that point?

CHAIR BELLA: Tim.

COMMISSIONER HILL: This may be a stupid question. Are there groups like this for SNAP or for those other programs? Is there an opportunity to coordinate? If there's an oversight body or commission on some of those

other public programs, is there an opportunity to coordinate there? Heaven forbid we should coordinate, but if there is.

CHAIR BELLA: Anybody aware of anything comparable?

[No response.]

CHAIR BELLA: It's a good question. It's a good question to figure out how, like if there are some, are we missing opportunities to collaborate? Thank you.

All right. Martha, unless you have anything else to add, we will wrap this part and go to public comment. You're welcome to stay up there if you like. So we will open it up to comments from the public. If you'd like to make a comment, please use your hand icon, introduce yourself, and the organization you represent. And we ask you keep your comments to three minutes or less.

[No response.]

PUBLIC COMMENT

[No response.]

CHAIR BELLA: Well, we're not seeing anything.

All right. Martha, thank you again. Keep those panels coming. Super important to hear real time from

folks doing this on the ground.

We will go ahead and take a break. We'll be back at 2:45 with our session on Medical Care Advisory Committees. Thank you, everyone.

* [Recess.]

VICE CHAIR DUNCAN: Welcome back. Audrey, it's nice to have you join us.

We're going to pick up where we left off in September on the medical care advisory committees. Based on the discussion we had, Audrey is coming back with three policy options for us to consider for us in the March report.

So with that, Audrey, I turn it over to you.

MEDICAL CARE ADVISORY COMMITTEES (MCACS) AND BENEFICIARY ENGAGEMENT

* MS. NUAMAH: Good afternoon, Commissioners. Today I will be following up on September's discussion about the importance of beneficiary engagement as a strategy to advance health equity.

Policymakers can engage with beneficiaries to develop a deeper understanding of the issues that affect their access and use of the Medicaid program, co-create

appropriate solutions, and identify potential unintended consequences that would negatively affect the people served by the program.

Federal rules require each state Medicaid agency to establish a medical care advisory committee, or 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. CMS recently proposed a rule on ensuring access to Medicaid services that also revises MCAC regulations.

This session will begin with background on federal statute and regulations related to MCACs and the recent proposed federal actions to implement changes to the federal regulations. Next, I will provide a summary of our work and share key findings and challenges with beneficiary engagement on MCACs. Then I will describe policy options to address these challenges. Lastly, staff would welcome feedback on the policy options presented today, including any options you would like to advance for a Commission vote and inclusion in the March report to Congress.

So as a reminder, federal regulations describe requirements for the appointment and composition of committee membership on MCACs. The regulations also touch on committee participation requirements and the support the committee can receive from the Medicaid agencies, such as staff assistance and financial arrangements.

This past spring, CMS released a Notice of Proposed Rulemaking, or NPRM, that would change federal MCAC rules. It would rename MCACs to Medicaid Advisory Committees, or MACs. It would expand the scope of topics to be addressed outside of health and medical care services; establish beneficiary advisory groups, or BAGs; and require state agencies to publicly post information related to MAC and BAG activities.

During the September meeting, I highlighted several key findings from a federal policy review, a 50-state scan, and stakeholder interviews from six states, which were Kentucky, Maryland, Nebraska, North Carolina, Oregon, and Virginia. Our analysis found that there is substantial variation in how states have implemented MCACs.

As a reminder, this work was conducted prior to the release of the proposed rule, which addresses some of

the issues that these states face.

Today we want to focus on key challenges that affect beneficiary participation and engagement. For example, state officials and beneficiaries cited several challenges to increasing beneficiary participation and engagement. State officials recognized that meaningful engagement efforts to strengthen the relationship between the Medicaid agency and beneficiaries is time and labor intensive and noted that states face difficulty balancing this investment with other priorities.

Our interviews also told us that beneficiaries feel more qualified to participate in MCAC discussions on topics that directly apply to their lived experience and feel less comfortable discussing more technical topics. State Medicaid officials also had questions about the use of financial incentives for beneficiary participation. The NPRM suggests more guidance will be released with the best practices for meaningful beneficiary engagement, although it's unclear when this guidance will be released.

Another finding we heard was that diverse beneficiary representation is lacking. Federal rules require beneficiary membership but do not specifically

speak to the diversity of those beneficiaries. However, states can establish their own representation requirements within the federal regulatory framework.

We found that few states have requirements for diverse representation or representation from historically marginalized communities, but when they do have these requirements, they are fairly narrow. One of the findings from states with beneficiary-only subcommittees found that when there was representation from marginalized populations, it can lead to more robust participation by beneficiaries than other advisory groups. The beneficiary members cited that this environment of peers with lived experience similar to theirs was less intimidating. The NPRM encourages states to consider diverse representation in their recruitment efforts but does not mandate it.

Another finding we heard was that beneficiary recruitment is challenging. The states we interviewed noted many difficulties finding beneficiaries to participate. One common recruitment approach is to recruit beneficiaries that serve on other state advisory committees or managed care organization committees. Medicaid officials commented that this strategy can create

challenges when multiple agencies and committees seek the same beneficiaries for input. Additionally, we heard that some beneficiaries and state officials interviewed described the MCAC's application as long, complex, overly formal, much like a job application. CMS defers to states to develop an application process. The NPRM indicates additional guidance on recruitment strategies is forthcoming.

The following are policy options that Commissioners may want to consider to address the challenges identified by our analysis.

These policy options would encourage CMS to release guidance to states to address some of the challenges states face in recruitment and engagement. It would direct state Medicaid agencies to include a diverse set of beneficiaries on their MCAC and also instruct state Medicaid agencies to eliminate barriers to recruitment and offer support to beneficiaries to ease their participation.

The first policy option is to address the issues where states seek more guidance. CMS should issue guidance and provide technical assistance to address the challenges experienced by states in recruiting beneficiary MCAC

participants, facilitating beneficiary engagement in MCAC meetings, and providing more information about the financial arrangements available to beneficiaries to facilitate their participation in MCACs.

The proposed rules does state that CMS would release additional guidance on model practices, recruitment strategies, and ways to facilitate beneficiary participation. However, it's unclear when this rule will be finalized and the guidance will be issued. For states that are currently working to address these concerns, having this guidance soon would help them do this.

From our analysis, these are the three areas that states identified where they would benefit most from guidance. States explained it would be particularly useful to have examples of other state approaches. State officials suggested technical assistance or a learning collaborative with other states would be most helpful to leverage resources that could be utilized by all states and generate greater beneficiary engagement.

The second policy option is to include diverse beneficiary representation. In implementing the requirements in 42 CFR 431.12(d)(2) that requires MCAC

members to include beneficiaries, state Medicaid agencies should include diverse beneficiary representation by recruiting beneficiary members from across their Medicaid population, including those from historically marginalized communities.

This policy option directs states to include a diverse range of voices as part of operationalizing the existing requirement to include beneficiary representation. State recruitment approaches should include ways to reach out to populations of varying race and ethnicity, age, language, disability, sex, gender identity, sexual orientation, and geography. The purpose of beneficiary engagement is to hear from beneficiaries, and there are many different types of voices that need to be heard. These broad range of perspectives can positively improve the administration of the Medicaid program.

The third policy option is about reducing beneficiary burden. In implementing the requirements for 42 CFR 431.12(e), to further the participation of the beneficiary members, state Medicaid agencies should reduce barriers to, and the burden on, beneficiaries in engaging in MCACs by streamlining application requirements and

processes and offering support to facilitating the beneficiary participation in MCAC proceedings.

As we discussed last month, beneficiaries may not be aware that MCACs are a tool for them to have their voice heard. State Medicaid agencies should leverage approaches to promote their MCAC and increase beneficiary awareness. States should also examine their application and member appointment policies and processes and identify opportunities for streamlining this process.

States should also address factors that may prevent beneficiary members from being able to attend meetings, which may include, for example, logistical barriers as well as challenges with understanding the meeting content. Addressing barriers and providing beneficiaries with additional assistance may help to facilitate their MCAC participation.

So staff hope to get feedback on this package of options and whether you would like to advance them. If there is support for moving forward with these policy options, staff will return with recommendation language and a draft chapter for the March report to Congress.

Here are the policy options for discussion.

Thank you.

VICE CHAIR DUNCAN: Thank you, Audrey. I appreciate you with the research as well as the feedback from the last meeting putting forth these policy options.

Any comments or questions from Commissioners?

Patti?

COMMISSIONER KILLINGSWORTH: So, Audrey, good information and helpful insights.

I do mostly support the recommendations. I kind of want to parse those out just a little bit.

So with respect to Option 1, I absolutely support that recommendation to issue guidance and provide technical assistance on model practices. I think that makes a lot of sense.

I also support Option 3 with a caveat that states should be expected to take the CMS-recommended actions to eliminate recruitment barriers and support participation, but that would not guarantee that those actions would be successful in fully eliminating the barriers, right? I think these are things that we think will work ideally, but I think would have to play out in order to know that.

The one that I'm probably the most concerned

about is Policy Option 2, as it's currently written, because it seems to almost belie the challenges that have been clearly laid out that states are facing in fulfilling a policy directive, and I just want us to be careful about sort of using policy as a simple tool to compel compliance when the challenges surrounding an issue are more complex and the actions taken may or may not be successful in getting to compliance.

So again, I think supporting states in those efforts to recruit, helping them support people in their participation makes a lot of sense to me, but I just wouldn't want to see states held accountable if they do all of the right things and in spite of doing those things still struggle to have the participation that we would like to see them have.

VICE CHAIR DUNCAN: Thank you, Patti.

Did you raise your hand, Heidi?

[No response.]

VICE CHAIR DUNCAN: Okay. Tim?

COMMISSIONER HILL: Just to follow up, I had 1 and 3, I'm kind of all on board. I think these all make a lot of sense, and it's good work.

On Option 2, I was struck by the same -- what are we asking? Are we asking for an outcome or a process? Are we asking states to sort of put together a plan to recruit, to drive to get to diversity, or are we saying you have to hit a target? And we just have to be really clear because one is going to be easier than the other, and I don't want, to the same point that Patti made, to hold states up if they try their hardest and still can't get folks in.

VICE CHAIR DUNCAN: Thank you, Tim.

All right, Heidi.

COMMISSIONER ALLEN: I mean, I think it's hard to define the word "try," because I was a Medicaid advisory director, committee director for several years, and would I say that I was ever put under any real pressure to get beneficiaries on there? I don't think that I experienced real pressure. I don't think it was like the type of pressure of an agency saying, "This is critical to us. We care about this. Make this happen." I think it was like, "Oh, this is part of the statute. You should try to have a beneficiary." And I feel like we have to -- and I don't know the policy answer, how it fits at the recommendations, but they are statutorily required to have beneficiaries on

there.

And other state organizations and agencies that serve the same population also have similar -- you know, so I'm looking here at the Substance Abuse and Mental Health Services Administration (SAMHSA) and their governing board requirements for community behavioral health clinics, and you can look at what are the requirements for community health centers by the Health Resources and Services Administration (HRSA). And they have 51 percent of their boards as consumers, which I think one of the things that we know, I read through your wonderful work, is that people don't feel like they can speak up. They are intimidated. They feel like their issues aren't heard. Well, yeah, if they were 51 percent of them, if they made it 51 percent of the committee, that probably wouldn't be as big an issue.

But the thing is that the agencies have to answer more to, well, we want a hospital representative. We want an MCO representative. We want dental representative. We want these other things. And like those voices, I think, get, you know -- yes, it's easier. Yes, you know, there's barriers, but I think that -- I think we need to have some way to make them really want to try, really want to try,

really prioritize how important it is for consumers to be able to weigh in.

And I noticed that the -- for the SAMHSA, what they did is they have three options. One is 51 percent of the board, but Option 2 is, okay, if you can't do that, then you have to specify other things that you're going to do to get consumer voice. And then they had another option where you can do like a third way of demonstrating, but they require outcomes.

And so I wonder if we could advance what is asked by putting a little bit more -- I don't know -- definition around -- I like Option 2 because I think that we need to say that the beneficiaries should represent the population, but you need -- you can't do that if you only have one beneficiary. Like one or two beneficiaries is not going to represent the Medicaid population, and I think that's the trouble that they have is they're not even getting one or two. So how do we flip that paradigm? That's, I guess, my very poorly worded question and comment.

VICE CHAIR DUNCAN: I think I heard at the root of that, Heidi, you were trying to -- how do you get the different, other agencies and groups to equalize with more

beneficiaries is what I heard you trying to say. Having more beneficiaries than having -- I don't want to call them "special interest groups," but hospitals, things like that.

COMMISSIONER ALLEN: Well, I guess my thing is that you can't have representation, which is Option 2, if you don't even have one beneficiary, and you can't do it with one beneficiary or two beneficiaries or three because they won't be representative. You need to have a lot of beneficiaries, and so it's like, how do you have Policy Option 2 when they're not even -- when the survey of states found that most -- a lot of states don't even have any?

So that's the question, and like, how do we prioritize for states? How can CMS help prioritize for states that this really matters? And it might require changing the statute to have a requirement that you have so many beneficiaries.

VICE CHAIR DUNCAN: Thank you.

All right. Rhonda?

COMMISSIONER MEDOWS: So I support all three of the policy options, and I strongly support the second one. I believe that at our last discussion on this same topic, there was a lot of talking about how people either at most

might be considering using a beneficiary that they've used elsewhere, but not actually doing any particular outreach or any defined effort to bring in new beneficiaries or to even make known the opportunity. I think it's important that diverse representation actually occur and that there be defined ways in which we're trying to bring them into the fold and to help them put some advice into the health system that they're dependent on.

VICE CHAIR DUNCAN: Thank you, Rhonda.

We'll go to Angelo and then Adrienne.

COMMISSIONER GIARDINO: Is this on?

VICE CHAIR DUNCAN: Yep.

COMMISSIONER GIARDINO: Okay. I guess I completely support the concept of having the voice of the consumer and the enrollee. I guess I'm just wondering, is this really a recommendation that we would put in our report? It seems very operational to me, and it would seem to me that CMS is going down this road. They have the options that Heidi talked about. There's other government agencies that get the voice of the consumer into things all the time. Is this really a policy that we have data and we're illuminating that, or are we just being normative and

saying we like this idea and we want you to do it this way? To me, that's not -- I don't see the evidence actually. I love the idea, but I don't see this as equivalent to some of the other things where we literally are putting out data showing why it's better to do it this way versus that way.

I just question whether this wouldn't be better as a letter to the leadership that we interact with or maybe it's a report or a chapter that talks about the benefit of this, but is it really a recommendation?

VICE CHAIR DUNCAN: Thank you, Angelo.

Adrienne? Oh, wait.

MS. NUAMAH: So I was actually going to address your point, Angelo, that we did see it in the data, and as our analysis found that states aren't doing this piece about including the diverse beneficiary representation.

One thing is that, yes, in the policy, it does say states need to have beneficiaries, but they are really struggling with how to actually do the diverse beneficiary piece.

And then in the proposed rule, CMS acknowledged it was saying that, yes, we encourage you to have diverse representation, but they don't go as far as to mandate it.

So what makes this different is that in the policy, we're saying state agencies should mandate having diverse representation as part of their MCACs, and if the BAGs get also approved too, as part of their BAGs as well.

COMMISSIONER GIARDINO: Okay. Thank you.

And then I would just encourage you to think and incorporate some of what Heidi was saying, because there are other state and there are other federal entities that have actually operationalized how to do that. And I am very familiar with FQHCs. So, I mean, if that's where we're going, then I think then it has to be more than every once in a while, you can find someone who was a Medicaid recipient who's now -- you know, Paul Ryan was on Medicaid for a while. I wouldn't think if he's on this board that he's really representing the beneficiaries. So I would say you have to do things a little bit more substantively.

VICE CHAIR DUNCAN: Thanks, Angelo.

Adrienne, then to Rhonda.

COMMISSIONER McFADDEN: It's very difficult to follow that, Angelo, but I will try.

So, Audrey, thank you for the work. I am supportive of all three policies. I do think as a package,

they make a lot of sense to me and in terms of policy too. As a representative body, I feel it should be reflective of what you're trying to represent, and so I do fully support policy too.

VICE CHAIR DUNCAN: Thank you, Adrienne.

Rhonda?

COMMISSIONER MEDOWS: Just to follow up, I do think this is policy. I do think it's imperative that the actual voice of the customer or client is well represented as we create and transform this health care program, and I think we do it for any other client or customer or a patient population with any other health program, whether it's private sector or government. I think it should be occurring in Medicaid as well.

VICE CHAIR DUNCAN: Thank you, Rhonda.

John?

COMMISSIONER McCARTHY: I just have to say MCACs can definitely be good, but they're an advisory committee.

So, Heidi, you brought up the boards of FQHCs. They have a fundamentally different role because they're actually running the entity. You can't have it without that, where this is just an advice -- it's purely advice.

The state doesn't have to take the advice. So that's another issue of trying to get people to be on these committees.

And I want to go back to that doesn't mean that states don't take advice from beneficiaries. They definitely do. They often do it in many other ways in doing it. I have to say it again. Part of it's through the legislative process. Having been a Medicaid director, there's a lot of hearings that you go through, and you hear a lot of input from people on what should be changed and things like -- and different pieces like that.

Sister agencies, such as agencies that serve people with intellectual and developmental disabilities, they often have advisory committees with people who are on waivers. They are very important, and I'm a little bit where Angelo was, which is we've got new rules out. Do we need to see what happens with those new rules to make some decisions around it? Because when I look at the policy options, fundamentally, they could be good, but it really depends like what's the devil is in the details on it, and then what is the stick that CMS would have to enforce it?

Again, I want to go back to if the state doesn't

do this, CMS is going to take all the FMAP away from the state, and the answer is no. It's just not going to happen, and so thinking through what would be done around how to help states move forward on this, but then also what would be the oversight?

VICE CHAIR DUNCAN: Thank you, John.

Dennis?

COMMISSIONER HEAPHY: John, your point about the advisory capacity, Massachusetts, I actually chair -- called an implementation council for implementation of dual eligible program in the state, and 51 percent of it is run by folks, by consumers, and other folks are represented -- represent providers in the community, hospitals, psych hospitals, and other providers of service as well.

And what makes the implementation council different from an advisory council is we have outcomes. We can actually measure the success of the council, and so I think what's missing from here is, how do you measure the success of these advisory committees? How do the people who are going to be on these advisory committees measure the success, their success?

In terms of the beneficiary representation, I

definitely agree with Heidi about the 51 percent.

And in terms of composition, this isn't about one of everything, like one of each, because that's gross. But it really is about true representation of the population on Medicaid, and we find, just on the council, that we don't have the voices of certain communities. We lack the knowledge and the information we need to improve the program.

And so I view that what CMS is trying to do is to really improve the Medicaid programs in states, and so the only way to do this is by having a diverse beneficiary representation, and that the states -- and I've been saying this forever. Too often states expect beneficiaries to come to them rather than the states going out to the beneficiaries and being in spaces that are uncomfortable for them.

An example would be members of MassHealth came out to a school for folks with complex care needs, the parents' group, all the parents, folks from in minority populations, different languages, but being in a separate space, being in a space where the majority of folks are representing the community. This shifts the dynamics and

shifts the power dynamic.

And so I view these advisory committees as an opportunity to shift that power dynamic so the state can actually learn and improve the programs in ways that they want to but may not know how to because they don't have that voice currently present in these -- in the current MCACs.

So I'll leave it at that.

VICE CHAIR DUNCAN: Thank you, Dennis.

Any other feedback from the Commissioners?

[No response.]

VICE CHAIR DUNCAN: Madam Chairwoman, any thoughts?

CHAIR BELLA: No. I mean, I'm thinking about other ways that we can also receive input so I don't have any particular thoughts. I'm very supportive of how we get the consumer and the beneficiary voice involved.

I'm also thinking about ways outside of these recommendations and what CMS is looking at to really do that.

So I think we can -- if we were going to take these as a package, if we need to break them apart, we can

talk about that after we kind of digest the feedback today, but no other thoughts.

VICE CHAIR DUNCAN: Thank you.

Audrey, do you think you got what you needed? Anything else that you need to hear from us?

MS. NUAMAH: No, thank you.

VICE CHAIR DUNCAN: Thank you again for the work. Appreciate it, and we look forward to what we come back with in March.

Now I think you're going to be joined by Melinda to talk about school health.

COMMISSIONER HEAPHY: Can I ask one more question to Audrey?

VICE CHAIR DUNCAN: Yes, you can.

COMMISSIONER HEAPHY: I apologize.

Have you asked how states or other stakeholders would feel about CMS having an advisory committee?

MS. NUAMAH: That came up in some of our interviews that it could be helpful, but we didn't really press more on it. It was more folks just speculating.

COMMISSIONER HEAPHY: I think that would be something to explore. I don't know how it ties into what

you're doing now, but I think that would be very interesting to find out.

VICE CHAIR DUNCAN: Thank you. Anything else?

[No response.]

VICE CHAIR DUNCAN: All right. Now, Melinda, come on up. We're excited to learn more around the school-based behavioral health services. You ladies were so effective last time. We had the conversation then CMS just, man, put out some guidelines right away. So we look forward to hearing from you and potential next steps.

SCHOOL-BASED BEHAVIORAL HEALTH SERVICES: FINDINGS FROM STAKEHOLDER INTERVIEWS

* MS. NUAMAH: Hello again. Today Melinda and I will be following up on our discussion of school-based services, which are services delivered in schools by providers who are employed by a school or local education agency, or LEA.

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 new opportunity, MACPAC contracted with Aurrera Health Group to examine how states and schools are

providing behavioral health services to students enrolled in Medicaid and the considerations for doing so. At this meeting, we will share findings from this work.

So I'll start with an overview of the project approach. Then Melinda and I will discuss key findings and common challenges we heard from our stakeholder interviews. Then Melinda will identify select policy issues that may warrant further attention from the Commission and will share next steps for the Commission's work. These are areas where further evidence gathering may result in consideration of policy options and recommendations in future meeting cycles. As we begin new analytic work in these areas, we welcome your thoughts on whether there are particular nuances we should be aware of or questions we should be prepared to address.

So just to note, our work set out to understand the experience of schools and states in providing school-based behavioral health services. However, many of the findings are not unique to behavioral health services and are relevant to school-based services generally.

So to learn more about how states are expanding coverage of school-based services, MACPAC and Aurrera

conducted interviews in five states: Arkansas, California, Michigan, Missouri, and New York. We spoke with officials in state education agencies, school district and LEA representatives, advocates, as well as other select state and national experts. These interviews took place from February 2023 through early May prior to the release of new federal guidance. MACPAC staff have since engaged with additional state and national experts to further our understanding of key issues and gather initial feedback on the guidance. We also spoke with CMS officials regarding the new guidance and the agency's plans for additional resources through the newly established School-Based Services Technical Assistance Center.

These stakeholder interviews illustrated that providing Medicaid-covered behavioral health and other health care services can be particularly challenging for schools, revealed common views and experiences related to the expansion of school-based services, access to care, financing and payment, and billing and documentation.

The first finding was around expanded coverage for school-based services. Four of the five states interviewed covered behavioral health services outside of

an individualized education plan, IEP, or individualized family service plan, IFSP. Commonly covered behavioral health services include diagnostic assessment, psychological testing, and individual and group therapy.

There is substantial variation in the extent to which LEAs bill for non-IEP or IFSP services, including behavioral health. All four states reported having limited data on the effects of covering school-based services, including behavioral health, outside of an IEP or IFSP. This is largely because implementation occurred recently, and the COVID-19 pandemic resulted in fewer students receiving care in schools.

One of the challenges in analyzing changes in spending and utilization is that Medicaid claims often do not differentiate between services provided to schools with and without an IEP or IFSP.

In the months leading up to the guidance last May, stakeholders in all five states had cited a lack of clear and updated guidance from CMS as a major barrier to expanding behavioral health services in schools.

Stakeholders in all five states have -- states have taken steps to enhance the behavioral health workforce

in schools, including broad-based efforts that are not limited to Medicaid, which sometimes leverage other available state resources.

Stakeholders also noted that a lack of clear federal guidance regarding the types of providers that can bill Medicaid in schools has hindered efforts in some states to expand the school-based behavioral health workforce. The new CMS guidance clarifies that states can cover services provided by school-based providers whose qualifications under state and local law may vary from those of non-school-based providers of the same service or whose scope of practice may be limited to the school setting.

Stakeholders noted that the federal requirement for an order or referral from a child's primary care provider or other licensed provider before rendering care can delay or impede access to behavioral health services for schools without affiliated licensed providers.

Several national experts also cited concerns that Medicaid agencies and managed care organizations sometimes deny coverage of services outside of school because of services that students are receiving in school through an

IEP or IFSP. For example, in one state, the Medicaid agency denied coverage of certain outpatient services based on the service needs documented in a student's IEP. However, the rules under the Individuals with Disabilities Education Act, or IDEA, state that services billed in school as part of an IEP or IFSP cannot preclude coverage of eligible services outside of school.

I will now turn it over to Melinda to go over the remaining findings.

* MS. BECKER ROACH: Thank you, Audrey.

Moving on to financing and payment, education officials in several states noted a perception among some school administrators that the resources needed to build systems and capacity for Medicaid billing outweigh the benefits, given the level of payment to schools. Contributing to this perception is the lack of transparency around how states use federal matching funds for school-based services and the extent to which they direct any of that funding back to the schools that are providing care.

States that use certified public expenditures to finance school-based services are not required to provide any portion of federal matching funds to schools, though

CMS encourages them to do so.

Stakeholders also highlighted a number of challenges related to the Random Moment Time Study, or RMTS, which is commonly part of the cost-based reimbursement method used in many states. We heard concerns about whether states can continue to notify school employees when they are about to be selected to participate in the RMTS and whether participants would have sufficient time to respond.

In its recent guidance, CMS says that in certain circumstances, states will be permitted to provide up to two business days of advanced notification as well as response time. The guidance also provides some additional flexibility for schools to update the RMTS participant list, which was another issue raised by some stakeholders.

Several stakeholders said that challenges obtaining parental consent can delay care for students. IDEA and the Family Educational Rights and Privacy Act, or FERPA, require schools to obtain written parental consent before billing Medicaid for services. However, stigma related to behavioral health and difficulty engaging some parents in their child's care can be barriers to doing so.

The new CMS guidance attempts to clarify existing federal requirements with regard to parental consent. The Department of Education is also currently considering comments on a proposed rule that attempts to streamline parental consent for students receiving services under IDEA.

Identifying and documenting medical necessity was another challenge cited by some stakeholders. It can be difficult for school-based providers to determine when behavioral health services needed to support a student's education could also be considered medically necessary and billable to Medicaid. School-based providers who lack experience with medical billing can also struggle to identify the appropriate medical codes needed to demonstrate that non-IEP services are medically necessary.

Some stakeholders reported that federal requirements pertaining to ordering, referring, and prescribing, or ORP providers, can prevent schools from getting paid for services rendered to Medicaid enrollees.

Claims must include the National Provider Identifier, or NPI, of any ordering or referring provider who must also be an enrolled Medicaid provider. However,

the administrative burden associated with the Medicaid enrollment -- Medicaid provider enrollment and NPI application processes can deter some school-based providers from meeting ORP requirements.

One stakeholder expressed similar concern about federal requirements that individual furnishing providers must be enrolled in the state Medicaid program, even if they are employed by an entity -- in this case, an LEA -- that is itself an enrolled provider.

There are strong concerns that the administrative burden associated with provider enrollment and the need to disclose certain personal information may deter school-based providers from participating in Medicaid and therefore limit Medicaid billing in schools.

Several state Medicaid agencies and schools said that third-party liability, or TPL, is an administrative burden that impedes the ability of schools to get paid for Medicaid services. Medicaid is generally the payer of -- is the payer of last resort for non-IEP services, which means that LEAs must bill any liable third parties, including commercial insurers, before submitting claims to Medicaid, yet school-based services appear to be rarely, if

ever, covered by commercial insurers. And so LEAs must wait on a denial letter before pursuing payment from Medicaid.

Because of these requirements, schools in several states said that they don't attempt to bill Medicaid when a student has commercial insurance and instead use state general funds or other education funds to cover the cost of care provided to those children.

CMS guidance describes existing flexibilities that can help alleviate the administrative burden associated with TPL. However, these options may be difficult for states to pursue. For example, no state currently has a waiver of cost avoidance because it's difficult to demonstrate that the pay-and-chase method of claims payment is more cost effective.

Finally, we heard from several stakeholders that the risk of negative audit findings is a barrier to maximizing Medicaid billing and a factor which can discourage states from covering non-IEP services. CMS guidance provides an overview of documentation needed to support federal audits and notes plans to address the issue further through the Technical Assistance Center.

Among the findings discussed, we've identified three Medicaid policy issues that may warrant further attention from the Commission. These are coordination and duplication of services, ORP and provider enrollment requirements, and TPL.

Future work could focus on identifying federal Medicaid policy levers available to address these issues. For example, the Commission could explore whether CMS and state Medicaid agencies should play an active role in monitoring and enforcing federal rules meant to prevent students with IEPs from losing access to Medicaid services outside of school.

The Commission may also wish to consider the requirement that school staff become enrolled Medicaid providers or to examine barriers to reducing the administrative burden associated with TPL.

We welcome your thoughts on whether the Commission should conduct additional work in any of these three areas.

States and schools are still analyzing the expansive new CMS guidance and assessing its implications for their programs. Going forward, staff will continue to

monitor for additional guidance and forthcoming support through the Technical Assistance Center as well as for information about the funding opportunity expected next year.

In the coming months, we also plan to publish an issue brief with background information on school-based services and select considerations for further supporting Medicaid billing and access to care in schools.

Finally, as a complement to the Commission's work on school-based services, we're also working with Aurrera to examine considerations for providing behavioral health through school-based health centers and anticipate publishing our findings from that work next summer.

That concludes our presentation. We look forward to your questions and thoughts on the potential for additional work in the areas we've identified, and I'll go back to the previous slide so you can see again what those are.

VICE CHAIR DUNCAN: So first, I want to say thank you for this work. As I stated at our last meeting in September, this really excites me, because I think between the research and the understanding through the stakeholder

meetings and then our recommendations, we can get something right that would improve the continuum of behavioral health care for the kids in this country. And so thank you for the great work that you've done. I'm excited about the three options you've put before us, but I'd like hear from other Commissioners.

Okay. Angelo?

COMMISSIONER GIARDINO: Yeah. I just want to thank you. As a pediatrician, I'm just giddy when I hear you talking about school-based services that might help kids get their mental health. So thank you for the work, and I look forward to seeing where it goes. Thank you.

VICE CHAIR DUNCAN: All right. Rhonda?

COMMISSIONER MEDOWS: Thank you for providing this follow-up discussion. You were great last time, and you've gotten only better this time.

With that, I do have a couple of questions for you, though. Who are the stakeholders? Were they all people from the Medicaid program, or were they people from the schools or a combination?

MS. BECKER ROACH: It was a combination. We spoke to representatives from state Medicaid agencies,

state departments of education. We spoke to several school districts and advocates as well including -- in addition to some national stakeholders.

Did I miss anyone, Audrey?

COMMISSIONER MEDOWS: Okay. On students who are on Medicaid or not, any student that's in the school that has an IEP, et cetera, all of that requires parental consent, correct? So that's really not different than if this was being services that were being provided under Medicaid, right?

MS. BECKER ROACH: There are additional parental consent requirements for students receiving services under IDEA through an IEP or an IFSP.

COMMISSIONER MEDOWS: Yes, but that's for any student, not just ones receiving services through Medicaid.

MS. BECKER ROACH: You're correct. FERPA requires parental consent before school can bill Medicaid, and there are additional requirements under IDEA for students who are receiving services through an IEP or IFSP.

COMMISSIONER MEDOWS: Okay. I kind of remembered that from my sons, and they didn't require -- they didn't have Medicaid, but it still required my consent before any

services, any behavioral health services are provided.

And then probably my last question for you is more -- and these are sincere questions, because I feel like I'm missing something in the conversation. I heard a lot of reasons why it's hard to change or why it's hard to do anything that's different, but my concern is, are we going to miss an opportunity to still try to leverage some of the Medicaid coverage and funding for behavioral health services? I'm concerned that I'm hearing a lot of no. Are there still options?

MS. BECKER ROACH: You know, I'll just say I think in all of our stakeholder conversations, there was generally a lot of enthusiasm for expanding access to Medicaid-covered services in schools. You know, sort of given the Commission's role, we were honing in on some of the barriers and the challenges to sort of help inform our thinking on opportunities and potential policy options to address those challenges and help schools and states further expand access to these services.

So yeah, I know we really honed in on the problems, but there's also, I think, a lot of optimism and enthusiasm.

MS. NUAMAH: And just to add there to your point, Rhonda, while the guidance does address some of these issues, I think that's part of the reason why we have these three policy issues here that we still think are opportunities to do more work.

COMMISSIONER MEDOWS: And TPL would apply to any student that has commercial insurance. It wouldn't be an issue when people are already on Medicaid, right? Because they're already on the payer of last resort.

MS. BECKER ROACH: Do you mind restating that question, Rhonda?

COMMISSIONER MEDOWS: TPL is one of the issues that that was cited as a concern or an issue, right, that you would have to get a denial from a commercial plan before you could actually apply for Medicaid coverage for the behavioral health services. And my thinking is that there's a population who are already on Medicaid as children. There's no TPL issue for them, right?

MS. BECKER ROACH: Yeah. The issue we were highlighting specifically comes up when Medicaid-enrolled students are receiving school-based services outside of an IEP, and in those instances before the state can -- excuse

me -- before the school can submit the claim to Medicaid for payment, if the student has third-party coverage -- and we hear most often about commercial insurance -- the school has to pursue payment from that insurer before they can submit the claim to Medicaid.

COMMISSIONER MEDOWS: But the children who are already on Medicaid have already gone through that vetting, right, as part of their eligibility to be in Medicaid?

MS. BECKER ROACH: This applies to Medicaid enrollees. This applies to Medicaid-covered children.

COMMISSIONER MEDOWS: Okay. Thank you.

VICE CHAIR DUNCAN: Thank you, Rhonda.

We've got Jami, Patti, Carolyn, and then Tricia.

COMMISSIONER SNYDER: Yeah. Melinda and Audrey, I just wanted to thank you for your continued work on this topic. I think it's so important as we talk about meeting members where they are enhancing access to care and addressing existing disparities. I think providing Medicaid-compensable services in schools is a part of that equation.

I also wanted to just say that the concerns that you detailed in your presentation today very much resonate

with me based on conversations that I had with school districts in both Texas and Arizona. These were issues that surfaced often as we tried to encourage schools to participate in the school-based claiming program.

Further, I just wanted to say I think the three areas that you've selected out of the concerns that you detailed in your presentation today are a really great complement to the guidance that CMS has offered in areas that they may have touched on but not explored in depth and I think will be welcome guidance to states as well as support to CMS in their efforts to ensure that school-based claiming programs are able to take advantage of offering services on school campuses.

VICE CHAIR DUNCAN: Thank you, Jami.

Patti?

COMMISSIONER KILLINGSWORTH: I will echo all of the commendations for excellent work.

I think I mentioned this in my remarks at the last meeting. So as a baseline, I think we all agree there is an access issue as it relates to behavioral health services, not just for kids, but really for all Medicaid beneficiaries. But as it relates specifically to kids, my

primary concern is just making sure that what we're doing is actually the best way to really increase access and, in particular, as it relates through the claiming process. What I want to be sure of is that the services that we are providing through school-based behavioral health services have the same quality and efficacy that we would expect to be delivered by any other Medicaid provider.

And having looked for research that really supports that, there's not much. Someone shared a study with me today which was helpful, but I think even that is more about health centers as opposed to school-based health services.

So I would just like for us to really maybe look again or think about how we can, at least as we go forward, really look at the impact of those services, not just in terms of our children getting them, but what impact are they actually having for those children, especially compared to behavioral health services, maybe that are delivered in different ways, to make sure that we're addressing the access issue in the most optimal way.

Thank you.

VICE CHAIR DUNCAN: Thank you.

Carolyn?

COMMISSIONER INGRAM: A couple of questions. Can you remind me if you all looked at pieces where how school-based health centers or this Medicaid in the schools program actually coordinates care for these individuals back with the MCOs?

MS. BECKER ROACH: Most of the states that we interviewed, they were carving school-based services out of managed care. I think the exception is California is moving in that direction -- and Missouri, although Missouri is having -- they're actually not providing any school-based services right now because they're having challenges contracting with the plans in the state. So it's not an area where we got a significant amount of input so far.

COMMISSIONER INGRAM: Okay. It seems like an area that's ripe, especially if they're taking care of the same kids and they all have to have plans of care to coordinate at least what services are being provided in the schools back with that. So maybe that's an area of focus that we could make a recommendation on.

The other area I wanted to see -- I think you addressed some of this in your research, but what happens

with the kids when there is summer break? They can't necessarily get access to the services at schools. Did you all look at what happens with those services that are needed during those time periods?

MS. BECKER ROACH: It wasn't a significant -- it wasn't a focus of this work so far, but it's something we can sort of put on our list for further exploration.

COMMISSIONER INGRAM: I'm just curious. Again, that goes back to maybe trying to figure out how they can better coordinate care across the whole Medicaid continuum, because there's periods of time when schools are not obviously going to be open, and kids are still going to need access to those services. I think COVID even perpetuated that a little bit more for these young people who weren't able to go to school and get some of those services there. Therapists couldn't get them to them at home. And then how are they supposed to continue that work and the therapy they were supposed to be doing? So something for us to think about really is, I think, as we move forward, really looking at behavioral health access to care. This is one component, but it seems like it should be better coordinated across the continuum to actually

serve the member.

VICE CHAIR DUNCAN: Thank you, Carolyn.

We've got Tricia, Heidi, and Tim.

COMMISSIONER BROOKS: I'll be quick because there have been a lot of good comments and suggestions on areas to continue to explore.

But we know that there is a mental health crisis among the youth of America, and it's not just school-based kids. It's also the younger kids, and I hope we don't lose track of that.

I don't know if there's anything in Medicaid that's easy. So the idea that this is hard is not a reason for us not to continue to do work in it and monitor the evolution beyond, you know, the CMS guidance and the free school -- free care rule and all of those things because, as has been said, if we bring the services to where the kids are, they're much more likely to take advantage of those services. So I just strongly support continued work in this area.

VICE CHAIR DUNCAN: Thank you, Tricia.

Heidi?

COMMISSIONER ALLEN: There's been so many

wonderful comments that have been made, and I think that I agree with so many of the things that were said.

I'm wondering if there's anything that could be used to align policies with the free and reduced lunch program for schools that -- which is used in a variety of educational policy areas to determine schools that serve high proportion of low-income students, if there's waiver opportunities for schools that serve high populations of low-income kids to step outside of these payment structures and allow schools to just hire social workers and clinicians to work in those schools.

I really take the point about what happens in the summer and what happens when they're not in school, but I have a child with mental health -- significant mental health needs. And actually, he does way better when he's not in school. School is a huge stressor. School causes everything to be worse. And we're all competing. Parents and students are all competing for these slots that exist from 3:30 to 8:00. And everybody wants those slots. And parents -- like I can help transport my kid. Parents who don't get off until 5:00 or 6:00 can't. There's just so many barriers to accessing care after school hours, that

bringing it into the school, I think, would just be such a boon. And making it as the least amount of burden possible would be ideal.

But I'm very excited about this work too.

VICE CHAIR DUNCAN: All right.

Tim?

COMMISSIONER HILL: It's great work and got a bit of policy dissonance going on in my head, because on the one hand, I kind of associate myself with the need for addressing the crisis, not just in schools but for kids generally and the access issues.

The one piece, though, that's causing me some dissonance is the focus on ordering and referring and provider enrollment and sort of along the lines that Patti was saying. Like some of those -- I'm not going to -- I'm not going to say that the provider enrollment processes in Medicaid are perfect. They are not. They are a lot to be -- left to be desired, but at its root, they're there to be sure that qualified providers are delivering services to the people who we're paying for.

And so I would be worried if our recommendations or thoughts would go forward thinking that a waiver there

or some sort of change there, absent some sort of thought about how provider enrollment is done Medicaid-wide, right? I don't want to create a situation where we're creating a loophole for folks who are less than qualified in Medicaid to be able to deliver services in the schools.

VICE CHAIR DUNCAN: Thank you, Tim.

Anyone else with comments?

Heidi, go for it.

COMMISSIONER ALLEN: I just want to respond to that. I think because I'm a social worker and I teach in a school of social work and we prepare educators, right, I don't think that school-based clinics should be held to standards that people outside of school-based clinics are.

So I'd like to see these outcomes that we're seeing in children behavioral health provided through Medicaid, because I actually don't see them anywhere. We don't hold providers accountable for outcomes. If we did that, it would be an entirely different system.

I think what you're talking about is do they have the degrees and education to provide scope of practice, and I don't think that because they do their continuing ed in -- like we have teachers college. Teachers college prepares

people to be clinicians through an educational framework. They might do different CEUs, but they're still getting the same kind of access to the scientific standards of care for kids that have mental health issues.

And so trying to create -- take people from the education system and say, okay, now you have to not only be really certified through the education system, but now you have to go through the medical mental health system as well, that's just a real barrier. And I don't see like the functional advantage of, you know, saying you have to be then certified in both, because if you get certified in mental health, but you're teaching -- or you're a therapist in a school, you still have to do all the school stuff too. So it's just like a double barrier.

And if we had a lot -- a big, long thing of outcomes research related to children's behavioral health and Medicaid and we know that there -- I mean, there's a dearth of evidence-based practices. There's a dearth of literature that supports that there's adherence to evidence-based practices. There's a dearth of literature showing that kids who -- that what might have worked in a clinical trial works in the real world and works with a

diversity of kids and would work with Medicaid kids. And so it's kind of like I don't know what standard we're comparing it to, but schools would only hire people to do mental health that have scope of practice to do mental health in schools.

So I think that there is a system to protect schools or protect Medicaid enrollees in schools for mental health through the education system. I don't know that it needs to be replicated.

VICE CHAIR DUNCAN: Thanks, Heidi.

I've got Dennis, Patti, John, and Sonja.

COMMISSIONER HEAPHY: I agree with what you were saying, Heidi, and I'd be concerned about Medicaid-approved providers having no understanding of the school system or the educational process being permitted to engage in the -- providing services without having that extra education it takes to work in a school system.

But could you explain why some places don't require the IEP?

MS. BECKER ROACH: Is there a particular finding that you're referring to, Dennis?

COMMISSIONER HEAPHY: Yeah. There was something

about some schools use IEPs and others don't. Am I wrong?

EXECUTIVE DIRECTOR MASSEY: Melinda, can you explain the free care policy?

MS. BECKER ROACH: Yes. So as Audrey alluded to, in 2014, CMS clarified that states can allow -- can cover services provided to students in schools that are not part of an IEP or an IFSP. And so I think it's about 25 states now that are doing that to some degree, and of course, in addition, under IDEA, schools are required to provide services to students with disabilities who qualify for an IEP or an IFSP.

COMMISSIONER HEAPHY: So I'm wondering if you just can look into that more as well as well as -- is that harming kids? Is that preventing kids from getting other services?

MS. BECKER ROACH: The expansion of coverage beyond an IEP?

COMMISSIONER HEAPHY: That doesn't require an IEP, yeah. I just see a lot of benefit to the IEP, and I'm just concerned that by kids not needing an IEP that they may not be getting all the services they need.

MS. BECKER ROACH: So to clarify, Dennis, you're

concerned that that's affecting services for students with disabilities who have an IEP?

COMMISSIONER HEAPHY: Who don't have an IEP.

MS. BECKER ROACH: Who don't have an IEP.

Yeah. So still in about half of the states, schools can't bill for those services. Again, we have about 25 states that are now covering those services, and I think Audrey made the point that that's the policy in about 25 states, but then the degree to which schools are actually billing for those services really varies significantly.

COMMISSIONER HEAPHY: Thank you. I'm just going to process that whole funding stream, and I apologize.

MS. BECKER ROACH: No, no. And we're happy to follow up as well.

COMMISSIONER HEAPHY: Yeah. Thanks.

VICE CHAIR DUNCAN: Thanks, Dennis.

Patti?

COMMISSIONER KILLINGSWORTH: Heidi, I appreciate all your comments and agree with you. There's a dearth of information available.

I want to have, I guess, a difficult conversation

carefully about what is the issue that we are trying to solve as a Medicaid access commission, right? So we are trying to improve access to medical services, to Medicaid services, to behavioral health treatment services. Our goal, our role is not to improve funding for local education systems, but to the extent that that's a viable pathway to improving access to Medicaid behavioral health services, then perhaps that's the right policy recommendation for us.

But where I get really concerned, we start talking about different credentials and requirements, different expectations that feel far more aligned with educational engagement, educational performance, and far less about behavioral health treatment. I get nervous that what we're really doing is focusing on increasing funding to schools and not on improving access to care.

And so that's why I keep pushing for this outcome data is -- what is it that we're really paying for? Because schools do psychological evaluations all the time. They do assessments all the time. I think the group therapy sessions are a bit different, but how does that relate and compare to the delivery of behavioral health

services in the, quote/unquote, "sort of traditional Medicaid treatment environment"? And are we doing what we're trying to do, which is improve access to Medicaid benefits for kids? That's the point I want to make.

VICE CHAIR DUNCAN: Any comments, Audrey, Melinda, on that?

Patti, I think you bring up the question, and at the end of the day, that is our direction as far as from access and providing those services. And one of the Commissioner's comments -- I believe it was Jami -- made earlier, where kids are in providing that access. But I do think you bring up a good point of the lane we need to stay in as we have these conversations.

All right. With that, John?

COMMISSIONER McCARTHY: I was kind of going back to what Heidi had said earlier and then what Patti had said. I was trying to think of this from the bigger picture of, how do we integrate all these systems to make it work better? I was more in line with what Heidi was saying of if you're going to have mental health providers, most likely the school is picking one that would most likely meet Medicaid requirements. And so why do we have

like extra steps in there?

And so thinking of it over as a system, which then got to where Patti was going, is a big part of this is really just about funding, and if you look at a number of states the way school-based services work is that the schools use certified public expenditures. And so they're getting their costs covered for the services that they provide, which has a different impact than when you bill Medicaid and if the state is putting up the state match, the rate that is being paid may not cover the cost of that person when they're in school. So there's this conflict that happens around this, and that's sometimes why you have schools not engaging in this because they actually would get less money if they would do it.

So I was trying to think of it not just in what we were -- what Melinda and Audrey had put up as policy options, but also thinking of how do we think about streamlining some of this and think of it a little bit in the bigger picture. And in some ways, it's the same conversations that we've had about things that MACPAC has had around social determinants of health or other areas, which are, how do you get things to line up across these

different programs?

So I think one of the things we do need to think about -- I would like to see us to continue to do some work in this, but it is looking at what are those different funding policy options to look at, back to the payment side of things, and how we pay for these services?

VICE CHAIR DUNCAN: Thank you, John.

Sonja.

COMMISSIONER BJORK: Thank you.

I'm very excited about this body of work because I think it will provide more opportunities for access in that it's another funding stream to support the providers who are already at the schools and that they can provide individual therapy, group therapy, some of the Medi-Cal covered, specific types of services for kids where they are. If you are going to bill the Medicaid program or Medicare, you have to enroll. You have to go by the rules of that program. So I don't really want to go down the path of arguing that the licensed clinical social worker or whoever's at the school providing services should be exempt somehow. I would rather look at how can we support them in getting through the enrollment process, which is it's not

that hard to get enrolled. But if you want to get paid by a program, you have to go by the program rules. Otherwise we're back to grants, or we're back to other types of funding. And what we're trying to look at here, which is very complicated, how to not get crossways with all the different funding sources, and this is just one path through this thicket of different options.

And so I would like to look at ways to support schools in getting their staff enrolled in Medicaid so that they can get paid.

CHAIR BELLA: Can I clarify one thing for us all, just to make sure, like just a quick sort of level check? These are not -- this is not -- these three areas are not moving toward recommendations this year. This is we are doing an issue brief. We are bringing -- putting the issue out for attention. We can talk about all the different things that you would have to look at. We can come back to the point about access, and we all agree access to behavioral health for young kids, middle-aged kids, adolescent kids, everybody is a challenge, right?

So if we want to then go deeper on these three areas and perhaps bring them back at some point for

recommendations, that's the signal we need to be giving today.

So we're doing an issue brief, regardless. We're going to talk about access, regardless, and we're going to talk about potential roles schools could play.

The question is, do we want to do more? We also don't have to have a completely figured-out answer to that today. I felt like people were starting to get a little nervous that we're sort of moving ahead perhaps quickly, and we're not. So just in case that helps anyone.

COMMISSIONER BJORK: I also want to say I think there are utilization statistics that we're going to be able to look at. Like at our health plan, we look at how many children are utilizing mental health services, and it's low, the utilization. It's not okay. There needs to be a lot more children accessing services, and so that's why I'm so excited about this possible pathway. There are not enough providers. Most have switched to telehealth, which is fine. It's a great -- it's another access pathway. But this possibility of going school-based is really exciting, I think, as well.

VICE CHAIR DUNCAN: Thank you, Sonja, and thank

you, Madam Chairwoman, for letting us know where we are in the path on this journey.

Heidi, you had your hand raised?

COMMISSIONER ALLEN: I was just going to signal that I did see in the materials that there had been a decision that people with education -- that some of the requirements for clinical practice were being waived in educational sense because there's -- there are rules about like supervision and what a case is.

Like when I worked in a hospital, I couldn't become a licensed social worker because I didn't see the same people on a weekly basis and have an ending, a therapeutic plan, and then a conclusion. So even though I was doing therapy, like crisis work all day long, it wouldn't qualify for licensure, and I wouldn't be able to enroll as a practitioner. So like there's some of those kinds of things that could end up becoming real significant problems, depending on how states determine what a licensed practitioner is.

And then I guess I would want to understand better how that federal ruling fits into this conversation. Do you have to have the same -- is there a way to become a

Medicaid provider, as an educational Medicaid provider, and have it look different than it would in what -- you know, who you see and how you see them and what you do?

But I get -- your point is taken that it isn't meant to make them better at school. This is meant to address their mental health process, and that those are very distinct roles.

VICE CHAIR DUNCAN: Thank you.

Jami?

COMMISSIONER SNYDER: Yeah. I just wanted to reiterate the importance of this topic of holding clinicians in this setting to standards that are set forth by Medicaid programs because it's a topic that's under discussion across the delivery system, right? Now that we think about -- think more about providing services in correctional settings and reimbursing for those services, this conversation is happening around whether we should hold correctional settings to the same standard that we hold other providers in the Medicaid program to.

It's also occurring on a daily basis for those states that have received 1115 approvals to reimburse for social services like housing and nutritional supports and

whether community-based organizations, in fact, should be held to the same standard from an enrollment, from a contracting, a billing perspective.

And so I just want to make sure as we have this conversation that we're kind of stepping back and thinking about how this might play out in other arenas, like arenas, because I think where we land will be important and will lay the groundwork for some of the discussion that is happening in other areas.

VICE CHAIR DUNCAN: Thank you, Jami.

Rhonda?

COMMISSIONER MEDOWS: My last question of the day, I promise.

Team, do you actually have statistics on the percentage of children who are receiving school-based programs who are on Medicaid and vice versa?

MS. BECKER ROACH: We don't have national data. That's something we can think a little bit more about.

COMMISSIONER MEDOWS: National or some of the school districts that were in your stakeholder report, what percentage of the students who receive a school-based program are actually enrolled in Medicaid already?

MS. BECKER ROACH: We got some state-level information about utilization of specific services, but nothing that I have offhand that we have on hand at the moment. We'd be happy to follow up with what we do have.

COMMISSIONER MEDOWS: That would be great. Thank you.

VICE CHAIR DUNCAN: Any other questions or comments?

[No response.]

VICE CHAIR DUNCAN: Well, Audrey and Melinda, if you can't tell the excitement, the passion about this, you're missing something. I think a lot was said. To Madam Chairwoman's comments, I think there's a lot of avenues we can take with this over time and look at, but do you have the information you need to move forward?

MS. BECKER ROACH: I think we do. I appreciate all the questions and the input, and we look forward to coming back to you in the future.

VICE CHAIR DUNCAN: Okay. And I would make one recommendation to check in the state of Wisconsin. I know when I left there, they were providing mental and behavioral services in schools, and I think they were also

providing it during the summer breaks. And then I defer to my fellow Commissioner from Tennessee. It's been 14 years since I've been in the great state of Tennessee, but I know that at the time I was there, there were some programs taking place in the schools too. And I don't know if there's any success stories from there to learn from.

COMMISSIONER KILLINGSWORTH: I think it's worth exploring. Thank you.

VICE CHAIR DUNCAN: Thank you. Thank you for the great work, and we look forward to more discussions around this. Now, Madam Chairwoman, if you have nothing else, we'll go to public comment.

CHAIR BELLA: Actually, if you would stay there for just one second. The only area -- and not to undercut -- that I'm not clear on, on where the Commission is, is on TPL. It was clear to me that there was interest on the first two that were up here -- or at least on the second part, the provider enrollment. Are we asking for going deeper on TPL? Can I just see some nods, one way or another? Yes. I might be the only one that didn't have those nods solidified, so that's great.

Okay. Are you both clear on the rest, then?

[No response.]

CHAIR BELLA: Okay, great. Thank you.

We'll open it up for public comment. If you would like to make a comment on any of the afternoon sessions, actually any of the sessions at all today, please use your hand icon, introduce yourself and the organization you represent. And as a broken record, I will say we ask you to keep your comments to three minutes or less.

You two are welcome to stay up there, or you can skate off, whatever you prefer.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Well, we have no one appearing to want to make a comment.

So I will just say, is there anything else from Commissioners on any part of the day today?

[No response.]

CHAIR BELLA: Kate, any announcements from you?

EXECUTIVE DIRECTOR MASSEY: No.

CHAIR BELLA: All right. Well, Day 1 is a wrap. We will start tomorrow morning at 9:30 with our session on home- and community-based services. Actually, we have a

couple on HCBS, and then we finished with duals. So thank you all, and we will see you tomorrow morning. We're adjourned.

* [Whereupon, at 4:01 p.m., the meeting recessed, to reconvene at 9:30 a.m., Friday, November 3, 2023.]

PUBLIC SESSION

National Union Building
918 F Street, NW
Washington, D.C. 20004

Friday, November 3, 2022
9:30 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, 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

[9:30 a.m.]

CHAIR BELLA: Good morning. Welcome to Day 2 of MACPAC. We are jokingly calling this "LTSS and Duals Day." So we're thrilled for that.

Welcome, Tamara and Asmaa. We will let you kick us off.

MEDICAID HOME- AND COMMUNITY-BASED SERVICES (HCBS): COMPARING REQUIREMENTS FOR STATES

* MS. HUSON: Great. Thank you. So good morning, Commissioners. Asmaa and I are here today to provide some background on Medicaid HCBS Section 1915 authorities and to share findings from interviews that probed on the administrative complexity for states associated with managing the various requirements for each of these authorities.

So as you recall, in our June 2023 report to Congress, the Commission outlined a Medicaid HCBS access monitoring framework with four key domains of access, as seen here on the slide.

The fourth domain of administrative complexity is the focus of today's presentation, and in some interviews

that were conducted last year, which are summarized in that June 2023 chapter, that work indicated that administrative complexity might be a challenge for states because of the time and resources necessary to meet federal requirements. And the fact that federal requirements vary across authorities adds additional complexity for states trying to administer their HCBS programs.

And so we've done some additional work to explore this complexity associated with managing requirements, and we also looked for areas to potentially streamline requirements to make it easier for states, which I'll describe in just a moment.

But first, to give a little bit of background on these HCBS authorities and what states consider in selecting them.

So states may offer HCBS via an amendment to their state plan or through a waiver. Our work focused on the four Section 1915 authorities that are listed on the slide, but states do have some other options. They can offer personal care services as an optional state plan benefit under Section 1905(a)(24), and they can also use Section 1115 demonstrations. However, I'll note that those

authorities were outside the scope of this project.

To go over these four authorities, Section 1915(i) allows states to offer HCBS using state plan authority to people who need less than an institutional level of care, which is the typical standard for Medicaid coverage of HCBS. And individuals must be eligible for Medicaid under the state plan with income -- [audio break].

[Internet disruption.]

VICE CHAIR DUNCAN: Yeah. You were doing a fantastic job, so well that it blew up the internet.

[Pause.]

CHAIR BELLA: Okay. Sorry about that, everyone. We had some magic happen with the building's internet.

So we will continue, Tamara, with where you left off. Thank you.

MS. HUSON: Okay, great.

So I think we left off talking about some of the different flexibilities. So the first one is statewide-ness. So states can waive statewideness in Sections 1915(c) and (j), which allows states to target authorities to certain areas of the state where there is need or where certain types of providers are available.

Next, using Section 1915(c), (i), and (j) authorities, states can waive comparability of services, which permits them to make HCBS available only to certain groups of people who are at risk of institutionalization, such as older adults or adults with intellectual or developmental disabilities.

And finally, Sections 1915(c), (i), and (k) allow states to waive community income rules for medically needy populations. And waiving the community income rules allow states to provide HCBS to people who would otherwise be eligible only in an institutional setting, often because of a spouse or parent's income and resources.

And additionally, states may consider other flexibilities when developing their HCBS systems. For example, Section 1915(c) waivers allow states to create waiting lists and limit the number of people who can enroll in the waiver as well as set limits on the amount that can be spent on each enrollee, and such flexibilities can help states better predict and manage costs.

States also consider a number of other factors when designing their HCBS programs, including state resources and capacity, the needs of different HCBS

populations, state policy goals, legislative direction, and lawsuits.

Just to give one example, the initial financial investment that's required to implement a new authority as well as the ongoing costs is an important consideration, and we also heard about challenges related to state staffing capacity to operate these programs, such as the high administrative burden associated with applications, renewals, and amendments for Section 1915(c) waivers.

Okay. So MACPAC contracted with Mathematica to explore the complexity of managing the administrative requirements of each of the Section 1915 authorities and potential ways to simplify them to make it easier for states to offer services.

So we started by reviewing the HCBS Authority Comparison Chart, which is a chart that was developed by CMS and a contractor that outlines the requirements and flexibilities of federal Medicaid HCBS authorities, and we used that chart to identify requirements that are administrative in nature and then grouped those into the five categories that you can see on the slide and that we use throughout this presentation.

So Mathematica developed for us a background report, comparing these five categories of requirements by Medicaid HCBS authority, in which they reviewed federal statute, regulations, sub-regulatory guidance, and other CMS resources.

Then they also conducted 17 interviews with both state and federal officials as well as policy experts.

And now I will turn it over to Asmaa to walk through the requirements and the findings from our interviews.

* MS. ALBAROUDI: Thanks, Tamara, and good morning, Commissioners. I will spend the rest of our time discussing the results of our qualitative analysis.

Interviewees provided feedback and identified opportunities to streamline or address challenges associated with each of the five administrative requirement categories Tamara discussed. For each category, I'll explain the requirement and the feedback we heard.

Reporting, monitoring, and quality improvement requirements vary across the four authorities. All the authorities have annual reporting requirements, but the reporting elements and guidance available differ

considerably.

Section 1915(c) waiver reporting requirements are the most prescriptive. States must complete annual CMS-372 reports, submit cost, utilization, and performance measurement data for each waiver they administer. CMS makes available a detailed technical guide to support waiver administration. For Sections 1915(i) and (j), annual reporting elements are defined in statute. Section 1915(i) requires reporting of the estimated number of enrollees to be enrolled and the count of enrollees from the prior year. Reporting elements for Section 1915(j) include the number of individuals served and total aggregated expenditures.

However, one factor that complicates reporting for both authorities is the absence of a technical guide. Section 1915(k) annual reporting requires data on utilization, expenditures, and quality. While a Section 1915(k) technical guide exists, it lacks detail and does not specify a format or method for reporting data.

Both Sections 1915(c) and (i) authorities require states to comply with an evidence-based review process, also referred to as evidentiary reports, prior to renewal.

As part of this process, states submit evidence demonstrating compliance with federal requirements, and CMS completes a findings report.

All HCBS authorities require states to implement quality assurance and improvement systems. Generally, states engage in similar quality improvement processes when operating Sections 1915(c), (i), and (k), but each authority also has different requirements. Section 1915(c) requires states to demonstrate that performance measures used to measure compliance with assurances and sub-assurances meet or exceed a threshold of 86 percent in their CMS-372 reports.

For Sections 1915(i), (j), and (k) authorities, CMS has made limited information available publicly on what states should measure and report on quality.

Interviewees described more challenges than benefits associated with meeting reporting and monitoring requirements. However, several state officials shared that they use the data required by CMS for their own quality improvement purposes.

When quality requirements were raised, many interviewees referenced the CMS Notice of Proposed

Rulemaking on ensuring access to Medicaid services. They said the rule, if finalized, would mandate states' use of the CMS HCBS quality measures set across HCBS authorities.

The remaining feedback was mostly centered around two challenges. First, state officials shared that they experienced challenges with report templates in CMS's Waiver Management System, or WMS, the system states use to submit annual CMS-372 reports, renewals, and amendments. Interviewees also noted challenges they have with the format of required evidentiary reports.

Second, we found that CMS guidance on Section 1915(k) annual reporting requirements is less detailed than that for Section 1915(c). When states express interest in Section 1915(k), interviewees said that CMS provides one-on-one technical assistance on the data elements that must be reported. While states noted the value of technical assistance from CMS, they said that clearer direction from CMS would create efficiencies and help states avoid having to follow up.

Separately, a policy expert we spoke with recommended that CMS develop technical guides for Section 1915(i) and Section 1915(j). Both federal and state

officials noted that the Section 1915(c) technical guide is intended as a reference for Section 1915(i). However, reporting and monitoring requirements differ between the authorities, and states may struggle to identify which ones apply to Section 1915(i) programs.

Both federal and state officials shared similar sentiments that the absence of a technical guide creates uncertainty about compliance with reporting and monitoring requirements.

Requirements for states differ by type of 1915 authority for purposes of applying for, renewing, and amending a waiver or state plan. Differences by authority exist in application length, submission process, time to complete, and the availability of a technical guide.

HCBS authorities also differ in their approval periods and renewal requirements. Section 1915(c) waivers have an initial approval period of three years or five years if the waiver serves individuals dually eligible for Medicaid and Medicare, after which they must be renewed every five years.

Section 1915(i) has a one-time approval after which the program can continue indefinitely unless the

state chooses to restrict eligibility for services to specific populations, in which case, there is a five-year renewal schedule.

Sections 1915(j) and (k) have one-time approvals and do not require renewal.

For both waivers and state plan options, states can submit changes to CMS via the amendment process.

Several interviewees described the Section 1915(c) waiver application and renewal processes as labor intensive, consuming resources that could otherwise be allocated to quality improvement. For example, states shared how renewals can involve months of back-and-forth communication with CMS, which can be burdensome and can create uncertainty about approval timelines.

Another area raised by interviewees was the renewal process for Section 1915(c) waivers. Some states questioned the need for a renewal process. One state described renewals as duplicative of the waiver amendment process. Currently, CMS has the opportunity to review anything in the waiver application during the amendment process, giving CMS the ability to gather the data and information about the service delivery system. Other

states suggested changes to renewal frequency, such as more frequent updates to their waivers; for example, every two years, rather than a comprehensive renewal application review every five years. Another suggested that for established programs, the renewal period should be longer, perhaps ten years rather than five.

Finally, and similar to the previous administrative requirement discussed, several states reported that the WMS is not user friendly because, for example, it doesn't allow for submission of a waiver amendment while a renewal is pending.

All Section 1915 HCBS authorities must comply with federal regulations requiring states to issue a public notice of proposed changes in the methods and standards for setting Medicaid payment rates. Each authority also has specific public notice requirements with the exception of Section 1915(j). The Section 1915(c) authority requires that states establish and use a public comment process for new waivers or for amendments.

To comply with the public notice requirements, states must share the entire waiver with the public, have at least two statements of public notice and public

comment, with one being web-based and the other being non-electronic, and establish a public notice and comment period of 30 days to be completed prior to the submission of the waiver to CMS.

Section 1915(i) requires states to provide a minimum of 60 days' notice before modifying the needs-based criteria for the state plan option, and Section 1915(k) requires states to consult and collaborate with the development and implementation council established by the state, which must include a majority of members with disabilities, older adults, and their representatives.

States and policy experts largely valued public input requirements and cited them as critical to enhancing transparency. They also shared the benefits of stakeholder feedback on changes being made to waivers or state plan amendments. Interviewees had mixed feedback regarding the Section 1915(k) Development and Implementation Council. States discussed the benefits of the council in providing feedback and standing up new programs. In contrast, policy experts explained that some states delayed or chose not to implement a Section 1915(k) because of the requirement to establish a council.

Separately, several interviewees shared challenges related to delays caused by the timing of public input requirements, specifically that the process can lengthen the timeline for implementation of waiver renewals and amendments.

Okay. I'll just continue. So we're on the cost neutrality section. For the cost neutrality requirement, the average per-person cost for waiver services should not be greater than the average per-person cost of the institutional services that the waiver services are standing in for. The goal of the requirement is to ensure programmatic efficiency.

Section 1915(c) waivers are the only HCBS authority which must comply with cost neutrality. States use their annual CMS-372 report submission to demonstrate that they are in compliance.

State officials generally noted that they had no difficulties meeting cost neutrality for their waivers. A number of interviewees shared that states do not encounter challenges meeting the requirements because institutional costs are generally higher than waiver services. However, we heard about challenges demonstrating cost neutrality for

certain populations. For example, states with no intermediate care facilities (ICF) had trouble meeting cost neutrality requirements for beneficiaries with intellectual and developmental disabilities. Ultimately, the solution was to use ICF costs from another state to prove cost neutrality.

A conflict of interest may occur when the same individual or entity provides a service and helps beneficiaries access that service. Each Section 1915 authority has requirements in place to ensure conflict-free case management services.

Section 1915(j) mandates that when a provider is also involved in developing a person-centered service plan, or PCSP, the state must describe the safeguards in place to ensure that the provider's role is disclosed to the individual or their representative, and that controls are in place to prevent a conflict of interest.

Section 1915(c) mandates that HCBS providers or those who have an interest in or are employed by an HCBS provider cannot also provide case management or develop the PCSP.

For Sections 1915(i) and 1915(k), those who

conduct eligibility determinations, level-of-care assessments, and develop PCSPs cannot be related or financially responsible to the individual or have a financial interest in any entity paid to provide care. There are certain exceptions to these requirements when there is only one entity available in a geographic region to provide case management and HCBS. Then a state must put in place conflict-of-interest protections to allow for such services to be provided.

Interviewees recognized the importance of conflict-of-interest requirements to ensure that HCBS programs operate with integrity. While states did not describe these requirements as burdensome, a few interviewees indicated instances in which they can be difficult to adhere to.

First, in some rural and tribal communities where provider availability is limited, conflict-of-interest requirements can further limit provider options for beneficiaries, and it is more likely that case management entities are also service providers.

The second challenge was around managed care organizations, or MCOs. Conflict-of-interest requirements

do not apply to MCOs that don't provide direct care or contract out services. However, some interviewees said that CMS guidance is not clear on expectations for MCOs that provide case management services. One expert shared that several states have indicated a significant level of questions from CMS.

Our findings indicate that the complexity of federal administrative requirements can cost states to dedicate a significant share of their time and resources to meeting these requirements, potentially reducing their capacity to focus on other program areas. Identifying opportunities to simplify requirements for Section 1915(c) waivers and state plan options could help decrease state burden. For instance, some state officials and policy experts shared suggestions to address administrative complexity across HCBS authorities, including but not limited to development of technical guides to alleviate ambiguity, establishing operational efficiencies, and modifying the renewal process.

In response to the feedback we heard, most of which is from the states' perspectives, we will circle back with CMS to place the state input into context relative to

CMS's policy goals and compliance obligations.

We welcome Commissioner feedback on areas of interest, which we can explore further as we begin thinking about policy options. Based on your feedback, our plan is to return in January with specific policy options for your consideration.

Thank you for your time today. I'll turn it back to the chair.

CHAIR BELLA: Thank you very much.

I saw some people's eyes pop out when you had the chart with 160 hours for a (c) and 114 hours for (i) -- saw your eyes, yes.

All right. Thank you. This is really interesting and really a good foundation for the work we're going to be doing in this area. Let me open it up to Commissioners for comments.

Patti.

COMMISSIONER KILLINGSWORTH: I think I have put in those 160 on many, many occasions, maybe more than that.

Tamara, Asmaa, thank you so much. That's an excellent job of summarizing what is a very, very complex topic and pointing out really the significant

administrative burden that states really encounter in administering these programs as well as the variation and requirements across the different authorities.

I did note that 1115 waivers were considered to be out of scope, and I think that's disappointing because there are many states and I think an increasing number of states that are relying solely on that authority for their HCBS programs.

When we talk about time frames, we had waiver amendments pending when I left in 2020 that continue to be pended today in 2023 and still not approved under 1115 authority. There's no time frame for approval.

So I do think that any efforts to streamline processes and reduce administrative burden should take all authorities into account, including 1115 waivers, to ensure that beneficiaries in 1115 waiver states aren't excluded from those improvements. That could reduce administrative burden and improve their access in those states.

In terms of burden, maybe not specifically called out in the memo, I would add critical incident reporting and management systems, which are another significant area of interest. They're very important. We see the

requirements continually becoming more and more prescriptive in that regard, I think largely as a result of an OIG report a few years back. And I would be sure that we call out amendments as well as applications and renewals.

Just quickly on the NPRM for ensuring access to Medicaid services, it does propose to begin to align some of the requirements across HCBS authorities, including 1915 and 1115, except where noted, but it does that by aligning with more requirements that are uniformly applied across all authorities, rather than seeking to streamline or reduce administrative burden in any of those areas. And so there will be new requirements in person-centered planning and in grievance systems and in incident management systems.

We've all heard a lot about payment adequacy and transparency and the infamous 80/20 requirement, which will add significant burden for both states and providers, the quality measure set, which you mentioned, access, reporting standardization of HCBS reporting requirements, and my fear is always that we standardize to more and not to less.

And I think part of what's frustrating for states is that after more than 40 years of operating these

waivers, certainly we've identified aspects of administering them that could be simplified and streamlined. And one was called out in your presentation around cost neutrality. I think it would be interesting to note how many times in 40-plus years of these waivers, a state has actually exceeded cost neutrality in a waiver. I would bet we could count them on a hand, maybe two at most, or maybe there's none. But I think it would make sense in that regard to take all of that learning and to begin to require states to monitor cost neutrality and to file these complex reports when there's a problem rather than every state reporting on every waiver every year for a problem that is largely nonexistent since institutional benefits are so much more expensive. And I think there's many more examples that I suspect you've heard or will hear about as this work continues.

So I look really forward to seeing your policy options in January and just appreciate your work. Thank you.

CHAIR BELLA: Thank you, Patti.

John and then Jami.

COMMISSIONER McCARTHY: This has got to be one of

my favorite topics because of my long time of being Medicaid director and fighting with CMS on some of these, and it's not their fault. It's more of the legislation itself.

And just going back to some of the things that Patti said and looking at what we need to look at, all these requirements are in place for the services we want people to get. But for institutional services, there is nothing like this in place. They have one review a year by a state assessor, and that's about it.

So adding more and more requirements just makes it harder. So I love the fact that we're looking at where can we streamline some of these.

And I would also argue, do we need it? We don't have these same requirements for physician services. I'm going outside of institutional, but physician, hospital, chiropractor, these are special. Now, I know why we need regulation to look at things, but I do really want to press on that one.

And the second goes back to what Patti was saying, and I wanted to clarify, because I wanted us to check, because I know you said for the budget neutrality,

it's average costs. But I believe you still can do per-person costs too, that you have that option as a state.

So, Patti, that is where sometimes some states have taken that option, and you do run up against that, not that you violate it, but it can be a limitation on services. But I would like us to look at who cares on that. And what would be the impact if we change some of those things of looking at that cap? And is it in the bigger -- we could save some money on it.

CHAIR BELLA: Patti and then Jami.

COMMISSIONER KILLINGSWORTH: Just a quick follow-up to that. John, so in the statute, I believe the statutory requirement for cost neutrality is to do cost neutrality in the aggregate, and in policy, it's allowed to be applied at the individual level. But you could still meet statutory cost neutrality in the aggregate, even if you've elected to apply in your waiver at a per-person level.

COMMISSIONER McCARTHY: Mine was just get rid of cost neutrality completely. I guess, what is the purpose of it that we're saying, and is it helping us?

CHAIR BELLA: Thank you both.

Jami?

COMMISSIONER SNYDER: I really appreciate, Patti, your comments about incorporating 1115 waivers in the scope when the 1115 authority is used to support states' HCBS programs.

As you talk with CMS and discuss the findings from your interviews, I would just really encourage you also to obtain some perspective from CMS on using the 1115 to support a state's HCBS work, because I think there's been some discussion in recent years at CMS around whether that's the appropriate authority, and we'd just love to hear more about their perspective on that.

CHAIR BELLA: Tim?

COMMISSIONER HILL: This is terrific work, and it's good to have the framing. I echo John and Patti's notion about the complexity here. And given my résumé, I'm probably the last person to make the comment I'm about to make, which is I would encourage you, as you talk to CMS -- I feel like sometimes we do reporting as a proxy. If we're reporting a lot, we're getting a lot of data, we must be doing something. But I do think it would be important to push and try and understand from them what is being used,

how is all the reporting that is coming in from states and the compliance, beyond just did they submit it or not, but how is it being used to either drive policy or to make changes, because I sometimes worry even when I was at -- we got to have something to know that there's compliance. But I think at some level, we need to push for a different kind of gestalt. We're building a system to protect people for a 40-year-old fear that somehow getting people out of institutions is going to make them worse off than they otherwise would have. I think we all can now believe that it's just great that people are in the community, and so why do we still have these, these systems set up to protect people when, in fact, maybe that's not as important -- not important, but the issue isn't what we thought it was 40 years ago.

CHAIR BELLA: Thank you, Tim.

Dennis?

COMMISSIONER HEAPHY: I am going to raise the issue of waiting lists and the documentation for that. Is there basic standards, requirements across states in terms of a justification for the waiting list, or is it by state and how the state determines whether or not waiting lists

are needed?

MS. HUSON: So states can use waiting lists, as you know, for Section 1915(c) waivers, and there is some guidance in the technical guide for the Section 1915(c)s about how they can manage those waiting lists.

I will also note that the access NPRM is making some changes to waiting list management to improve the transparency of how states are managing their waiting lists.

I will also refer back to some prior MACPAC work from 2020 on waiting lists where we did a 50-state compendium documenting how many states have waiting lists as well as how they manage those waiting lists, and we categorized them by first come, first served or priority and kind of went through the different approaches that states take and some of their justification for why they may or may not have waiting lists.

But I think that we'll also see some changes as a result of the NPRM, and it's something that MACPAC is tracking, and maybe we can come back to once that's finalized.

COMMISSIONER HEAPHY: I'm just wondering if we

don't have an obligation to press for reduction in waiting lists, and I don't know what -- how to do that, what information you need for us to be able to justify that. But it seems that's an obligation we have. It's to reduce waiting lists across states. And then this is going to raise a bigger topic, and that's so much of the requirements are diagnosis based towards ID/DD populations, but the needs of folks with schizophrenia and other diagnoses, might be equal to those needs of folks who are ID/DD, but they're not eligible for services because the diagnosis is different. And so how do we better understand the unmet needs of populations who have equal need or perhaps greater need than folks in the ID/DD population, but they don't have access to those services because they're not diagnosed with ID/DD?

MS. ALBAROUDI: Yeah. So that's an excellent question, and I think that's something that we can explore in future work, sort of what populations aren't able to receive services through HCBS currently and what are the eligibility challenges there. Thank you.

CHAIR BELLA: I can't see this side of the room. There's a glare. I'm assuming there's no hands.

All right. Clearly, there is a great deal of interest in this. Having been inside CMS, CMS folks don't go to work every day trying to make things complicated, even though sometimes they put out rules, Patti, that might be complicated.

I am happy that we are going to be able to sit down and talk to them. I'm sure they have ideas on what they would do differently, but the underwriting theme that John and Tim and Patti have started about why, why do we still collect this, what do we do with it, like do we even know everything that -- does CMS even realize -- like do all parts of CMS even understand all the different things they're getting and understand how they might use it to drive the goals? I think those are really important questions.

John?

COMMISSIONER McCARTHY: And back to that, I want to make it clear, even with my comments. When I was Medicaid director here in D.C., CMS was going to terminate our 1915(c) waiver because of issues we had, and there were issues. And so that was a good process to make us fix it. It needed to be fixed and work through those things.

And some of this, though, just the question is we do it for this service. We don't do it for other services. So how do we fix that? How do we identify things with the data that they're getting? How do I identify things where there are problems with CMS, and then what do you do to fix those things? The problem, of course, that CMS is in, even for D.C., if they were to terminate our waiver, we were just going to institutionalize everyone. And everyone was saying that wasn't a great fix either.

So we need to, I think, a part of it in talking to CMS too, is find out from their view, what is their balance on some of these different pieces? It does go back to a conversation that has been had, which is why is institutionalization a mandatory service and not an optional service, and if you change that, would you have a better playing field on this one?

CHAIR BELLA: Yeah. I mean, I think much of the work that MACPAC is doing is trying to level the playing field and trying to allow, facilitate, encourage access to services at home or in the community when people want them.

Yeah, Dennis.

COMMISSIONER HEAPHY: I'm wondering, is there

opportunity to benefit from talking to beneficiaries as well who are under different waivers, see what their experiences are like and how they differ? Again, I'm specifically thinking again of folks who are on waiting lists and what the impact is on them versus folks who are in other states that provide more services. I think we need a snapshot of beneficiary experience across different waiver types. That might be interesting.

MS. ALBAROUDI: Yeah, I appreciate that comment and considering the beneficiary perspective. I think maybe as we think through the policy options, if it makes sense to reach out to beneficiary advocacy groups or beneficiaries themselves, we can definitely consider that and see what makes sense for different policy options.

COMMISSIONER HEAPHY: Thanks.

MS. ALBAROUDI: Thank you.

CHAIR BELLA: It's really exciting kind of revisiting this. Requirements sort of just get stuck on, and they grow over time, and people sort of don't look at them. And so we're revisiting that, taking another look at that.

I would just encourage us to be very concrete

about what we would need Congress to change and what CMS has the ability to change and thinking toward being able to make practical, implementable, actionable recommendations that are actually going to make a difference and knowing where we need to make those is going to be really helpful as we take this work forward.

Do you both have what you need?

MS. ALBAROUDI: Yes, I think so. Thank you. Yes, yes.

CHAIR BELLA: All right. Any last comments from Commissioners before we move into -- Asmaa, you're staying with us, right? Okay.

Tamara, thank you.

All right. So we're going to roll into payment policies, and Rob is going to join us.

This is like many of our dreams about a day with all of these sessions back to back to back.

So welcome. We'll turn it back to the two of you.

MEDICAID PAYMENT POLICIES TO SUPPORT THE HOME- AND COMMUNITY-BASED SERVICES WORKFORCE

* MR. NELB: Great. Thanks so much.

So we're going to continue our discussion of HCBS this morning by talking about using Medicaid payment policies to help support the HCBS workforce.

I'll begin with some background about the HCBS workforce and the frameworks that we're using to approach this work, and then I'll review some initial findings from our review of state policies and interviews with national experts on some of the topics listed here.

In the next phase of our work, we're planning to interview state officials and other stakeholders to learn more about these issues in more detail, and so for today's meeting, we're really hoping to get your feedback on our initial findings to help us know where to focus our future efforts.

As we just discussed, the Commission outlined a four-point access framework in its June report last year, and this session is focusing on that first piece, ensuring availability of providers to serve beneficiaries.

By the HCBS workforce, we're referring to a variety of professionals that help assist individuals with their long-term care needs. These include direct care workers employed by HCBS agencies who help assist with

activities of daily living, direct support professionals also employed by agencies who assist individuals with intellectual disabilities or developmental disabilities, and finally independent providers who are employed by beneficiaries themselves through self-direction options.

According to PHI, in 2022, there were approximately 3.5 million HCBS workers. Most of these provided care at home, and about 40 percent of them were employed through self-direction. In addition, there's a number of individuals who provide care in group homes, assisted living, and other residential care settings.

As the Commission has talked about previously, there's several -- many states are facing HCBS workforce challenges as the demand for HCBS outpaces the growth in the HCBS workforce.

COVID-19 has exacerbated these challenges, and according to a recent survey by the Kaiser Family Foundation, nearly all states have reported shortages in one or more HCBS settings.

Since Medicaid is the primary payer for most HCBS, we are looking at how Medicaid payment policy can be used to help address some of these challenges. And to do

so, our work is guided by MACPAC's Provider Payment Framework, which aims to look at the statutory goals of Medicaid payment policy and how they relate to one another.

Economy on the left is defined as a measure of what is spent on provider payments, and access and quality on the right is defined as outcomes related to payment. Efficiency in the middle is a measure that compares what is spent to what is received. And so to improve efficiency, states can change their payment methods or implement other policies to try to get more value for what they're spending.

You may recall we used a similar framework in the past for our work looking at the role of Medicaid payments to help support nursing facilities. As you may recall, we found wide variation in nursing facility payment rates that didn't always relate to staffing rates, suggesting potential opportunities to improve efficiency by changing payment methods.

We cataloged a variety of payment methods there but didn't have enough information to evaluate which was more effective than others, and so the Commission earlier this year ultimately recommended more transparency in state

nursing facility payment policies to help support these types of evaluations in the future.

Okay. So as a first step in our work, we've been contracting with Milliman to review state payment policies described in 1915(c) waivers and also interview national experts from eight organizations, including CMS.

In the next phase of our project, we'll be interviewing state officials, provider associations, consumer advocates, and managed care plans in five states.

And so now let me walk through some of our initial findings. First, in understanding what we're talking about when we say HCBS payment rates, we focused on three core services that are covered by all states that account for the vast majority of HCBS spending: home-based services, day services, and around-the-clock care.

So off the bat, one of the main challenges in comparing payment rates across states is that every state defines these services a bit differently. And so, for example, in our review of the 1915(c) waivers, we actually found 253 unique state-defined services that fell into these three categories.

Despite this variation, there are some common

features that go into HCBS rate development. HCBS worker wages and benefits on the left here are the biggest component of the rate and obviously are a key area of focus when we think about using Medicaid payment policy to help support the workforce.

However, the experts we spoke to also highlighted other components that go into the rate, such as assumptions about HCBS worker time; for example, like a staffing ratio you might have in a group home.

In addition, there are other service-specific costs, such as costs of transportation to see someone at their home or costs -- activity space at a day center, and then administration program support and overhead, which does include costs for overseeing the quality of care in the setting. And all this adds together to get to this HCBS payment rate.

So looking more specifically at how these different components get developed, we found in our review of the 1915(c) waivers that most states use data from the Bureau of Labor Statistics as a starting point for developing that HCBS wage assumption. However, the experts we spoke to noted several challenges with this data source.

First, BLS doesn't include a specific category for direct support professionals or other HCBS workers, and so it's hard to find a good benchmark that's reflective of the skills and demands of this work.

Second, even if you did have a good benchmark, folks noted that cataloging current wages may not necessarily reflect the level that would be needed to ensure sufficient access.

And finally, it noted that in many states with all these different HCBS authorities, there are sometimes different wage assumptions used for different waivers or programs which creates additional challenges as workers may want to switch from one waiver to another that might pay a little better.

To develop many of the wage and nonwage assumptions that go into the rates, many states conduct formal rate studies. These typically involve an outside contractor who might collect data on HCBS provider costs, using things like a provider survey, and they also engage with stakeholders to get input about the various rate assumptions.

The experts we spoke with noted the value of

these studies in helping to provide a benchmark to understand the cost of services and funding needs. However, the publicly available information on these rate studies is relatively limited. Not only are they difficult to find, but when they were available, the publicly available documentation we found often didn't provide a lot of specifics on the details that go into the rate assumptions in a format that's comparable across states. For example, it's hard to look at those and get a sense of what are the different wage assumptions that states are using or how does the wage compare as a share of the entire rate.

Another challenge we heard about during the interviews is that state budget constraints limit state's ability to fund rates at a level that may be recommended by a rate study. The stakeholders we spoke with noted how the variabilities in the state legislative process can create uncertainty for providers about available HCBS funding and whether there will be certain payment rate increases.

To help address some of these challenges, Congress recently increased federal funding for HCBS through the American Rescue Plan Act, known as ARPA, and

all states have chosen to use at least some of this increased funding to increase HCBS rates.

States currently have until March 2025 to spend their ARPA funding, and after it expires, states will need to provide additional state funding in order to sustain any rate increases.

According to a recent study by NASHP, at least 22 states do have some plan in place to sustain rate increases, but of course, that means more than half of states do not.

In our upcoming state interviews, we plan to learn more about how this is playing out in specific states and how they're planning to respond to the changes in ARPA funding.

Our review so far is primarily focused on fee-for-service payment rates for HCBS agency services, but it's important to note that states can also use self-direction and managed care to pay providers rates that may differ from fee-for-service. So self-direction is an option for beneficiaries to choose and manage the individuals who provide their care, and it's commonly used for home-based services.

In many states, beneficiaries have some authority to determine the rate that they pay their provider typically within a specified budget. In other states, the state can set a specified payment rate for the independent providers. However, that rate may be a little bit different from the rate that's paid to an HCBS agency because self-directed workers don't have the same overhead costs that an agency would.

In managed care, MCOs generally have flexibility to negotiate payment rates with providers. However, states can use the new Managed Care Directed Payment Authority to require MCOs to pay specific rates.

As a middle ground, another option that some states use is to develop benchmark rates, also known as comparison rates, they provide to MCOs to help support their provider negotiations, but they don't require the MCO to pay that specific rate.

Although our study was primarily focused on how those HCBS rates were developed, we also heard a lot during our interviews about new approaches states are using to regulate the share of HCBS payments spent on worker wages. In particular, states are increasingly implementing wage

pass-through requirements, which require HCBS agencies to direct a portion of the HCBS rate increase to worker wages. So in about 24 of the states that increased HDBS payments through ARPA, they tied those rate increases to some sort of wage pass-through requirement.

In practice, the experts we interviewed noted that these wage pass-through policies are difficult to monitor and enforce, since many HCBS agencies don't submit standard cost reports that could be used to track the share of payments spent on staffing.

During our interviews, we also heard stakeholder feedback on CMS's recent proposal to require 80 percent of Medicaid payments for homemaker, home health aide, and personal care services to be directed to worker compensation.

Unlike the wage pass-through requirements that states are implementing, this new threshold would apply to the entire HCBS rate for the service.

So in general, some of the experts we spoke to noted that there's limited data to evaluate how many providers would be affected by this threshold, and then in addition, they noted that the threshold doesn't consider

the overall rate adequacy. And so it's hard to figure out whether 80 percent of the rate would be sufficient to support the HCBS workforce.

And finally, we heard concerns from stakeholders about CMS's discussion in the proposed rule about potentially expanding this policy to other HCBS services such as habilitation, which generally have higher overhead costs than personal care services and may be more difficult to meet the 80 percent threshold.

As Commissioners may recall, MACPAC didn't comment on this proposed policy when came out this summer because we didn't have enough data to evaluate the effects of the policy. The comment period for this proposal has closed, and so now we're monitoring to see what CMS finalizes. However, if there's Commission interest, we can continue to ask about these issues in our upcoming interviews.

All right. Finally, although our study was primarily focused on how Medicaid payment policy can affect the workforce, we also heard about nonfinancial strategies that states are implementing alongside payment changes to help advance their access goals. So, for example, to help

expand the pool of HCBS workers, some states are running public awareness campaigns to help increase public interest and awareness in the role of direct care workers. Some states are also pursuing more targeted campaigns to expand the use of family caregivers and also improve benefits for self-directed workers who are not employed by HCBS agencies.

To help retain workers, we also heard of states pursuing a variety of training and certification opportunities including career ladders which provide opportunities for workers to grow in their current position. In some states, these certifications and career ladders are tied to bonuses and wage increases that are supported by the Medicaid payment policies.

So that concludes my presentation for today. We are planning to publish Milliman's compendium of the 1915(c) waiver payment policies on our website, and as I noted, we'll be continuing our interviews on this topic. So as we move forward, it would be really helpful to get your feedback, again, on what issues we should focus on and whether there are any other issues we should look into.

We're obviously still in the very early stages of

this work, but to the extent to which you may envision some ideas for potential recommendations to address these policy issues, it would also be good to know whether there's certain information that would be most helpful for your discussion of potential policy options in the future.

Thanks.

CHAIR BELLA: Thank you very much, and thank you for getting this work done.

I'll start out and just ask both of you, was there anything that surprised you in what you saw that you want to make sure we're aware of?

MR. NELB: Yeah. Let's see. I think the complexity of defining these services was a bit surprising. We used this HCBS taxonomy that's been used by researchers to generally track spending, but then when you look into the details, there are so many different services that have slightly different definitions. So just the challenge, I guess, of just compare -- you know, how would you even compare rates within a state or across states when the services are slightly different is the challenge.

And then the other piece, I think, was with the rate studies, we were sort of hoping, I think, to get a

little more detail in there about what the wage assumptions were or other components. CMS on its website provides tools for states to break out the costs in some standard ways, but when you look at the actual state reports, every state does it a bit differently. And again, it's very difficult to compare across states in any standard way.

So those were two that stood out to me. I don't know, Asmaa, if you have anything else to add.

MS. ALBAROUDI: I think one thing that stood out to me was the challenges with using BLS and the wage assumptions there and the fact that states do rely on BLS data.

CHAIR BELLA: Patti. And then, Jenny, I'm actually going to come to you at some point too and see if anything you're seeing was reflected or surprising, because you get a different perspective of that as well.

Patti, you can start us off.

COMMISSIONER KILLINGSWORTH: I was actually not surprised by the number of different services or definitions of services. In fact, I was surprised that there weren't more, just based on what we know about variations across states and even among waivers within

their states.

First of all, thank you all so much. I don't think there is a topic that is more pressing or more important as it relates to access to home- and community-based services. So I really appreciate that you're looking into this in depth, and I think we want to encourage that, maybe even considering some expansions in terms of the scope of your review.

Quickly on the pass-through requirements, I think it is a policy that is well intentioned, but you pointed out several fundamental flaws, the most important of which is it still won't ensure that the Medicaid payment is adequate, including the payment to the frontline worker. So it just doesn't accomplish its intended goal, and it adds all sorts of administrative challenge.

So I think you also highlighted one thing that I want to reinforce is that we just don't have data. We don't have good workforce data. We don't have good payment data. We really don't have the information that we need to be able to make good recommendations around what constitutes good public policy in this space, and so I think we have to begin with this very thoughtful data-

driven approach that will help us understand what is an adequate payment for the services and how should that be appropriately apportioned between the workforce, those sort of frontline costs, if you will, and then other essential employer or agency cost.

The other thing, I think, that's really important is that we have to think about this workforce in light of an LTSS workforce, and I know we're focused here on 1915(c)s, but as a practical matter, this same workforce is supporting people across long-term services -- programs, services, and settings. And so habilitation is a perfect example of a service that uses a significant portion of these workers, and what we don't want to do is create recommendations that end up creating access issues for certain populations by favoring policy toward one type of program or one population who served. So I think we have to think about the impact of policy recommendations on all HCBS programs, all HCBS populations, all HCBS authorities, and also, quite frankly, on nursing homes, because they share a common workforce. And so you can't do things in one space without affecting the workforce broadly.

I do think we should look at a comprehensive

approach. The payment pieces are really, really important. The nonpayment pieces are also really, really important. And so those things that support effective recruitment and support effective retention, the workforce themselves would tell you are critically important, along with an adequate payment for the delivery of services.

I personally don't think that we can set effective public policy without at least a couple of years of data that we can look at that really informs what payment should look like and if Medicaid even has any authority to be dictating whether or not what providers actually pay to their frontline workforce.

And then finally, I think a piece of this work is coming to the realization that we are at a place -- and you pointed this out in your remarks -- that the increasing demand for LTSS and the not increasing availability of a workforce based on simply the demographics of our country mean that we will likely never again have enough people to deliver all of the supports that individuals need. And so there are implications for access broadly as we think about if not people, then what, and how do we ensure that people have access to the supports that they need to live safely

in their homes and communities? And that means really rethinking the Medicaid benefit framework, the HCBS framework, and making sure that we are including in our benefit packages alternative services and supports that really maximize safety and independence in the home setting and allow people to not rely on a workforce that is increasingly in short supply as sort of the default way of meeting their services and supports needs. So I would encourage you to make that part of the conversation as well.

Thank you both.

CHAIR BELLA: Just a few thoughts, huh? This is great. It's great.

Jami?

COMMISSIONER SNYDER: This is such important work. I really thank you, Rob and Asmaa, for pursuing this topic.

I can tell you, having departed the Arizona Medicaid agency only, I guess, 10 months ago or so, this is top of mind for Medicaid directors around the country, and it's a pressing issue.

But to your point on during your presentation,

you really pointed to the variability state to state in terms of how they approach the provision of HCBS services down to the definitional level, which I think is really important.

And to Patti's point and to your point, the lack of publicly available data, I just think at this point, there's a real need for more consistency in reporting, more transparency around payment policies as they currently exist, and it's just so important that we take the time to do thoughtful research before we start or begin to advance definitive payment policies in this space as advanced with the draft rules, so just really appreciate your ongoing work.

And I also wanted to thank you for your willingness to kind of dig in around the Rescue Plan Act funding and what states plans are following the availability of that funding when it runs out in March of 2025. As you know, some states have elected actually to close out their work with the ARPA funding even earlier, and I think there are real concerns across the country because so much of that funding, as you mentioned, has been dedicated to provider rate increases, and how those

providers are using that funding, in a way, that is going to create this real cliff effect once the ARPA dollars are no longer available, so just appreciate your ongoing research in that area as well.

CHAIR BELLA: Jenny, I put you on the spot, but would you like to make comments? And then John and Carolyn.

COMMISSIONER GERSTORFF: Sure. I can ask a couple of questions.

On Slide 7, you had kind of a breakdown of the different pieces that go into an HCBS payment rate for services that have direct care workers, and I was wondering what the biggest data limitations you might have found are for some of these non-wage assumptions in reviewing.

MR. NELB: Sure. So that was actually the biggest limitation. So not only did different states define their services differently, but then also different states break out these components differently. So you can't just even compare across states.

Again, as I mentioned, CMS has put out guidance and a standard template about how you could start breaking these into some common components, but if every state does

it differently, it's hard to even know how they compare.

So we talked about the limitations that go into the worker wages of BLS and finding an appropriate benchmark. With some of these other pieces, the absence of cost reports for some of these agencies makes it difficult. Some states are starting to explore more standard cost reporting for HCBS agencies, but in the absence of that, there might be like a one-time provider survey that's done when they do a rate study, but then it's not updated year to year. So it's hard to know how these different components of the cost might change over time.

And yeah, things like these overhead costs may vary a lot between large or small providers, urban/ rural, different pieces, and so it's hard to standardize of what the statewide rate should be.

COMMISSIONER GERSTORFF: Thank you, Rob. That's excellent.

One other question in the work that you've done here, did you run into any considerations or interactions with direct care worker union negotiations and requirements there?

MR. NELB: Not in our work with the national

experts, but I think we are hoping to interview some unions as part of the state work and so can hear more about that and how it has influenced the rate development.

CHAIR BELLA: Thank you.

John?

COMMISSIONER McCARTHY: On this slide here, having -- we talked about this -- having set these rates back in the '90s when I was a consultant for states - - and it's funny. Some of the states I go back to, and they still have the same models that I gave them in 1998. One of the things you had said was the data is not available, which I agree with publicly. Every state that I worked with or led, that model exists someplace. It's just that you give it to CMS, but it's just not posted anywhere. So somewhere that model does exist.

I will say the issue is -- and you brought it up, Rob -- that the number one issue I ran into any state, either I worked with or led, you have a budget. And so you're just -- you're getting to that last part, the rate. by modifying some of the things in there of where you land, and I know both of you said, oh, there's no comparable wage component. But even if there was, do you set it at the

50th percentile? The 25th percentile? You have that authority. You're really trying to come up with something in there, which then, for me, led to the idea of managed care and having managed care just to open negotiations for rate, right? Theoretically, you would end up with better rates.

And what happened in Ohio, so Ohio had personal care in state plan. Our HCBS services, our waivers were not in managed care, but our state plan option was. And so they went out and negotiated rates, and the providers came back, were upset with me because the plans were at rates below fee-for-service rates. And when I asked the plans why this was, they said, well, we got a network of what we needed, and then another group of providers came in and said, well, we'll do it for 98 percent. And another group came in and said we'll do it for 96 percent, and another group came in and said we'll do it for 94 percent.

And so they were down to 94 percent, which made me unhappy because when I asked them -- this is the question I'm going to get to. When I asked them what about quality when it came to services, there was no measure for it.

So one of the things, if you could look at in this, is there any way to look at what the states are paying and some of the quality measures that they have in their 1915(c) waivers around there, especially if we could do some comparison between self-directed programs, which theoretically, just theoretically, you gave the person a budget. They could go negotiate rates that they would need to be able to attract the people they need. It's not perfect, right? Because your budget limits that. It's not like you had an unlimited budget, but if you could somehow look at tying that, the rates to quality, and do we see any type of just pointing in a direction on that, it may not be perfect, but if there's something we could look at between quality and payment rate.

MR. NELB: Yeah. Definitely, we can look at that in the interviews. In the review of those policies, there's very limited use of value-based payment in the rates. So they are kind of still just paying certain number of minutes or hours or whatever. But yeah, we can definitely ask about how states are considering quality when they set the rates, and to the extent that they are doing value-based payment, what's happening.

COMMISSIONER SNYDER: And not just asking about it, but can we compare any states across to see -- we know their quality metrics from their 1915(c) waiver. Do we see anything different across that?

I know there's a lot of different -- and Patty is looking at me. There's a lot of different reasons between that, and I'm excluding 1115 states, but --

CHAIR BELLA: Thank you, John.

Carolyn?

COMMISSIONER INGRAM: My questions are similar along the lines of self- direction that John was going in, to look at the quality of services and if you could compare it by service entity, so self-directed, agency-driven, or even those inside managed care.

And the reason I'm pretty passionate about this in my state, unfortunately -- and you can just google it. It's all over the news, but there's some really horrible cases where people unfortunately took advantage of people with disabilities because of the money situation and the ability to go in and not have those services monitored and not have any type of quality outcomes. And unfortunately, the outcomes were really horrible for those individuals.

And so I think we have to look at how is the quality tied back to what we're paying, so we're not incentivizing people to go in and abuse folks with disabilities who don't have a guardian or a parent who's able to take care of them in some way and to oversee that process. So I think that's something we have to definitely look at and that I'd direct us to do.

The other area is just then also the effects that we see in terms of access to care and what happens with these services in an economic downturn. So I think -- I don't know if you'll be able to get this data going back far enough, but I can tell you from a managed care perspective, we definitely see a change whenever there's an economic downturn and the number of requests coming in for services to be provided in the community.

And so, again, just getting back to that quality component, we want people to live safely in the community. We want them to be taken care of in the community. But what does that look like also in an economic downturn, and what can a state do or think about in that regard?

That may be a really hard thing to tackle, because I'm not sure you're going to find the data going

back far enough to be able to tell. But if we can, that would be some things to look at.

Thanks.

CHAIR BELLA: Yeah. I have to say -- Patti is going to talk to you, but I'm struggling. I don't disagree on the quality side. I don't know where we're going to find that. Do you? Do you both have a good idea on how closely can we tie payment and quality?

MR. NELB: Yeah. We can ask about it qualitatively in interviews, but it will be difficult to do quantitatively. The ideal analysis that John outlined , of comparing payment rates to quality outcomes is challenging because we don't actually have payment rates in a standard way. And then we don't have consistent quality data across states. Even if we did, as you may recall in our nursing facility work, at the end of the day, you find wide variation in payment. You find wide variation in quality. They don't always match. And so we're kind of left asking for more data and things.

But it's a great point and can continue to highlight in our work, and I'm open to ideas if people have thoughts on and how we can incorporate it more.

COMMISSIONER INGRAM: We're not going to find it tied back to quality exactly, but maybe it's the pursuit of starting to try to tie these things in that direction, so the specific cases I'm talking about, there's motivation to move people out of -- into self-directed care sometimes because that's not always in managed care, and managed care companies have certain oversight tools. They require plans of care in place, face-to-face visits, checking in on people, and that doesn't always exist in the fee-for-service system. Maybe it does in some states but not everywhere. And I think those end up having -- you're incentivizing people because the payment rates are a little bit different, perhaps, referencing back to John's example, but you're not overseeing them with the same type of quality oversight.

And so we may not be getting to quality outcomes quite yet, and maybe that's where we need to recommend that states or CMS go, but there's definitely differences in how people are being treated and taken care of, both inside managed care and outside of managed care. And I'm not saying that that happens everywhere. I just know that I've seen that example.

So I think if we can kind of compare between, again, agency self-directed and then when those are in managed care and outside of managed care, what are the processes to try to get towards a quality outcome? Maybe we're not really going to see the quality piece. Maybe there's processes in place. Does that make sense?

MR. NELB: Yeah, it definitely does. And it's something focusing on the self-direction. It's one we can look at, and it's something we heard. I mean, just looking at this graphic, some people maybe want to reduce that administration overhead component of the rate. But then some experts we spoke with highlight how that over oversight is maybe important for ensuring -- supervising the workers and ensuring quality care. So we can definitely highlight those tradeoffs and see what we learn more from the states.

CHAIR BELLA: Yeah, that makes sense. I mean, I think -- yeah. Patti and then Dennis. But I think part of what we're doing in all of this work is laying the foundation of understanding what do we have, and what do we need, and how are we going to fill that gap? And so it's really -- it's as important to highlight the things that

we'd like to know that we can't or don't for any reason so that we can figure out how are we going to get to that point, because we know what we want.

Patti and then Dennis.

COMMISSIONER KILLINGSWORTH: Carolyn, I'm really glad that you brought this topic up, and, Rob, I'm always amazed when I see the level of knowledge that the staff have as I look at the work that you all do. It's just incredible. You really pointed out the fundamental challenge, which is when we don't have consistent quality measures and we don't have consistent policy or payment approaches and so marrying the two seems really challenging.

And yet I think it's critically important that we do so. If you think about how quality has traditionally been measured in the HCBS space, it's mostly been about compliance. It's sort of evolved to, do you have a plan of care? Does that reflect the things that matter to you? Are you getting the services that are in it, without regard to the impact that those services actually have on your life, your quality of life, and whether you're achieving the outcomes that matter to you? And so to be able to get

to a place where we're actually incentivizing real outcomes and paying for real outcomes, in my opinion, would be the standard that we would want to be able to achieve.

There is a little bit of work that's been done around value-based payment in HCBS that might be helpful for you to look at. NCOR has produced a couple of reports just working with providers within their association who have been a part of some value-based payment initiatives.

There's another document that's really focused primarily on leveraging payment policies to drive employment outcomes among people with intellectual and developmental disabilities, and I can forward that to you. I can't think of the -- Lisa Mills is the author of the report, but I can't think of the name of it right offhand.

But there are some really shining examples of how when you begin to align payment with outcome, you can really improve outcomes and honestly oftentimes achieve a much more efficient use of Medicaid service delivery. For example, in the work that Lisa Mills did, you'll see that by paying for outcomes in employment, you're actually able to sort of fade away the supports and help people be more independent in the work setting, less reliance. That’s a

workforce benefit, right, if you're not continuing to use a workforce, if that person is now able to be independent or to rely on coworkers or to leverage technology in that employment environment to be more independent.

So I think it's where we want to go. We're just a long way from it at this point.

CHAIR BELLA: Thank you, Patti.

Dennis and then Jenny.

COMMISSIONER HEAPHY: I really appreciate the comments that were made about quality and data collection transparency. Really, really important stuff.

And NCI-AD caps and other entities are looking at quality measures for these services and looking at it from the perspective of the consumer, and so we are moving in the direction of getting some standards.

I think I'm going to come at this a little bit differently. We've talked about keeping folks safe in the community. But another perspective on that is really providing people the opportunity for dignity in the community. It seems increasingly that the personal care attendant services and direct work services are being medicalized and used through a medical lens, and that

medical lens is really narrowing and redefining what it means to be supporting people to achieve their goals of living in the community.

There are times when direct care workers are providing medical services as a part of supporting a person's ability to live in the community, but there are times when those personal care attendants are not providing those medical services at all. It's really supporting the person to achieve their goals and living in the community, and so as we're framing this, I think it's really important to look at it from the perspective of historically what's been the purpose of and what's the goal of providing home- and community-based services. It's not to move in a nursing home into the community. It's about providing people the service they need to actually thrive in the community, and sometimes it's medical, and sometimes it's not.

I also wanted to ask about -- we know that the workforce needed is just not going to be there, and so in projecting into the future, alternative services, we know they are waiting list for day habs. Folks are sitting at home languishing.

Other opportunities to provide alternative services, if they're like -- if they're like an MCO, they've got a care plan, and they know that the person really loves baseball, getting them to a baseball game once a season or something, at least something to look forward to. They're not sitting home isolated and by themselves. Doing away with the dual use restrictions, I think it would be really helpful, because that tends to barrier the access to services when people may not be available.

And I think I'm also wondering about how do you set a creative baseline set of requirements across states and determining rates? Is there some way of looking across nationally and saying here are things we think every state should look at when they're determining rates for the direct care worker services? I think it's become wary of the medicalization of the services, and some folks who may benefit from redefining it as a medical service as opposed to just a service.

And I say that not just like as a believer in independent living philosophy, but as understanding that people who work as PCAs, direct care workers, they can go on to many different fields. PCA is narrowly defined as,

well, it's your career, it's your step up into a medical career, and that's really moving away from the idea that it's your step up into any career, and that your ability to work with folks in their homes is really an opportunity to get a job anywhere.

And I think specifically for folks who may have criminal justice encounter histories and they might not be able to get a job in an agency and therefore not be able to provide service in someone's home, I think there are folks in the community who really benefit from these, provided from folks who went outside the workforce for a while.

And so I think part of what I'm saying is let's reframe some of the conversation away from the medical side, understanding that MCOs have goals and quality. I agree 100 percent, but it's how do we make sure that it does not prevent people who have the ability to reach daily risk and reach goals in their lives when it comes to living, working, volunteering, engaging the community meaningful ways.

CHAIR BELLA: Thank you, Dennis.

Jenny?

COMMISSIONER KILLINGSWORTH: So I just wanted to

circle back to something I forgot earlier. We have recent implementation of electronic visit verification for a lot of these services, and I'd expect there to be significant startup costs and staff time for increased training of implementing these systems that would be needed in provider payment rates for that implementation phase but then should come down over time. Has that been something you've run into looking at that in admin and overhead costs? Any considerations there?

MR. NELB: In our review, we didn't get at that level of detail. Certainly, electronic verification came up. That's one of the challenges states are facing now, but at this point, we're just more focused on -- we're primarily focused on the worker wage component and the nonfinancial part. It's a consideration but wasn't the primary focus.

COMMISSIONER HEAPHY: A lot of folks in the community are really concerned about EVV negatively impacting access and decreasing the workforce. And so it would be really helpful to see if over time the workforce decreases because of EVV, talking about the lowest wage workers and now folks being -- to attract electronically,

and if there are folks that we -- I'm talking about a lot of minority workers, women, and just concerned about the impact of EVV, whether or not it's -- whether or not their concerns are justified or not or just about concern about only taking a job that they're going to be electronically tracked versus taking a job at Wendy's. And so I just -- for the same wage. So I just think it's something it would be really interesting to track over time.

CHAIR BELLA: Thank you, Dennis.

John?

COMMISSIONER McCARTHY: I do have to bring up on the EVV part of it that -- and I was thinking about that from the quality measure because states are getting the data at least to see no-show rates, are people showing up or not, and while this is a difficult topic, I will say the flip side of the coin is if you looked at Florida, before they put in their system, which was just a telephone-based system, their number of HCBS claims in the Miami-Dade County area went down by 50 percent when they implemented that.

I, at the time, was Medicaid director in D.C. We were working through -- we thought we had a fraud problem,

and sure enough, after I left, there was a big OIG investigation, and close to what was like 40 percent of HCBS claims in D.C. Medicaid's waivers were found to be fraudulent.

The other side of EVV is you're fighting fraud, which is millions and millions of dollars going out of the program, which could be going to serve people and higher rates and things like that. So we have to have a balance in there around those different pieces, and I totally understand what Dennis is saying, but we also have to have the other side of how do we make sure, because people are going into homes that they're actually getting the services they need.

But could we use some of that data, back to the quality question, is one of the ideas.

COMMISSIONER HEAPHY: I think the points you're making are important ones.

CHAIR BELLA: All right. Anything else you need from us at this point? Level of interest off the chart. Yes, yes, yes.

[Laughter.]

CHAIR BELLA: We're really excited.

Remind me. The interview findings will come back when?

MR. NELB: I think we're targeting in March.

CHAIR BELLA: Okay.

MR. NELB: We'll see. We're doing them now, and then there's going to be another presentation in January. So we're trying to space them out a little bit, but we'll definitely keep talking about HCBS in the meetings to come.

CHAIR BELLA: Wonderful. Thank you very much, both of you, for this work.

All right. Heading into the last session, which is on state Medicaid agency contractors, otherwise known as SMACs. It might be the second worst acronym next to BAGs. Drew and Kirstin will be leading us through this.

Actually, since half the Commissioners have gotten up, which is totally understandable, we're going to take a five-minute break. So we'll start this in five minutes. Thank you.

* [Recess.]

CHAIR BELLA: All right. In with our last session of the day. Welcome, Kirstin and Drew, to talk to us about SMACs.

OPTIMIZING CONTRACTS WITH MEDICARE ADVANTAGE D-SNPS: STATE MEDICAID AGENCY CONTRACTS (SMACS)

* MS. BLOM: Great. Thank you, Melanie, and thanks everyone. Good morning.

So Drew and I are here to talk about the ways in which states can optimize their contracts with Medicare Advantage dual eligible special needs plans.

So to begin, we're going to do a quick refresher of D-SNPs and the contracts that they have to sign with states. Those contracts are referred to as state Medicaid agency contracts. Drew will then walk through the key themes that we've gathered from our review of those contracts across states, and then we'll conclude with next steps.

Many of you are familiar with Medicare Advantage special needs plans. These types of MA plans are designed to provide care that's tailored to the needs of a specific population. Our focus is on dual eligible SNPs, or D-SNPs, which provide coverage to duals. Duals can be in other SNP types too, or they can be in regular MA. There's no requirement that they enroll in D-SNPs.

D-SNPs are unique in that they are required to

enter into a contract with the state in which they operate. Through that contract, they're required to coordinate Medicaid benefits with an individual's Medicare coverage and sometimes even cover Medicaid benefits.

All SNPs are also required to establish a model of care within their SMAC, which describes the basic framework for how the plan will meet the needs of its enrollees. This is unique to SNPs and is not required of other MA plans.

D-SNPs are a vehicle for integrating care with almost 6 million duals now enrolled in them. In 2020, 51 percent of duals that were exclusively enrolled in managed care for their Medicare benefits were enrolled in a D-SNP. D-SNPs are the most widely available product for integrating care for duals, but the level of integration varies because there are different types of D-SNPs.

About 20 percent of all duals are enrolled in any type of integrated care, such as through a D-SNP aligned with a Medicaid managed care plan. So that gives you a sense of not that many duals are necessarily even in an integrated care model of any kind.

You'll hear us refer to full and partial benefit

duals. I think most of you know this, but just a quick recap, full duals are people who are eligible for full Medicaid benefits, which is in addition, of course, to their Medicare coverage. Partial duals are only eligible for Medicaid assistance with their Medicare premiums and cost sharing, and they otherwise don't have Medicaid benefits.

So this slide shows the three types of D-SNPs. They're listed from lowest to highest level of integration. Coordination-only D-SNPs, or CO D-SNPs, like the name implies, that coordinate Medicaid benefits with Medicare coverage, and they're the most widely available. Thirty-eight states and D.C. have CO D-SNPs.

Highly integrated D-SNPs, or HIDE SNPs, are required to cover Medicaid behavioral health or LTSS or both. They're available in 15 states and D.C.

And then finally, fully integrated D SNPs, or FIDE SNPs, are the highest level of integration. They are required to cover both behavioral health and LTSS unless the state has something carved out. And they must do so through a Medicaid managed care plan that's operated by the same parent company as the D-SNP so that there's an

alignment there for the beneficiary.

FIDE SNPs are available in just 12 states and D.C., but that is increasing. Next year, there will be two more states offering these SNPs.

You guys are probably familiar, many of you, with recent CMS rulemaking and how it's tightened the definitions of these different D-SNP subtypes, which could have implications for states in the next couple of years. For example, FIDE SNPs will be required to use exclusively aligned enrollments, among other things. So plans in some states like California and Pennsylvania could lose the FIDE SNP status if they aren't able to achieve exclusively aligned enrollment.

So as I mentioned earlier, D-SNPs are required to contract with states, which gives states an opportunity to tailor their contracts to their own priorities to some degree. States are not required to contract with D-SNPs.

The federal government established minimum requirements for these contracts, which were enacted in the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA, and then following enactment of MIPPA, years later, additional requirements were added through the

Bipartisan Budget Act of 2018.

The states, of course, can go beyond those minimum requirements to require greater integration or to better tailor their contract with the D-SNP to their priorities or their populations in their state.

Some of the Commissioners will recall that a couple of years ago, we produced a chapter in our June 2021 report that detailed contracting strategies that states can use to increase the level of integration in their SMACs. That was a really weedy report, but we looked at things like how states can limit enrollment to only full-benefit duals in order to ensure that the model of care is tailored to the needs of that group, moving partial benefit duals into a separate plan benefit package.

Some of the available strategies that we outlined in that report are doable in all states, but others can only be used in states that have experience with Medicaid managed care. So, for example, in order to operate exclusively aligned enrollment, a state would have had to have some managed care experience. Exclusively aligned enrollment, which is a mouthful, is an arrangement where full-benefit duals are enrolled for their Medicaid benefits

with a Medicaid managed care plan that's operated under the same parent company as the D-SNP, again, to kind of create that aligned arrangement.

And then how states leverage their SMACs can depend on a number of factors. We've talked about experience enrolling duals in Medicaid managed care as being important for optimizing those strategies. There's also, of course, just the availability of D-SNPs in the state. Even if a state has D-SNPs, they might not cover the entire state.

On top of that, alignment between D-SNPs and Medicaid managed care organizations under the same parent company makes some of the higher level, higher level of integration strategies, like exclusively aligned enrollment possible.

And then a recurring theme for us in the duals space is the issue of state capacity. States need time to review contracts with their D-SNPs. They need time to conduct oversight. So states might struggle in that department if their bandwidth is limited or if they have competing priorities.

So now I'm going to turn it over to Drew to

discuss key themes from our review of these contracts.

* MR. GERBER: Thank you, Kirstin.

Building on that prior work, our project this work cycle aims to better understand how states are currently leveraging these SMACs, as well as the challenges and considerations that guide state approaches to optimizing these contracts to further integration for dually eligible individuals.

A core focus of this work will be examining how states oversee and enforce compliance with their SMAC requirements. As a part of this work, we undertook a review of SMAC language, which we'll share the results of today, and in our upcoming stage of work, we plan to conduct interviews with key stakeholders in several case study states, which I will also touch on toward the end of the presentation.

With our contractor, we reviewed executed SMAC contract language for all D-SNPs operating during federal fiscal year 2023, focusing on provisions that fell within five categories: coverage of Medicaid benefits, care coordination, integrated materials and member communications or member experience more broadly, data

sharing, and as well as reducing health disparities and improving quality.

In our analysis of these contracts, we identified commonly used contracting strategies in instances where states leverage their SMACs to go beyond what is required by federal requirements. However, more information is needed to understand how states oversee these contracts and ensure compliance in achieving their integration goals, which is something we will get at with our interviews in the next stage of the work.

Here, we have a bar graph highlighting an example or two of some of the more commonly used contract provisions in each of our five categories. As a reminder, Commissioners can refer to our full table of selected contracting strategies in your briefing materials.

In 2023, there are 45 states and the District of Columbia in which D-SNPs operate. They also operate in Puerto Rico, which was excluded from our analysis.

In the left-most column here, you see that of the total of 46, which reflects the number of states with any D-SNP type, there are 21 states that contracted with HIDE SNPs or FIDE SNPs. Those states could contract with either

plan type, both, and they may also require -- or contract with coordination-only D-SNPs, but the point is that these are states that are contracting with plans requiring a greater level of integration.

Moving from left to right, we can see our first example of a provision related to coverage of Medicaid benefits, specifically in this case, who can be enrolled within a D-SNP. In total, at least 15 states in our review included language in their SMACs limiting enrollment in some or all of their D-SNPs to only full-benefit dually eligible individuals. Alternatively, some of these may require D-SNPs to have separate plan benefit packages for full-benefit dually eligibles.

As you can see, of those 15, 14 were states that contract with these HIDE of FIDE SNPs, which makes sense as HIDE SNPs and FIDE SNPs are required to provide certain Medicaid benefits, typically only available to full-benefit dually eligible individuals.

In the next column, we have care coordination. Provisions ranged from requirements for developing individualized care plans or regarding the makeup of a beneficiary's interdisciplinary care team, but highlighting

sort of a basic step, we found that at least 11 states included language in their SMACs setting out requirements for care coordinators. This would cover areas such as requiring specific training, maybe on Medicaid services, or requiring specific background experience for these care coordinators. Nine of those states contracted with HIDE SNPs or FIDE SNPs.

In the next column, looking at integrated materials and member experience, we found that at least 19 states required a review of Medicaid information in the D-SNP's marketing and communication materials. Fourteen of those states contract with HIDE SNPs or FIDE SNPs.

While we found this provision was more common and it was found in about two-thirds of states that contract with HIDE SNPs or FIDE SNPs, still overall, the requirement was reflected in SMACs for fewer than half of all states that have D-SNPs operating.

In the next column over, data sharing in general was a common area of focus for SMACs. States could require D-SNPs to report Medicare quality measure data to the state. Plans do report this data to CMS, but unless states require it in their SMAC, they're not able to access this

data. In the next stage of the project, we plan to dig in further into how states oversee the data they receive and how the data gets used to further state integration goals.

And then finally, these final two columns relate to reducing health disparities and improving quality. For improving quality, at least 13 states set requirements related to supplemental benefits in their SMACs. These supplemental benefits are additional benefits that Medicare Advantage plans can offer that go beyond what is offered in original Medicare. These benefits are primarily health related, though there are certain non-health-related benefits allowed for targeted populations. Common supplemental benefits do include things such as dental or vision, but states may set requirements in their SMACs that align these benefits more with Medicaid benefits or that are more tailored to their dually eligible population.

In terms of reducing health disparities, which may reflect an area that's a new priority for states, at least six states, all of which are states that contract with HIDE SNPs or FIDE SNPs, have included requirements that D-SNPs identify and reduce health disparities among their enrollees or share data on these disparities. This

requirement may be included as part of the D-SNP's model of care.

Sort of to summarize all that and what was in your briefing materials, a review found that states are using contracting strategies in their SMACs intended to further integration with varying levels of frequency. Certain provisions were more widely used across states, while others had relatively limited use. For example, again, data sharing provisions were probably the most common, while few states added requirements for something like enrollee advisory committees, which D-SNPs are required to establish.

In the next stage of this project, we will conduct interviews with state and federal officials as well as health plan representatives in several case study states. Through this work, we aim to learn the factors that influence states as they develop their SMACs, how states oversee and enforce their contract requirements, and where state requirements have contributed the most to progress in integrating care.

As you can see for our next steps, we've begun the interview process and anticipate continuing our

interviews through the end of the year. We'll be returning in January to report out on those interviews, and depending on Commissioner interest, we can develop potential policy options to present at a future meeting as well.

Thank you all. We look forward to questions you may have and the conversation about states optimizing their contracts with D-SNPs.

CHAIR BELLA: Thank you very much.

I have several thoughts and questions, which I will hold and start with John, please.

COMMISSIONER McCARTHY: I don't think I saw this in there, but maybe I just missed it. Did you talk to states that have D-SNPs in them but don't have SMACs and why they're not using it?

MR. GERBER: For a D-SNP to operate in a state, they're required to have a SMAC.

COMMISSIONER McCARTHY: I mean, how should I say it? That they have a SMAC, but it's just a generic one, that it doesn't have any requirements in there?

Let me rephrase it a different way. I think we talked to the states that are doing these things, right? And it's great work we've got. Here's what it is. But

what I'd be interested in, too, is the states that are not utilizing this. Why are they not utilizing it? Because what I had found in the past, before I worked in any of these things -- I was a Medicaid person. None of my staff understood -- we didn't know what we didn't know. Like we couldn't figure it out. We talked to other states, and so I think it would also be helpful to find out why states aren't doing some of these things, what are some of the barriers that they see. I know you're going to talk to plans next, but getting that perspective.

CHAIR BELLA: Thank you, John.

Patti?

COMMISSIONER KILLINGSWORTH: I love that we have saved all of the simple topics for today. If it weren't enough to talk about Medicaid, we're going to talk about Medicare too, but it's really important work.

And I think, John, to your point, states are just in vastly different places with respect to their knowledge and their capacity and even their interest in advancing integration for duals. I think there are still states who may not understand why it's so important and what the opportunities really are for this population.

In addition to the interview topics that you mentioned, some things that I think would be really helpful to understand are some of the barriers that limit the effective use of data to advance integration. There's been some progress, but it's still very, very challenging to get to the data that you really need.

State capacity limitations, kind of following up on John's points, to really advance integrated care options and specific recommendations that might help address some of those limitations, some of the federal policy barriers that undermine or impede state efforts to advance integration -- and here, I always go back to enrollment is one of those that I think of a lot. And just sort of highlighting, surfacing some of those for discussion.

I'd also like for us to think about not just how our states using their SMACs today to drive integration, but how could they? What are the real potential opportunities there?

Other categories I can think of that I've already seen used or that could be used much more extensively would include integrating systems and program administration, so where you literally have a health plan acting like a health

plan on behalf of these beneficiaries and not as two health plans that are somehow trying to coordinate together, so that there's a single care manager who's responsible across the full realm of benefits, that care manager is knowledgeable about the full range of Medicare and Medicaid benefits, really doing things in an integrated way.

Provider networks is another. It's really important that there is overlap across the Medicaid and Medicare networks as people are aging out of one program and into another.

Enrollment, especially with some of the default enrollment flexibilities now that D-SNPs can utilize, and then how we maintain continuity of care through that SMAC agreement.

Models of care. There's so much opportunity to really leverage the full model of care requirement and document, which is broader than just care coordination, to really drive integration. And I would include within your Medicaid benefit category, supplemental Medicare benefits, which you mentioned as well. But I think that's an area where particularly since there are no home- and community-based services that are really a part of the Medicare

benefits, save a very limited home health benefit, it's an area where you can at least get some things into that benefit structure that can really support people who may have home- and community-based needs that might not otherwise be available to them.

Thank you. And I'm interested, by the way, very interested in pursuing further.

CHAIR BELLA: Thank you, Patti.

Carolyn and then Dennis.

COMMISSIONER INGRAM: Yeah. I think just a couple of questions, I wanted to see if you found, in your work so far, have you seen anything around the idea of what states are planning to do or thinking about doing or taking advantage of the D-SNP option when they've been in the MMP? So maybe lessons learned in the MMP structure that then get incorporated into the D-SNP? It may be too early for that. Maybe we're going to see that in the next round when those start to transition, but that's maybe something to look for.

And then did you have a comment? And I'll go to my next question after that.

MR. GERBER: I was just going to say that I don't

know if we've seen that so far, but in our separate MMP monitoring work and interviews with those state staff, we have heard that the states are thinking about how to transition some of those elements of the MMP into their SMACs.

COMMISSIONER INGRAM: Oh, good. Maybe that's something to ask them when you're talking to them and figure that out, that we can add to this, because I think there's a lot of lessons learned in the MMP that we can bring into the SMACs and then those states that weren't in the MMP maybe can use those to optimize the program in terms of integration.

The other thing, the other question which goes to access to care is the timing of all of this and making sure people understand the timing of when SMAC agreement can go out and how that then affects Medicaid procurements, which then affects the ability to have an integrated care program and access to care for people who are on Medicare and Medicaid. It's all set really by federal government and by what Medicare does, and I know we don't oversee Medicare in this committee. But it does intersect, and it's restrictive to states. If you wanted to make a move and

make a change and start integrating care and give that access to somebody to have a fully integrated program between Medicare and Medicaid, you can only do it at certain times. And if you miss that window, you miss the time to be able to actually do that for your constituents and for your members. And I don't know if we can do anything about that, but I do think it's something we should at least look at, because it does affect access to care.

And that's all I have. Thank you.

CHAIR BELLA: Thank you, Carolyn.

Dennis and then Tim.

COMMISSIONER HEAPHY: Thank you.

In the research that you did, did you look at the percentage of SMACs that required the D-SNPs to provide data in the format in the way the state required versus the D-SNPs providing the data in the format that they preferred?

MR. GERBER: I don't know if we looked at it at that level of detail. We looked at sort of common data sharing provisions. I think less so whether there was state requirements on the sort of preferred format or

receiving the data in a way that integrates into existing state systems.

I do know from some initial work we've done that it is an area states are looking at in terms of setting up their state systems to receive things such as Medicare encounter data. So it is an area that states are, I think, in the middle of looking at.

COMMISSIONER HEAPHY: Because I think it'd be really interesting to follow because where states have to manage five different data systems coming into it and the data -- and the way the plan has defined services or categorized services may be different in each one. And then the state needs to take all the different data and try to compare the quality of the plans. Just it makes it untenable, and so how do we simplify the process, ensure that plans are driving the system and not the plans?

And then with that, did you encounter anything in terms of states addressing concerns with lack of transparency around access to utilization management or determination of needs with off-the-shelf AI or centralized determination of need services that are not in keeping with the states' priorities?

MR. GERBER: I don't think that fell into our review of SMACs.

MS. BLOM: Yeah. Yeah. I think that wasn't on our list, Dennis, but we can take that back and think about if there's a way to get at that through some of the interviews.

COMMISSIONER HEAPHY: I've got a whole list for you. I won't share them all today, but just I think in terms of it, it would be interesting, I think, to interview CAC members, member of the consumer advisory committees of the D-SNPs and beneficiaries themselves to find out, do you have a care plan? Do you have a care coordinator? Do you know who to contact at your plan if you need something? Just to get a sense across the board what people's experience of integrated care is and how the care coordination function actually works. This will be true of determination needs. Does a care plan drive the benefits the person receives from the plan, or if the care team comes up with a care plan -- let's say the person requires a certain kind of wheelchair. The utilization manager returns it, even though the care plan says that the person needs X, Y, or Z piece of equipment. That make sense?

MS. BLOM: Yeah, that makes sense. The beneficiary perspective is kind of always in the back of our minds in our work. So we'll think about that as we're going through this process. We're trying to get at what is in all of these contracts and try to look at that in a comprehensive way, but as you can imagine, that's a lot of work, just that sort of first step.

COMMISSIONER HEAPHY: And I'm sorry. Just two things for now, and one is -- maybe you didn't look this far, but I think it would be really helpful to learn what SMACs or whether SMACs are actually requiring public-facing data dashboards to be included because they're important for a number of reasons, but from a beneficiary perspective, they're extremely important for beneficiaries understand which plan to choose. And they can only know that by being able to see the quality of each plan.

Then the last thing I'll say for now is, did you find any SMACs or did you look at how SMACs may be augmenting the star rating system to ensure that the way the plans are being measured is actually appropriate to the populations they're serving? Because we know that the star rating system in CMS is just not adequate, appropriate to

the populations, the overall populations that are eligible for these D-SNPs, like folks under 65.

CHAIR BELLA: Thank you, Dennis.

MS. BLOM: Yeah. Thanks, Dennis.

CHAIR BELLA: Tim and then Jenny.

COMMISSIONER HILL: To pile on a little bit, I like Dennis's point. On the beneficiary perspective, we talked a lot yesterday about bringing the beneficiary's voice to some of the work that we're doing. I had done some work in the last couple of years around care integration and D-SNPs with duals, and it's on the beneficiaries. And the conclusion I came away from is we have a view about what integration means from a policy perspective, and it's very different for a beneficiary. And I think -- sometimes I think we outsmart ourselves with all the great ideas we come up with, but I think it would be really important to have a beneficiary perspective about what it really means to be in one plan versus another, if anything, and what's important to them.

CHAIR BELLA: Thank you, Tim.

Jenny?

COMMISSIONER GERSTORFF: So thank you for this

overview and work. I thought it was very interesting.

But I know SMACs are only one element that states have for managing these programs, and so I was wondering if there was -- if it was in your plan for any upcoming interviews or other work streams to look at other tools for promoting integration, like leveraging Medicaid capitation rate strategies.

So there was a white paper published last week co-authored by Manatt and Milliman that explores opportunities and barriers from an actuarial and a policy perspective, specifically those that can be impacted by Medicaid rate setting strategies. So I'd be interested to see if we're doing anything more there.

CHAIR BELLA: Thank you, Jenny.

Just to do a little cleanup comment, I would say, first of all, not surprisingly, I'm thrilled with the work.

I'm disappointed to see the use of the SMACs, though. The concept of a SMAC was introduced in 2008 with MIPPA. I think they started to be required in 2013. So 10 years later, we have an inventory for the first time, which is wonderful, and I think our natural instinct is to say let's get more states -- including me, I guess, by

criticizing that there's not more -- say let's get more states put these things in their SMACs.

But I think we also have to step back and say, what are we actually doing with the information that comes out of the SMACs? And this goes to the point of not having state -- either don't have state capacity or we don't have the Medicare knowledge for good reason at the state level. So we can be as creative as we want about recommending states ask for a bunch of reports. Some states are asking for the Medicare Advantage bids, which wasn't included in this work, but being able to then understand that, translate that, and use that as a way to support your own integrated strategy is a whole different -- it's a whole different thing.

And in some conversations I have, I get worried that people think we have what we need because the state can do whatever it needs to do with a SMAC, and there's sort of the theoretical idea of what a SMAC can do, which is this amazing lever that a state can use. And then there's the practical reality of what happens when you withhold a SMAC and someone comes to your legislature, or what happens when you don't have staff to review the SMAC,

or what -- you know, and on and on. And so there is a big gap between sort of what we might see on paper or not and how these tools are actually being used to further our goals which, just to remind ourselves and for the new folks, our number one goal is that every dual in the country should have access to integrated care. And our ways of doing that are to increase the number of integrated products and increase enrollment in those integrated products.

And I would just say a couple of things on that. I just don't want us to lose sight of that. I love that we look at levers, but we constantly need to come back to support states in having a strategy, help them understand the paths that are there and then the levers in those paths, and we have to continue to advocate support for states to do so.

We're spending close to $5 billion a year. So giving 55-, $56 million on a $5 billion spend is really nothing, and I want us to be aggressive about continuing to advocate for that larger recommendation that we did in the past that will allow us to then have reason for states to have levers to execute.

And I guess the last point I'll make on the soapbox is, as we think about having people have access to integrated products, we have to think about taking away opportunities for non-integrated, sort of non-meaningful integrated products, and that means we have to look at -- SMACs are not required for C-SNPs, for I-SNPs, for ACOs, for anything other than a D-SNP. And I'm not saying that we should be recommending that we put SMACs on all those products. The states can't possibly manage that process. But if we don't address, continue to address the lookalikes and the C-SNPs, which are becoming lookalikes, and the I-SNPs and the ACOs, we're not actually giving states the tools they need to be able to have control over the type of integrated product that they want to put into place.

So I would encourage, as we continue this work, we're asking the questions about how do we also dampen, eliminate, whatever, non-integrated products. And I'm just going to go out there and say I also want us to take a look at coordination-only D-SNPs and understand what is being coordinated.

And the majority of growth in D-SNPs today is all coordination only, and what are we learning about that?

Are there some good practices?

I'm not being biased just because I'm from Indiana, but Indiana had a great practice for some of the folks on its aged and disabled waiver with coordination-only D-SNPs.

But I don't know that we have a sense of how states are using the data that they're getting from their coordination-only D-SNPs, and is it really taking us back to our goal? Is it really an integrated option for beneficiaries in those states like we want to see?

So my thoughts, just a few.

John?

COMMISSIONER McCARTHY: I agree with everything you said, and I'd love to see that.

And being more on the side of the free market and having things work, in Ohio, we worked with you, Melanie, when you were at CMS, to do the Medicare-Medicaid Program. The incentive there was we got the savings, right? The state shared in the savings from Medicare, because really a lot of the savings goes to Medicare.

Do we know why the CMS is bringing down the MMP programs? Because that was another tool, a really

integrated tool, and then moving to the FIDE SNP, because states then lose -- you have some incentive but not the same amount of incentive that you had, monetary incentive on that side. Is there anything that MACPAC has heard of why there is a step back from that?

CHAIR BELLA: I have heard, but I'm happy to let Kirstin or Drew respond.

MS. BLOM: I mean, I think that the movement has all been toward D-SNPs for a while. Even some states kind of self-selected into that before CMS made that change. Enrollment in the MMPs was always fairly low, except for perhaps in Ohio. And then their state participation was not where it was hoped to be, I think.

I think there's also the issue with the evaluations that kind of never really showed sort of that dollar expectation around savings, and I think that was a driver.

CHAIR BELLA: Yeah. I mean, I think the biggest challenge is that the MMPs are done under CMMI authority, and there are certain tests on quality and cost. And the evaluations didn't show what would be necessary to meet those tests.

A couple of things, though. Most of the evaluations don't even have the Medicaid data in there, right? And also, you could argue that what we were evaluating with the Medicare data was the ability to set a rate, not actually what happened with the spending and the quality.

So I think there are states that are interested in having something that looks more like what the MMP was, and I'm hopeful also, as this work proceeds, there will be opportunities for states to do that.

COMMISSIONER McCARTHY: It was just so complicated and so hard, so that was one part of it, back to, Kirstin, what you were saying, that low take-up rate. We almost dropped out four or five times but glad we did it.

And I think the other thing, then, the argument that I was making is, okay, maybe the evaluation didn't show some of the things. Okay. But do we have any evaluations on D-SNPs that are showing better outcomes than we had from MMPs? I think the answer is no. I don't know, though. If you're evaluating one program and you're saying it's not working, are you evaluating the other one? So

just something for us to be thinking about as we go forward.

CHAIR BELLA: Or are we evaluating fee-for-service? Yes.

All right. On that note, other comments from Commissioners?

[No response.]

CHAIR BELLA: Kirstin and Drew? Again, interest not just for me seems to be high on this topic. So do you have what you need?

MS. BLOM: Yeah, I think we're good. Thank you, guys.

CHAIR BELLA: Okay. Then thank you very much.

We will open it up to public comment. We welcome comments on the sessions today around HCBS and SMACs. If you'd like to make a comment, please use your hand icon, introduce yourself and the organization you're representing, and please keep your comments to three minutes or less.

Yeah, we have Henry. Welcome, Henry.

PUBLIC COMMENT

* MR. CLAYPOOL: Hello and thanks. I'm Henry

Claypool. Gosh, I guess I'm representing myself today. I guess I'm Claypool Consulting for that, or I'm the Policy Director at the Community Living Policy Center at Brandeis University. So that sounds a little better anyway.

I wanted to commend the Commission for -- at least I was able to attend this morning's agenda, and wow, did you pick a lot of work to do. And I'm so pleased to see the agenda and really applaud the staff for the work that they're doing around HCBS. It is so needed, and thank you.

My comments are really just kind of going to pertain to, I think -- again, I'm having a hard time tracking exactly which of the HCBS presentations, but I think it's your -- the work around (c) waivers. I wanted to just first acknowledge that in the scope of who might be considered a kind of direct support profession or a direct care worker, the challenge of making sure that people providing peer support are included there, and how are we looking at habilitation as an HCBS kind of benefit, et cetera?

So with that as a comment, I wanted to also get to this idea of there's a movement to -- and the

Commission staff acknowledged this direct support worker. They're specific to people with IDD, and there is a -- I believe they have legislation introduced on the Hill, and I would just ask that that be examined pretty thoroughly, because I think it leads to greater fragmentation, especially in light of the presentation earlier, where we're really focused on what it would take to start to streamline some of the HCBS authorities.

It would be unfortunate if we started moving that another direction when we look at categorizing or classifying the direct care workforce. I think we have to be very careful there, and I wanted to put that in the record.

And finally, there were comments made about the fact that we're unlikely to see a human-based workforce that's going to meet the growing and existing needs of the population that's currently eligible for HCBS, and as we know, it will expand.

I applaud the efforts to look to technology to see what types of efficiency we can realize there, but I think I urge the Commission to think about a very important issue, which is immigration. And it is likely the only

lever that policymakers have, unfortunately, to address some of the workforce needs going forward.

I think there are a range of options that other sectors of the economy have used to address their labor demands, and I think it's about time we start thinking seriously in this field about how we might position that or use existing authorities, which are very, very limited and under-resourced, but I think you get the gist of my point.

I think, ultimately, it may be a legislative proposal, and we all know how fraught that has been historically in getting the Congress to act on immigration. But I don't think it's an excuse for not doing this important work.

And again, a final note, I would just ask the Commission to please maybe avoid using that venue in the future. I was there last night for another event, and I noticed that they had a portable wheelchair ramp. It's a historic building, and they don't, I think, technically comply with the ADA. But that's not to diminish the great work of MACPAC.

Thank you so much.

CHAIR BELLA: Thank you, Henry.

Lydia?

MS. DAWSON: Hi. My name is Lydia Dawson. I'm the Senior Director of Government Affairs for the American Network of Community Options and resources, ANCOR. We are the association of Medicaid-funded providers supporting people with intellectual and developmental disabilities.

And I wanted to offer thanks and appreciation to MACPAC for looking at the unique relationship that reimbursement rates have on access to services and the direct support workforce crisis, and I was hoping to just offer to the Commission that there's a pending rule right now out of the Department of Labor. We've been referring to it as the "overtime rule," informally, but the formal name of the rule is "Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales, and Computer Employees," but principally, the rule proposes to increase the salary threshold for overtime pay for -- from what it is currently at, approximately 35,000 to the 35th percentile of earnings of a salaried workers, which right now is approximately $55,000, but likely at the time that the rule would be finalized, it would look a little bit more like 60,000. But I'm hoping to draw your

attention to that rule because it will significantly increase the cost of delivering services for people with intellectual and developmental disability.

And while in no means, I mean to make comment that that the rule is not important or that investments in the workforce are not important, but again, just speaking to the importance of ensuring reimbursement rates and payment policies are adequate to support new federal policymaking, which has a fiscal impact on service providers and people who are Medicaid- funded. While these rules out of the Department of Labor are intended to support employers and the workforce across the nation, there is a unique impact to Medicaid-funded providers and specifically those supporting people with intellectual and developmental disabilities, because there's no means to unilaterally or independently change the payment rates for those services to accommodate or to create commensurate funding necessary to implement the rule.

And given the workforce crisis and the precarious nature that we find ourselves in and access to services for people with intellectual and developmental disabilities, especially in home- and community-based services, it's so

critically important that there's interagency dialogue between the Department of Labor specifically for this rule and Health and Human Services to ensure that as federal policymaking creates a new higher fiscal impact of delivering services, that policymaking to ensure adequate payment Of services is in alignment with that.

So we have certainly some specific recommendations from ANCOR, which we are more than happy to share with the Commission, but also just hoping to draw attention to this issue and how it interrelates with Medicaid payment and ensuring adequate providers to support people with disabilities in their homes in the community.

Thank you.

CHAIR BELLA: Thank you, Lydia.

Christina?

MS. WU: Good morning. This is Christina Wu with the National MLTSS Health Plan Association.

So on behalf of the MLTSS association, I wanted to express our appreciation for this extremely critical work on direct care workforce payment.

We recommend that the Commission spend some time understanding the role of MLTSS plans in strengthening the

workforce and commend the Commission for including managed care plans in your interview list.

We wanted to flag that we recently published a comprehensive report on this topic, which culminated from nine months of engaging our member MLTSS plans and in-depth research, and our report highlights many emerging promising practices that MLTSS plans are currently engaging in, including developing value-based payment arrangements with providers tied to workforce development goals, internal capacity building within plans to develop workforce development teams to support their provider network, and collaboration between MLTSS plans as well as with the state on areas including data collection and sharing.

Additionally, given their role managing their provider network, MCOs are well positioned to advise states on the appropriate inputs and critical data considerations for cost studies that states are conducting on providers' projected costs to help determine the true cost of care.

So we recommend that you read our report for more details on each of these emerging promising practices and the aligned state and federal policy recommendations, and we encourage you to reach out to the MLTSS association with

any questions.

I also wanted to flag that our affiliated organization, the Long-Term Equality Alliance, is currently partnering with the Community Living Policy Center at Brandeis University, supported by ACL on a landscape scan of the data sources available to monitor and measure workforce adequacy and impacts on unmet need. So we, through this work, examined data sources available to measure availability of workers, gaps in care, wages and benefits, stability, and consumer experience, including looking for any opportunities to link these data at the provider or individual level, which we saw as currently limited, giving the lack of standardization across plan and state reporting requirements.

So we've dug into the feasibility of using EVV data, which was mentioned by a few Commissioners, and see potential for leveraging this data in certain states that have required reason codes, but we recommend some initial work to assess the accuracy of EVV data before it can be used for evaluation purposes and linking to payment data.

Our report will be published in the coming months, and we are happy to discuss any of these findings

further.

So again, I just really want to thank you all for taking on this important work on the HCBS workforce that really has the potential to move the needle on HCBS access and quality. Thank you.

CHAIR BELLA: Thank you, Christina.

Okay. If we have anyone else who'd like to make a comment, please use your hand icon. I can't believe we didn't have any SMAC comments, and you guys stayed up there.

[No response.]

CHAIR BELLA: All right. Are there any additional comments or questions from Commissioners?

[No response.]

CHAIR BELLA: Our next meeting is December 14th, the 14th and 15th, so a little over a month.

I want to thank Kate, thank the staff, thank the tech team. Really appreciate all the work that went into the last two days' discussions and excited to see this work come back.

Thank you all. We are adjourned.

* [Whereupon, at 11:51 a.m., the meeting was

adjourned.]