PUBLIC SESSION

Hemisphere Room A
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Thursday, December 14, 2023
10:30 a.m.

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: Hello, everyone. Welcome to the December MACPAC meeting. We are thrilled to get started, and Linn is going to kick us off with a session on data, continuing our exploration in this area. Welcome, Linn.

MEDICAID SEXUAL ORIENTATION AND GENDER IDENTITY (SOGI) DATA COLLECTION

* MX. JENNINGS: Thank you. Good morning, Commissioners. During this work cycle we are presenting on the availability of Medicaid primary language, limited English proficiency, sexual orientation, and gender identity, or SOGI, and disability data, for purposes of measuring and addressing health disparities, and access to care and health outcomes. Today I will present findings on Medicaid SOGI data.

Before presenting the findings, I want to bring to your attention that last month CMS released an updated model, single streamlined application with SOGI questions, released a corresponding training related to the addition of these questions, and released guidance to states for adding these questions to the Medicaid and CHIP

applications. So the findings presented today, which include our literature reviews, state survey and interviews are from this past summer and fall, so they reflect the experiences of states collecting these data prior to the guidance being released.

Today I'll start by covering the definitions for this work, and then I will present an overview of the health disparities and federal priorities for collecting these data, and methods and modes for collecting SOGI data, and then I will finally also present the considerations for collecting SOGI data and next steps for this work.

Sexual orientation and gender identity are considered core aspects of how individuals conceptualize their own identities, and data about how individuals identify their sexual orientation and gender identity allow stakeholders, which includes CMS, states, and researchers, to identify sexual and gender minorities and disaggregate these data to understand the experiences of these populations in accessing health care services.

So for the purposes of this work, these are the definitions that we are using. Sex assigned at birth is used to identify the binary sex listened on someone's birth

certificate, and this can be used for verification purposes with other data sources.

Sexual orientation encompasses multiple dimensions of identity, attraction, and behavior, and this information can be used to understand the experiences of individuals who do not identify as straight or heterosexual.

Gender identity is defined by one's sense of self, identity and expression through behavior and appearance, and by the social and cultural expectations that are associated with sex assigned at birth. And this information can be used to understand the experiences of individuals who do not identify as cisgender.

And sexual and gender minorities is a term that is used to identify those who are part of the LGBTQ+ community.

When SOGI data are collected they can be used to measure health disparities experienced by sexual and gender minorities, and research findings indicate that compared to straight and cisgender individuals sexual and gender minorities are more likely to report having a chronic condition or a disability, to report a need for mental

health services, to report poor provider experiences, which can include facing discrimination, a lack of culturally competent care, and provider refusal of care. And they also are more likely to report difficulties with accessing care due to cost and gaps in coverage.

In 2022, the Biden administration issued an executive order to advance equality for lesbian, gay, bisexual, transgender, and intersex individuals. As part of this executive order, the Equitable Data Working Group established a subcommittee on SOGI and variations in sex characteristics data to develop the federal evidence agenda, LGBTQI+ equity, or also called the Evidence Agenda. And this provides federal agencies with a roadmap for developing and implementing SOGI data action plans to measure and address health disparities and inequities experienced by sexual and gender minorities.

Additionally, the Office of the Chief Statistician of the United States developed best practices for collecting SOGI data on federal statistical surveys. The report includes recommended approaches for asking these questions, but it does not require a specific approach or mandate federal agencies collect these data.

And as I said, in November CMS released a new model single, streamlined application, which includes SOGI questions, and these are included as a new optional demographic data section on the application.

CMS also released an informational bulletin with guidance to states for adding these questions to the Medicaid and CHIP applications, and the guidance states that adding these questions is optional for states. States that add these SOGI questions, if they add them exactly as worded on the guidance, they are not required to submit changes for CMS approval, and the guidance specifies protections for these data.

Medicaid and CHIP agencies are prohibited from using or disclosing applicant or beneficiary demographic information, including SOGI, for any purpose other than those directly related to the administration of the state plan. Further, beginning in calendar year 2025, states that choose to collect these data should be able to report them to T-MSIS, but more information is still to come from CMS regarding the reporting guidelines.

Medicaid SOGI data are collected in a number of ways, including on the Medicaid application, in federal and

state surveys, and in electronic health records. Currently there is no federal standard for collecting these data, but there are a number of validated approaches, including those adopted by CMS's newly updated model application.

SOGI data collected on the application can provide Medicaid beneficiary level information, and these can be disaggregated to measure differences in use of services. The majority of state Medicaid programs are not currently collecting SOGI data, and at the time of the most recent review of Medicaid applications only a few states collect gender identity information on the application, and there is variability in how states ask these questions.

A couple of states also ask the SOGI questions as an optional survey that is provided to applicants after submitting the application.

Federal survey data can also be used to look at Medicaid-covered sexual and gender minorities, so federal survey data provide stakeholders with population-level information and can be disaggregated to identify Medicaid-covered sexual and gender minorities. In a review of 13 federal population health surveys, the State Health Access Data Assistance Center, or SHADAC, identified five surveys

that asked questions about sexual orientation and two surveys that asked about gender identity. And in a sample size analysis they identified that all of the surveys that asked about sexual orientation and one of the two that asked about gender identity have sufficient samples for reporting about sexual and gender minorities who were covered by Medicaid.

Drawing from our literature review, our survey of Medicaid programs, and stakeholder interviews we identified several factors, which are shown in this figure, for the Commission to consider regarding the collection of SOGI data, for purposes of measuring and addressing health disparities. These considerations align with many of those raised in the Commission's prior recommendations regarding race and ethnicity data, and some additional considerations were raised in the September and November meetings.

Based on our findings, states reported wanting to use SOGI data for a number of purposes, but states are still very early in the development and implementation of collecting these data.

Regarding programmatic purposes, states are considering adding these questions so that they could use

the data to assess and ensure the program is inclusive of sexual and gender minorities and their health care service needs.

Regarding research purposes, states reported that these data could be used to inform the development of targeted interventions to address barriers to accessing health care services and inequities experienced by sexual and gender minorities.

States reported challenges with updating state data collection and reporting systems, and regarding the updates to the application states reported challenges due to lack of standards at the time of our interviews, and in our surveys, states reported difficulties with collecting SOGI data due to the lack of standards and guidance about how to collect these data. However, it is possible the newly released CMS guidance to states addresses this challenge.

States also reported challenges with language translation. Translated terminology and constructs should be consistent with terminology used by sexual and gender minorities that speak languages other than English. The newly released CMS model applications also include

translations in all language that are available for the model application.

And for newly added questions, training may be needed so that assisters feel comfortable asking these questions and explaining the rationale for their inclusion. The newly released CMS model application includes a presentation of slides with information about why these questions were added and includes information about how to ask these questions of applicants.

States also reported challenges with application length and shared that these applications can be long, so the additional questions may increase individual burden of completing an application.

Regarding data systems, states reported challenges with updating systems used to store and report state Medicaid eligibility and enrollment data to T-MSIS and concerns about adding new questions to the collection system prior to knowing how to report them to CMS. Currently states are not able to report SOGI data to T-MSIS, but the CMS guidance indicates that data elements will be available for states to report in calendar year 2025.

So for data quality considerations, self-reported data are considered the best method for collecting information that reflects an individual's identity. However, administrative forms and surveys are sometimes only filled out by one household member, or a parent or guardian for some populations, and so self-reported data may not always be possible.

Identities can also change over time, and interviewed experts discussed the importance of collecting SOGI data multiple times so that individuals have opportunities to provide responses that are reflective of their current identities.

The lack of standards for SOGI data can limit the comparability and accuracy of data across data sources. Currently there are many recommended questions for collecting SOGI data, and additional research is still needed for adapting measures to children and adolescents.

Data collection methods should also allow for the data to be generalizable to the Medicaid population, and this should be inclusive of sexual and gender minorities. A lack of these data prevent stakeholders from being able to disaggregate the data by sexual and gender minority

populations, and this can lead to the exclusion of these populations from efforts to measure and address health disparities.

And regarding data privacy, when demographic data are collected the collection mode should specify how the data can and cannot be used and that responding to these questions is optional.

There are federal protections to ensure data privacy and to protect individuals from discrimination on the basis of sexual orientation and gender identity. State Medicaid agencies are required to restrict Medicaid beneficiary and applicant information for uses that only pertain to the administration of the Medicaid state plan. And in the 2023 CMS guidance to states for collecting SOGI data on the Medicaid and CHIP applications, CMS includes examples of prohibited use or disclosure, which would include, for example, enabling child welfare investigations.

So at the next Commission meeting I will present our findings on Medicaid self-reported disability data. And then regarding today's presentation we had anticipated potential policy options related to the collection of SOGI

data. However, given the new CMS guidance to states it does not appear that there is an immediate need for action. And so it would be helpful today to receive Commissioner feedback on considerations presented today and whether there are any other factors to include.

I will put up the considerations slide as a reference, and I will turn it back to the Chair.

CHAIR BELLA: Thank you, Linn. I know I speak on behalf of all the Commissioners when I say thank you for the thoughtful approach you are taking to this work. It is always eye-opening to understand what we do and don't have on the data front. I know there is a lot of interest from Commissioners so I will open it up for comments, questions, feedback. Heidi, I am looking at you. Yes. Do you want to kick us off?

COMMISSIONER ALLEN: So first, Linn, I want to thank you so much for all of your work in this area. The presentation and the materials just really lay out such a cogent and nuanced argument for why and how we should collect SOGI data, and I was very hopeful that today, looking backwards, that we would be able to vote on policy recommendations, but there is no better outcome than to

have CMS jump the gun -- not jump at their gun, but our gun -- and add this to the streamlined application.

It is really exciting. I am very hopeful that states will take this option. If you look at participation in BRFSS in 2022, 23 states included sexual orientation, gender identity in BRFSS, which allows us to take a more public health look at SOGI. So I am hoping that maybe the same number of states will choose this streamlined application.

One consideration that I flagged when I read your report is this kind of interplay between T-MSIS developing the standards for how it can be submitted to them. While states are trying to decide whether or not they should add it to the application, it seemed to imply that there may be some states that are hesitant to adopt it until they know how T-MSIS is going to accept the data elements.

And so I just hope that CMS really will work closely with states so that one is not waiting for the other but that they are working in tandem, because even though it will start being available in 2025, that is still a very long way out from when researchers can start to look at this data and identify disparities in access and use and

quality of care and in health outcomes, all of those things which are just almost impossible to get from surveys because the sample sizes are too small.

So there is just this wealth of information that would be available when T-MSIS is ready to make that a part of their dataset, that is just incredible and will just advance the field of health equity for sexual and gender minorities enormously. So the quicker that happens, the quicker we know more about this population.

So if there is any way to articulate that I would be appreciative, but thank you so much for your work. I'm excited.

CHAIR BELLA: Thank you, Heidi. Other comments? Questions? I can't see Dennis and Rhonda. Dennis, thank you.

COMMISSIONER HEAPHY: Thank you and thanks for the work that you are doing on this. I would love to find out more about what the best practices are that are taking place in this space, in the collection of this data, and educating folks on why the data is important from a public health perspective. Because so often people don't understand why the questions are being asked, and therefore

they are not going to respond. So what are the best practices states are using, and how is it being used to measure quality of services in states?

It will inevitably be important for CMS, as it is building its systems for using this data, again, a better understanding of what states are doing in determining how they are able to help them and measure quality of care and equity in access.

CHAIR BELLA: Thank you, Dennis. And I think the silence is mainly because you have covered what we want to see, and Heidi gave some more feedback as well as Dennis on other things you could consider for the chapter. Other than that I think it is so thorough that you have silenced us all.

Tricia?

COMMISSIONER BROOKS: Yeah, just quickly, I think it was the slide deck referred to research that suggested that people are not offended by asking the question, because some assisters or navigators or agents, brokers, whomever maybe uncomfortable asking the questions themselves. And I am not sure there has been a lot of transparency. If we could lift that up in any way, I think

it would be helpful.

CHAIR BELLA: Thank you, Tricia.

All right. Linn, do you have what you need from us?

MX. JENNINGS: Yeah, this is helpful, and I will make sure to highlight all of these things in the chapter, and so thank you for those comments.

CHAIR BELLA: And then you'll be back.

MX. JENNINGS: And I'll be back.

CHAIR BELLA: All right. Thank you very much.

CHAIR BELLA: We are going to transition into a session with Rob on transparency in Medicaid financing. Welcome, Rob.

[Pause.]

BARRIERS TO IMPROVING TRANSPARENCY OF MEDICAID FINANCING

* MR. NELB: Hi there. Good morning. All right.

So today I'm going to review barriers to improving the transparency of Medicaid financing methods. I'll first begin with some background about Medicaid financing and review MACPAC's prior work in this area. Then I'll review some initial themes from expert interviews

that we've conducted about barriers to improving the transparency of financing data at different levels listed here. Later this winter, we're planning to conduct additional interviews with state officials and provider associations, and so today, we're looking for your feedback on any particular issues we should explore further in those interviews.

In addition, we'll be looking for your feedback about whether there's interest in developing policy options for data transparency that build on MACPAC's prior recommendations in this area.

In this work, we're not looking to comment on whether certain financing sources should be permissible but rather are focusing our efforts on data transparency, which is a first step for future work to analyze this important issue.

First, some background. The Medicaid statute currently permits states to finance the nonfederal share of Medicaid spending from a variety of sources, including state general funds, health care-related taxes, and intergovernmental transfers or certified public expenditures from local governments.

According to GAO, the use of sources other than state general revenue to finance Medicaid has increased in recent years. This is predominantly driven by a more than doubling of the use of health care-related taxes between 2008 and 2018.

This figure shows the national distribution of Medicaid financing for different types of Medicaid payments in 2018. Overall, you can see that about 68 percent of Medicaid spending was financed by state general funds. However, DSH and non-DSH supplemental payments are more likely to be financed by providers, typically through taxes or intergovernmental transfers.

In some of our past interviews with states and providers, we've heard a common narrative about why this is often the case. Although providers would generally prefer rate increases that are financed with state general funds, states have limited budgets and challenges raising the nonfederal share. As a result, they often look to providers to help finance these payments. When they do so, they tend to do it through a supplemental payment rather than a base rate increase because it's easier to target the supplemental payment to the provider who financed the

payment.

Over the past several years, MACPAC has examined provider financing from multiple angles. First, in our work on DSH, we have found that supplemental payments are often targeted to the providers who finance the payments.

More recently, we've seen a rapid growth in managed care-directed payments, which are also financed often by providers, similar to fee-for-service supplemental payments.

The widespread use of provider-financed payments affects our ability to analyze Medicaid payment policy in two ways.

First, at the provider level, taxes and IGTs reduce the net payments that providers receive, which makes it difficult for us to accurately measure payment amounts.

And second, at the federal level, these arrangements effectively increase the share of federal spending above the statutorily determined map, which raises questions about what value is obtained by this increase in federal spending.

So to illustrate the effects of financing on provider payments, this figure shows more details about how

taxes and contributions from local governments reduced net payments to DSH hospitals in 2011.

Although the gross payments reported on Medicaid DSH audits were above Medicaid costs -- cost of care for Medicaid patients, we estimated that taxes and funds from local governments effectively reduced net payments by about 11 percent. As a result, the net payments to DSH hospitals in this year were below their costs of care for Medicaid-covered patients, resulting in a different perspective about Medicaid payment adequacy.

To illustrate the effects of financing on federal spending, this figure shows a hypothetical example of an $8 provider tax that's used to finance a $100 gross payment to hospitals. Although the share of Medicaid spending in this example is matched at a 60 percent FMAP, the effective FMAP, after accounting for provider contributions to the nonfederal share, is 5 percentage points higher.

In 2016, MACPAC recommended that CMS collect provider-level data on sources of nonfederal share for hospital payments, and earlier this year, in 2023, the Commission made a similar recommendation for nursing facility payments.

Because provider-financed payments account for a large share of Medicaid payments to these providers, greater transparency is needed to enable more accurate analyses of their Medicaid payments.

Ultimately, collecting more accurate information on payment amounts is a first step needed to assess whether payments are consistent with statutory goals.

MACPAC's recommendations have not yet been implemented, and so if there's Commissioner interest, there's an opportunity for the Commission to make additional recommendations that perhaps provide more specificity to MACPAC's prior recommendations or make them more comprehensive by including additional types of providers.

Again, at this time, we're primarily focused on transparency, which -- first step to get the data that would be needed to inform other types of financing recommendations in the future.

Okay. So with that background, let me dive into some of the initial themes we've heard from our initial interviews with national experts.

In the coming months, we're planning to conduct

additional interviews with state officials and provider associations to explore these topics in more detail.

First, at a high level, we heard a lack of clarity among stakeholders about what the goal of increased transparency was and how CMS might use the data, the data that it collects. In particular, there was concern that in light of some recent CMS proposals, such as the Medicaid Fiscal Accountability Rule, or MFAR, that CMS might use any data it collects to reduce the use of financing methods that are currently permissible under the Medicaid statute.

Although some stakeholders acknowledge the value of calculating net payments to providers, others question why CMS would need to know this since the Medicaid statute currently sets most rules for upper payment limits based on gross payment amounts, not net payments.

In contrast to the often contentious relationship between states and CMS around taxes and IGTs, the experts we spoke with highlighted CMS's recent school-based claiming guidance as a more positive example of CMS working collaboratively with states and providers to clarify financing policies, and so it might be helpful to learn from this experience moving forward.

Next, we looked at barriers to improving the transparency of financing at the state level, including information on the methods that states are currently using to raise the nonfederal share and the amount of funds raised from these various sources.

So CMS currently collects information about state financing methods through a set of standard funding questions that states respond to when they make any changes to their payment methods, the state plan amendment or managed care. However, these data are not currently publicly available.

The experts we spoke with thought this information might be useful and does provide a perspective about the comprehensive view of state payment methods. However, because of the volume of state plan amendments state submitted here, it may be challenging to synthesize all this data to get a comprehensive view about state financing methods.

In terms of financing amounts, the statute currently requires CMS to collect data on state-level provider tax amounts, but in our review, the information collected seems to be incomplete.

So, for example, in 2018, states reported $29 billion to CMS in provider taxes, but in response to a survey from GAO, they reported $37 billion in provider taxes.

In addition, it's important to note that intergovernmental transfers and certified public expenditures are not currently reported to CMS.

The experts we spoke with noted that state budget officers already do track the different sources of Medicaid financing, and they need to have this information in order to put up claims for federal funding. And so it may not be particularly hard for states to compile this information. However, they noted it may be difficult to identify exactly which financing source is used to finance which payment.

In some cases, the taxes or contributions go to separate funds that are used to finance certain supplemental payments, but in other cases, the financing is used, put into a larger pot of the state budget, and so it's hard to exactly track where the funding is being used.

So then moving down to the provider level, the experts we spoke with highlighted a number of potential mechanisms that could be used to collect this data as well

as some of the potential challenges of doing so.

First, for context, in the MFAR regulation, CMS proposed that states would report financing data on new provider-level supplemental payment reports. Although MFAR was ultimately withdrawn, Congress has begun to require states to submit provider-level data on supplemental payments. But this new statutory requirement doesn't include financing amounts.

If financing data were added to this report in the future, some of the experts we spoke with noted that, again, it may be challenging for states or providers to link the financing to a specific payment.

In addition, there's a limit that the supplemental payment reporting just deals with supplemental payments and wouldn't capture information on provider financing used for base rate increases.

Another potential data source that experts discussed was provider cost reports. Currently, Medicare cost reports do include some information on Medicaid provider taxes. However, it's lumped in with information about other taxes that providers pay.

It's less clear how intergovernmental transfers

or certified public expenditures may be captured on cost reports. So it may be more difficult to use cost reports to collect these data.

In addition, it's worth noting that not all providers submit cost reports. Hospitals, nursing facilities, and other large institutional providers typically do submit cost reports, but other non-institutional providers do not.

A third option to consider is having the state report provider-level financing data based on the information that it collects. In our review, we learned that this approach is actually now being used in Texas as part of a new state legislative requirement. Specifically, the state has begun reporting provider-level financing data for taxes, intergovernmental transfers, and certified public expenditures. And in Texas's case, they have been able to link the financing to specific supplemental payments. And so we're planning to examine this data more in the future.

A final challenge we discussed with experts was how best to use provider-level financing data to determine net payments at the provider level. The experts

highlighted a number of issues to consider.

So first is the fact that some provider-level financing is used to fund Medicaid payments that's not returned to the provider. As a result, some of the experts we spoke with thought it might be better to characterize these provider contributions just as a cost rather than considering them offsets to specific Medicaid payments.

Second, for large health systems, experts noted that it may be difficult to track the specific services that financing and supplemental payments support. As a result, it would be easier to calculate net payments at the facility level rather than to calculate net payments for specific services within a facility.

And third, some experts questioned about how local government contributions such as intergovernmental transfers should be accounted for. In some cases, intergovernmental transfers come from local taxes, similar to state general funds, but in other cases, intergovernmental transfers come from other patient care revenue for publicly owned facilities, which is more similar to a provider tax.

Fourth, we heard about contingency fee payments

that some providers pay to consultants to help them develop new payment and financing arrangements, and these are another added cost that might affect the net payment that providers receive at the end of the day.

And finally, we heard about private arrangements between providers to redistribute provider tax-funded payments so that all providers are paid back the amount of tax that they contribute. This arrangement is currently the subject of several lawsuits between states and CMS, but it's important to keep in mind since it affects our ability to know the final amount that providers are being paid.

So in terms of next steps as we continue this work, as I mentioned, we're continuing to interview additional state officials and provider associations to learn more about these issues.

In addition, we're planning to further examine some of that new provider-level financing data in Texas to further illustrate how this type of data might be able to inform federal policy.

Finally, if Commissioners are interested in developing transparency policy options in this area, we could return at the January meeting to discuss these in

more detail.

We plan to include a chapter in MACPAC's June 2024 report summarizing our findings, and it could include any additional transparency recommendations you'd like to make in this area as well as any perspectives about longer-term work that the Commission would like to pursue in this area.

So that concludes my presentation for today. To help guide your conversation, here are some policy questions for you to consider related to some of the themes that we discussed.

Again, we're looking for some of your initial feedback on our initial findings as well as your thoughts about transparency, recommendations, and future work that we can do.

Thanks so much.

CHAIR BELLA: Thank you, Rob.

I know you all think I only get excited about duals, but I get really excited about this.

There's a lot to unpack here. I think just sort of as a base level, the first thing we need to kind of give Rob feedback on is, are we interested in having

recommendations about data transparency come back? Given the Commission's interest in this in the past -- and it's a very consistent theme for us -- I'm going to assume that's yes. But I'd like -- as you make your comments, please validate that we are interested in that, or if you're not interested in that, obviously get that out as well.

And then let's also get on the table, things that you would like to think about on a longer-term approach that they could be related to additional transparency or other things related in the payment and financing realm.

So with that, I will open it up for comment. Bob, then Patti.

VICE CHAIR DUNCAN: First of all, again, thank you, Rob, for just great work. In reading through this, I mean, it just shows how complicated and intertwined this is, and I think we owe it to ourselves as citizens of this country to understand how financing works and how dollars are being used.

To that first question you asked, how can CMS, states, and providers reduce concerns about how financing data will be used, you talked about in the report and today where there was one example around the school health issue

that the states felt was a collaborative effort. What can we learn from that to help specify the clarity of what CMS would use this data for and create more of a collaborative workforce between the states and CMS so that we can get to a point of transparency?

MR. NELB: Yeah. I think the key part with that guidance is that it's really forward looking and kind of helping to support states and using the existing flexibilities that are allowed in the statute.

I think there's concern that if CMS started using these data to do like a retroactive disallowance of an arrangement that a state had that was sort of previously approved by CMS but is sort of in these gray areas of policy, that that might be counterproductive.

Thinking about how this information of transparency for future policy can maybe be different from sort of oversight actions of trying to take away federal funding might be a distinction to make and sort of clarifying again what the intent of this data might be for.

VICE CHAIR DUNCAN: Thank you.

CHAIR BELLA: Thank you, Bob.

Patti?

COMMISSIONER KILLINGSWORTH: It's really, really good work on a very complicated topic.

First of all, I do support sort of taking the next steps to really increase transparency as it relates to this issue.

I also support a longer-term strategy once we have greater insights to really think about potential changes that are needed in other policy areas, and in that vein, one of the things that I really am concerned about that I'd like for us to dig deeper into is how these kinds of payment flexibilities, payment policies impact access to certain home- and community-based services, because these payment mechanisms tend to favor institutional providers, right?

So if you look at who is using them, it's primarily nursing facilities, hospitals, and ICFs, and it allows them then to experience, I believe, rate increases that home- and community-based providers typically don't experience, because they have the mechanism available to them. So it's really that intersection of Medicaid and the ADA and are we restricting access to where people would really like to receive their long-term services and

supports by virtue of making the policy flexibility available to institutional providers almost exclusively.

So if we could add that sort of to the future, but in general absolutely support continuing to look into this and appreciate your work.

CHAIR BELLA: Tim. Thank you, Patti.

COMMISSIONER HILL: So I too think continuing to do the work and thinking about this long term in terms of helping to create more transparency and understanding of the financing process. I do note that you just blew by the little example, though, of how the money works. I don't envy you trying to explain that in a very easy way.

The one element I'd like to add and to think about is to not think about this solely as a provider payment issue. It is a provider payment issue, and to Patti's point, there's a disparity issue about some providers getting payments or not. But there's a broader -- in my mind, a broader equity issue here across states and within states who have the sophistication and the wherewithal to take advantage of it. Without any value judgment about whether these are good, bad, or indifferent, there are rules around financing, and some states are

better at understanding those rules and maximizing their flexibility relative to other states. And to me, that creates equity issues across the states.

And so having a better understanding of the transparency and maybe being able to make those rules a little clearer to others so that there's kind of a boat-floating effect, if you will, I think is important.

CHAIR BELLA: Thank you, Tim.

Jami and then Jon.

COMMISSIONER SNYDER: Yeah. Rob, thanks so much for your work in this area. I think it's incredibly important, and I too support a longer-term strategy in terms of looking at transparency in this space.

I'm really encouraged or at least interested by Texas's effort to create a reporting mechanism around provider-level financing. At this point, it sounds like you're just starting to dig in around kind of the structure they're establishing. But at this point, do you believe that the foundation they're building in Texas perhaps could be used on a broader basis?

MR. NELB: Yeah. It does seem really promising in that the data is reported at the hospital level and then

in a way that can be linked to the hospital-level supplemental payment data that we have.

So we'll see, but hopefully, in the next year, we'll be able to come back and show you, again, the net payments, so like that example I showed with DSH hospitals generally, but we could actually look at specific hospitals and show this is -- you know, it might look like you're getting paid a lot above Medicare, but then after the tax, it might be a bit lower.

So in Texas, there's not a statewide provider tax, but there are -- sort of local governments are the ones administering the tax. And then they pass on an intergovernmental transfer to the state, but both of those elements are being reported as well as administrative fees that are retained by the local government. So there's some useful information there.

There's also some information on the certified public expenditures which are used for like school-based services and stuff. I think we have less information on the payments there.

One of the issues with schools is that we don't yet -- with a certified public expenditure, the state can

claim the funding but isn't actually required to pass the federal funding on to the school. And so we don't actually know the extent to which that's happening. So I think we'll be able to make more progress on the hospital side. But the schools might be a topic for another day.

CHAIR BELLA: Before John, I have a clarifying question, Rob. Can you go to slide 12? It's related to what you were saying Texas is doing.

States are not reporting IGTs? I thought they had to report the IGT when they were using as part of the payment that went into the SPA.

MR. NELB: Okay, yeah. CMS asks about IGTs and the standard funding questions, including often information about this is the transferring entity and the amount that's being sent. That's a prospective -- when they're submitting a new state plan amendment, this is what I think I'm going to spend and this is how I think I'm going to finance it.

On the back end, when they go to claim federal funding, the state just says, "I am certifying that I provide this amount of state share to claim the funding," but they don't indicate whether that state share was

generated from state general revenue or IGTs or other things.

CHAIR BELLA: I got it. So you're able to put a dollar amount there based on what the state is putting in prospectively that they want to do on the IGT front, but it's sort of all mixed together on the back end when they're pulling it down.

MR. NELB: Yeah. And to be clear, the number here was based on a survey from GAO. So states have this information, and GAO was able to ask them, and they provided it. But CMS currently doesn't ask for this information on an annual basis, and so that's sort of the disconnect there.

And then the Form 6411 is the statutorily required report, but it's sort of optional, and it's a little bit disconnected from the actual claiming of funds. And so that may kind of explain some of the discrepancies in the dollar amounts that we see.

CHAIR BELLA: Got it. Thank you.

John, then Heidi, then Angelo, then Dennis.

COMMISSIONER McCARTHY: Again, thanks, Rob, for great work on this.

I totally agree that we should be moving forward on this one on transparency, and it is a very complex topic, a lot of different pieces to look at. I'm going to bring up two more to add to it, but I think this is exactly what MACPAC's here for, to look at the policy questions.

If we go back to your policy questions that you were raising earlier, one of them is just currently what is in statute now we should be looking at. There's a disparity between what supplemental payments can be made in fee-for-service versus managed care in this example.

If you look at provider taxes, for instance, if you look at managed care taxes, there is a formula in statute that if you pass that test, you can do a managed care test. Well, some states have figured out how to pass that test, and it meets the letter of the law but maybe not the spirit of the law.

So those are some of the things that I think for MACPAC, we could take a look at going forward, and this is really important work.

Again, the start of it is the transparency part. I agree that that is -- we need to know how payments are being made and where they're coming from.

Thanks.

CHAIR BELLA: Thank you, John.

Heidi.

COMMISSIONER ALLEN: Thank you so much for this, Rob.

I also support making policy recommendations based on transparency for transparency's sake. I think when you're talking about $37 billion and just basically wanting to know some simple things about what that money looks like and how it's flowing, it seems like a no-brainer.

But I'm struck by how complicated this is, how high stakes it is, and how things that are really, really critical and key can be lost in the complications and the high-stakes nature, which is simply that we want to know if providers are getting enough payment to support the Medicaid population and its goals of access, high-quality care, timeliness, and positive health outcomes. And we simply don't know if it's above that threshold or below that threshold, and that makes it really difficult to use policy levers like payment, which is so critical to target where we want to see better investments of money to improve

outcomes where we identify that they are not up to par.

For example, mental health, we know that we need better access to mental health. Well, how do we target payments to improve access to mental health? We can't say how much people are making sometimes, and that is so difficult.

And so I guess looking at this avenue for understanding, it seems discouraging because of all of the concerns that people have, the complications. I would be interested in knowing, is there any avenue for MACPAC to think about alternative data collection that would allow us to get at net provider payments, so that we can actually look at the relationship between net provider payments and access for beneficiaries?

And if so, is it worth teasing out these two issues of, one, transparency for thinking about things like supplemental payments and what the fiscal policy should be and what CMS wants to do, separating that out for trying to understand are providers getting enough money to serve the population and the access goals of the program?

And I don't know if the answer is no, there are no other options, this is our route, which I think then

makes it, for us, higher stakes too and that we should articulate that. There is no other way for us to understand the relationship between payment and access, and so we have to figure this out, not just we care because we care about transparency, but we have to. Or would people be open to, okay, well, let's collect the data in a different way, Texas, GAO, whatever, that would allow us to do the work that we need to do?

So that's kind of my question, comment for future meetings.

CHAIR BELLA: Rob, do you have any initial response?

MR. NELB: Yeah. An important issue that we could certainly tease out as we continue to explore this area. It is hard to think about how you can analyze payments without getting information on how much people are paid and their costs, but we can explore.

And there may be specific approaches for certain provider types. I mean, we've looked at, again, with hospitals using cost reports or other things, but when you really peel back the onion, that this financing data really makes it hard to really trust the information that's on

those reports, and so it's important to collect there.

You highlight behavioral health or other provider types, and we're we are doing more work. We're going to come back soon on physician payment. Perhaps the good thing there is that some of these non-institutional providers are less likely to use some of these financing mechanisms. So we may be able to make more work and analyzing the relationship between payment and access, because we don't have this complication about financing.

But for these providers, especially hospitals, nursing homes that rely so heavily on provider financing, it's really hard to get at this without some of the data.

And yeah, this is a challenging topic and perhaps discouraging. I think it is -- we'll see as we look at the Texas data, there might be -- in some ways, it was actually encouraging in the interviews to see that states may actually have some of this data, and it's just not being collected. And so perhaps if we can get that information, it will, again, be a first step for future work we can do at the federal level.

CHAIR BELLA: Thanks, Rob.

Angelo, then Dennis, then Carolyn.

COMMISSIONER GIARDINO: Let me just echo real appreciation for this. I've envisioned if I ever fell in a bowl of spaghetti and tried to dig myself out, I'd want you there, Rob, because this just feels so complicated.

Now, that said, I also want to echo what Commissioner Dr. Allen said. I don't think anybody's doing anything wrong here, and I think it's really important that we frame this in a way -- this is not a gotcha moment. This is a quest for transparency around how states are using statutory and regulatory vehicles to come up with that nut of money they need to run a program to serve people who live at or below the poverty level. So I don't think there's anything wrong.

But as I think about this, why would people tax themselves? Most of my experience is people try to avoid taxes. So why would people tax themselves? I believe it's really a noble purpose. People are trying to figure out, with the regulatory and statutory vehicles available to them, how do they generate the funds to, I think, pay the providers what they need to deliver the care at cost.

I have worked with providers for 35 years. Very few people try to make money on Medicaid. It tends to be

underfunded. So I would be really interested in a frame of reference in terms of in the ecology of states trying to generate the funds that they need so that people don't go broke delivering care to Medicaid recipients, how are they putting this together, but again, I do not see anybody, frankly, doing anything wrong here. I don't think we're trying to find that there's someone who's figured out how to jury-rig this so that they're making a ton of money.

Most of the providers that I know that are doing are doing this for a very noble purpose, and you are legally allowed to use the vehicles that the laws of the nation provide you to fund yourselves.

So I just want to make sure that really comes out in anything that we write, because I get the sense that there's a mistrust in this, and there's some folks that are thinking this is how you're going to get me in trouble. And frankly, that's one of the reasons why people don't want to be involved as providers with the Medicaid program, because they're always waiting for that next shoe to drop when they're going to have that compliance problem. And many, many private folks that get involved in Medicaid avoid Medicaid because they're always waiting for somebody

to find they're doing something wrong and then they get in trouble.

So I would just really want us to pursue transparency but not in the spirit of "got you," but in the spirit of this is such a complicated system, and we may have overcomplicated it. And folks are just trying to generate the funds so that they can serve these folks in their community that deserve care.

CHAIR BELLA: Thank you, Angelo.

Dennis and then Carolyn.

COMMISSIONER HEAPHY: Thanks. Rob, no surprise that I'm overwhelmed by the data that you presented. I've read this information, and it's mind boggling.

And I want to see if we can just simplify this a little bit and ask for another panel, some guests come in, and this time advocacy groups like family -- I don't know -- Families USA or Justice in Aging and other groups, to ask them what transparency would mean to them, how it might benefit, what data might be helpful for them if it was collected, how might that data help them a better understanding and improving access to care for folks around the country and address some of the equity issues. Patti

alluded to the ADA and institutional bias, things like that.

By bringing a group of folks in to have a conversation about how this work might actually -- as I think Angela just said, it's like not a gotcha thing, but how can we to say it in a way that's going to be meaningful to folks who are on Medicaid? So I think it would be great to bring a panel in and discuss this from an advocacy perspective.

I don't know if you have thoughts on that or --

MR. NELB: We can look into it and think or maybe at least make sure we reach out to more advocacy groups in the interviews.

I think one of the -- let's see. Two challenges. I think advocacy groups, just like we don't have the data, other outside advocacy groups often don't have as much data about awareness about this as well. And then there's a lot of -- but then at each state level, obviously different groups are involved in different financing, certain payment arrangements and things. So we can think through.

We certainly have heard on the HCBS side about the -- in our other work on HCBS payment about the inequity

between nursing homes and HCBS.

And then, yeah, but it's --

COMMISSIONER HEAPHY: I guess I'm trying to get out of the minutia of what specifically needs to be asked as opposed to how transparency can really help support the ability of states and providers to do what they need to do.

MR. NELB: Absolutely, yeah. The thing we always hear is people want to know, again, how their payment rates in their state compare to other states, and to get that, you really need all this data. But then perhaps if that data were available, it could help inform efforts to maybe increase rates in a state that is a poor payer compared to other states. Having those benchmarks are certainly useful.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: Thanks, Dennis.

Carolyn.

COMMISSIONER INGRAM: Thank you. Thanks, Rob. I really liked your presentation. It did make it clearer, especially the pictures. When I was first Medicaid director, I had to call on a colleague to draw me pictures of all of the different matching streams so I could

understand UPL, DSH, state general fund matches, IME, GME, taxes. So the pictures are very helpful.

I agree with my colleagues that we need more transparency in this area and would take it to the step I think maybe where Heidi was going in terms of outcomes and also that Angelo talked about. Medicaid agencies do these things because they're trying to increase access to care and trying to help providers, but a lot of the states are also really trying to tie these back to outcomes now with the work that they're doing. And that's really the important part that we care about. Are we actually making a difference in terms of outcomes and health outcomes and bringing access to care?

So I'd like to take a look at it from that angle of the states that are doing these -- well, everybody's doing them, but what are we seeing in terms of them being successful to increase outcomes for our members?

MR. NELB: Definitely. And yeah, in some of our prior work, we've seen the -- I think the challenges of using the provider-financed payments to promote value-based payment-type efforts, because sort of the providers sort of expect to be paid back the amount they contribute. And so

it's maybe harder for the state to put different quality goals and things to that, but we can continue to explore that and think, again, for this additional federal funding that's being put in, what value are we getting out of it. So thanks for that.

CHAIR BELLA: Rob, can you remind me the -- I know we talk to CMS all the time about these things, but I know CMS wasn't part of the last conversation and the states weren't. What do we know about what they wish they had and where they think their hands are tied? Are we able to -- do we have a pretty good understanding of that?

MR. NELB: To be clear, we did talk to federal officials in CMS, and we continue to talk with them as we continue this work.

Let's see. So the present lawsuit sort of aside, you know, there is, I think, interest in transparency as well and just sort of making sure everyone is clear about the rules of the road and things here.

I do think CMS has proposed the additional transparency, but there is maybe concern that the statute doesn't provide them enough rationale to sort of collect this data. So if there were to be additional transparency

requirements there may be need to be a legislative change rather than just a regulatory, again, because the current statutory construction of Medicaid is generally all focused on that gross payment amount. There are fewer hooks CMS can use to sort of justify collecting that net payment information, even if they also recognize that it would be important to do.

So yeah, I think that's some piece there.

And then, you know, let's see. I think as we think about the different methods, and again, thinking about the goals and how some of this would be used, their current process of these standard funding questions and things were created to deal with concerns about certain financing arrangements that were impermissible in the '90s and 2000s. And so, you know, kind of separating the information that they collect for oversight purposes versus what information would be used for future policy analysis, we're thinking about and, again, where should this data collection be housed, and again, how does the informational stuff you are collecting relate to the oversight functions that CMS also has and takes that responsibility seriously as well.

CHAIR BELLA: I'm smiling because I can remember about 20 years ago these questions being introduced and having to defend and explain and an effective FMAP became a thing.

So I guess what's exciting to me about the opportunity in front of the Commission is also taking a look at those five questions that were originated over 20 years ago. Like do they still fit with how we think we can best accomplish the goals today and the statutory issues and the HCBS issues. I mean, the first step is the data transparency, but as we move forward really not taking anything for granted and making sure that we are checking things that have been around well before the program has sort of evolved into the delivery system that it is today.

Let me see if there are any additional comments from Commissioners?

I would like to put Kate on the spot with her own Medicaid hat on but I will not.

All right, Rob, do you have anything else you need from us? So tell us again, really quick, what happens next? You will be back with recommendations.

MR. NELB: Yeah, at least with policy options. I

think the thought is to come back in January. We will be done with most of the interviews by then but then we will also have some of that hopeful analysis of the Texas data to give a sense about, again, why this information is so important to collect. And then the goal is for something in the June report, but by coming in January that will give us time to iterate if you'd like on the details, and then we'll present the final chapter in April, and if you'd like to make recommendations, we would do a vote then.

And then this is, again, a first step. I think you've all highlighted some important areas to continue work in this area. So that will be something for us to think about and reflect on how whatever chapter we do could be a starting point for future work in this area.

You know we have a long-term plan on hospital payment, and you are going to hear more about DSH and other things today, so some of this will sort of tie into that. But there is a lot more work to do in this area, so we will be busy.

CHAIR BELLA: I see a future of many recommendations to many different parties. Verlon.

COMMISSIONER JOHNSON: Yeah, thanks. Again, like

everyone else said, I totally support the work moving forward.

For the chapter that we will have, will we reiterate what we have already recommended before that CMS and others have not taken up at this point?

MR. NELB: Yeah, so I think there are a few. But, you know, sort of the previous recommendations were just in the context of hospital and nursing facilities, so if you want to collect provider level data you might reframe it, and you want to collect it more broadly for all these provider types and have a kind of comprehensive strategy instead of different strategies for different types of providers, might be less administratively burdensome and provide more useful information, that kind of thing.

So yeah, the goal is to build off of what you said before and hopefully provide a little more detail to help Congress or CMS in implementing it.

COMMISSIONER JOHNSON: All right. We didn't lose sight of that, so that was a good point. Thank you.

CHAIR BELLA: All right. Thank you. We are running ahead of schedule, but that is fine.

We are going to open it up right now for public comment on the first two sessions from the morning. If anyone would like to make a comment, please use the hand icon and introduce yourself and the organization you are representing. And we ask that comments are kept to three minutes or less. We will open that up now.

Looks like we have Charly. I think if you unmute -- yep, welcome.

PUBLIC COMMENT

* Ms. Gilfoil. Thank you very much. My name is Charly Gilfoil. I am with the National Health Law Program. I work on issues of demographic collection in Medicaid and CHIP. I just wanted to express my gratitude for MACPAC doing the work and research on the adoption of SOGI measures in Medicaid and CHIP applications in a single, streamlined application. We are also really thrilled to see them moving forward on this work.

I wanted to highlight a few concerns that we had that perhaps the Commission could consider for the report. Particularly, and some were mentioned in the presentation that Linn gave, we are particularly concerned about the lack of standardization across states and the standard that

has been encouraged or adopted by CMS thus far.

The method that has been adopted to collect data on sexual orientation and gender identity is one that actually doesn't align with the best practice recommendations of experts in the NIH research that was published last year. So the gender identity question is a two-step measure that asks for sex assigned at birth and then asks for current gender identity, and the options that are provided, actually other trans people, by singling out trans people for whether they are a trans woman or a trans man, instead of just man or woman.

The measure recommended by NAESM would just give three options -- man, woman, or trans -- and the point of that is really to be able to allow trans people to identify under a broader umbrella and to solve some of those small-numbers problems.

While it is hopefully not the endpoint of where that measure is going, we are concerned that the CMS adopted measure, it will further harm the trans community and it will also contribute to that small-numbers problem of not being able to disaggregate data.

So that is one issue. The other issue that I

wanted to point out is the binary sex question is still on those applications, on both the marketplace and the encouraged measure that is being adopted on the Medicaid and CHIP applications. CMS still has a mandatory question for the individual to report their sex, whether it is male or female. That only confuses people who are trying to navigate their insurance coverage and understand how that question is different than the question on sex assigned at birth and gender identity.

I think there is probably reasons having to do with eligibility that CMS is interested in keeping that question, but we really want to continue to push CMS to explore other ways to determine eligibility without introducing that confusion.

Finally, I just wanted to really echo the recommendations for CMS to provide technical assistance and guidance to states, assisters, brokers, navigators, everyone who is helping people fill out this application. As was noted in the communication and comments there is really, really low nonresponse rates to these questions, and individuals are really not more afraid to share this information than they are other information having to do

with their demographics.

But there really needs to be guidance to states to help educate on why this data is important and how it will be used, as well as for states having to code this information, particularly with the gender identity question, the technical assistance on the infrastructure in advance of when this data is a part to be reported in T-MSIS.

I would love to follow up. I have been working on this with a number of colleagues across organizations, including the Walker Institute. And thank you so much for this work.

CHAIR BELLA: Charly, thank you very much for your comments. Feel free to continue to send comments to the email address that is on the screen, and I am sure that folks here will reach out if they want to follow up with some of those details as well.

Anyone else like to make a comment from the audience? I can't believe nobody wants to comment on payment. I bet when we make recommendations, we will get some comments.

All right. Thank you again, Rob and Linn, for

this morning's sessions. We are going to take a break now, and we will come back at 1:00 with Rob to talk about DSH. No, no, no. At 1:00. Oh shoot. Aaron. Sorry. We will come back at 1:00 with Aaron, and then we will follow that with our session on medical care advisory committees.

So thank you, everyone. We will see you back here at 1:00 Eastern time.

* [Whereupon, at 11:40 a.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

VICE CHAIR DUNCAN: All right. Good afternoon, Commissioners. Welcome back.

We're going to kick off the afternoon sessions with Jerry and Aaron walking through our annual analysis of DSH, and for the new Commissioners, this is a standard format that we follow each year. We'll have time to comment on the text after the meeting discussion.

So with that, Jerry, you look ready to roll.

ANNUAL ANALYSIS OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS TO STATES

* MR. MI: I am. Thank you.

Good afternoon, Commissioners. Today Aaron and I will be presenting our statutorily required analysis of disproportionate share hospital allotments.

I'll start with some background on DSH policy and then move to our statutorily required analyses, which look at the relationship of federal DSH allotments in three measures of need.

First, I will present on the rates and levels of the uninsured, followed by the amounts and sources of

uncompensated care within each state, and the number of hospitals with high levels of uncompensated care that provide essential community services.

I will then discuss the upcoming DSH allotment reductions beginning next January, before handing it off to Aaron to present our future work and next steps.

So I first wanted to start with some background on DSH. As a reminder, under the Medicaid statute, states are required to make supplemental payments to hospitals that treat a high proportion of Medicaid and low-income patients. These supplemental payments are known as disproportionate share hospital, or DSH, payments.

DSH payments are limited by state DSH allotments, which vary widely by state. Allotments for these payments are based on DSH spending in 1992 and adjusted for inflation. States have wide latitude to distribute DSH payments to virtually any hospital in the state, but total DSH payments to a hospital cannot exceed certain types of uncompensated care that the hospital provides.

Under current law, the fiscal year 2024 federal DSH allotments are scheduled to begin on January 20th, 2024.

So moving on to our statutorily required analysis. According to the Census Bureau, 26 million people or 7.9 percent of the United States population were uninsured in 2022, a significant decrease of 0.4 percentage points from 2021. The uninsured rate in 2022 was highest in adults below age 65, individuals of Hispanic origin, individuals with incomes below the federal poverty level, and individuals in states that have not expanded Medicaid.

As part of the PHE, CMS implemented a continuous coverage requirement, which prohibited states from disenrolling Medicaid beneficiaries, thereby decreasing the uninsured rate.

Following the end of the continuous coverage requirement, states have begun, and will continue, Medicaid eligibility redeterminations.

Medicaid enrollment is expected to decline, and the number of uninsured individuals is likely to increase. According to CMS, by October 2023, over 9 million Medicaid enrollees have been disenrolled.

Hospitals can receive DSH payments up to their levels of uncompensated care. DSH uncompensated care is defined as unpaid costs of care for uninsured individuals

and Medicaid shortfall. The most recent available data on uncompensated care for all hospitals comes from the 2021 Medicare cost reports, which defines uncompensated care differently as charity care plus bad debt, and some of this data is reported for uninsured individuals.

Hospitals reported a total of $39 billion in charity care and bad debt in fiscal year 2021, which represents 3.6 percent of hospital operating expenses. Fifty-seven percent of this amount is charity care for the uninsured. Twelve percent is for charity care for the insured, while bad debt is 31 percent, though this data is reported for both insured and uninsured individuals.

We also looked at how this varies by state that have expanded Medicaid, and on average states that have expanded Medicaid have nearly half the levels of charity care and bad debt compared to non-expansion states.

The other piece of additional compensated care is Medicaid shortfall. Medicaid shortfall is the difference between a hospital's cost of care for Medicaid-enrolled patients and the total payments it receives for those services.

Medicare cost reports do not include reliable

information on shortfall, which is why we often use the annual American Hospitals Association survey for a national estimate. However, while the AHA survey has reported information about Medicaid shortfall in prior years, the survey did not report 2021 Medicaid shortfall information.

In 2020, the last time the survey reported these data, Medicaid shortfall totaled $25 billion and a payment-to-cost ratio of 88 percent, which is largely unchanged compared to prior years.

We can reliably estimate Medicaid shortfall for DSH hospitals, but with a significant data lag using Medicaid DSH audit data.

In 2019, DSH hospitals reported $21 billion in Medicaid shortfall before accounting for DSH payments, which translates to a Medicaid payment to cost ratio of 87 percent, though it should be noted that this varied quite extensively by states, with many states paying over 100 percent of Medicaid costs for DSH hospitals.

To show this variation by state, we bucketed the states by the extent to which they paid hospitals as a percentage of costs for Medicaid beneficiaries. On average, states paid 96 percent of Medicaid costs.

However, as you can see, there is wide variation by state.

On the left, you can see that for the 12 states that have the smallest payments as a percentage of costs, you see that these states pay, on average, 85 percent of costs.

On the right, you can see the 12 highest paying states. These states, on average, pay 16 percent over costs for Medicaid beneficiaries. However, it should be noted that these payments do not account for provider financing of Medicaid payments. Many of these states use intergovernmental transfers and provider taxes to fund these DSH payments and other supplemental payments. This means that these amounts are likely larger than the net payments that these hospitals received after accounting for provider contributions. In addition, DSH can pay for unpaid cost of care for the uninsured, which is not included in this figure.

This year, we also looked at hospital margins in fiscal year 2021. We looked at margin data for all hospitals, as well as for deemed DSH hospitals. Deemed DSH are DSH hospitals with high Medicaid or low-income utilization. These hospitals are statutorily required to

receive Medicaid DSH payments.

Operating margins, which just looks at the cost and revenues associated with patient care, were negative for all hospitals and deemed DSH hospitals, while on the other hand, total margins, which includes other income and HHS's provider relief funding, were positive. After accounting for DSH and provider relief funding, the total margins for all hospitals were 10 percent and for deemed DSH hospitals were around 9 percent.

For the final statutory requirement, we use data from the Medicare cost reports and AHA annual survey to report on deemed DSH hospitals that provide essential community services. The definition for essential community services is not included in statute. So our definition includes criteria like inpatient psychiatric services, burn services, whether or not a hospital is a critical access hospital, et cetera. This is the same definition that we have used in prior reports.

When using Medicaid DSH audit data, we found that 694 hospitals met deemed DSH criteria in 2019. Ninety-two percent of these hospitals provided at least one essential community service, while 55 percent provided three or more,

compared to 38 percent of non-deemed DSH hospitals.

Moving on to our estimates of DSH allotment reductions. The DSH allotment reductions are scheduled to be implemented on January 20, 2024. There will be $8 billion in reductions each year during fiscal years 2024 to 2027. The reductions will also affect states differently and will range from 5.1 percent to a 90 percent reduction in fiscal year 2024.

We continue to find that both reduced and unreduced DSH allotments share no meaningful relationship with different measures of need that Congress has asked us to consider and will continue monitoring congressional action on DSH.

Now I'll hand it over to Aaron to discuss future work.

* MR. PERVIN: Thanks, Jerry.

So I'm going to be going over some of the future work that was described in the draft chapter. It's going to be outlining some of the supplemental and DSH payment work that we'll be working on over the coming year.

So as we discussed in September, the Commission has long held that DSH payment policies should be assessed

in context of all other payments a hospital may receive. This can include base payments within fee-for-service and also managed care. This can include other payments that might pay a hospital up to their upper payment limit, and it can also include directed payments within managed care.

In recent years, some states have started substituting managed care directed payments for DSH payments, especially in light of the impending DSH allotment reductions. In CMS's recent proposed managed care rule, CMS proposed to limit these directed payments to the average commercial rate for Medicaid services.

The average commercial rate generally is substantially higher than Medicaid costs and can result in hospitals receiving a surplus of Medicaid payments that is more than total uncompensated care for both Medicaid and the uninsured. This can have the result of lowering the total amount of DSH payments a hospital can receive.

This pie chart shows how much these payments make up a share of total Medicaid spending to hospitals. As we discussed previously in September, DSH is one of many types of supplemental payments that a hospital receives. The Commission has articulated a view that this payment policy

must be developed within the context of all these other supplementals and other base payments and also directed payments that the hospital receives.

Supplemental payments make up a greater share of Medicaid spending than base payments within fee-for-service while directives make up a greater share of Medicaid spending than that of supplemental payments in 2021. So we're going to be diving into this in the coming year.

We're now engaging in a long-term work plan to further examine newly available data on all types of supplemental payments. This work has three work streams focusing on the following. The first is documenting supplemental payment methods and goals. The second is analyzing supplemental payment targeting, and the third is developing a hospital payment index so we can examine overall payment rates across hospitals and states in a standardized way.

Our work will consider how these different payments work on their own and also their interactions and will inform the following policy questions. The first, are payments consistent, or are these payment policies consistent with statutory goals of efficiency, economy,

quality, and access? The second being, are these payments targeted to hospitals based on measures of need? And the third is, what is the value of paying hospitals more than their cost of care for Medicaid patients or what Medicare would have paid for the same set of services?

As Rob presented earlier, he's also leading a project that you heard earlier on improving transparency on state sources of revenue for how states finance the nonfederal share, which will also help to inform some of this work.

Just to summarize some quick next steps, the DSH chapter itself will be published in the MACPAC 2024 report. We're also going to continue to monitor congressional action on DSH, especially since DSH allotments are scheduled to be reduced in January of next year.

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

VICE CHAIR DUNCAN: Thank you, Aaron. Thank you, Jerry.

Commissioners, any questions, thoughts, comments?

John.

COMMISSIONER McCARTHY: Jerry, can you go back to

the slide where you showed the bar graph looking at cost coverage? I just want to make sure. You had said something on this chart that I want to make sure we got clear. You were pointing out, I believe, in the last bar graph, the third one, one furthest to the right, the fourth quartile. I believe you had said on that one that it would appear that hospitals are being paid more than their cost, but then you would have to subtract out the taxes.

But in this chart, wouldn't the tax already be accounted for in the cost? Or maybe, Aaron, you're looking -- so in other words, if it was simply a "I paid $10 in taxes. I get $10 back," on that chart, it would show up as 100 percent cost coverage. So that's where I was a little confused on that, if I'm reading the chart wrong, because I would have assumed that the taxes will already be in the cost, and thus, that wouldn't be a problem with that chart.

MR. PERVIN: Sure. So there's provider taxes. There's also intergovernmental transfers. There's also CPE -- or sorry -- certified public expenditure.

COMMISSIONER McCARTHY: Let me clarify. Only on taxes. I totally agree on CPEs. Especially IGTs wouldn't be caught there, but on the taxes, wouldn't it be caught as

a cost?

MR. PERVIN: So this is using DSH audit data, and while Medicare cost reports do include information on costs for the provider, the DSH audit data does not appear to capture provider financing within their calculation of Medicaid costs.

COMMISSIONER McCARTHY: But it would -- it does capture taxes that are paid by the hospital, all taxes paid. So that would be caught in the cost report. So it would show up as a cost in the cost report.

MR. PERVIN: It would show up potentially as a cost within the cost report. However, the way that provider financing is collected within the cost report, it's aggregated to such an extent that you can't differentiate between Medicaid and Medicare and also other payers.

On the cost report, it is captured as a provider cost within -- and it's included in our total margins calculation, but on the DSH audits, it is not captured in that same way.

COMMISSIONER McCARTHY: Okay, thank you.

VICE CHAIR DUNCAN: So that clears mud for you,

John?

COMMISSIONER McCARTHY: That was not my understanding of how that is done, so I'll follow up later on.

VICE CHAIR DUNCAN: Okay.

MR. PERVIN: We can also follow up later. Could be that I'm answering mistakenly, but we can clarify also.

VICE CHAIR DUNCAN: Thank you, Aaron.

Any other questions or comments?

All right. Seeing -- oh, John. You're back.

COMMISSIONER McCARTHY: I'm sorry. Can you go back to the pie chart one at the very end?

See, Melanie, you were talking about payments earlier. Payments and DSH or my other two favorite topics.

So on this one, I just wanted to -- this is more of a comment than a question. When we look at this chart, we see DSRIP is 2 percent. So we're looking at this at an aggregate level right across the country, but for those states that are using DSRP, which there's only a -- there's not that many. I can't remember how many it is. That 2 percent may be a big number for that state. It's not a -- so when we look at the charges, for the record, it's like

that -- it looks like it's a small amount, but for a state specifically, it could be a large amount. So I just want to point that out.

VICE CHAIR DUNCAN: Thank you for the clarification.

All right. If no other questions or comments, I'll remind Commissioners, we have a chance to look over the draft after the public meeting to edit and make comments as well.

Jerry, Aaron, again, thank you for great work and appreciate what you've done.

Now we'll move on to Audrey.

[Pause.]

VICE CHAIR DUNCAN: Audrey, thanks for joining us. Audrey is here today to discuss medical care advisory committees. And this is something we will be voting on tomorrow. She is going to be bringing three policy options based on our previous conversations at our last couple of meetings. And so please listen for the tone and clarity in those options as she prepares to bring forth recommendations for a vote tomorrow.

So with that, Audrey, it's all yours.

ENGAGING BENEFICIARIES THROUGH MEDICAL CARE ADVISORY COMMITTEES (MCAC) TO INFORM MEDICAID POLICYMAKING

* MS. NUAMAH: Hello, and good afternoon, Commissioners. During the past two Commission meetings we have discussed the findings and policy options about how state Medicaid agencies can use their medical care advisory committees, or MCACs, to engage beneficiaries to ultimately inform Medicaid policymaking and program decisions. Today I will review the draft chapter for the March 2024 Report to Congress. We will pick up on the policy recommendations that we discussed last month, and you will vote on them tomorrow.

The draft chapter starts with highlighting the importance of beneficiary engagement, then it provides background on the federal statute and regulations related to MCACs and recent proposed federal actions to implement change to the federal regulations. Next, the chapter describes the key findings of our work, such as state implementation of MCACs and the beneficiary experience of participating in MCACs. Then the chapter features three recommendations that address the challenges states and

beneficiaries face with MCACs.

Staff would welcome feedback on the tone and clarity of the chapter as well as the recommendation language, which we updated based on the feedback from our November meeting.

The chapter begins with a review of the importance of beneficiary engagement. As we've discussed, Medicaid beneficiaries can offer state Medicaid programs their unique insight and feedback on how programs and policies are meeting their needs, challenges in accessing care, and opportunities for improvement. State efforts to engage meaningfully with beneficiaries should be mindful of historic distrust of health care systems and other institutions as well as the factors that affects beneficiaries' ability to provide feedback.

Implementing equitable engagement strategies takes time and dedicated effort. State Medicaid agencies use varying methods to incorporate beneficiary input into policy and program decision-making outside of MCACs, such as member-only advisory councils or town hall listening sessions.

Next the chapter reviews the federal rules and

regulations which requires each state Medicaid agency to establish an MCAC that consists of various stakeholders, as seen here on the slide. States have adopted various approaches to structuring and running their MCACs.

The chapter also acknowledges that CMS released a notice of proposed rulemaking, or NPRM, that would change federal MCAC rules, such as renaming MCACs to Medicaid advisory committees, expanding the scope of topics to be covered, establishing a beneficiary advisory group that is a beneficiary-only subcommittee, as well requiring state agencies to publicly post information related to both their Medicaid advisory committee and the beneficiary advisory group activities.

The purpose of these changes from CMS is to increase the two-way communication between state Medicaid agencies and stakeholders and promotes transparency and accountability by state Medicaid agency to committee members.

MACPAC also contracted with RTI to conduct a federal policy review, a 50-state scan, and stakeholder interviews from six states. So the chapter reviews our findings from this scan in order to show the state

implementation of MCACs. As a reminder, this work was conducted prior to the release of the proposed rule, which does address some of these challenges.

Some of the challenges that we heard from states are difficulties finding beneficiaries to participate, and showing that a majority of states have beneficiary vacancies on their MCACs. The federal rules require beneficiary membership but does not specifically require the diversity of those beneficiaries. However, states can establish their own representation requirements within the federal regulatory framework.

Most states offer MCAC members at least one type of support to incentivize beneficiary participation on MCACs, but we heard from beneficiaries that they don't often accept these stipends because of the fear it may affect their Medicaid eligibility.

We also heard that states cite several challenges when it comes to increasing beneficiary participation and engagement. State officials recognize that meaningful engagement efforts to strengthen the relationship between the Medicaid agency and beneficiaries is time and labor intensive, and noted that states faced difficulty balancing

this investment with other priorities.

The NPRM suggests more guidance will be released with best practices for meaningful beneficiary engagement.

Then, the chapter highlights our findings as it relates to the beneficiaries who participate in MCACs and highlight some of the challenges that we heard from them during our interview process.

Some of the beneficiaries stated that the MCAC application is long and complex, and feels much more like a job application. CMS, however, defers to the states on how to develop such an application process.

Across all the interview types we heard that the time commitments for traveling and attending MCAC meetings can also be a barrier to participation. Beneficiaries also expressed feeling more qualified to participate in MCAC discussions on topics that directly apply to their lived experience, and felt less comfortable discussing more technical topics.

The beneficiary members who had the opportunity to sit in on beneficiary-only subcommittees, however, reported that they had more robust consumer engagement and participation. They noted that this environment felt less

intimidating.

Now I will discuss the recommendations, rationale, and implications that are in the chapter, that address some of the challenges that we have identified in our analysis.

The first recommendation is: in issuing guidance and in providing technical assistance to states on engaging beneficiaries in MCACs, CMS should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate beneficiary engagement in MCAC meetings, and clarify how states can provide financial arrangements to facilitate beneficiary participation.

So last meeting Commissioners noted that this policy option, now a recommendation, should not be redundant to what CMS has indicated will be released as forthcoming guidance. Up until this point, CMS has not released guidance around MCACs, so this recommendation actually emphasizes what the guidance should focus on and the additional areas of need that states have identified.

From our analysis, these areas are the approaches for recruitment and retention of beneficiary members specifically from historically marginalized groups,

strategies for assisting beneficiaries in understanding the technical topics in the Medicaid program, as well as clarification on the rules for providing financial arrangements without affecting beneficiaries' eligibility.

State officials suggested technical assistance would be most helpful as well as resources that can be utilized by all states and generate greater beneficiary engagement. The proposed rule states that CMS will release additional guidance more broadly on model practices, recruitment strategies, and ways to facilitate beneficiary participation. However, it is unclear when this rule will be finalized and the guidance will be released.

The implications for this recommendation are for federal spending, the Congressional Budget Office, or CBO, score this recommendation, and they indicated that it would have no direct effect on federal spending. CMS would have to dedicate resources to develop the guidance and provide technical assistance to states.

For states, the federal guidance could assist states with their efforts to engage beneficiaries on MCACs in ways that promote beneficiary voice and contributes to policymaking decisions. For beneficiaries, when states

increase meaningful engagement, they will be able to have a more positive experience and may be able to make greater contribution to MCAC discussions. There would be no direct effect on plans and providers.

The second recommendation is as follows:

In implementing requirements that MCACs membership should include beneficiaries, state Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment, and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

Engaging beneficiaries from historically marginalized backgrounds allows them to share their unique experiences and concerns. The NPRM encourages states to consider diverse representation as part of their member selection of Medicaid beneficiaries, but is not mandated.

This recommendation directs states to include a diverse range of voices as part of operationalizing this existing requirement. State recruitment approaches should include ways to reach out to populations of varying races, ethnicity, age, language, disability, sex, gender identity,

sexual orientation, and geography.

Last month, the Commissioners recognized that diverse beneficiary recruitment may be challenge for states. However, the Commission still noted it is important. In response to this feedback, we crafted the recommendation in a way that would be more actionable and specific. States should set the expectation about how the beneficiary representation on their MCAC will reflect their Medicaid population, and be transparent in their plans on how they plan to implement this.

The implications for Recommendation 2 are: CBO said there would be no direct effect on federal spending. States will have to invest resources in developing strategies and policies for recruiting beneficiaries from communities that are marginalized, and we also recognize that given some of the other programmatic needs that this may be challenging.

However, for beneficiaries, there will be increased participation from beneficiaries from more historically marginalized communities. Again, there would be no direct effect on plans and providers.

And lastly, for our third recommendation, in

implementing requirements to increase the participation of beneficiary members in MCACs, state Medicaid agencies should develop and implement a plan to reduce the burden on beneficiaries in engaging in MCACs by streamlining application requirements and processes, and by addressing logistical, financial, and content barriers.

Addressing barriers and providing beneficiaries with additional assistance would respond to concerns identified by beneficiaries in our analysis. States should examine their application and member appointment policies and identify opportunities to simplify and streamline this process. States should also develop provisions to make meeting times and locations more accessible for participation. Greater use of financial arrangements, allowed under federal regulations, could also help address some of the financial barriers cited by beneficiaries.

Finally, states should take steps to assist beneficiaries' understanding and prepare for MCAC meetings, particularly if topics are technical in nature, to ensure that beneficiary points of view are considered in those areas.

The implications for Recommendation 3 are: the

CBO score indicates there would be no direct effect on federal spending. States will have to dedicate resources to assess current barriers to beneficiary participation and develop a plan for addressing them. Again, given some of their other programmatic needs, this may be challenging. However, streamlining the MCAC application process and addressing some of the logistical, financial, and content-related concerns for beneficiaries would reduce some of the key barriers to their participation.

Lastly, there would be no effect on plans and providers.

So staff hope to get feedback on the tone and clarity of the chapter as well as each recommendation. I welcome questions and comments on the chapter and these recommendations. When you are ready, I have each draft recommendation teed up for easy reference, and I will turn it back to you all. Thank you.

VICE CHAIR DUNCAN: Thank you, Audrey, and thank you for capturing some of our comments and thoughts at the last meeting. We will have this brought forth tomorrow as a vote, so any comments, thoughts, concerns about the polished recommendations? Please, now. Go ahead, Jami.

COMMISSIONER SNYDER: Thanks so much, and thank you, Audrey, for this important work. You have done a great job of summarizing and integrating some of our comments into the recommendations.

One quick question. I know in your first recommendation, part of the recommendation to CMS is to include strategies to facilitate beneficiary engagement. In the third recommendation, which speaks to states, not CMS, we asked that state Medicaid agencies develop and implement a plan to reduce the burden on beneficiaries in engaging with MCACs. But do we also want to include language that also compels states to develop strategies for facilitation beneficiary engagement in those MCAC meetings, to ensure that their engagement is meaningful and that they are able to participate fully in these?

MS. NUAMAH: So just to make sure I'm tracking for Draft Recommendation 3, you are saying to add something here about strategies for increasing and facilitating beneficiary engagement, specifically for the states?

COMMISSIONER SNYDER: Exactly, yes.

VICE CHAIR DUNCAN: Thank you, Jami. We will go to Sonja, then Dennis.

COMMISSIONER BJORK: Thank you for a great chapter, a great presentation, and I am strongly supportive of all three of these recommendations. We have consumer advisory committees at the health plans in California, and ours is really strong and good and diverse and engaged, so I know it can be done, and I think that these recommendations really promote it.

And I am looking forward to hearing Dennis' comments as well as, I know Heidi actually was the organizer of the state's MCAC, so I'm looking forward to hearing their comments as well.

But nice work.

VICE CHAIR DUNCAN: Thank you, Sonja. Dennis?

COMMISSIONER HEAPHY: Thank you. Thanks, Audrey. This is great. And I'm not asking for a rewrite of any of this but it is important to the folks who engage in these processes, something that was stated a moment ago, is that you can actually measure the input and the outcomes of the policies so that states can somehow identify how beneficiary input actually shapes policy, or the outcomes of policy themselves. And then in doing that, I think it might be easier to actually engage folks. Folks often don't

want to get involved because they don't feel like it's going to have any impact on them or on Medicaid policy themselves.

So I just think it would be helpful to have some sort of statement about, if not today or in the end recommendation as drafted today, but somewhere, at some point saying that states should be able to measure the impact of beneficiary involvement in their final policy decisions. And I can talk to you offline about this, but a lot of it is culture and engagements. I will talk to you offline about that. But with the recommendations, somehow by holding states responsible to actually be able to show that engagement leads to changes and how policy is developed.

MS. NUAMAH: Sorry, Dennis. Can I just ask a clarifying question?

COMMISSIONER HEAPHY: Sure.

MS. NUAMAH: Are you saying to include that in the recommendation language or somewhere in the chapter itself?

COMMISSIONER HEAPHY: If you can, or in the chapter itself, because I don't want to disrupt what you've

done here because it's great. So whatever works best.

MS. NUAMAH: Thank you.

VICE CHAIR DUNCAN: Thank you, Dennis. Heidi, your name was called. Do you have any comments or thoughts?

COMMISSIONER ALLEN: Was there somebody ahead of me, though, I thought? John? No? Okay.

Well, I am obviously in support of all three recommendations, and I think one thing that I feel like I -- I guess I struggle still with the fact that this is a statutory requirement for all Medicaid programs that there is beneficiary participation in these councils, and yet it's still not happening and there are all these vacancies. And I think that issuing guidance and recommendations is really good. I just wish there was some way -- and maybe this is something that we could talk about in the future -- but to elevate the importance of beneficiary voices and make it something that is really important.

I think something that maybe, John, you said at one point, which is the only lever to make people do things is like the FMAP, and they are not going to do anything to the FMAP. And I hear that and I think, oh, how do you get

states to want to do this, and really want to do it well. And maybe guidance is the answer to that, but I wonder if thinking about further incentives for states or reporting requirements or something in the future, if there are ways that we can get them to really prioritize it as something that is just a value to the Medicaid program.

And maybe, Dennis, what you said about kind of tying it to ways that the program has changed and been improved might help because then it's like working backwards, you know, where are we going to ask people to engage where we can see their impact.

But I'm really excited about this. I hope that we don't completely drop this topic and maybe we approach it from different perspectives of beneficiary voice in implementing it. Maybe move on from advisory committees to other ways of incorporating voice. But I think it's just such a touchstone for us, as a Commission, and we so value when beneficiaries come and talk to us, and we learn so much from them, that I hope we can just continue to think about it over the next cycles.

VICE CHAIR DUNCAN: Thank you, Heidi. We've got Rhonda, Tricia, then John.

COMMISSIONER MEDOWS: Just briefly. Thank you to Audrey. I support all three recommendations, and I really, truly, and honestly appreciate you incorporating the comments from the last discussion. Thank you.

VICE CHAIR DUNCAN: Thank you, Rhonda.

Tricia?

COMMISSIONER BROOKS: Thank you, Audrey. Great work. We're certainly big fans of making sure the beneficiary voice is heard, but not only heard, but listened to and incorporated. And I think this picks up on some of what Dennis was saying as well as Heidi.

When you think about the 1115 waiver process, states have to put their proposal out for public comment. They have to take the public comment, and then when they submit the proposal to CMS, they have to describe how they have addressed the comments that they received.

And I'm not suggesting that that is the specific way that you could do this, but I agree there's got to be some accountability. It's not just about checking the box that we got this person and that person on the Commission or on the committee, but how did we incorporate their feedback into meaningful change into the program? And I

think that's the piece we haven't nailed down yet, and I'd like to see us continue to work on it.

VICE CHAIR DUNCAN: Thank you, Tricia.

John.

COMMISSIONER McCARTHY: This is a tough one for me. I agree with the recommendations in general, but they're very high level. And then I was trying to think if I put my former hat on and I saw these things, it's like yes, go do more stuff, but it doesn't tell me necessarily how to do it. And I know we give a couple of examples in there, but that's the part that I am struggling with, just from a Commission standpoint, is how far we go on some of these.

So to say recruit more people, but then we don't say here is the best practice or this is the state that's doing the best practice on there on how to do it -- again, I know we hit on a few of those -- that's -- I guess my question is more -- not to Audrey, but to the Chair and Vice Chair and Kate of, like, what is our role in that? Is our role to say here's best practices around this, or is it to make the recommendation?

CHAIR BELLA: Well, that's funny, because Kate

and I were just sitting here talking about, like, how do we actually help the states do this?

When we talked to the states, I don't know that we identified best practices. To the extent that we did, it would be good to make sure they are highlighted in the chapter.

If there are best practices to point to, then we want to be pointing to that in the chapter. If there aren't best practices to point to, then as there has been interest expressed about continuing work in this area and continuing to figure out how to bring the consumer voice in and this is one of those ways, we need to be looking for best practices or looking to others who find best practices or getting that kind of input, because I agree with you, otherwise the recommendations, while well intentioned, aren't going to realize the intended outcome that we want.

Jami, and then Kate probably has a comment.

COMMISSIONER SNYDER: Could that be part of CMS's role in providing technical assistance, gathering those best practices and enlightening the states to best practices around the country? I don't know if we need to articulate that in the recommendation, but it seems to me

that they're well positioned to gather that information.

EXECUTIVE DIRECTOR MASSEY: Yeah, I would just say that in Audrey's chapter, through the interview process, when states identified particularly promising practices or strategies that they adopted, they were absolutely specified. We generally, in our recommendations, don't capture best practices. What we're doing is trying to provide a direction for both CMS and the states to pursue because, as we all know, each state's Medicaid program is individual.

For example, on the recommendation that's talking about diversity, it should be a state's decision, and it should be something that they really wrestle with, which is, what does diversity mean in the context of their state? Does it mean race and ethnicity, demographic characteristics? Does it mean that engaging with individuals living with disabilities is important? Do considerations related to urban/rural policies if that's top of mind for the state important? And does that perspective need to be reflected?

And so these things, I think, can be fluid, but they should be specific to the needs of the state. And so

for that reason, we weren't as inclined to be prescriptive or to say this best practice is the North Star that all states should be migrating towards.

MS. NUAMAH: And I know you said the question wasn't for me, John, but just to add, I think that's also part of the reason why we have Recommendation 1 as well in terms of really wanting to make sure CMS can provide some of that additional guidance for the states around how to do these areas. So the two recommendations that are more for the states also do align well with Recommendation 1 in terms of the areas where states may need some of this additional help. That's where CMS can step in. So they all kind of connect together in that way.

VICE CHAIR DUNCAN: Thank you.

Adrienne.

COMMISSIONER McFADDEN: Yep. Audrey, thank you again for the work. I also want to chime in my support of the three recommendations.

To Kate's comments, I really appreciate those because I think the one thing that I wanted to be sure of is that the spirit of what we're -- our recommendations were captured and the specificity of looking at

historically marginalized populations wasn't read strictly, and that the states were able to sort of interpret that to the needs of representations of what their program looks like. And so I just wanted to make sure that we continue to capture that within the chapter.

CHAIR BELLA: Thank you, Adrienne.

Dennis?

COMMISSIONER HEAPHY: What John said sparks something in me, because I agree with you, John. The recommendations are not enough, and I agree with the recommendations. I think we can put them forward.

But, Audrey, as the work continues, I think we need to do a deeper dive into better understanding what role disengagement, discrimination, stigma, all those sort of things play into why folks don't get engaged in these committees, because there's a reason that folks don't get engaged.

And so I think part of this is states have an obligation to better understand the folks that they're serving in Medicaid and Medicare, so they can do a better job of meeting the needs of the population.

I think the recommendations are important, but we

need to dig deeper or the states need to dig deeper to better understand the populations and how they are, which is needed to get folks on the committees.

VICE CHAIR DUNCAN: Thank you, Dennis.

Verlon?

COMMISSIONER JOHNSON: Yeah. I was actually going to say something very similar to Dennis.

Again, John, you did a really good job of summarizing a little where I was coming from and where I was thinking about this.

I still have a concern. I know what we're saying in terms of really setting the stage, making sure that states understand the importance of their populations, but when I look at the recommendations, which I completely support as well, I still wonder, do all states really understand the importance, and are they assessing where they are? Because if I read that recommendation, if I were a state Medicaid director, honestly, and I saw, oh, I should do these things, I'm not necessarily sure, if it's not in my priority at that time, that it's something I would consider.

So I know there's probably not a way we can add

more teeth to that, but I just wanted to bring that point up as a concern for me, to be honest with you. Thank you.

VICE CHAIR DUNCAN: Thank you, Verlon.

Any other thoughts? Yes, Carolyn.

COMMISSIONER INGRAM: I just want to thank you also for adding in the chapter the information about the requirement for Tribal consultation, and I echo my support for the recommendations, but I'm wondering also if there's something we can add about going further and encouraging states, especially for Tribal communities, to be able to participate via video or teleconference.

VICE CHAIR DUNCAN: Thank you, Carolyn.

Anyone else? Sonja.

COMMISSIONER BJORK: Regarding the reflecting back to the group on how their feedback was used, there's also best practices about that. So I know we're not going to put it in the recommendations, even at our health plan, from small things to big things, we show them how their input mattered. And that's why the group is so engaged.

So a small thing was we wanted to get rid of the "Advice Nurse" magnet. Nobody uses that. No, the consumer group said, "We love the magnet. We put it on our fridge."

So we kept it, and they all got a special magnet.

But then there are big things. Like, our transportation vendor was terrible, and they kept bringing to us instances of missed rides and late rides and things. And we ended up -- we got rid of that vendor, and so it wasn't only because of their feedback but how good they felt that the things that they shared got accounted for.

So at the end of every year, we do a recap. Like the December meeting involves "What did we accomplish this year?" "Oh, we had a speaker come and talk about the housing programs in the community." "Oh, we dealt with the 'Advice Nurse' issue." One of the members wrote an article for our newsletter. So we showcase all these things that they have done, and then they feel like, "Wow. My hours that I spent here really mattered."

So I'm not sure how to work that in. It's also not impossible. These are really commonsense type of things as well. So I think that it could be the role of CMS to assemble a package that they can give to the states, a how-to, you know, and so I don't know how directive we can be about that.

When we say technical assistance, is it clear

enough? I mean, is that -- that's what that is, right? Creating a guidebook and suggestions and thinks like that.

So I'm not saying change anything in the recommendations, but I agree about putting maybe some teeth, some more stronger language in the chapter about the importance of reflecting back on accomplishments and how feedback was used.

VICE CHAIR DUNCAN: Thank you, Sonya.

Dennis?

COMMISSIONER HEAPHY: This the last comment. The implementation council we have for the duals demonstration, every year we have an annual report, and the annual report very much outlines all the accomplishments of that year, and then we have a record over every year of all the achievements and unfinished business. So not only we have the achievements that were accomplished but unfinished business. So we can track what's been done over the last 10 years in One Care, which has actually been very helpful for CMS and for other states, for advocates in other states.

So I think what you're saying is absolutely right, Sonja, and this is something that gives folks a

sense of empowerment and actually does show that Medicaid can be improved in states by including beneficiary voice.

VICE CHAIR DUNCAN: Thank you, Dennis.

John?

COMMISSIONER McCARTHY: I just want to point out again that this is hard. Running an MCAC and getting input is difficult to do in any situation. I ran one here in D.C., which was super engaging, and one in Ohio, which wasn't as much, but we made it more engaging by doing some changes. So I do want to point out that I think states really do try on these things. I don't think states are purposely not doing some things. That may be the case, but these are hard to do.

And I'll just give an example. In our Recommendation 3, we say make it easier. One of the issues is time off of work, and the implication that I read from that is, "Oh, you shouldn't do the MCAC during the day. You should do it some other time of the day." When they've got issues with employees, then can they do it?

And then for us at MACPAC, all of our meetings are right during the middle of the day. So it's not like we're holding meetings -- or maybe we do sometimes at

night. And we want public input. So there's a little bit for me of like practice what you preach on some of these and understanding some of those different pieces to it. Again, I think we're going in the right direction.

I think some people took what I said earlier as I want more teeth in it. I'm not saying that -- I wasn't saying I wanted more teeth in it. I was just saying it -- and I agree, Audrey, there's pieces in there. We've pointed out states, but it was just more about how far do we go with some of those things.

But again, I just wanted to point out that I think a lot of states are trying hard on this one, and it is good to point out, hey, here's what's working, not what's working. And I think some people hit on it with can we have CMS -- I guess that was my question. Was it our role to identify best practices, or is it CMS's role to identify best practices? What I heard was really not our role, maybe. Maybe it's CMS. So I wanted to clarify that part.

VICE CHAIR DUNCAN: Thank you, John, and again, appreciate your insight.

Melanie.

CHAIR BELLA: I think when there are best practices, it's everybody's job to point them out in these kinds of things.

I'm having similar flashbacks to John of multi-hour MCAC meetings, and I'm thinking about the powerful special interests that were paid lobbyists sitting around the table.

While these recommendations, I'm fully supportive of the recommendations, I do just want us to keep remembering that we need to take any and all avenues that we can to find ways to get real people's voices into our work.

I'm thinking about the duals demos and requirements around that. There's no way the MCAC, no matter how well intentioned, could have possibly sort of gotten the depth of input that you need from people who you want to be excited about those programs, so not losing sight of how to look for other avenues to get meaningful, dominant beneficiary voice into the design and monitoring and implementation of the program.

Audrey, I know that you are in full support of that, so just important to keep that in mind for all of us.

VICE CHAIR DUNCAN: Thank you, Melanie.

Anyone else?

[No response.]

VICE CHAIR DUNCAN: All right. I'll remind my fellow Commissioners that, again, you'll have an opportunity to provide feedback on the chapter after the public meeting. So again, put your thoughts and comments in that as we'll work through. This will be coming again to vote tomorrow on the recommendations that presented.

Yes, Heidi.

COMMISSIONER ALLEN: Sorry. I was just wondering, are we making any changes related to the comment about technology and technological act -- you know, like allowing people to participate online? Because we have to vote tomorrow, right? And so any changes that we make, we would need to identify today.

And I did think that was a really -- when I worked, when I had my Medicaid advisory committee, we would take things on the road all the time, and we would go to all these small towns in Oregon, but technology has made it so much easier for people to participate and bring voice. And so having it somewhere, the word "technology" somewhere

in one of the recommendations, I think might be a good -- and then we can, of course, add a sentence or two in the chapter. But I would like to see it somewhere in the recommendations.

CHAIR BELLA: So Kate and team are furiously typing, I think, some options for taking the feedback that we got. So they'll take that back, and if there are -- I don't think there are going to be any material wording changes, but there could be some tweaks here and there, and that will come back to us tomorrow and be called out before we vote.

Do you want to say anything else on that? Thank you, though, for clarifying. It's fun to sit here and watch the word scramble that happens when we give feedback. So thank you, everyone, for the feedback.

All right, we're going to take public comment. Do you want me to take that, Bob, or would you like to do that?

VICE CHAIR DUNCAN: You can run with it.

CHAIR BELLA: All right. Well, thank you, Bob. Thank you, Audrey.

We're going to open it up to public comment. So

anyone who would like to comment on this and the upcoming recommendations, please raise your hand. Introduce yourself and the organization you're representing, and we ask that you keep your comments to three minutes or less, please.

All right, we have Arvind. If you unmute, Arvind, you are able to speak.

PUBLIC COMMENT

* MR. GOYAL: Can you hear me?

CHAIR BELLA: Yes, we can hear you.

MR. GOYAL: God bless. My name is Arvind Goyal. I'm Medical Director for Illinois Medicaid Program.

I only got the last, I guess, half hour of your discussion. So I apologize if this is any sort of repetition, but I did want to say that you all recognize the challenges in recruiting Medicaid beneficiaries to serve on these committees. We've had that challenge as well. We filled that challenge partially by using parents of Medicaid beneficiaries, if they're children, sometimes spouses, sometimes advocates even, but it's a challenge.

So it's in the law. I think we do need better representation, and we also recognize that Medicaid

beneficiaries may not have all the resources, the time, or interest to serve.

So here's my input. I think we need to either incentivize or penalize lack of participation of Medicaid beneficiaries to make a difference. A recommendation probably will not make a material difference in any sort of near future.

Incentivize, I can think of, and I think I heard it mentioned, maybe a small percentage of federal medical assistance percentage (FMAP) increase that would allow the states to pay Medicaid beneficiaries to participate. If there is a payment for it and not just travel expenses, many states may be able to pay, but if there is a payment for it, we could even go to the extent of asking, hey, who wants to serve, and there could be an election rather than an appointment.

I just don't think that unless you make some sort of incentivizing or penalizing recommendation -- and I think incentives that work much better in this particular case. It would be a tremendous help.

And I would stop there, and I would be happy to answer any questions in the remaining time from the

Commissioners.

CHAIR BELLA: Thank you very much for your comments, Arvind.

MR. GOYAL: Thank you.

CHAIR BELLA: All right. It looks like that's it. So we have a break now. We will come back at 2:30, and Martha will join us to talk about unwinding data. So we will see you all at 2:30 Eastern time. Thank you.

* [Recess.]

CHAIR BELLA: All right. Welcome back.

I might be a minute early, so we'll drag out this introduction. Martha, it is always lovely to see you. Thank you for joining us to give us an update on the unwinding and the data that we have and we expect to have. So I'll turn it over to you. Thank you.

DATA UPDATE ON UNWINDING THE CONTINUOUS COVERAGE PROVISIONS

* MS. HEBERLEIN: Thanks, and to change things up a little bit, it's just me. There's no panel with me, although I did have some good support behind me to check the numbers. So hopefully, they're all right.

As Melanie said, we're going to be talking about

data today. So I'm going to begin by reviewing the reporting requirements related to the unwinding before I present the most recently available data from CMS that includes renewal outcomes, enrollment changes, transitions in coverage, operations data, and then I'll conclude briefly with next steps.

So CMS has long indicated the agency's plans to monitor state progress in unwinding the continuous coverage requirement, providing states with a template and data specifications for reporting in March of 2022. States were required to complete a report summarizing their monitoring plans as well as submit a baseline and then monthly data for a minimum of 14 months on their post-PHE progress. Monthly reports track progress and include pending and completed applications, renewals, and pending fair hearings.

The Consolidated Appropriations Act of 2023, or CAA, codified a number of the unwinding metrics and other reporting requirements specifically related to renewals, call center operations, and transitions to exchange coverage.

The CAA also required CMS to publicly report

specific measures and establish monetary penalties if states do not report the required data.

All the existing -- all the data states must report under the CAA are included in existing data sources and given that, states do not need to submit a separate report or any additional data to comply.

Just last week, CMS released an interim final rule implementing the CAA reporting requirements and associated financial penalties, and this rule was in effect as of December 6th, 2023.

To begin with renewal outcomes. As of July 31st, 2023, all states and the District of Columbia had completed at least one full cohort of unwinding-related renewals. August was the first month in which all states reported data. So from March through August 2023, a total of 27.3 million individuals were recorded due for renewal nationally.

The most recent August data indicate that approximately 51 percent of individuals were renewed, 27 percent had their coverage terminated, and 22 percent had renewals still pending at the end of the month. Of those whose coverage was terminated, about 71 percent were

terminated for procedural reasons or because an individual did not complete the renewal process.

As expected, the outcomes varied by state. Commissioners, there is a state-level table on renewal outcomes in the appendix of your materials. So Kansas reported the highest percentage of individuals renewed as well as the lowest percentage of terminations. Conversely, South Carolina reported the lowest percentage of individuals renewed, and Idaho reported the greatest percentage of individuals having their coverage terminated.

Across the states, the share of terminations for procedural reasons was more than 50 percent in 38 states and more than 75 percent in 26 states.

It's important to note that there are several factors that complicate the interpretation of these data. Specifically, states have flexibility in how they distributed renewals during the unwinding period, and almost half, or 22 states, chose to prioritize renewals for some or all individuals they had identified as likely ineligible.

Additionally, the adoption of mitigation strategies or Section 1902(e)(14)(A) waiver flexibilities

may also affect the renewal outcomes and the reporting of data. For example, some states are temporarily pausing some or all procedural terminations, either as a mitigation strategy to comply with federal renewal requirements or voluntarily to conduct additional outreach, and they may report zero procedural terminations as a result.

Moving on to enrollment. From March to July 2023, overall enrollment in Medicaid decreased by about 2.3 million individuals from 94.1 million to 91.8 million. This included about 1.1 million children. The overall change in enrollment accounts for individuals who are disenrolled as well as individuals who may have newly enrolled for coverage or reenrolled.

I want to note here that the time frame for these data does not include those individuals reinstated as a result of the ex parte processing issue that we have discussed at prior meetings.

As always, enrollment changes varied by state. While most states did experience declines in enrollment, 12 states actually experienced increases in overall enrollment, and 11 states experienced increases in child enrollment.

A few examples are presented on the slide in terms of the range of changes, and there is also an appendix in your meeting materials.

So the majority of individuals losing Medicaid should have other coverage options available. One model projected that about 20 percent of individuals found ineligible for Medicaid or CHIP would have a subsidized exchange option and about one-third were likely to obtain other coverage outside the exchanges, primarily through employer-sponsored coverage. However, it's unclear whether these individuals will actually enroll in coverage or experience a gap in coverage or become uninsured during the transition.

Initial data on coverage transitions show that few beneficiaries who are transferred to state or federal exchanges have actually enrolled in a QHP, or qualified health plan. In the two-thirds of states that use the federal exchange, about 8 percent of applicants that were transferred to the exchange selected a plan. In the remaining 17 states and D.C. which operate state-based exchanges, about 12 percent of applicants selected an exchange plan.

At this point, the data do not allow us to look at whether children leaving Medicaid are enrolling in separate CHIP. However, enrollment in separate CHIP programs has increased by approximately 4,000 individuals between April and June 2023, which is below the anticipated increase in enrollment.

So to monitor state operations, CMS also releases data on applications and processing time as well as average call center wait time and abandonment rates. CMS and others -- you've probably heard it here -- have noted that excessive call center wait times and call abandonment rates may indicate barriers to completing applications or renewals over the phone as well as getting questions answered.

Between April and August, call center volume increased in all but three states. The majority of states, 35, also experienced an increase in call wait times. The average call center wait time in August was about 12 minutes, but this ranged from zero to 46 minutes. Twenty two states reported wait times of 5 minutes or less, and five states reported wait times of 30 minutes or more.

Call abandonment rates also ranged from less than

1 percent in four states to approximately 56 percent in Nevada. In assessing call center performance data, it's also important to remember that there's variation in how states operate their call centers. For example, some call centers also serve other programs, so staff would be answering questions related to SNAP or TANF as well as Medicaid.

So CMS also monitors and releases data on applications received and processing time. While CMS has acknowledged that processing time may increase during the unwinding period due to pending applications as well as increased application volume associated with individuals who have been disenrolled and subsequently submit new applications, states are still required to comply with the established timeliness requirements.

Specifically, they must process applications based on modified adjusted gross income, or MAGI, within 45 days, and those based on non-MAGI methods within 90.

Almost 2.8 million Medicaid and CHIP applications were submitted in July. This is an increase from 2.4 million in March. Eleven states saw an increase in applications of more than 30 percent, and four experienced

an increase of 50 percent or more in application volume. Twelve states experienced a decline during this time.

From April to June 2023, 50 percent of MAGI determinations were processed in less than 24 hours, and more than two-thirds, or about 70 percent, of MAGI determinations were processed within seven days. Approximately 5 percent of MAGI determinations were outside those standards and processed in more than 45 days.

So compared to the same quarter in 2022, the share of MAGI determinations that were processed in 24 hours and within seven days increased, and there was a 2 percentage point decrease in the percentage of applications processed in more than 45 days. To sum it up, those numbers have improved since last year.

As required, states are continuing to report to CMS, and CMS is reviewing these data and reporting them publicly in line with the CAA requirements. CMS has not issued any corrective action plans to our knowledge, although it has sent two letters to states since the unwinding began.

One was in August based on May data reporting that we talked about a little bit, and then the other was

later on the ex parte issue. And in response to the ex parte issues, CMS has required states to pause disenrollments and reinstate coverage in response.

So the next several months will continue to be a busy time for states and CMS as they continue to process the renewals, and we'll be back at subsequent meetings as issues come to light and to share future work to assess what we can learn from the unwinding.

With that, I'll turn it back to Melanie and try to answer any questions you may have.

CHAIR BELLA: Thank you, Martha. We know you'll be back. That is an understatement. It's very reassuring for us to know that you're keeping an eye on all of this.

Open it up, Tricia? Would you like to start?

COMMISSIONER BROOKS: Sure. I'm not quite sure where I want to start, but thank you, Martha.

I just want to point out that sometimes the national landscape masks issues in specific states. So when you see that 5 percent of applications are over 45 days and that's an improvement, I think you're going to find that a lot of those applications are clustered in a few very large states.

Right now, we know that Texas has a 180-day backlog before an application hits an eligibility worker's desk, and I'm not seeing the action on that I would really like to see.

In terms of the data reporting, you touched on the transitions of Medicaid to CHIP. I think we may see some data come out of CMS on that. We've been tracking those data based on both CMS enrollment reports and state websites that report data. And at some point, our most recent data would show that in states with separate CHIP programs, there's been a decline of 2 million kids in Medicaid and only an increase in CHIP of 137,000. And that compares to Urban Institute estimates, indicating that 57 percent of children in Medicaid would transition or would be eligible for separate CHIP programs.

And states don't actually have to use the reliable data that they have in the ex parte process to move those kids to CHIP, and hopefully, they're going to fix that in the eligibility rule that's due out in the spring, but more needs to be done on that.

We also don't have data on transitions of 1931 parent caretakers to TMA, to transitional Medicaid, and

this is really critical in the non-expansion states where a lot of parents -- where eligibility is extremely low, and they won't even qualify for premium tax credits in the marketplace. As much as we've seen better data on renewals than we ever have in the past, it's still not sufficient.

And I just want to put on the Commission's radar, the need for us to look, take a much harder look at the data that's out there that's being required to be reported. My soapbox is the performance indicators. There's some 80 -- more than 80 performance indicators. We've seen about a dozen of them published. Those indicators have been on the books since 2014.

CMS always said they were going to do a phase two, and it seems like now is the time for CMS to carry forward these reporting requirements on an ongoing basis, and those reporting requirements are tied to the enhanced funding for systems that states are getting.

And we're not seeing the light of day of the PI data, the performance indicator data. In fact, some of it is not as useful as the renewal data has been. You've got things grouped redeterminations of ineligible versus eligibility couldn't be established or procedural, right?

And those are all redetermination -- all determinations. It's not just renewal or application. You can't break it down that way. You can't break it down by eligibility group.

So a lot more work needs to go into specifying the kind of data that helps us make informed decisions about how we're running these programs, and hopefully, the Commission can continue to work on this because I know that data transparency and accountability is a very high priority for us.

Thank you.

CHAIR BELLA: Thank you, Tricia.

Other comments?

[No response.]

CHAIR BELLA: Martha, do you have a crystal ball of what we should expect through the next few weeks and into the start of the year and what you might expect to continue -- what our next update might be?

MS. HEBERLEIN: No, I do not have a crystal ball.

The data have been pretty consistent in terms of procedural disenrollments throughout the time period. Things have gotten better, a little better in terms of ex

parte rates. Remember, these data are from August. So we know states were doing a lot of work and also pausing procedural disenrollments in the time frame right after these data. So I think we will see some indications, maybe, that some of those ex parte efforts have improved the rates and some of the procedural disenrollments at least were paused during the time that they were doing work. And maybe after they've restarted those procedural disenrollments, maybe the numbers will decline.

I do think we will continue to see some additional data on the transitions, both, as Tricia said, to CHIP but also some more transitions to the exchange. I'm curious to see what happens during open enrollment. People who lose Medicaid don't have to wait for open enrollment, but there's a lot of effort during this time frame talking about the opportunity to enroll, and so maybe there will be an uptick. But we'll see.

CHAIR BELLA: Tricia and then Dennis.

Thank you, Martha.

COMMISSIONER BROOKS: So one piece of new data that we should be seeing, probably by springtime, is CMS is requiring states to come back and report on the outcome of

the pending renewals. So that 20 or 23 percent that Martha reported, CMS is asking states to come back 90 days after the reporting month. So at the end of December, states are supposed to report through September, I think it is, and they indicate that after they do some cleanup on that, that they will be making those publicly available. So that will give us a slightly better picture of the outcomes.

What it doesn't give us is a sense of how many people are coming back in, and this is where following application volume is really important, because if someone is reinstated during the 90-day reconsideration period or they come back in at month four, it's all going to show up as a new application. So following that application volume will give us a better sense, and then you'll start to see the differential between disenrollment numbers, which Kaiser is saying is over 12 million right now, and the actual net decline in Medicaid, which is only running at about 7 million. So people are getting back in, and it will be helpful to continue to watch those data.

MS. HEBERLEIN: And I would just add, in addition to what Tricia just reminded me of, is that there are some states that are reporting reinstatement and reenrollment

data. I think it's nine according to work that SHADAC at the University of Minnesota has done, looking at the data dashboards, and they report it differently.

I think Virginia, for example, is like within 30, 60, or 90 days. So it's not a consistent measure, but there are some state-level data out there on the reinstatements.

CHAIR BELLA: Thank you both.

Dennis and then Carolyn.

COMMISSIONER HEAPHY: Tricia, this question was actually for you. Maybe you answered already. What else should we be looking for in the next few months beyond what you just stated? How long should we be, and what specifics should we be looking for from states and CMS?

MS. HEBERLEIN: Well, a couple of states are already done. I think some states, especially those who have delayed to address the ex parte issue, I think, may be pushing out renewals longer than they had anticipated. So I think it staying on top of when they're coming back into the process and what that means for their run-out, for lack of a better word, and then as the run-out runs longer, you're going to run into people who then hit their 12-month

renewal date. And so you're going to have some overlap between new redeterminations plus finishing up the work of the unwinding as we move to the end in the May-June-July-ish period.

I don't know if that answers your question.

COMMISSIONER HEAPHY: It does. I didn't mean to put you on the spot, but I was actually hoping Tricia could answer some of that question as well.

MS. HEBERLEIN: Well, sure, Tricia is always welcome to jump in and answer the questions for me.

CHAIR BELLA: Do you have anything to add Tricia?

COMMISSIONER BROOKS: I don't think so. Unless CMS takes it upon themselves to do some additional special studies, using whatever data they can, I'm interested to see because they've indicated a couple of times in different forums that they will do some CHIP transition data. I haven't heard them say anything about TMA, but those are the kinds of things we should be taking a harder look at.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: Thank you.

Carolyn?

COMMISSIONER INGRAM: Do we know from the work that we've done or the states that are seeing increases what's working best to capture or to contact members to get them to respond to bring their applications to completion or for those that have fallen off? What's working to get them back on?

MS. HEBERLEIN: Anecdotally and mostly, what I would say is the individualized outreach. Some of the broad-based messages - renewals are coming, everybody has got to renew, especially when the time frame is so long, did not seem to be really hitting the mark.

There's been a couple -- there was a recent Health Affairs blog that talked about this, and we've heard it. Dan brought it up at our September panel that some of the more targeted outreach where a provider talks to the individual or an assister talks to an individual, that they're more likely to follow through on the renewal than if it's more of like the broad-based outreach, which I understand is a lot harder to do individualized outreach than mass media.

COMMISSIONER INGRAM: As we get moving forward, I would think we want to look at what recommendations we want

to make that -- of what works well to keep in place, and so I think if there's a way for us to keep tracking that, hopefully not just anecdotally, but what we can find in data around what works best, so that can help inform our recommendations.

Thank you.

CHAIR BELLA: Thank you, Carolyn.

Other comments?

[No response.]

CHAIR BELLA: Well, keep it coming, Martha. Thank you very much for your vigilance on this. We'll look forward to your next update.

Kirstin. Nothing more exciting this afternoon than a proposed Medicare rule.

[Pause.]

CHAIR BELLA: I say that in all seriousness. The rest of you may think that is a joke.

Welcome, Kirstin.

POTENTIAL AREAS FOR COMMENT ON CMS PROPOSED RULE ON MEDICARE ADVANTAGE FOR CY2025

* MS. BLOM: Thank you, Melanie. I am excited to be here to talk about this rule.

Good afternoon, everyone. I am here to walk through CMS's most recent proposed rule on the Medicare Advantage program for contract year 2025.

I will start by providing some background on the rule and then summarize selected provisions that affect dually eligible beneficiaries enrolled in MA. I will summarize provisions that overlap with the Commission's work. Our work will serve as the basis for any potential comments. And then we will end with next steps before opening it up for Commissioner discussion.

CMS published the rule in the Federal Register last month. It would make changes to the MA and Medicare Part D programs, including changes to plans that are designed to provide coverage to dually eligible beneficiaries. Those are the dual-eligible special needs plans, or D-SNPs. D-SNPs are available in most states, and they enroll millions of duals, so they continue to be an area of focus for the Commission.

Broadly, the rule is looking to increase the percentage of duals who get their Medicare and Medicaid benefits from the same organization, I think with the goal of reducing confusion and sort of simplifying overall.

Also you will see, in the rule, that there is an effort to reduce the number of plans that beneficiaries have to choose from as well as a number of them that might be marketing to duals.

Like I said, I will summarize provisions where we have prior work or work underway and that represent areas for potential comment.

To start, the rule includes a set of interrelated provisions designed to increase the percentage of duals enrolled in MA, that are in health plans which also cover their Medicaid benefit, so that they can get both under the same parent organization, and that plan could be either a D-SNP or an affiliated Medicaid MCO.

These provisions include several sub-provisions. First is the special enrollment period. The rule would replace the current quarterly special enrollment period, or SEP. A SEP is a period outside of the annual enrollment period in which changes can be made to your coverage. So it would replace the quarterly SEP for duals with one that allows monthly changes to coverage, and it would create a new monthly integrated care SEP specifically to allow duals to choose an integrated D-SNP. So the first part of that,

changing the quarterly to monthly, is probably going to affect primarily partial duals, and then the second one, enrolling in an integrated D-SNP, is targeted at full-benefit duals.

These proposed changes to the SEP are in line with the Commission's June 2020 recommendation to allow duals flexibility under the SEP for enrolling in integrated plans on a continuous or monthly basis. At the time, we had recommended that CMS permanently accept MMP-eligible beneficiaries from the quarterly SEP so that they could enroll in an MMP at any time.

The proposed rule would also limit enrollment in certain D-SNPs to full-benefit, dually eligible beneficiaries who are also enrolled in an affiliated Medicaid MCO, leading to an arrangement that is referred to as exclusively aligned enrollment. Because one organization is responsible for the beneficiary's Medicare and Medicaid benefits under exclusively aligned enrollment, that strategy is seen as maximizing the potential for integration.

States can require exclusively aligned enrollment in their state Medicaid agency contracts, or SMACs, but not

all states have done this, and CMS expresses concern in the rule that the market, as a result, as become complicated and many duals are actually enrolled in unaligned plans.

To streamline the process for meeting these requirements CMS does establish a crosswalk under which MA organizations can transfer their enrollees under the same parent organization into a single D-SNP. Exclusively Aligned Enrollment would be required for integrated D-SNPs under the rule by 2030.

And then the proposed rule would also limit the number of plans that an MA organization can offer in the same service area as the affiliated Medicaid MCO. This is meant to reduce the number of plans that can market to duals throughout the year. I know this is very "weedy" so bear with me.

So then the proposed rule, in addition to those interrelated provisions, would do a few other things that are relevant to our work. It would reduce the threshold at which regular MA plans become D-SNP look-alike plans. A look-alike plan is a regular MA plan -- it is not a SNP -- but that has 80 percent or more of enrollees who are dually eligible. The current threshold is 80 percent, and CMS

would lower that threshold to 70 percent in 2025, and then down to 60 percent in 2026.

In our prior work, we have looked at D-SNP look-alike plans. We found high levels of enrollment growth in those look-alike plans relative to regular D-SNPs, and expressed concern that those look-alike plans could draw duals away from integrated products and work at cross purposes to state and federal efforts to integrate care.

The proposed rule would also allow unreconciled MA plan encounter data to be shared with the states for purposes of care coordination and quality improvement, among other things. By allowing the unreconciled data to be shared, CMS is giving states an opportunity to access that data before the risk adjustment reconciliation is completed, which would avoid delays for states in getting eyes on that data.

And then lastly, the proposed rule would also make an adjustment to change an existing requirement for plan notices to be in the language most commonly spoken in the nation to the languages most commonly spoken in the state. This policy change is relevant to work that we have underway, exploring access barrier for people with limited

English proficiency. The change would likely reduce administrative burdens on health plans, and might help reduce disparities for people whose primary language is not English.

So building on your interest in this, and our prior work, we have drafted a comment letter for your review, which you have in your materials in addition to the memo explaining all of these changes. Comments are due January 5th. I think we are looking today for feedback from you in terms of whether we have kind of hit the areas that seem the most relevant, both reflecting your interests as well as our prior work. And then I'm happy to take any questions. I think because of the holiday and the due date of these comments we are looking for kind of a compressed time frame, unfortunately, for getting feedback from you and getting that letter submitted to CMS.

So with that I will turn it back to Melanie.

CHAIR BELLA: Thank you, Kirstin. I have a couple of areas that I will save until the end.

First, does anyone have any concerns with submitting comments?

[No response.]

CHAIR BELLA: Okay. I mean, especially for the new folks, reminding ourselves our North Star goal is every dual, or at least every full-benefit dual have access to an integrated care program in their state, and we have been working on ways to get increased enrollment in integrated plans, and get more integrated options available. So these are in line with that, both trying to get people in aligned products but also trying to close avenues to people getting in unaligned products. I do think it is consistent with Commission work, and we should be pleased with CMS for putting this forward.

Like I said, I will hold a couple of things I would like to share, Kirstin, for feedback, but I am going to open it up to Commissioner comment. Patti.

COMMISSIONER KILLINGSWORTH: I am going to be the person who gets the second-most excited about duals in the room, right behind Melanie.

I absolutely think that we should comment. I absolutely think that we should support the proposed recommendations. If you look at what is happening with enrollment into D-SNPs, and, by the way, D-SNP plans generally, what you see is that the bulk of the growth in

plans and in enrollment is in unaligned coordination only SNPs that really offer no benefit for full-benefit dual eligible. And so I agree with CMS that notwithstanding the fact that states have the state Medicaid agency contract as a tool that they can leverage, it's simply not enough, and these are really needed policy changes.

I know that we probably cannot put this into the letter but ultimately, I would like to see that threshold for look-alikes go even further down, beyond the 60 percent. In my opinion, any time you have over 50 percent of a population that is full-benefit duals then you should probably really be looking at that plan to have to meet the same requirements as another plan would.

And I will continue to say I think we are leveraging the authorities that we have available to us the best that we can, but it still doesn't fix the problem of making sure that there is an integration option available to every beneficiary who chooses that, and that it is a meaningful choice for them, not subject to very aggressive marketing tactics that are often misunderstood by a very vulnerable population.

CHAIR BELLA: Kirstin, when we first commented on

look-alikes, when the 80 percent was proposed, I don't think we ever verbalized 50. We encouraged CMS to keep an eye on where the majority of folks might be if enrollment was congregating below 80 percent. We have not said 50.

MS. BLOM: No, we didn't specify that we had a preference for 50. I think in our analysis we used 50 as like a benchmark because we had seen, in our work, some high growth rates in that group as well. But we didn't choose that number.

CHAIR BELLA: Yeah. I think whether we say 50 or not it is kind of carrying on the message that there needs to be continued sort of rigor around whether the threshold needs to continue to come down. And I would also, as you all know, or Kirstin knows, like us to be thinking of that on C-SNPs also. There are a lot of chronic care SNPs that are targeting specifically diabetes and congestive heart failure, C-SNPs that are targeting duals, and I think probably would trigger these thresholds and then avoid any of these integration requirements. That may go beyond what we can say, but I think it is something we, as a Commission, should keep in mind.

John?

COMMISSIONER McCARTHY: I have two questions, really. The first one I was struggling with a little bit, and Melanie, it goes back to some of the work we did, I did in Ohio when you were still at CMS. On the monthly enrollment, in the rule is it a person can change their plan every month, or just that any month they can choose to opt in, and then is there a lock-in period for a time?

MS. BLOM: I think it's they enroll in every month, in any month.

CHAIR BELLA: And only in an integrated product. They could be switching every month, and I think they could be going from the approved integrated product to fee-for-service back into an integrated product. So any time the integrated product is involved I think they can be making choices monthly.

COMMISSIONER McCARTHY: This goes back to when you said should we submit a comment or not, and I always say, well, it depends on what the comment letter says. Because on that beneficiary choice is really important, but also having a person move in and out continuously does not help on integration. And I know previously I had lobbied for at least a one-year period after you've made a choice,

quarterly -- you know, if you look at something --

So my point is, on the Medicaid side of the world when we did this basically if you choose a managed care program you were in it for a year unless something changed and there was a real need to change, and then you could make a choice. I don't know if our comments, if I would agree with allowing people to change every month if it is an integrated product. So that's one question.

CHAIR BELLA: If I'm channeling CMS I think it would be helpful to think about the changes they are making sort of in aggregate. So in addition they are making some changes on what brokers can do. They are making these enrollment changes. Everything is intended to create an unlevel playing field for non-integrated products.

So I think the Commission has been on record about the importance of continuity of care, particularly for duals, and so I think that this is one that it is a hypothesis that they are testing about letting people make changes with integrated products and not letting you do it with non-integrated products. So I think, at a minimum, figuring out what we can evaluate by what patterns of activity we see, which will also be influenced by states

because if there are eight plans in a state, my guess is you are going to see different activity than if there are three plans in a state. And if the state is more, you know, deliberate or defined about the supplemental benefits there is less switching.

So I think there is a lot of agreement with what you are saying. I would like to see us asking for, you know, paying careful attention to what data we see about the switching and see if it is achieving the goal of getting people to have continuous periods of integrated coverage.

COMMISSIONER McCARTHY: The second part was, and Patti hit on this at the end, I always hate to second-guess people's choices. So people are choosing plans now, and so they are trying to narrow some of that. But it still makes me concerned if people are choosing the plans that they are choosing, they are making that choice, I know we say it's aggressive marketing and there are issues around that, but there's something that's going on that's making people choose those plans and not the integrated ones.

So I am a little bit concerned about saying, in a comment letter, hey, we should put limits around certain

pieces. If people are actually making choices the question is, I get it, are they informed choices or not, but they are still choices that people are making. So I think that is going to be one area that, for me at least, to really think about, about how we say that, how we word that section in there.

CHAIR BELLA: Thank you, John. Dennis, and then Carolyn.

COMMISSIONER HEAPHY: Carolyn, you go first.

CHAIR BELLA: That's good because she wants to jump in on this switching, I could tell, when John was talking.

COMMISSIONER INGRAM: That's right. Thank you, Dennis. I appreciate it. I think we should comment also, but I'm sharing some of the same concerns that John has brought up, for maybe a few different reasons. One, if we are trying to make sure that people have quality interventions and have good outcomes once they choose a plan, it's really hard if we have people switching in and out of a managed, integrated product into a fee-for-service product and then back in again. So I think also our comments need to be careful in reflecting that.

We saw that happen in Part D, for those of us who have been around a long time. I'm dating myself, but when they first brought that up you could switch all the time. They got rid of that after 2018, I think, because of the problems it caused.

The other area, in terms -- and Melanie brought up a good point about the broker commissions and how they are trying to do some restrictions on that -- my concern is that if they don't look at it appropriately, you're going to have brokers incentivized to them move people between products every month. So we just want to make sure they are thinking about it as a whole picture, as you've mentioned. Yes, get rid of some of the marketing tactics, but then don't have people be able to replace that in a different way, where they can just move people between products every month.

CHAIR BELLA: Thank you, Carolyn. Dennis?

COMMISSIONER HEAPHY: I'm thrilled about all the proposed changes. I hear the concern about switching month-to-month, and I think that can be reduced if rather than having multiple brokers the state has control over the marketing. Like we did with the SHINE Program in

Massachusetts, I think all states should be required to have, and that people go to this program and it literally just provides the facts about what's available to them, as opposed to having brokers that are making money off of moving people from plan to plan, because that lack of continuity of care is just a nightmare. It really is. And so I agree with that 100 percent.

I wondered, how much of the churn or the switching between plans will actually occur, does actually occur? It would be good to get those numbers because I don't hear from folks in the world that that's actually a big issue, that people are switching between one plan to another. But I think it would be helpful to understand that.

I also agree with you, Melanie, about the 50 percent, lowering it not only for the D-SNPs but for the C-SNPs as well.

But I had one question, Kirstin, and that is states can decide that a plan, if it is going to have an aligned D-SNP in the state, that plan cannot have any unaligned plans in the state. Correct?

MS. BLOM: They can require that they have an

aligned Medicaid managed care organization. Yes.

COMMISSIONER HEAPHY: And so I guess one thing, if I read what you put in the document correctly, that CMS would still allow unaligned plans to be in states if they're in certain areas of the state. Is that correct?

MS. BLOM: For a time. I think by the time -- by the 2030 deadline, that's still --

COMMISSIONER HEAPHY: Okay.

MS. BLOM: -- getting phased out.

CHAIR BELLA: Well, I think that if you're in a state that doesn't have Medicaid managed care for behavioral health and long-term care for your duals, the 2027 and 2030 provisions don't apply. And I think, Dennis, that might be what you're saying is so states that don't have their duals in managed care for those services, there isn't this forced aligned enrollment. All the D-SNPs could continue to kind of go the Medicare route because the hook there is the state having the managed care program in place.

COMMISSIONER HEAPHY: Correct.

CHAIR BELLA: That is a concern of mine is this doesn't go -- this doesn't do anything to address

unalignment in those states, and there are states that -- there are some managed care states that don't have behavioral health and long-term care, and there are some states that don't use managed care as a delivery system platform. And then what about the duals in those states? Those D-SNPs would continue to be able to operate and not have these same requirements.

Is that what you're thinking, Dennis?

COMMISSIONER HEAPHY: It is, yes. It still leaves folks vulnerable in these states to being in plans that don't meet their needs.

CHAIR BELLA: So, Kirstin, that is one of my things. I would like us to call out, while we appreciate this, that there are states that don't have the Medicaid managed care corollary to allow for the narrowing of unaligned products and advancement of aligned products, and I realize we can't change everything overnight. But it would be nice to understand how maybe that would sort of be the next step that you would expect to see CMS try to take and if we could comment on that.

Related to that, in those states, it's the coordination-only products. CMS and Congress both have the

ability to define the requirements of the coordination-only D-SNPs. There hasn't been any activity on that front since 2018 or arguably earlier, and calling out -- I think those two things go hand in hand. The growth in unalignment is growth in coordination-only D-SNPs, and I think it's important for us to be calling that out.

And the last thing I would say -- and this is really getting in the weeds. I apologize, fellow colleagues. This is very forward thinking, and we're seeing a world in 2027 and then in 2030 that the state is really calling -- you know, creating the plans that are going to be there. And if those plans aren't there on the Medicaid side, those plans can't operate as D-SNPs on the Medicare side.

So that works, but that means that procurement decisions and choices states are making now start to impact what their D-SNP landscape looks like in 2027 and 2030 and beyond. And for states that aren't really deep and they don't speak Medicare NOIA and they don't speak sort of Medicare BID, they may be somewhat fluent in the SMAC acronym, but lack understanding -- I think it's going to be really hard for states to understand how some of those

choices could have impacts when it's 2037, years from now.

And so reinforcing the need to continue to provide technical assistance and support to states to make sure they understand, because you could imagine that there's a situation where maybe a state decides I'm going to re-procure all my Medicare things or I'm going to throw all populations in the same bucket, and I'm going to reduce the number of plans I have to three.

And in 2030, those plans that may have been chosen more on an ability to serve an overall population, not a dual-specific population, would be the only three plans that could serve them on the D-SNP side. And I'm not sure that that is necessarily what states would understand.

We have seen examples in the past where states have -- something has happened in a procurement that has changed the D-SNP landscape, and so I just think it's important.

And, Patti, maybe you would comment you agree or disagree, but there are important procurement choices states are making about whether putting all populations together, reducing or expanding the number of plans, and those will have impacts that I'm not sure Medicaid

directors who don't have a lot of depth in Medicare will fully be thinking about and be able to comment on this round of changes.

I don't know. Do you want to say anything, Patti or John, Jami, Carolyn?

COMMISSIONER KILLINGSWORTH: Yeah. I think that's a good call-out.

I also think when you think about the technical assistance, it would just be helpful to states, as they're designing procurement processes leading up to those states, that they're thinking about not just the design of their systems, but to the extent that they're going to limit that they're really asking in the procurement about capacities around duals and what integrated programs are going to look like, kind of an integrated model of care for the population.

So I think you're right. I think they'll probably -- there are probably more states than not that would really benefit from some robust technical assistance around thinking that through.

CHAIR BELLA: Adrienne, I saw your hand too. I just wanted to see if John or Jami -- did you have a

comment?

COMMISSIONER SNYDER: Yeah, I was just going to mention I know we're going to see Tim tomorrow, so it might be an opportunity to put a bug in his ear around technical assistance working in coordination with his colleagues at CMCS.

COMMISSIONER McCARTHY: What I didn't know on this one, Melanie, and thinking about it in the opposite direction is in going forward and the state realizes this -- and let's just say they've got a hospital system that has a really good MA plan that people love, and they're not a current Medicaid managed care provider. Could a state in the future do a procurement to allow that MA plan in to be a Medicaid provider, but only for duals? Right? So it wouldn't be for everyone.

What I've been struggling with and not getting good answers on so far is, what does it mean to have a Medicaid contract, and could you do something like that? Because that solves that other problem, but it also puts a whole bunch of pressures on the state in the future too if you were to go do -- like, could you do a separate procurement for your, quote/unquote, duals plans in your

state and then that could lead to other competition. All of these things to just --

CHAIR BELLA: Yeah.

COMMISSIONER McCARTHY: When it comes to procurements for states, this stuff is so -- any procurement is really hard. Medicare doesn't deal with procurements in the past. It's just anybody who meets the requirements is in. So the procurement issue is one big issue.

And then the second big issue, which I didn't see in here, is the issue about passive enrollments, and if a plan in Ohio, they're doing great, their duals plan is doing great, but in Kansas, they've got a whole bunch of violations, in the past, this has caused states big problems, because you have to cut off enrollment in Ohio, even though the Ohio plan is doing great.

And so back to what you had said before, if you were a state and you say, hey, we only want to go with three plans, you got three plans, and all of a sudden your duals plan gets cut off because of some issue in another state, how is that dealt with? I mean, that's another issue.

These are super complicated issues, and thinking through this, like you were thinking, into the future is hard to do.

CHAIR BELLA: Yeah. We should confirm with Tim. I think the entities that are capitated to serve duals for behavioral health and LTSS is how the managed care is defined, and that could be separate. States have separate entities serving their duals today. If the state could choose how it wants to structure the entities it pays to provide duals LTSS and BH -- so in your case, Ohio could have a procurement. That system could compete and win and keep its dual contract.

But as you said, most states are looking to have fewer procurements and fewer plans to monitor and not looking to create more procurement opportunities.

We can ask Tim that tomorrow. Tim is going to have a long list of things tomorrow. I keep looking to see if he's on here to get a heads-up.

Adrienne. And then, Dennis, I don't know. Your hand might have still been up? No? Okay. Adrienne?

COMMISSIONER McFADDEN: Yeah, I think my comment was really thinking through some of the previous comments,

which were -- I think, one, I'm in support of doing a comment letter, but two, certainly, I think it's really important to have access to the integrated model. But I do think continuity is really important, and all of that is in service of creating better quality -- or access to higher quality health care.

So having the special enrollment period be so frequent, I think, sort of challenges, and there's this healthy tension. And I'm just wondering if there's any way for us to insert into our comment letter potentially, we even think about data collection around how the SEP frequency could actually be used as an incentive for managed care plans to improve quality to say that the managed care plans that have proven quality would be the ones that could be eligible for picking up enrollment during those SEPs.

CHAIR BELLA: Sort of like in the states that use auto enrollment incentives for the higher quality --

COMMISSIONER McFADDEN: Correct. I hate to be a skeptic, but I would think that having this setup would maybe encourage more M&A sort of activity within states just to be able to have a parent plan that has both. And

that doesn't necessarily get us to our goal of quality.

CHAIR BELLA: All right. So what you're saying is the higher-quality plans would be eligible to get enrollment on a monthly basis. Oh, that's interesting. Okay.

Dennis, I do see a hand. Yes.

COMMISSIONER HEAPHY: I like what you said, Adrienne, but I think it should be both, because if folks are in plans that don't have high quality and they want to move to a higher-quality plan in a month, they should be able to do that. There's all those times when the market and the quality of the services should really be able to drive people's opportunity to move between plans, and if there are people moving back and forth between different plans on a regular basis, then I think we do have to take a look at that and see what the problem is, because it might be folks who this plan offers this and that that month and this plan offers that and they want that that month. But I don't think that's as common as people think. I think people stick with their plan.

But I do like what you said, Adrienne, because that's something we think is really important, that there

should be incentive for plans to be able to get enrollees actually based on their quality.

I guess the question is, Tim -- and this would be for us as well -- sometimes those quality metrics don't come out for three years, and a lot can change in three years. And so what is the metric we used that enables a plan to say yes, with a plan that should be -- that earns the right to get new enrollees this month?

CHAIR BELLA: Thank you, Dennis.

Other comments?

[No response.]

CHAIR BELLA: Kirstin, I'm not going to ask you if you have enough information and feedback. I'm going to assume you have more than enough.

We'll get some volunteers to review this. It will be a fairly quick turnaround, but I think we're pretty clear on what we've said in here. So it shouldn't be a rigorous ask for folks.

So thank you everyone for that discussion. Thank you, Kirstin.

And we are going to conclude the day hearing about MACStats. So welcome, Jerry.

HIGHLIGHTS FROM MACSTATS 2023

* MR. MI: Hello. So MACStats is scheduled for release tomorrow, December 15th. For members of the public we will have MACStats both compiled as the published book as well as separated into individual tables on our website. Most of the tables have both Excel and PDF versions for your convenience.

MACStats is a regularly updated, end-of-year publication that compiles a broad range of Medicaid and CHIP statistics from multiple data sources, including census, enrollment, survey, and national- and state-level administrative data. Listed on this slide are the six sections of MACStats.

Key statistics of this year's MACStats show similar results to last year. These key statistics focus on Medicaid and CHIP enrollment spending compared to other payers, Medicaid's share of state budgets, and more.

In fiscal year 2022, over 30 percent of the U.S. population was enrolled in Medicaid or CHIP at some point during the year.

Looking at the state-funded portion of state budgets, Medicaid was a smaller proportion compared to

elementary and secondary education. Medicaid and CHIP combined were a smaller share of national health expenditures when compared with Medicare.

So moving on and getting into the trend of the data, over the last eight years Medicaid and CHIP enrollment has increased by about 57 percent. Most of this change happened during the initial years after the bulk of ACA expansion. Most recently, enrollment in Medicaid and CHIP increased by about 1.6 percent from July 2022 to July 2023. This follows a 7.2 percent increase in Medicaid and CHIP enrollment from July 2021 to July 2022.

It is important to note that while enrollment is higher than it is in 2022, it has been decreasing from its peak as states begin to disenroll beneficiaries following the end of the continuous coverage requirement. Enrollment decreased in 20 states in 2022.

Furthermore, this graph shows growth trends in Medicaid enrollment and spending. Overall, spending and enrollment have had complementary trends, both rising and falling compared to policy changes and economic conditions, such as economic recessions and expansions.

In this graph, spending for health programs are

compared with spending for other components of the federal budget. In general, the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the program were enacted in 1965. Since 202, both Medicaid's and Medicare's share of the federal budget have been lower than in prior years because of a large increase in other mandatory program spending for pandemic-related relief, such as unemployment compensation, coronavirus tax relief and economic impact payments, and other housing credits.

In fiscal year 2021, we see that over 70 percent of enrollees are enrolled in comprehensive managed care, and this accounts for over 50 percent of Medicaid benefit spending. LTSS users accounted for only 4.9 percent of Medicaid enrollees, but almost 30 percent of all Medicaid spending. That is, $199 billion was spent on services for these 4.3 million enrollees. Note that this estimate only includes enrollees using at least one LTSS service under a fee-for-service arrangement and does not include those receiving LTSS under a managed care arrangement.

In fiscal year 2022, DSH upper payment limit and other types of supplemental payments such as DSH payments

made under Section 1115 waiver authority accounted for over half of fee-for-service payments to hospitals.

Total spending for four-year equivalent enrollees across all service categories ranged from $3,584 for children to $23,935 for the disabled eligibility group. Spending for managed care capitation payments was the largest service category across all eligibility groups.

In 2022, 34 percent of Medicaid enrollees had annual incomes less than 100 percent of the federal poverty level, and 54 percent had incomes below 138 percent of the federal poverty level. As of July 2023, 39 states and D.C., one more state than last year, are now covering the new adult group.

MACStats also reports on beneficiary health, service use, and access to care using survey data from the National Health Interview Survey, or NHIS, and the Medical Expenditure Panel Survey, or MEPS.

In 2022, children and adults with Medicaid or CHIP coverage were less likely to be in excellent or very good health than those who have private coverage. Children with Medicaid or CHIP coverage were as likely to report seeing a doctor or having a wellness visit within the past

year as those with private coverage, and more likely than those who are uninsured. While most children and adults with Medicaid or CHIP coverage had a usual source of care, they were less likely to have one compared to those with private coverage.

Children and adults with Medicaid or CHIP coverage are as likely to report having a very difficult time reaching their usual medical provide compared to those with private coverage.

This is our figure notes and sources, thank you.

CHAIR BELLA: Thank you, Jerry. Jenny. All right. So we have some comments.

COMMISSIONER GERSTORFF: Thanks, Jerry. So I really just want to tell you that I appreciate the work that you guys put into all of these tables and in the MACStats every year, we being actuaries. I, and a lot of other people too, use this all year long for different insights, research, and reconciliation when we are doing studies.

And I also want to highlight I especially appreciate the technical appendix that you have with the coding specifications for using T-MSIS. So as more people

are using T-MSIS I think it is really helpful to provide that guidance and kind of lead there.

A couple of considerations for future year exhibits, and we may or may not consider them but I just wanted to put them out. Maybe looking at very high cost to individuals to understand their trends over time, if we are getting more very high cost people, and then breaking that down into characteristics like if we are seeing a growth in high-cost infants.

And then my other one is we have a few states that have moved or are planning to move, non-citizens who receive emergency services and only qualify for emergency services into managed care. And I think, over time, that is going to result in longer average duration of coverage, but should be lower average per capita costs, and that could be something worth monitoring.

CHAIR BELLA: Thank you, Jenny. Tricia?

COMMISSIONER BROOKS: Thank you, Jerry. I love MACStats. Can you go back to the slide before your sources? I just want to make a point about the first bullet, because when some people see this they think, oh, Medicaid and CHIP result in lower outcomes than private

insurance. But the reality is we're talking about a socioeconomic environment for these families that is very different than those people covered by private insurance, and I just feel the need to say that because I think that Medicaid and CHIP certainly serve children and families very well.

CHAIR BELLA: Thank you, Tricia. John, and Patti, sorry.

COMMISSIONER KILLINGSWORTH: I just have a really quick question, or maybe it's more of a comment. When are we going to get to the point of where we can include all managed care data as well as fee-for-service data?

MR. MI: Yeah. So currently we are actually scoping out and undergoing a project on HCBS, and that project includes a portion looking at the managed care side of the data. So I imagine it would probably still be a couple of years, but we are currently looking through the managed care data.

COMMISSIONER KILLINGSWORTH: Thank you.

COMMISSIONER McCARTHY: I had the same question, Patti, because on Slide 8, if you go to Slide 8, that managed care line in that one is huge, but it really

encompasses many of those other things in there. So same question is when can we start breaking that out and not just have managed care as a separate payment.

CHAIR BELLA: Put a reminder on your calendar for December 2025, when MACStats comes forward to ask Jerry, or whomever, how we're doing on that managed care. It's a really important point. I don't think it's for a lack of interest or trying, for sure.

MR. MI: Yeah, I really want to note that this is something that we have been paying attention to for the past couple of years, and it is on our radar.

CHAIR BELLA: Any other comments or questions for Jerry, before this makes a big splash? Bob?

All right. Jerry, thank you very much. Thanks for all the work that goes into that.

CHAIR BELLA: We will close the day by opening up for public comment on the session since the afternoon break, or actually any of them from today. If anyone would like to make a comment please use your hand icon, introduce yourself and the organization you are representing, and we ask that the comments are three minutes or less.

It looks like we have Laura Cohen.

PUBLIC COMMENT

* MS. COHEN: Hello. Thank you. My name is Laura Cohen, and I am with Rehabilitation and Technology Consultants. I really appreciate the comments today and different perspectives.

One of the things about changing networks, or changing plans, month to month, in my experience as a clinician I noted, in the state that I was in, people would change plans depending on what services they needed, specialty providers or services, or like surgical services. So the networks really were a driving force of that as well as the quality of the services that were available.

I think that is a really interesting place to be curious to see if we can't capture user stakeholder input at that point of why they are changing, because I think that would give very valuable information.

And I really liked the idea about -- I'm sorry, I lost my place, but thank you for the opportunity, and I appreciate the work you're doing.

CHAIR BELLA: Thank you for making the comment. You might have been working to Adrienne's thought about tying some of that switching to quality.

MS. COHEN: Mm-hmm.

CHAIR BELLA: But thank you, and we are always interested in collecting data to better understand when there are policy changes made, so thank you very much.

MS. COHEN: Yes, thanks.

CHAIR BELLA: All right. We have no other comments. We are regrouping -- not regrouping; what word am I looking for? -- regathering, gathering --

EXECUTIVE DIRECTOR MASSEY: Reconvening.

CHAIR BELLA: -- reconvening -- that is the word -- reconvening tomorrow morning at 9:30, where we will kick off the day, taking a vote on the MCAC recommendation. So there will be a little bit of tweaking, and we will come back to the Commissioners in final form for review and for votes, and then we will finish the day talking about duals, and then we will send you all off into your weekend.

So thank you, everybody, for your engagement today. We will see you all tomorrow at 9:30 Eastern time. Thanks very much.

* [Whereupon, at 3:37 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, December 15, 2023.]

PUBLIC SESSION

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

Friday, December 15, 2023
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 our December meeting. Audrey, lovely to see you back.

We are going to start it off this morning voting on the MCAC recommendations.

VOTE ON RECOMMENDATIONS FOR THE MARCH REPORT TO CONGRESS

* EXECUTIVE DIRECTOR MASSEY: So, to start, Audrey, do you mind reviewing the recommendation language and then also indicating where there were changes relative to what was discussed yesterday?

* MS. NUAMAH: Sure. Good morning, Commissioners.

So in response to some of the feedback that we heard yesterday, we did change the language for Recommendation 3, and I'm happy to preview that now for you all.

The main change here was to really address the feedback to make sure we include more around facilitating the beneficiary engagement. So we added some language here so that states can really make sure that they are developing and implementing a plan to facilitate the

beneficiary engagement while also reducing some of the barriers that we heard. And in addition to the barriers that were previously listed, we also added this technological piece as well. So that is now fully included in the recommendation.

There are a lot of other substantive comments that we heard from you all that we will also include in the chapter text itself that relates to some of the feedback that you provided.

CHAIR BELLA: Okay. I think we're ready to call for the vote. We're going to take these votes in a package, but I do think we just want to go through each of the recommendations one more time, please.

MS. NUAMAH: Sure. Happy to. So the first recommendation goes as this: In issuing guidance and in providing technical assistance to states on engaging beneficiaries in medical care advisory committees, MCACs, under Section 42 CFR 431.12, the Centers for Medicare and Medicaid Services should address concerns raised by states related to beneficiary recruitment challenges, strategies to facilitate beneficiary engagement in Medicaid MCAC meetings, and clarify how states can provide financial

arrangements to facilitate beneficiary participation.

The second recommendation will go as follows: In issuing guidance and in providing technical assistance to states on engaging beneficiaries and Medical Care Advisory Committees, MCACs, under Section 42 CFR 431.12, the Centers for Medicare and Medicaid Services -- oh, sorry.

The slide is incorrect, but I still have the language in front of me for the Recommendation 2. This one is: In implementing requirements in Section 42 CFR 431.12(d)(2), that Medicaid medical care advisory committees (MCAC) membership include beneficiaries. State Medicaid agencies should include provisions in their MCAC bylaws that address diverse beneficiary recruitment and develop specific plans for implementing policies to recruit beneficiary members from across their Medicaid population, including those from historically marginalized communities.

And then the third one is correct, and that one is: In implementing requirements and 42 CFR 431.12(e) to increase the participation of beneficiary members in Medicaid medical care advisory committees (MCACs), state Medicaid agencies should develop and implement a plan to facilitate beneficiary engagement and reduce the burden on

beneficiaries in engaging in MCACs by streamlining application requirements and processes and by addressing logistical, technological, financial, and content barriers.

CHAIR BELLA: Thank you, Audrey.

Any questions or comments from Commissioners before we call for a vote? And just as a reminder, we're voting as a package. So the vote will be on all of these, all three of these together. Comments or questions?

Tricia.

COMMISSIONER BROOKS: So I heard the word "meaningful" numerous times yesterday in relation to engagement, and I'm not seeing that in any of the recommendations. Sorry to throw a cog in the wheel.

CHAIR BELLA: So what is your suggestion?

COMMISSIONER BROOKS: I think you could insert "meaningful" before "engagement," where it appears in two of the recommendations.

CHAIR BELLA: Can you pull the recommendations back up, please, Audrey?

COMMISSIONER BROOKS: I think "meaningful engagement" has a different meaning than "engagement."

CHAIR BELLA: Okay. The second one is not -- I

don't see the word -- the word "engagement" is not in the first recommendation.

MS. NUAMAH: The strategies to facilitate beneficiary engagement, Tricia, here you would like "meaningful."

COMMISSIONER BROOKS: Yes.

CHAIR BELLA: Yep. Okay.

MS. NUAMAH: And then in this third one, "implement a plan to facilitate meaningful beneficiary engagement"?

CHAIR BELLA: Okay. I think that makes sense. I think that is responsive to what we've heard. Tricia, thank you. No cog. That's no cog in the wheel.

Does anyone have any concerns with that? If not, what we will do is ask for a vote as amended by Tricia's suggestion to add "meaningful" in those two places. And the record would reflect that.

Dennis.

COMMISSIONER HEAPHY: I support the measure, but just something to think about in the future, because we're always asked this, "Dennis, what does 'meaningful' mean?" and it means measurable, and so meaning how you can measure

the impact. We discussed that a little bit yesterday, like having a measurable impact. So meaningful actually can be qualitative and quantitatively measured.

CHAIR BELLA: Okay. Thank you, Dennis.

Audrey, can you make sure that the chapter is clear about the importance of meaningful and the ability to measure to ensure that we have meaningful engagement?

MS. NUAMAH: Yes.

CHAIR BELLA: Thank you, Dennis.

Rhonda?

COMMISSIONER MEDOWS: I'd like to make a motion for approval of the recommendations with the amendment.

CHAIR BELLA: Thank you, Rhonda.

All right. Before Kate calls the vote, I do just need to report that on December 11th, the MACPAC Conflict of Interest Committee, chaired by our wonderful Vice Chair, Bob Duncan, to my right, met by conference call to apply our conflict of interest policy with respect to each Commissioner's reportable interest. Both the conflict of interest policy and the Commissioner reportable interest are posted on the MACPAC website.

As a result of that review, the Conflict of

Interest Committee determined that for purpose of our votes today, no Commissioner has an interest that presents a potential or actual conflict of interest related to the recommendations under consideration.

So, with that, Kate, I will turn it to you to call for the vote.

EXECUTIVE DIRECTOR MASSEY: Great. So we are voting on the package of recommendations addressing Medical Care Advisory Committees as amended. I will call your name, and if you could indicate yes, no, or abstain, I'd appreciate it.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: And Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Great. So 17 yeses, no no's, no abstentions.

CHAIR BELLA: Wonderful. Thank you very much. Thank you, Audrey, for all this work. We're thrilled to see this advance. Thank you.

All right. We will now move into our first session of the day and welcome Gabby and Drew to talk about MMP, Medicare-Medicaid plan transitions. Welcome both of you.

MEDICARE-MEDICAID PLAN (MMP) TRANSITION MONITORING: INTERVIEWS ON STAKEHOLDER ENGAGEMENT

* MS. BALLWEG: Thank you, and good morning, Commissioners. Drew and I are here today to discuss the transition from Medicare-Medicaid Plans, or MMPs under the Financial Alignment Initiative, to integrated dual eligible special needs plans, or D-SNPs. I will provide the Commission with updates from our recent round of state interviews, specifically focusing on approaches to engaging plans, providers, and beneficiaries throughout the transition process.

I will begin by providing a background on the

MMPs and the Centers for Medicare and Medicaid Services' rulemaking as well as revisit the Commission's transition monitoring framework. Next, I will discuss stakeholder engagement strategies and feedback, followed by continued monitoring efforts.

According to CMS, there were almost 13 million people dually eligible for Medicare and Medicaid in 2022. Integrating Medicaid and Medicare coverage for dually eligible beneficiaries has the potential to improve their care and reduce cost shifting between the two programs. In 2022, about 1.75 million individuals were enrolled in integrated products.

Integrated products for dually eligible beneficiaries primarily include dual-eligible special needs plans, or D-SNPs, operating under the same parent organization as the Medicaid managed care organization, that provides an individual's Medicaid benefits, and Medicare-Medicaid Plans, or MMPs. MMPs feature one three-way contract between CMS, the states, and the health plans, that includes elements like passive enrollment, integrated member materials, and provisions for states in sharing savings to Medicare.

D-SNPs feature two contracts, one between the D-SNP and CMS and another between the D-SNP and the state, referred to as a state Medicaid agency contract, or SMAC, which allows states to leverage contracting tools to increase integration for beneficiaries. As of December 2023, beneficiaries were enrolled in MMPs across eight states.

In May 2022, CMS announced it would sunset the MMPs and encouraging participating states to transition MMP enrollees to integrated D-SNPs. CMS also urged states to incorporate elements of their MMPs into their contracts with D-SNPs. In some cases, CMS required that states adopt MMP elements into their D-SNPs, such as enrollee advisory committees. All eight demonstration states have agreed to transition to integrated D-SNPs by the end of 2025 or earlier.

As a part of the transition, states were required to submit transition plans to CMS by October 1, 2022, which all states did. States were required to include the following elements in their transition plans: how states would maximize integration throughout the transition, how the ombudsman program would be sustained without federal

funding, and how states would engage stakeholders in the policy and operational steps states would need to complete to achieve these goals. The Commission commented in support of the rules move towards greater integration.

MACPAC has been monitoring this transition from MMPs to integrated D-SNPs and provided our first update to Commissioners at the December 2022 meeting, which detailed our transition monitoring framework as shown. Since then, MACPAC has regularly engaged state staff regarding their transition to integrated D-SNPs as well as the progress in completing transition activities within the two-year timeline that CMS outlined.

In MACPAC's June 2023 Report to Congress, the Commission outlined its MMP transition monitoring framework, covering four key domains: stakeholder engagement, Medicaid managed care procurement, information technology systems changes, and enrollment processes. Using this framework, MACPAC conducted a second round of interviews in July and August 2023, focused on stakeholder engagement with seven of the eight MMP transition states.

During the interviews, state officials shared that they are obtaining stakeholder feedback from

beneficiaries, providers, and plans to inform their transitions. To reach these stakeholders, states leveraged existing avenues of communication such as advisory committee, and dedicated additional resources to engage stakeholders on policy and operational matters related to the MMP transitions. Nearly all states mentioned harnessing existing infrastructure to conduct stakeholder outreach, and most frequently, described reaching stakeholders through advisory committees and networks associated with the Financial Alignment Initiative, or FAI, demonstration.

For example, officials from Rhode Island have relied on the demonstration's Consumer Advisory Committee as their primary vehicle to update and engage stakeholders. In Massachusetts, the state is using information gathered from its contracted ombudsman program to better understand current member concerns and in order to address them as a state reprocures its integrated care plans prior to the transition to D-SNPs.

States also described in our interviews methods to enhance stakeholder engagement efforts, ranging from listening sessions and focus groups to hosting webinars or

developing email listservs, along with specified email inboxes. As a part of Michigan's outreach strategy, the state is using webinars to engage stakeholders through an educational approach, detailing key aspects of their MMP demonstration and the transition to an integrated D-SNP. These webinars are paired with an email inbox to collect comments from outreach sessions, ultimately facilitating additional stakeholder conversations.

At the time of our interviews, states were still in the process of collating feedback from beneficiaries, providers, and plans to inform their transition. However, some of the initial feedback was generally consistent across states. Officials shared that beneficiaries hope states maintained the integrated features in the new D-SNPs, including one identification card, no cost sharing, and access to a care coordinator as the primary point of contact.

However, they also discussed issues with case management that they hoped will be considered during the transition. For example, in Ohio, beneficiaries shared case management issues with state officials, which the state attributes to the workforce shortages and turnover

among case managers and waiver service coordinators.

These case management problems, including turnover, were common across most states, and beneficiaries who used LTSS often shared with states that they received a new waiver service coordinator every six months, and they felt that they were frequently educating the coordinators about their care needs.

Providers generally expressed that they do not want additional administrative responsibilities associated with the health plan contracting to impact daily care delivery or to require rate adjustments. Among nursing facilities, billing challenges were a common issue with the MMP demonstration that they shared with officials, and states like Michigan are working to address these issues during the transition.

States have heard concerns from health plans about the enrollment process in the transition to D-SNPs, and the plans are primarily concerned about the size of the population that they will have to enroll as well as rates, such as in Rhode Island, where the state is integrating LTSS into Medicaid managed care more broadly. However, the states said that plans are primarily focused on challenges

that they have experienced prior to the establishment of the MMPs, and are mostly concerned about rates in the new managed long-term services and supports environment.

Most states shared that they intend to use stakeholder input to develop next steps in the transition. For example, public meeting sessions on the transition in Rhode Island are informing the state's development of their requests for proposal, model contracts, and future program design.

In some cases, state legislatures have shaped provisions to the transition plans that states submitted to CMS in October of 2022, influencing the scope of Medicaid managed care procurement. For example, Ohio's Biennial Budget Bill included a directive to take the state's Medicaid managed care program for dual-eligible beneficiaries statewide as a part of the MMP transition. As of 2023, this program operates in 29 of Ohio's 88 counties.

As states move closer to the calendar year 2025 deadline of transitioning their MMP enrollees into integrated D-SNPs, MACPAC will continue monitoring these state efforts. We will focus on state procurement in

Medicaid managed care organizations in the next round of interviews, identifying how states are implementing their procurement processes, including any challenges or opportunities they may encounter along the way. We anticipate movement on procurement in most states in 2024, as they prepare to award and execute contracts with Medicaid managed care plans that will have aligned D-SNPs.

During Medicaid managed care procurement most states will have to temporarily suspend stakeholder engagement, except for in South Carolina, which is an application state. Application states can accept any plan that applies to serve as a Medicaid managed care organization as long as the plan meets qualification requirements. The noncompetitive nature of this approach allows South Carolina to continue stakeholder engagement throughout the procurement process.

Among the other states that must suspend stakeholder engagement during procurement, one has developed a strategy of including beneficiary input during the procurement process, while others are focusing on obtaining as much stakeholder engagement as possible prior to and post procurement. At the time of our interview,

officials in Massachusetts shared that they will be receiving applications for consumer reviewers to provide input on the state RFP and submitted bids.

Consumer reviewers are individuals who the state selects from among MMP enrollees and FIDE SNP enrollees, and family members and caregivers of beneficiaries or people who are elderly or have a disability. They will review health plan bids and will eventually help select bids, meeting with the state Medicaid agency to provide feedback and share any concerns.

We are happy to take any questions on the transition process thus far or on our framework for monitoring the transition. We plan to return to update the Commission at subsequent meetings as new information emerges.

Thank you.

CHAIR BELLA: Thank you, Gabby. Just to remind Commissioners, so we have this is sort of context setting and then we'll roll into the panel where we have three panelists that will talk about MMP transition. They will also talk about future D-SNPs and what crystal balls they have.

But how about we start with some questions for Gabby and Drew, if you have any, on the work, or you have some things you want to make sure are included in the future phases. Patti.

COMMISSIONER KILLINGSWORTH: Thank you all so much for the information. Gabby, at the very beginning of your remarks you talked about I think 7.5 million dually eligible beneficiaries who are in integrated plans. Does that include all types of D-SNPs, including the coordination-only D-SNPs?

MS. BALLWEG: Are you referencing the 1.75 million individuals enrolled in integrated plans?

COMMISSIONER KILLINGSWORTH: Okay, that was the number.

MS. BALLWEG: Yes, 1.75.

COMMISSIONER KILLINGSWORTH: And what types of plans does that include?

MS. BALLWEG: That definitely includes MMPs and D-SNPs.

COMMISSIONER KILLINGSWORTH: All D-SNPs?

MS. BALLWEG: I think it's just the integrated D-SNPs, right Drew?

MR. GERBER: Correct. The number that comes from the MMCO annual report.

COMMISSIONER KILLINGSWORTH: Okay. Great. Thank you. That's super helpful.

So as a part of monitoring the transition will we be looking at whether people end up in the integrated care models as opposed to non-integrated D-SNPs? Is that a part of what we will look at?

MR. GERBER: Yeah, so we do have phases of the interview process with states discussing enrollment processes, and that's where we will be looking to make sure that there's not a drop-off among beneficiaries and ensure that there is a smooth and seamless process.

COMMISSIONER KILLINGSWORTH: And are states, is there some sort of a process that's been created to track that, literally, beneficiary by beneficiary, so that we understand the net impact of this transition on integration?

MR. GERBER: Currently, we do not have a model among staff. I believe we will be speaking with state staff to see how they are tracking that, but again, that is a question I think that you can ask our panel.

COMMISSIONER KILLINGSWORTH: Yeah. What worries me is that if there is not an established process for reporting and every state is doing it differently, we need some sort of a process on the front end by which we can really monitor the impact of the transition and understand what happened from an integration perspective.

MR. GERBER: Thank you.

COMMISSIONER KILLINGSWORTH: Thank you.

CHAIR BELLA: Yeah, I think that's really important, Patti, and it's something we can highlight in the chapter, in addition to asking our panelists what the plans are.

Other questions for Gabby and Drew? Verlon.

COMMISSIONER JOHNSON: This is probably more a clarification question. You talked about the existing engagement and the enhanced engagement. Were all states using some type of enhanced engagement model or was it just a few of them?

MS. BALLWEG: All states that had already conducted their stakeholder engagement or began that process have been using new engagement and old engagement models.

COMMISSIONER JOHNSON: Okay. I just wanted to make sure. Thank you.

CHAIR BELLA: John.

COMMISSIONER McCARTHY: Gabby and Drew, in those interviews what were the biggest concerns states brought up? First around engagement, just around the engagement piece, and then second, just other concerns they brought up.

MS. BALLWEG: I think in terms of concerns around engagement just making sure that they reach all of the different stakeholders was the primary concern. I know some states were concerned about reaching older beneficiaries specifically, but they are trying to put plans in place to be able to reach that population better.

Overall, I don't think that states expressed much concern for the transition. They seemed to be relying on previous work in terms of transitioning. And then, as well, they seemed to see there is not a lot of concern coming from the beneficiaries, providers, and plans, or at least not as much as maybe was anticipated.

MR. GERBER: Just to quickly add on to that, when we conducted our interviews toward the end of the summer, I

would say that some states had noted that beneficiary or stakeholder groups that had been very involved and active in the MMP conversation itself were not necessarily all showing up yet to conversations around the transition. I do believe that has changed in the five or so months since we began our interview process, and in general, states were taking active steps to engage and target those beneficiaries for their feedback.

CHAIR BELLA: Can we go back to Slide 9, please? And Dennis, I see your hand. Are we concerned that the states aren't more concerned? I mean, this is really complex. I know you're laughing, but especially it surprises me that -- I think it's important that we pay attention to the first set of bullets on here, about what beneficiaries want to see retained, and understanding how those are going to be retained. And it would surprise me if states were feeling like everybody is kind of seems fine with this. And I don't know if that's because we're still a couple of years out. But do we have a gauge of -- well, I suppose we can continue talking to states and see how that plays out, but it would, and I know we're looking at a multi-series thing here.

But I assume we're not sort of done talking about stakeholder engagement and then we're moving on, and I think it's going to be important to continue to come back to this, especially if the states are feeling like they haven't heard from all the groups yet.

MS. BALLWEG: That's actually a really great question. I'm glad you brought that up. States are really emphasizing that stakeholder engagement isn't just a one-time phase. It will be occurring throughout the transition as a whole. And so especially in states that aren't able to engage stakeholders during the procurement process they are making an effort to go back and continue that engagement throughout the entire transition. So hopefully that will be able to address any potential concerns, especially among the beneficiary population.

MR. GERBER: Yeah, and in terms of whether we should be concerned that states are or are not concerned, I think what we had heard from state officials during our interviews is that most of the feedback has been expected or feedback that they've been receiving throughout the tenure of the MMP itself. I think as we move into speaking with states about procurement, I think when those RFPs

begin to come out, as some of them have, I think that is where you have something more tangible where we can engage both with states and states can be receiving feedback before and after procurement about potential issues.

CHAIR BELLA: Thank you. Dennis.

COMMISSIONER HEAPHY: Thanks. Melanie stole my question. The lack of concern is a huge concern, and I think that the messaging is to consumers or beneficiaries not to worry, this change is not going to be large, they're not going to have a big impact on continuity of care and the way things are working, then I think stakeholder engagement will be lower.

So how do we, how do we ensure that people understand the real impact of going from a three-way contract to two separate contracts and the potential for denials for Medicaid services or plans not using Medicaid benefits available, and even just paperwork or lag time in access to services. It's far more complicated, and impact on folks' lives really may be far greater than people understand.

So I do worry, because different states have different levels of understanding of Medicare policy, and

so they may think that they have it under control when, in fact, they don't, only because they don't understand the full impact of the split in the contract.

CHAIR BELLA: Thank you, Dennis. Jami, and then Patti.

COMMISSIONER SNYDER: So a quick question. Beneficiary engagement is super important, but provider engagement, I think, is equally important with a transition like this. Just based on your interviews do you feel like states are doing what they need to do to really engage providers and help them understand what the transition is going to look like for them? And if you can expand at all upon kind of concerns or considerations that providers raised I would appreciate that as well.

MS. BALLWEG: Yeah. So states have been able to engage with providers. They haven't had, I think, as many issues trying to reach that population.

Primarily, the concerns that they have is focusing on that additional responsibility that they may have in this new system with a D-SNP instead of an MMP.

But I don't know, Drew, if you have anything else to add on that.

MR. GERBER: I think states have assured us that the providers, especially the LTSS providers that have been part of the MMP demonstration and are expected to be contracting with integrated D-SNPs, have been very vocal. So that's not been an area where they've, I think, struggled to receive feedback.

CHAIR BELLA: Patti?

COMMISSIONER KILLINGSWORTH: Can we go back to the monitoring framework for just a second? And I wasn't here when this was created. So I apologize that I'm circling back to something.

But one of the things that seems to me would be really important to look at is how states plan to structure their state Medicaid agency contracts with the new D-SNPs. There's so much that these states could do from a SMAC perspective to make sure that experience is as seamless as possible for beneficiaries to try to preserve that for them and to address some of the concerns that I think providers will have.

But I'm curious, and we won't know until we get there, I guess, but how many states will incorporate those kinds of provisions into their state Medicaid agency

contracts, and then the processes that they will have for actually monitoring to make sure that happens.

I'll give you an example of that. In Tennessee, in our state Medicaid agency contracts, we actually included for FIDE plans a requirement that they integrate all of their internal systems and processes for people enrolled in the plan. So the single care coordinator, care coordinator gets access to all of the Medicare and the Medicaid information, right? It's all integrated within the case management system, and that's an actual contractual requirement. And then we had processes to monitor that from a readiness perspective prior to launch.

So from a technical assistance perspective -- and I know we'll talk about this in the next section too -- supporting states in that process, but then from a monitoring perspective, being able to look at whether states were able to leverage those to ensure as much continuity, not just in services, which is important, but continuity and experience, which I think really matters too.

CHAIR BELLA: Do you want to comment, Drew?

MR. GERBER: I'm just going to add on that that

is something that's come up in our separate SMAC project. So that is something that we're aware of, and I believe in our conversations with state officials, there's a high level of awareness among them that there is the potential to copy large pieces of the three-way contract into their state Medicaid agency contracts. But it's important for us to keep in mind. Thank you for raising that to ensure that that process is happening and understand how state officials are conceptualizing that.

COMMISSIONER KILLINGSWORTH: Thank you.

CHAIR BELLA: Thank you.

John?

COMMISSIONER McCARTHY: I was just going to say to Patti what Drew just said, which is these are -- we're only looking at the MMP states. So I would just hope that they already have that in place, that they would be moving forward, because I know in Ohio, we have those things in our contracts, so that that would just be kind of moved over for it, which is different than non-MMP states where it would be brand-new on some of these -- on some of these different pieces.

I do want to circle back to the question I had

earlier and then people got concerned over it and how Drew and Gabby answered it, which was your answer was those states aren't concerned. I think the question was around the engagement part of it. In talking to states, I know states are concerned about this. Any transition is a really, really difficult piece.

I've said this before when I brought up the MMP program in Ohio. I said if I ever had to do it again, I would never do it again, because it was the hardest thing in all my time of being a Medicaid director to do, and that was with amazing support of people at CMS. It was still super hard to do. So I do know that states are concerned about the transition of this going forward. I think it is what was said earlier, that in my discussions with people, it's still far away. You're still kind of dealing with the conceptual pieces of things, and states are -- the ones I've talked to at least are taking it very seriously and want to make sure that this works. It is a big transition.

CHAIR BELLA: We'll strike from the record that he would never do it again.

All right, Dennis.

Thank you, John.

COMMISSIONER HEAPHY: Yeah. Thank you.

I'm wondering, are we planning on making recommendations to states for things to put in their SMAC contracts, best practices in developing SMAC contracts based on all the evidence you're finding?

MR. GERBER: We don't currently have anything, I think, ready to speak on it at the moment. We are planning to come back in January with some takeaways from interviews related to the project itself, and then we are planning to present in March as well, where we may have potential policy options that could lead to recommendations.

COMMISSIONER HEAPHY: Okay. Thank you.

CHAIR BELLA: All right. I have one other question about procurement. I know we're going into the procurement, but did you hear states talking about challenges with trying to line up a typical Medicaid cycle with the Medicare Advantage time frames?

MS. BALLWEG: We did hear some challenges in that respect. States didn't delve deeply into that piece with us, but I do know that was something on their minds. And as we go into our interviews on procurement, we can definitely probe more in that area.

MR. GERBER: Yeah. I would say when we put together our monitoring framework, it was definitely on the mind of state officials. Since we focused primarily on stakeholder engagement in this last round, it hasn't come up as much, but I'm sure states will have plenty to share with us when we connect back with them.

CHAIR BELLA: All right. Well, as we talked about yesterday, the upcoming changes that are proposed that we won't bother our panelists with today, since they are still proposed.

The procurement choices that states are making and lining that up start to have bigger and bigger implications as we get down the road to try to support aligned enrollments. I think keeping that as a key point of what we're working with states on and understanding where they or CMS might like some flexibility will be really helpful.

All right. Any other questions on this piece before we move into the panel?

[No response.]

CHAIR BELLA: Okay. Thank you very much for setting the stage.

Drew, I think you're going to lead us through? Yes? We'll welcome our panelists, thank them. We love panels, and we often don't get people in person. So we actually have three in-person human beings who care about this topic perhaps more than we do. So welcome. Thank you. [Pause.]

PANEL ON THE MEDICARE-MEDICAID PLAN TRANSITIONS AND THE FUTURE OF INTEGRATED CARE FOR DUALLY ELIGIBLE INDIVIDUALS

* MR. GERBER: I'm moving on to our panel discussion on the Medicare-Medicaid plan transitions and the future of integrated care for dually eligible individuals. I'd like to thank all our panelists for joining us today.

To begin this session, we'll have a 45-minute moderated panel where our panelists will discuss the transition away from the MMPs under the Financial Alignment Initiative, the emerging landscape for the D-SNPs, the product to which demonstration enrollees are being transitioned, and the future more broadly of integrated care for duals.

In the interest of time, I'll ask our panelists

to limit their responses during the moderated portion to two to three minutes. I know our Commissioners have plenty of questions they want to get to when they get to engage with our panelists. In order to facilitate this around the two-minute mark, I'll raise my placard to help our panelists know when to wrap up their remarks.

After the moderated portion, Commissioners will have 30 minutes to engage with the panel before concluding with discussion amongst themselves about what they heard.

While I'm sure our panelists need no introduction, I'll give them an abbreviated one real quick. To my right is Tim Engelhardt, who directs the Medicare-Medicaid Coordination Office within CMS, which is dedicated to improving services for individuals dually eligible for Medicaid and Medicare.

Then we have Michael Monson, CEO and President of Altarum, a nonprofit organization focused on improving the health of individuals with fewer financial resources and populations disenfranchised by the health care system. He also serves as a trustee of Altarum's board, as well as the chair of the board for the Long-Term Quality Alliance.

And finally, we have Michelle Herman Soper, Vice

President of Public Policy at Commonwealth Care Alliance, a health care services organization and health plan, where she is focused on designing and implementing a public policy agenda that aligns with CCA's values and mission to support high-quality coordinated care for individuals with significant needs.

To kick us off, in May 2022, in its final rule, CMS announced the MMPs would sunset and encouraged demonstration states to transition their MMP enrollees to integrated D-SNPs. All eight states with capitated models agreed to do so by the end of 2025 and submitted a transition planning document to CMS in October, as Gabby spoke about.

As staff just presented, our work over the past year monitoring progress has included conversations with states in which we heard stakeholder engagement is occurring in advance of a procurement phase.

To kick things off with our panel, a question for all our panelists, here we are, about a year in. What opportunities and what challenges do you see for states, plans, or beneficiaries that were perhaps not apparent back in October?

And I'll start with you, Tim.

* MR. ENGELHARDT: I appreciate the chance to be here.

I feel the need to add to the record, John, fewer hospitalizations, fewer nursing facility placements, where he created that MMP product in Ohio. So I think deep down inside, he would do it again.

[Laughter.]

MR. ENGELHARDT: So we appreciate your great work and the successes from that. Also appreciate that we don't have to be concerned that this Commission is not concerned. So thank you for that, and thank you to the great staff at MACPAC.

Drew asked about opportunities, challenges. First, I want to separate policy issues and operational issues. On the policy side, this transition is an opportunity to rationalize and simplify choices, the market for a population that struggles with health literacy.

We have states right now where we have MMP products, we have D-SNP products, we have D-SNP look-alike products. We have all these other MA products and C-SNPs and I-SNPs and everything else, all in the same place.

Much that we support choice and competition for a lot of people, it's just too much, the opportunity to simplify this is -- I just think is extraordinarily important and the transition from MMP to another state has been the catalyst already for a lot of states to rethink the broader contracting strategy, not just let's take this group and move them another place. It's let's rethink the entire market and how we structured it, in many cases, leveraging the SMAC, as Patti has mentioned. So we have that important opportunity.

With that, the important opportunity to strengthen our focus on performance improvement in a smaller, more manageable number of products, which at the end, that's what I want to make sure is what this is all about is not the system, not the alignment. What this is about is better outcomes for older adults and people with disabilities, and so that's our primary focus.

A couple challenges too. One, if we're serious about stakeholder engagement, serious about partnerships with states, CMS can't be on this panel right now and give answers to every question about that transition, perennial challenge.

And then we're always worried when we move people at great scale. I'm happy to report that we did it in California earlier this year and did it remarkably well. About 98 percent of those people who were in MMP are now in the integrated the D-SNP product, about 2 percent made other choices during an open enrollment period. So we have at least some operational experience to build on going forward.

MR. GERBER: Moving over to Michael.

* MR. MONSON: Well, thank you. Thank you for the opportunity to be here today, to MACPAC, and it's a pleasure to be in such esteemed company. I was commenting before, I hope nothing happened in this room because we'll lose most of the duals experts in the country.

[Laughter.]

MR. MONSON: There's a few of us, and that's actually part of the theme of what I want to talk about today. To the great work that Drew and Gabby shared with us earlier and the conversation that just ensued prior to this, I think we've heard about some of the good and some of the bad that's happened.

The fact, I actually think it's -- as much as

there's work to be done around stakeholder engagement with participants, the reality is we do not hear the same noise as this transition is happening that we did around the MMPs when they were happening. Now, some of that might be because people don't understand as much, but I also think there is more stakeholder engagement now that that's happening than that happened in the past.

But ultimately, the challenge that we're facing here and has become very clear over the course as these transitions are happening is just a general lack of expertise at the state side and, to some degree, at the federal side as well around these populations and the complexity that's around them.

Now, the clock is ticking. There's pressure on leaders to move, which is good because deadlines are clarifying, and we're seeing movement happen, but now they're coming up a very steep learning curve and are faced with timelines that are inflexible and state contracting processes which are appropriately deliberate. And that is, I think, the challenge that we're seeing at this juncture.

But ultimately, understanding how these programs interface and understanding the levers that policymakers

have and how to use them and then the oversight component that was referenced a little bit earlier, which I think we'll have an opportunity to talk about later, these are real issues for us to be focused on to ensure that dually eligible participants get the care that they deserve.

MR. GERBER: Thank you.

Michelle?

* MS. HERMAN SOPER: Thanks, Michael. Thank you, and just to echo comments of how thrilled I am to be here and to be presenting with this amazing panel.

Two quick seconds about the Commonwealth Care Alliance for those who might be unfamiliar. We are a not-for-profit health services organization that has health plans and care delivery systems that are designed specifically to serve people with significant medical, behavioral health, and social needs. We are based in Boston and serve about 100,000 people across Massachusetts, Rhode Island, Michigan, and California, but the majority of our health plan members reside in Massachusetts and are members of two fully integrated programs, the Senior Care Options Program which is for individuals 65 and older who are dually eligible, and then One Care, which is our MMP,

our Medicare-Medicaid plan.

So I have some thoughts about some of the national opportunities and challenges with this transition and then also several Massachusetts and One Care specific comments for the One Care program.

I think a couple of opportunities that we've seen in the last couple of years since the transition was announced, one -- and I also want to commend the Medicare-Medicaid Coordination Office for doing this when it announced the possibility and then the final decision to end the MMPs. It also incorporated several best practices from the Medicare-Medicaid plans into D-SNPs, such as enhanced screening for social needs, more consumer engagement, proper official channels for consumer engagement, a new opportunity for states to measure D-SNPs performance separate from the Medicare Advantage population. So there were a number of really positive changes to D-SNPs at the same time.

And also, there's just an increased attention to integration. I think in the sort of health policy duals world -- and we're seeing a lot more states and stakeholders interested in how to make care better for

duals -- there are some challenges that we see specifically, and this is nationally and in One Care.

These programs were designed by and for specific individuals with unique needs. So I think there's just some concern that in a more prescribed model under the Medicare Advantage system, some of these changes and opportunities for input and sort of continuous improvement might be lost.

We've seen some states roll their duals, some demonstration states thinking about or planning to roll their duals demonstration programs into broader Medicaid managed care, and I think we're just a little bit concerned that the programs will lose some of the targeted and important population focus as it happens.

For One Care specifically, in Massachusetts, it's the only demonstration that serves individuals 65 and older, and there is no FIDE SNP right now that serves that. There's a couple of other programs in the state but not to that -- not a FIDE SNP. And we're just concerned that we'll be retrofitting a model that was designed to serve a specific population into something that was not designed for that purpose.

And then again, we've talked about this, and I heard this in the comments too. It's just an extremely, extremely complicated process. So I just wanted to note that both from what I see in Massachusetts and other states and then also my experience at the Center for Health Care Strategies before, just the amount of work it takes to stand up these programs is significant.

MR. GERBER: Thank you.

Continuing on this theme, I'm going to ask a question to each of our panelists individually, beginning with Tim. I think we're all interested to know how MMCO is assessing the progress states are making with their transitions. Are there particular areas of concern that you're paying particular attention to or areas where states are doing well as they consider their next steps?

MR. ENGELHARDT: The last discussion teed this up really well, so I'll be brief.

We're in with some states, kind of a policy decision-making phase. Where we're paying a lot of attention is on the arcane back-end junk about how we structure contracts right now, and I say it's arcane in the back end. It becomes really important, and Michelle

already alluded to it. How we structure contracts on the Medicare side dictates what we know about medical loss ratio, about star ratings, and overall quality performance just because of how that kind of gets rolled up on the Medicare side.

So to date, all of the states have been working on making really, I think, good decisions about that process to ensure that we still got the level of transparency and population specificness that has been really important to date. So that's a big one.

The next phase scares us -- is, of course, the procurement phase scares us for multiple reasons. One is because it's a point of, as we've all lived in many of our cases, potential disruption in the integrated care offerings in a particular state, as we've also all lived potential disruptions in our time frame. And so we're in procurement mode in a couple of states already. We'll be in it with many more very soon, providing a little bit of technical assistance where we can, but ultimately, it's a state-driven selection process.

And then in 2024, the operational work will ramp up significantly, again, with the California blueprint, a

ton of beneficiary testing of materials, of notices, a lot of operational testing with the plans to ensure that the back-end stuff -- the enrollment, transactions, other things -- don't distract us and don't disrupt anybody as we navigate the operational phases of the transition.

MR. GERBER: Thank you.

Michael, as Altarum is engaged in providing technical assistance to states planning to transition their demonstrations, how have you seen state staff using policy levers available to them to bring an MMP level of integration into a D-SNP? What barriers have you seen for states to do so, for example, around system changes or enrollment processes?

MR. MONSON: Thank you, Drew.

One thing I didn't mention earlier is that Altarum, one of our -- our newest business unit is Altarum Medicare-Medicaid Services for States, which is actually purpose built to help states actually gain access to the expertise so they can run these programs better, and so we are -- we have the good fortune of working with several states. I can share only obviously the public information. We don't share confidential information.

But we are seeing states are leveraging their SMACs. They see those as a tool, and they understand that there's power in that tool, whether it could be trying to align the benefits with Medicaid or integration with models of care and enabling some financial integration.

We're also seeing a desire to use HIDEs and FIDEs and applicable integrated plans as appropriate so that they can be exclusively aligned enrollment. There can be unified appeals and grievances.

Tim was just alluding to procurement. Competitive bidding processes are actually a good tool because it allows the states to actually declare what they want to have happen and then get the partners that will be working with them and then using crosswalk, which that -- I don't know if there's the last rule or the rule prior -- the ability to crosswalk individuals so that they don't -- that participants are minimizing their disruption.

The SMAC giveth and the taketh away, though, is what I would also say in terms of barriers, and I believe it was Patti who mentioned this earlier, that it is a limited tool. First of all, it can't enable true shared savings. You can only get the synthetic shared savings.

It does nothing with Medicare fee-for-service or Medicare ACOs. It's silent, and there's no power.

It also requires a level of expertise to implement and oversee that almost no state has, in all honesty. Most states don't -- are just learning what a Medicare bid is, are just learning to understand what a model of care is, and probably really don't even understand what a PBP is, just to be honest.

And so you can try to put those things in, but you need to then have the robust oversight of those plans. You could have the most beautiful SMAC in the world, and if you don't have the expertise and the capacity on your team to appropriately oversight those health plans, it's useless.

Obviously, we are losing the passive enrollment and the shared savings as part of the MMPs, and then we have the plan lobbying that's been going on around coordination-only D-SNPs, which I'll talk about in a little bit.

We're doing a bunch of things to help states. We are helping them by bringing them subject-matter expertise. We are helping them by leveraging learnings across states,

even if it's just things about like how do you think about which model. Do you want to FIDE model, a HIDE model aligned with an MLTSS, maybe a program or direct contracting, making sure they understand how to do that very important participant stakeholder work, both participants, providers, et cetera? And ensuring that they leveraged the best parts of their Medicaid programs. Many of these programs are running effective managed care programs today. There's a lot of learning there. These shouldn't be done in silos. Things like independent enrollment brokers are actually a real component that can help make sure these transitions go well and the participants get what they need.

MR. GERBER: Thank you.

Michelle, I'll turn it to you with some of the plan perspective. What elements of the MMPs would you support carrying over into contracts with D-SNPs? What are your plan’s policy and operational priorities based on what you've observed with the transition to date, such that it is? And are there areas where further clarification from states or CMS might be useful?

MS. HERMAN SOPER: Sure. Thank you.

So on the sort of key elements that I wanted to highlight, one is -- and this is just so important that there's one accountable entity to manage the full range of Medicare and Medicaid services. Not all states that are going to transition into a D-SNP model or, for that matter, that are thinking about implementing new integrated programs have that situation. There are many benefit carveouts.

In our experience, it is really the most effective foundation for being able to provide person-centered holistic care to individuals with a whole set of needs. It allows us to address social determinants of health needs. It allows our interdisciplinary care teams to work effectively and really bring all of the important components together.

The other point -- and Michael just alluded to this -- is passive enrollment, and I realize -- and I've had many conversations with Tim over the last couple of years about this. We know passive enrollment is not coming into the D-SNP model. We are fully aware.

And we also just -- I wanted to note that we appreciate CMS's incremental steps to encourage aligned

enrollment over the last couple of years and rulemaking cycles to encourage and, in some cases, really push enrollment into the same plan. We think that's really important.

That being said, I think passive enrollment is the most effective way to encourage and get to CMS and state schools of integrated enrollment and get the greatest number of people enrolled while also maintaining protections and the ability to opt out, disenroll, change carriers, what have you.

From a plan perspective on that, in 2026, we are -- and we are currently bidding on the One Care and SCO programs. So assuming we are fortunate enough to continue our work there, we will really be focused on sustaining enrollment in a D-SNP model. Again, from our perspective, passive enrollment has really allowed CCA to focus resources on care and other activities away from enrollment and marketing, which is just a reality in the Medicare Advantage market. It's very competitive. It's increasing, and we're competing with a lot of big players that have very deep pockets for enrollment and marketing. So I think that this just -- it changes the way that we are looking at

investments and enrollment, and I think that is just something that is -- it's a concern moving forward.

In terms of operational priorities -- and this is really conceptual because we are still operating an MMP -- I just wanted to note a couple things, and one reoccurring theme through all of my remarks is really ensuring that we maintain the flexibilities in a demonstration and allow to make program changes as they are needed to better -- best serve our members, particularly around benefits.

Enrollment concerns, besides passive enrollment, the state right now effectuates enrollment into One Care, moving forward in 2026 plans as well. The role of independent brokers, we're just not exactly sure how that will work. So we just want to make sure that there is a significant amount of education to make sure that there are no barriers to enrollment.

And then last is just making sure that we can get the payment right to best support a population under 65 years old.

MR. GERBER: Thank you.

So that sort of touches on some of the current issues with the MMP transition. Of course, what are we

transitioning to in the integrated D-SNP landscape? D-SNPs are arguably the most widely available integrated care product for duals today, operating in nearly every state and enrolling more than 5 million dually eligible individuals, albeit with varying degrees of integration.

CMS has published a number of rules in recent years aimed at furthering integration in D-SNPs and requiring higher levels of care coordination and alignment for plans.

Yesterday, the Commission heard from staff about a recently released proposed rule, which we won't get into too much right now, but to begin with, Tim, what do you view as the most effective policy levers states have to integrate care for their dually eligible population? How is the dual's office identifying the barriers that keep care siloed for the population, even in states outside of current MMP demonstration states?

MR. ENGELHARDT: Well, we've talked about it a lot already, the state Medicaid agency contract, SMAC, being the most powerful, but it's limitations beyond managed care. It's the most powerful legal tool. So I won't belabor that one.

It is a really powerful policy tool that we've been perseverating a lot lately. It is baked into the MMP model that we've been talking about. It is not necessarily outside of it, but can be, and it's the term that we use "exclusively aligned enrollment." That means -- we define it as everybody in a D-SNP is also in that same sponsor's Medicaid managed care product, right?

States effectuate this through the SMAC by setting enrollment limitations on a D-SNP, and that exclusively aligned enrollment is really, really important. In fact, it's important relative to like mostly aligned enrollment, right?

So the difference matters because exclusively aligned enrollment is a catalyst for a bunch of other policy things, right? If everybody in that D-SNP is also in the Medicaid managed care product, it's what allows us to do integrated member materials, so like that integrated ID card that beneficiaries value but also directories and handbooks and everything else that comes with it. To us, that's like we tie that to exclusively aligned enrollment.

It is legally now the gateway to unified appeals and grievance processes across Medicare and Medicaid. It

is legally, thanks to provisions in the Bipartisan Budget Act of 2018 -- it's what triggers the "aid paid pending" protections that are natural and known to us in Medicaid but otherwise don't apply in Medicare, except when we're in this exclusively aligned enrollment environment.

It is the gateway, coupled with some other policy tweaks, to that clarity on the MLR, on star ratings, on giving states access to some of our information systems for the purposes of oversight and monitoring together.

It's what simplifies provider billing the most, and of course, most profoundly, it's the real manifestation of like actual accountability for total care, for whole person care, and not just like pieces of it, so that exclusively aligned enrollment policy lever is the one that we're particularly perseverating on that one.

MR. GERBER: Thank you.

Turning to Michael, while rulemaking seeks to raise the bar in existing integrated plans, we recognize that only a subset of states contract with highly or fully integrated D-SNPs, and most duals are still enrolled in coordination-only D-SNPs, which tend to offer minimal levels of integration. Many states may not have the

knowledge or bandwidth to leverage their contracts with D-SNPs to increase integration, and many states may not even have experience enrolling duals in managed care.

What barriers do you see to increasing state uptake of integrated care, and what are maybe some solutions that Altarum has been working on?

MR. MONSON: Yes. So access to experts is still the fundamental issue. I mean, honestly, there's probably 50 to 75 duals experts in the country. I wasn't kidding before when I said, gosh, nothing should happen in this room, because people tend to either know Medicare or they know Medicaid, and there are very few people who understand both. That's true at states. That's true at the federal level. That's true in plans. That's true in providers. And so states really have trouble accessing this talent.

Now, at least the FAI states have some knowledge. They've been running this for a little bit. The non-FAI states have nothing. They're really kind of in the dark ages at this point, not by fault of their own.

And then they have trouble -- everyone has trouble retaining the talent because the plans tend to come and scoop away that talent once it's been developed.

There's this concept in economics, and some economist leaders will just pick it up, of diffused benefits and concentrated losses. So we have a handful of plans that have a lot of money to lose. If you're a D-SNP and you don't win a Medicaid managed care contract, whether it's exclusively aligned or not, it's going to be very hard for you to continue to operate. So then you lobby legislatures. You lobby the executive branch. You hire away the employees. You've got a handful of providers, nursing homes in particular, that have large post-acute businesses, and because of the way Medicare Advantage works, it doesn't reimburse it well. They don't want beneficiaries in these programs, and we saw that in the demonstrations. They encourage people to leave the demonstration.

The benefits accrue to a very large group of people who tend to have no political voice, and then we have state Medicaid departments that are totally outgunned by all of these other players, which is why we built -- that is actually the reason we built Medicare-Medicaid services for states to actually provide them some weaponry.

We can't ignore the financial components of this

program. The shared savings are gone. All of the savings, almost all of the savings that happen in these programs when there's integrated care accrues to Medicare. There are real costs to states to putting these programs into place and deciding to launch an integrated program. It's expensive.

We were just talking about all the complexity, and John was saying he'll never do it again. And if you can't get any of those savings, that makes it hard. There are some ways to get it, but you have to do a lot of cost up front, and then it takes a couple of years until you get some of that savings back. So these are real challenges for states moving forward and disincentive for states to move into integrated care.

MR. GERBER: Thank you.

Michelle, relative to the demonstrations, what are some of the programmatic and operational challenges present in the D-SNP model?

MS. HERMAN SOPER: Sure. Again, just to repeat myself again, we just are very concerned that -- and again, particularly for One Care, but across the country really, that we can maintain the flexibility and the same channels

for consumer, member, family, and other stakeholder input.

Massachusetts is really exceptional with the way that it has structured its program and will continue to structure its program to collect that input, but again, we just want to make sure under a more standardized program that doesn't -- is not under demonstration authority that we can continue to make the right changes.

We just talked a lot about integrated financing, and just to put like a finer point on it, even in FIDE SNP model, even under an exclusively aligned enrollment structure, which I think will be the new gold standard, rates are still developed separately, right?

So even if one accountable entity takes the full pot of money to spend in the most high-quality, efficient way, Medicare develops rates through its own system. Medicaid develops rates here. So who's checking to make sure that changes under one program are reflected in the other. And so I think that it just now -- and a three-way contract into the joint rate-setting system in the demonstrations still developed separately, but there was more of a check to make sure -- and Massachusetts definitely benefitted from this over the years -- just to

check to make sure that plans and programs had what they needed to be able to care for their members appropriately, so who is reconciling the right changes is a question.

Specific to the One Care population, we don't know how that will fare under the Medicare risk adjustment system. So I think, just for us, that is a big question mark and concern.

On quality measurement too, this is really specific to One Care. We'll be transitioning from a joint CMS and state quality measurement system to the Medicare stars ratings. For our population, which is 60 percent of our population has a significant behavioral health or physical disability, 40 percent -- almost 40 percent have a substance use disorder. Almost 60 percent have a serious mental illness. We're concerned about what that means to move our population to a stars and quality rating system that applies to all Medicare Advantage populations, even if in Massachusetts that they're looking at the D-SNPs separately, which is really important.

And then again, just back to the point I made, just to emphasize again the importance of education around the new enrollment process and making sure that all of the

stakeholders from CMS and MassHealth and down to the people who are enrolling in the program really understand the changes and the implications around what's available.

MR. GERBER: Thank you.

And finally, while we've been monitoring the MMP transition and developments in the D-SNP model, I think we all recognize that most dually eligible individuals are not in any integrated care product at the moment, and that the sort of current work is not the final step.

I have a question for all panelists. I think we've been fairly disciplined on time, so feel free to be a bit more expansive in your answers, if you want. I won't stop you this time. How can the lessons of the MMPs and development of integrated D-SNPs in the demonstration states transfer to other states looking to integrate care for their dually eligible population? And where, more broadly, do you see the future of integrated care going for this population? Again, we'll begin with Tim.

MR. ENGELHARDT: I think there's an important role for knowledge transfer, right? So we have a technical assistance, broader integrated care resource center. They've been very valuable to some states. It's just

important to me. Like, our own staff play a lot of that function with other states to share information across state lines, right? That's important.

But I might focus on the policy transfer here, too, because it came up already, but this has been a major focus of our rulemaking over the last several years has been to bring elements from the MMP experience into the broader Medicare Advantage and D-SNP program.

A lot of this stuff, we baked it into the cake, right? It's there for all states now. You don't have to -- if you've never heard of an MMP, it doesn't matter because we baked it into the cake. We shrank the gap between what we created 10 or 12 years ago and what exists on a much broader scale and on a permanent basis outside of demonstration authority now.

So it's like worth reflecting that like it is a different world than it was 12 years ago when D-SNPs were temporary, when there was like no benefit flexibility in Medicare compared to now. We have this incredible flexibility with the Medicare program, that in many ways now exceeds what Medicaid can offer in many cases. So much more has evolved over time.

And exclusively aligned enrollment, integrated member materials, integrated appeals processes, "aid paid pending" -- like care coordination elements, joint oversight, the benefits stuff, yeah, enrollee advisory committees, in a world where we now have a categorical adjustment index based on disability and dual eligibility status and Medicare star ratings that didn't exist 10 years ago and a world in which we brought a health equity index into the Medicare Advantage program, so many things have evolved. There's so many learnings from it. They're like baked in the cake now, and so to me, that's the catalyst for getting it to any other state that hasn't participated in this.

Long-term future, we have comment solicitation out right now on this topic, but we hope to be in a place down the road in which being in meaningfully integrated care is normative and not the exception. We talked about the number earlier where we were at 200,000 people 10 years ago. We're pushing 2 million now. We want that number to grow, and I think through this process, we actually will.

We've been focused so much on the transition of a product to another place, it masks the fact that

legislative changes in Ohio will make that not just a transition of something. It will make it an expansion of something as well. We see the same thing in California where we now have integrated products on a much greater scale. I view this as a stepping stone to get to that future state.

MR. GERBER: Thank you.

Moving to Michael.

MR. MONSON: Yeah. Well, first of all, I would say hats off to Tim and, Tim, to your team and MMCO because all the great stuff of the MMPs is baked in now, with two exceptions, right? The shared savings and, as Michelle mentioned, passive enrollment. We have default enrollment, and default enrollment is good, because if you're newly -- and if you're in the right state in the right place, you can be default enrolled.

I do think that there's a piece that we did learn in the MMPs that when people enroll were opted in, when they were placed in and then they stayed for a period of time, they tend to stay because they liked it. So we have giant groups of people who opted out of the demonstrations and then all the non-demonstration states where people

never got the opportunity to have passive enrollment. I do think it's something to consider about making sure that beneficiaries have the ability to experience integrated care and then make an informed decision from there.

We can't ignore coordination-only D-SNPs. They are siphoning off full-benefit dual eligibles in a very unproductive way. The new rules, if they're finalized, will help a little bit. But ultimately, this is about political will to say that these plans just shouldn't exist. There is no argument to be made that they actually improve care for participants if you're in one plan is coordination-only D-SNP and another plan is Medicaid managed care organization.

Now, as we move to this D-SNP chassis for integrated care, we need to realize that outside -- that the payer of last resort understanding that the policy community has around fee-for-service is very different, and what I would argue is that there's a deep lack of knowledge because most of the policy community doesn't understand Medicare Advantage, and that arguably, in this D-SNP world, we're not following the payer of last resort rules as they should be.

So where are there opportunities around this? Well, it's the same that we see in fee-for-service. There are places of natural overlap where there's always been confusion, DME, supplies, home health, to some degree, NEMT.

But now we have all these supplemental benefits. Tim just alluded to this. Home-delivered meals, respite, personal attendant. These things are not -- these things can and can be required inside of a SMAC to happen. But ultimately, because policymakers, I think, don't fully understand how a bid is developed, they don't understand what a PBP is, they don't understand how that we can make sure that, in fact, we are following the statute and ensuring that Medicare is paying first for what Medicare should pay first for, and that Medicaid then follows on.

So what are some of the key lessons that states can think about and learn as they move if they haven't been in an MMP? Well, the contract management teams, that close partnership with MMCO and the health plans and the states was a very important tool as the MMPs came up, and it would be a tool for other states to continue to think about using if it could be leveraged.

Working closely with provider partners, we know that provider partners are important stakeholders. We know that they have the ability to direct beneficiaries in and out of these programs, and so they need to be informed.

The SHIPS. We can't forget about the SHIPS, especially partial duals. That's where they're going to get a lot of their knowledge from.

I mentioned briefly before about independent enrollment brokers instead of plan-paid brokers. Let me just be clear. An "independent enrollment broker" is a Medicaid term, so everyone in this room should know it, but sometimes there's some confusion. And I'm talking about the brokers that are paid for by the state to provide unbiased advice to a participant about how to make a decision.

This is the way it works in Medicaid. We don't have hand-to-hand marketing in Medicaid. It's very different in the Medicare world. As we bring these programs together, we have to come to terms with that, because we have brokers and agents, and this is what Michelle was referring to before -- I believe what you were referring to before -- that are out there working to move

participants around. And what we don't want to have happen is participants land a plan just because that plan has the resources to hire and incentivize brokers and agents. That doesn't mean they have a better plan. We need to make sure that participants are able to make the choice that they want to make about integrated care, about how much they want and how little they want, and not because someone's getting financially incented to do that. So the idea of eliminating paid brokers for these populations, I think, is something to deeply be considered.

We've talked a lot about the stakeholder process and how important that is. We can't forget that that is critical. These populations deserve to have a say in how these programs are developed.

We've talked a little bit about this too, but I want to just put a point on it, a finer point around that states need to think about, as they construct their integrated care programs, how it fits with their Medicaid program, whether it's a fee-for-service program or a managed care program.

The new rules, if they get finalized, will have a lot of work for states, actually. States are going to have

to do a bunch of things if they're running Medicaid managed care programs, and honestly, they need to start planning now because it's not that far away.

But also, we know that the Medicare Advantage rules are very rigid, and from a policy perspective, there would be a lot of benefit to be thinking about how we actually provide -- you know, maybe someone who sits next to me to the left here, authority that existed under the demonstrations around timelines, for instance, to be able to say we're not going to follow the Center for Medicare's very rigid timelines on Medicare Advantage. We want to allow it to match up with the Medicaid book of business to follow for whatever's going on in that locality of the time.

Obviously, every state would benefit from having a dual strategy. You all made that recommendation. Unfortunately, that has not been acted upon as of yet. Until that happens and until there's funding that goes with that, it will be a side-of-the-desk activity for most states, because there are so many other things that are always going on, and people are just going to keep hearing John in their head saying, "I'd never do it again." And --

I don't mean to pick on you, John.

I'm going to say it because Tim can't say it, but MMCO needs more authority. This general lack of understanding about duals exists inside of the federal government as well. MMCO should have more authority to work across the Centers for Medicare and CMCS. They should have the ability to interpret regulatory guidance for D-SNPs and other SNPs as well to have duals. Demo authority would be really nice to try some new things and obviously timing.

And then the elephant in the room that we actually haven't talked about yet is that we have two programs that while designed at the same time, were not designed to work together the way they're operationalized today. And they never will, and so the best path forward would actually be a new title. That would actually allow us to align these programs up correctly and would solve not all of our problems, but many.

And I guess I would just leave it for those states that haven't really jumped into this yet, the water is good. Come on in. You can start in the shallow end of the pool, because you actually really can make a difference

and improve the health and the well-being and the quality of life of your dual eligible participants.

MR. GERBER: Thank you.

Michelle to take us home.

MS. HERMAN SOPER: Thank you so much. And Michael actually just set me up. I have a couple of plan perspective comments to share. But I will also just, before I do that, come to John's defense, because as a contractor with the Integrated Care Resource Center, at the time that Ohio was setting up its demonstration and being in some of the MOU negotiation meetings, it was an incredible undertaking. He worked really, really hard across his organization, along with CMS.

I'm going to start sort of where Michael left off. I think that one of the lessons -- and it does not come without challenges -- but one of the lessons is really thinking about how to implement these programs in a very targeted way that focuses on the population. You know, we've talked a lot about, and I know everybody here knows about the different care model administrative requirements. That necessitates a deep level of expertise at these programs.

When the demonstrations were launched, most states had a couple of people. Some states were able to form a whole department. That takes a lot of resources, making sure states have the adequate resources to do that is also fundamental to that.

But, you know, we do see a lot of benefits to have programs like we do in Massachusetts right now, which are either a separate duals program or might, in another state, include other high-need populations such as Medicaid LTSS users. We think that having these separate programs sort of separate from the general Medicaid program can better target program requirements, attract contractors that have special expertise in this population.

And also, just for a plan like CCA, as we are watching the Medicaid market consolidate among several big plans, as more and more states move towards exclusively aligned enrollment, which I absolutely support, I think that, again, there becomes an increasing amount of consolidation in the market, both for D-SNPs and for Medicaid plans as we are thinking about a larger, broad, fully comprehensive Medicaid program.

So again, it's just making sure that that sort of

targeted focus is still there in the programs that really are unique to this population.

A couple of other points I wanted to make, and this, again, goes back to one of my themes which is member, family, and stakeholder engagement. MMCO created opportunities and requirements, actually, for all D-SNPs to have enrollee advisory committees, which we were really, really excited about. I think that plans can take it farther, and I think states can require plans to take it farther.

One of my favorite programs to talk about at CCA is our Member Voices Program, and that is a formal, structured way to involve member feedback into our care delivery and operational activities. We have set panels where we meet regularly to help guide decisions. We have had very prescribed member input on things like redesigning our onboarding process, selecting a transportation vendor, identifying barriers to Medicaid adherence, and I could give you some more examples too, but it's a very formal way to incorporate that feedback into our decisions, and I think that has been a really fundamental part of how we work.

Again, I am totally repeating here, but I do think the state shared savings is hugely importantly. It is a huge incentive, especially as America ages and Medicaid LTSS expenses for the aging population will just, I think, explode in the next 10 to 20 years. Giving states an incentive to develop these programs is going to be really important.

And then sort of the last thing, from the plan perspective around integrated financing too, I just wanted to note allowing us to control or be accountable for the full amount of the capitation rate has really allowed us to invest in clinical innovations that we would not have been able to do as a Medicare Advantage plan or a Medicaid contractor. It allows us to pull the financing. And I want to keep us on track so I'm happy to provide more details about that. But again, that provides the right incentives and the right resources for plans to really step up and be creative about ways to better serve our population's needs.

MR. GERBER: Thank you, Michelle. And again, thank you to all of our panelists for being with here today and sharing your insights. I will pass it back to the

Chair and for Commissioners to ask our panelists about anything that they heard in our panel today, along with any other issues related to dually eligible individuals that came from other presentations during this meeting.

CHAIR BELLA: Thank you, Drew, and thanks to our panelists. Kate leaned over and said, "This is the best gift I could possibly have." She is not wrong.

Okay, John, kick us off.

COMMISSIONER McCARTHY: I think I have got to clarify my remarks to Michael, and that is what I meant when I said before was the MMP process was the hardest thing I've ever done in my career as Medicaid director in two different places. I mean, I got to work with Michelle here in D.C., one of the greatest people I got to work with in my tenure, in getting stuff done. I remember going to Michelle and like, "What's a SMAC?" I had no idea, as director then. I was like, what is this thing?

And what I'd seen was my partners, Tom Betlach and Darin Gordon in Arizona and Tennessee, with Patti, go down this other path of doing things that was much easier from an implementation side.

But having said that, I was super proud of the

MMP program, MyCare Ohio, which I think was one of the better ones. And that's one of the things that concerns me. When we launched it, it was back to the shared savings piece. One of the reasons we did it was for shared savings, to get that. We were supposed to have one cap rate -- that's why I entered the program -- and then after we entered, we were told no, there will be two, and then it was difficult to set those rates. So I think that will be one of those issues going forward.

But Mike, I do want to clarify. I do encourage states, and we work with states, to do an integrated model, and it's super important to do that.

But Tim, I think the question I have, in you guys thinking through it, was why take down the MMP programs, because some of them were so successful. And I heard what you said before, and get more alignment, but the ability that states already have to keep them and keep doing improvements within them versus taking some of the things away -- and I'm really concerned about some of the things that Michael and Michelle brought up, especially about enrollment.

Because that's one of the things we saw was we

saw certain providers, let's just say, 100 percent disenrollment, you know, opting out from certain providers in certain areas. And we worked really hard in Ohio to keep people in. I think we had still, at the end, it was one of the highest rates of people remaining in the program, and as Michael said, people getting the ability to experience it first and then make a decision versus just opting out. Can you address a couple of those, of enrollment and then also why end the MMP programs?

MR. ENGLEHARDT: Yeah. Well, first I'll reiterate that it's a different world than when John successfully went through that traumatizing process, again because things have changed very significantly outside of the demonstration context, partly because we brought stuff in the demo context, or partly because Congress and other things intervened.

So again, D-SNPs were temporary then. They are permanent now. MMPs are not. So there's a big opportunity here to put something on a more stable, legal platform, which I think and hope will be a motivator for longer term investment in the product. So that was a big one, right?

Similarly, because of the MMP experience and the

stuff that was so hard to work through, John and so many others, administratively we now, at CMS, know how to do stuff that we didn't know how to do before. So integrating member materials is a good example, or the appeal process, or others. In some cases we had legal obstacles, but in other cases we just administratively didn't know how to do it, and now kind of reached a state of confidence and comfort from what we did in the demonstration context.

And then third, and really importantly, is this issue of simplification. Again, in your state, Cuyahoga County, year after year, leads the way in having the most Medicare choices for anybody. So when you talk about dually eligible individuals, like literally pushing 100 different health plan options at any given time. We have to remember that duals, they get more options -- PACE, D-SNPs, and MMPs -- but they all had the other options too. So every other MA plan, you go to Medicare Plan Finder and say you're dually eligible in Cleveland, you've got a lot of reading to do because the list goes 50 pages long.

So the opportunity, albeit incrementally, to simplify the options and not force people to educate themselves on do I like this MMP, do I like this D-SNP, do

I like this other product, is just increasingly important in a way that, frankly, I don't think we thought coming off the Affordable Care Act and a very, very different Medicare Advantage environment.

So those things have evolved, we think. We lose some stuff, right, but the totality, we think, is a real positive.

CHAIR BELLA: I'm going to ask a follow-up on that. The Commission is very concerned about what happens when you pull up Cuyahoga County and you see all those choices. There was one MMP in Cuyahoga County and there's a lot of coordination-only and other non-integrated D-SNPs.

So on the theme of does MMCO have the authority that you need, you've done an amazing job of pulling over the MMP features that you could into the D-SNP world. With regards specifically to coordination-only, do you have the authority you need should you want to do something to raise the bar on coordination-only when you get to the next phase of work after this proposed rule?

MR. ENGLEHARDT: We operate in an environment of federal statute and regulatory process that doesn't always allow us to do everything we think might be in the best

policy direction, and there is no doubt that those constraints affect us in certain ways. I would point everybody, though, to the proposed rules that are out for comment right now, where we think we take some pretty significant steps forward on the simplification front, getting us toward that future environment.

So there is always more, but I think we've proposed, at least, some pretty important steps recently.

CHAIR BELLA: Jami, and then Patti, unless, Patti, it's right on this? Okay, Jami, and then Patti.

COMMISSIONER SNYDER: Thanks for joining us today. A really great discussion. I appreciate, Drew, your questions during the panel presentation.

As Drew and Gabby outlined, our real focus as a Commission is on monitoring the transition, right, for these states. So I'm curious to hear from you, Tim, what the greatest area of vulnerability or risk was with the California transition, because I want to make sure that we're keeping our eye on the ball with those areas where we need, and really focus.

And Michael, I'm curious to know, from your perspective, now that you're working with a number of

states, what you see as that area of vulnerability or risk as well.

MR. ENGLEHARDT: Policy risk, operation risk, right? So California, I think, really made some courageous and smart policy decisions, and in their context, they went the route that I talked about with exclusively aligned enrollment, and that allowed them to preserve a lot of the unique. They had a clinical care coordination, with their focus on dementia care, for example, and others. So that stayed. And because of the exclusively aligned enrollment, all these other administrative, really important things about the materials and processes stayed. But those weren't easy decisions, and I commend the team at DHCS for that.

Once we crossed that bridge, I think our own MMP experience taught us that it's reasonable to be neurotic and scared about operational stuff going awry. So for really multiple years we obsessed over testing the details, right, the transactions and the notices to people and everything else. We had a couple of glitches, but by and large it was just an incredibly smooth process. Again, a big credit to DHCS for their work on that. So those

neuroses will stay with us as we navigate the other transitions.

MR. MONSON: So I would add to that, that I'm kind of looking at it from the view of the balcony across multiple states, which is attrition. I am concerned about attrition. I mean, there will be some natural attrition just as we move. I don't know what the attrition was in California but I'm sure there was some.

MR. ENGLEHARDT: Two percent.

MR. MONSON: That sounds good. But I do think that depending on how many plans are able to operate in a market, you will see more and more attrition, because that's where it comes from.

I am very concerned, too, on the ongoing basis about states being able to understand how to manage their SMACs, and do that oversight component. I mean, at this stage, states that are in the middle of the transition, they are just trying to get through their transition, which is appropriate. But then it gets to that point of ongoing compliance, and there's just a lot of learning to do. It's not that people can't do it. There are dedicated people all across our country in Medicaid offices who want to do

this, and we just need to make sure they have the capacity to do that, and we give them the tools to do that, and the knowledge to do that.

But we can't ignore it because the Medicare folks, man, they are focused on that dollar and how to maximize that dollar, and they are moving those bids around all the time, and it's confusing. It just is confusing.

CHAIR BELLA: Patti, then Dennis, then Carolyn.

COMMISSIONER KILLINGSWORTH: Thank you all so much. This has been fascinating, and it's such an honor to have all three of you here.

I'm going to make a few comments and then I have a question, but I'm going to do this on a holiday theme. So I'm going to start with Thanksgiving, which just passed, and express some gratitude for the remarkable progress that really has been made. I know we can't really talk about the NPRM but as you know, Tim, I do think it has some really important steps forward in terms of advancing integrated care, and I am super grateful to see that happening.

Setting aside the real meaning of Christmas, which follows Thanksgiving, Christmas is also a time when

we think about additional gifts that we might like to have. And so Michael has done a great job of laying some of those out, things which would really further, and ultimately, I think are essential to further advancing opportunities for meaningful integration. So getting to a place, and having an array of integrated options available is great, but having an array of options that are not integrated, that pull people out of integrated arrangements is not great. And the way that marketing currently happens and people end up in plans that they didn't even know they were choosing is not great.

So some of those additional steps are really, really important, I think, to really level the playing field for beneficiaries. Choice is choice when it's informed choice. Choice is not choice when it's manipulative. I think there's a whole lot of manipulation that happens, and people end up in places that they don't want to end up. And so when we think about plan switching, understanding the reasons why people switch I think matters.

But then after Christmas comes New Year's, and New Year's is a time of new beginnings. Golly, if we were

designing a program for dual eligible beneficiaries today, we would not do it the way that we did it in 1965, although that was a really good year. But we weren't thinking ahead to today and what people want today and what people need today and what these two very complex insurance programs are incapable, really, of delivering today as they are currently constructed.

So we are doing the best we can with the statutory framework that we have, but it is woefully inadequate for the needs of this population.

So maybe I'll just pose the question to all of you. If you could redesign -- and I know you can't, but if you could -- if you could resign a dual eligible chassis to serve this population well, what would be the key elements of that new structure, assuming you had all the authority in the world.

CHAIR BELLA: Michelle, why don't you start.

MS. HERMAN SOPER: I mean, that's an amazing question, and I think I could talk for an hour about that answer. I think that some of the features that I talked about already, which is, one accountable entity with rates that fully, completely, in that entity. I think, you know,

whether or not that should be a federal program, a state program -- and I'm not going to go there because that's another huge can of worms.

But I do the Medicare-Medicaid Coordination Office has been an amazing partner with states. Whether or not a partnership should continue versus one or the other sort of having actual authority is, I think, a question. So I think that would just be more clear in a program. Whichever way it would go, I think that's really important to be clear.

And then I think it would have to be designed in a way that had full stakeholder input from the plans. I mean I think that, you know, as I move from sort of a state technical assistance role into a plan role, I understand more about the operations and sort of the reality of how things need to work for a plan to be effective. And then I think there's a bunch of people even on the plan side that need to hear more from the states and the federal government, and then member family advocates, provider feedback is incredibly important and just adds a whole new lens. So I think that would be really important as well.

And then I think to, again, not sort of focusing

on a new title versus a revised program, I think that there are a lot of things under the current system that don't work and that we don't have the authority to change. I also think there is an existing chassis and a huge amount of knowledge and a huge amount of work that has been done around MMPs, fully integrated D-SNPs. So I think that a perfect system would figure out -- again, this is what I would want, not necessarily what can happen tomorrow -- but I think a perfect system would not forego that experience and knowledge and resources, but would also, obviously, expand the authority to make things work better as opposed to continuing to fit a round peg into a square hole.

MR. MONSON: So I will add to that. So a few things.

I actually do think that the concept of whether or not it should be a state or federal is actually a really important concept, and I would actually say that there's a lot of strong reasons that it should be a state-based concept, largely because people are going to move in between Medicaid and whatever this new program would be. And it would be very complicated for states to have to run two LTSS programs or two BH programs, and it could create a

lot of confusion for all parties.

I would add that we should have a standard benefit package that's a more enhanced benefit package than we do today. Obviously, if you go to a state level, then it could be -- you know, that could be enhanced and including benefits that we don't have today.

One of the big glaring misses today is that you have to have a waiver, and if you want to send somebody home first for personal attendant care, as opposed to going to nursing home. So this would be an opportunity to fix that type of situation.

I think pooling the money. As much as the MMP was great, the money was coming from lots of different pockets, and it was treated as different pockets. Even in a FIDE SNP, the money is coming from different pockets and treated as different pockets, and you have to encounter it. And encountering is its own little world, but it's real, and it drives operational complexity. So the ability to pool the money so that it can be used truly flexibly -- and almost like the PACE program has got a pooled financing situation that allows for money to cross back and forth. Even the Medicare ACOs have abilities to do that, that

plans don't.

I think also thinking -- we need to be thinking about options that are not only plan options. We've had an entire conversation that is almost entirely focused on plans, but there are states where plans don't exist, and they're not going to exist on the Medicaid side, either because of complexities around delivery in a rural, sparsely populated state and/or the political tenor of a state where managed care is not going to be acceptable. And that's okay, but we need to have multiple modalities so that we don't leave out entire groups of people who would benefit from integrated care.

That's where I was going. I'll end there.

MR. ENGELHARDT: So less institutional bias, more focus on kind of recovery-oriented behavioral health treatment.

CHAIR BELLA: We'll let you pass on that one --

MR. MONSON: Thank you.

CHAIR BELLA: -- but we're coming back.

Patti, do you have anything else?

[No response.]

CHAIR BELLA: Okay, thank you.

Dennis, then Carolyn, then Jenny.

COMMISSIONER HEAPHY: I just want to say thank you all because I feel so affirmed, and from the consumer perspective, that all the concerns that we've been raising are valid, real, and worth further conversation.

I know Tim probably feels picked on, and we are grateful that you and your team are there because you listened to us and you are making changes. And I think what's challenging for us to know is what is within your power and what's not within your power, and so I think as MACPAC is considering recommendations or what it may be moving forward is to better understand what's realistic for us to ask you to do and what needs to be done another way.

I think, Patti, you mentioned Thanksgiving and Christmas. We're going throw in Hanukkah where maybe we can get eight small meaningful gifts. And I'm not going to list them all, but letting states have -- requiring states to -- giving states more control so that they only have independent brokers, where there aren't these brokers that are there just to make money and to switch people back and forth.

That there would be FMAP match to it to give

states the capacity to actually review all marketing materials of plans, that we look at ensuring the plans abide by state and not national plan standards or a method, where that's a termination of need or utilization management.

Let's see. I know we're not going to get to this -- and Michael spoke to this -- is a misalignment of Medicare and Medicaid and the need for third title.

But really defining what the model of care is, I don't know if we're going to get to a standard package, but at least an understanding of what the model of care should be, I think is a baseline, a baseline for us.

And, Tim, you alluded to it, and we believe it's really got to be around independent living and recovery and supporting the dignity of the person.

I think that the oversight is huge, because even in Massachusetts, which is great, we found that nine years into the demonstration, plans was still not creating person-centric care plans, that we had to have an entire process that included plans, beneficiaries, consumers, and providers come together and really look at the entire LTSS delivery system and how plans are working to bring it back

to baseline and say, where are we? What is care coordination? Is care coordination actually being provided? And so we have to make sure that as we're moving forward, we're also looking at practices today.

And in terms of SMACs, I guess a question for you, Tim, and maybe others, is it seems that it could be an unlevel playing field for the states with this yearly SMAC renewal if CMS is not working with the states and partnering with them to really protect and strengthen their ability to work with plans, to ensure the plans are doing what the states want, because the states know what the folks in their state need, and their plans are pushing back and saying, "Well, then we're just not going to contract in your state." And meanwhile, half the beneficiaries in the state are enrolled in their plan. That's a huge issue.

And I guess there are a lot of other things. The star rating systems, it needs to be changed. And the concern about rebalancing spending -- and we need to discuss value-based purchasing, but that really hasn't happened, and how to ensure that that does happen.

Again, there's a lot more I want to say here, bit I thank you all just look forward to a further conversation

as we go along. I know that we really would have -- there was one question in there. But if you have any thoughts on what I just said, I'd appreciate it.

MR. ENGELHARDT: I do. And as usual, I almost exclusively agree with Dennis's premise on here. I'd wrap a few of them into the reality that the system design, how we integrate stuff is so important. It's what the focus here has largely been. It is not in and of itself like totally determinative of people getting good outcomes and good experiences. Even in our own work, we're really proud of some of the systems we put in place. We still have too many people who didn't know their care coordinator's name or how to reach that individual. We had too many people who we couldn't find, right, because we didn't have good address information. They weren't responsive to our outreach efforts, and to this day, we have outcomes that aren't equitable or maximized relative to what we want.

So that's a harsh reality that we have to internalize because it tells us that the structure is really important, but it's not sufficient in and of itself and our ability to monitor and oversee and push, not just as the federal government, not just the state government,

but as the broader community as kind of embodied by the One Care Implementation Council and others like it is still really paramount to get to the places we want to go.

So thank you, Dennis.

CHAIR BELLA: Thank you, Dennis.

Oh, do you two have comments?

MS. HERMAN SOPER: I have a couple comments.

First, I want to thank Dennis for his incredible insights and feedback and just that is very much appreciated.

I think, just broadly, some of the things that Dennis raised, I think really underscores too the need to continue to focus on state resources and education to enact some of these changes.

One of the things that he spoke about was an effort in Massachusetts called the Care Model Focus Initiative, which MassHealth drove and brought essentially all the plans to the table to figure out what's working, what's not, and how to fix it, and that it underscores the fact that the state needs to have the resources and expertise and willingness to do that, which MassHealth absolutely does and embraced.

You need to have consumers and members who are willing to speak up, who have the great depth of information about how to talk operationally about a system, which again comes from a robust consumer engagement through the whole process. And it takes the flexibility in the demonstration, in some cases, to make some key changes.

So I just want to underscore how important that is and how it's not a simple fix and requires a lot of work to get to the point. I think that we were able to take a harder look at some of the things that needed to be improved.

MR. MONSON: Can I just add one thing? Because it's a build on what Michelle was saying, because I think they're in Dennis's excellent set of points. He asked a question about what needs to be done around SMACs and capacity for states.

I do feel that, in some ways, we have all this money available for infrastructure for Medicaid, the ABD funds, 90/10, and maybe we need to think about how we redefine what infrastructure is so that we can create human capital infrastructure for states in order to actually be able to oversight these programs, because ultimately,

that's the problem as you have so many SMACs coming in. It is complicated. So put aside the complexity of a SMAC, the state has to process them all. And that is its own piece, and then CMS has to process them all too, right? And there's no reason to say you don't necessarily want to have all these SMACs because there are benefits to them.

But I would just maybe put it on the table to think about how do we provide resourcing to our dedicated public servants so that they're capable of being able to engage on these topics.

COMMISSIONER HEAPHY: If I could just add one more thing, Melanie? I apologize.

CHAIR BELLA: Sure. No, you're good.

COMMISSIONER HEAPHY: And that is states are committing, at least in Massachusetts, to maintain robust commitment to rebalancing spending and investment in Medicaid, and we're concerned that those really earnest desires won't be able to be fulfilled as rebalancing continues and more and more resources are going to be required of Medicaid, not just in Massachusetts, but in other states.

And so will that actually undermine people's

desire and just being enrolled in, in D-SNPs? Because they will have reduced access to the more robust LTSS and other services, recovery services that are available in D-SNPs.

CHAIR BELLA: Thank you, Dennis.

Patti, for a quick question, then Carolyn and Jenny.

COMMISSIONER KILLINGSWORTH: Just a quick comment. Actually, Michael, you talked about the challenge of reviewing all of those SMACs, and I would say yes. And then the harder challenge is actually monitoring the implementation, right, because without monitoring, it's pretty meaningless, and so setting all of those processes in place, and the more you have, the more monitoring you do.

Thank you.

CHAIR BELLA: Thanks, Patti.

Carolyn?

COMMISSIONER INGRAM: Thank you for being patient with all of our questions and joining us today. I agree with some of my colleagues that things have come a long way.

When I was Medicaid director trying to implement

an integrated program, our whole state office laughed because Medicaid was in one office and the Medicare folks were in another office talking to us about our waiver, and they weren't even sitting together. So we really appreciate, Tim, your work putting all of these pieces together and getting everything coordinated for states.

To Jami's point, a lot of our concern goes around smooth processes for members so that they can be integrated into these new products as they come and the MMP closes down, and a lot of that hinges on these procurements that states run and having to get that aligned along with getting these SMAC agreements done.

So are there things you all are doing to monitor that to make sure the states are getting the help they need and moving those procurements forward, things that we should be looking out for? I think we all know those can turn into a big mess sometimes, and I know we don't want to see anybody waylaid as they're trying to get these things done.

MR. ENGELHARDT: Probably, if you ask most of the states that we work with, they'd say the primary value-add from CMS is two things. One is they've been nagging us to

get these procurements out, because we're worried about timing and delays and challenges and court cases that kind of create transition disruptions. But the other is -- and this goes well beyond the MMP transitions. As CMS has reinstated several Medicare requirements and limitations on sponsors for when they can expand their service areas, we call this past performance outlier status. We have a whole set of rules that dictate when certain sponsors can expand or not, and oftentimes that it runs the risk of bumping up against a state who's saying we want there to be a statewide D-SNP or whatever else. And it is one of the many, many, many places still that we have to navigate the reality of the two different payers and their own sets of rules.

I think, largely, in a good way, I think those are important good rules, but we've tried to increasingly work with the states to be cognizant of some of the Medicare limitations and timing issues as they structure their own procurement so that we're at least not caught off guard by how those fit into the equation.

If states go through procurement processes and they select lots of different plans that aren't currently

incumbents through that competitive process, it certainly raises the bar on how we manage the transition process itself by introducing other players, by introducing the possibility of provider disruptions in different networks too. And so the sooner we're aware of that, the sooner we can begin to mitigate the risks associated with that process.

CHAIR BELLA: So, Tim, on that, very specifically, do you have the authority you need to be able to line up some time frames on procurement, particularly as the alignment of those procurements becomes more and more important in the out-years?

MR. ENGELHARDT: We're doing everything we can to align with the Medicare time frames that we don't believe we can meaningfully effectuate or change in the context of this transition.

CHAIR BELLA: I'm going to try one more. I'm going to try it a slightly different way. Should the Commission spend more time looking at how to align more with how the states might want some flexibilities around Medicare timing? Would that be helpful?

MR. ENGELHARDT: Yes.

CHAIR BELLA: Okay. Thank you.

I feel like I'm interrogating the witness. I'm sorry. Tim is my favorite person in the world, I want you all to know. Maybe next to my dog, Juno.

Jenny.

COMMISSIONER GERSTORFF: I'll ask my question, and then you can guess my profession.

So I have a slightly different question for each of you on encounter data, sharing encounter data with states.

Michelle, I would ask, where do plans struggle with sharing encounter data? And, Michael, I would ask, would states have the capacity and expertise to do anything with the data if it were shared? And, Tim, I'd be interested if there are opportunities or any kind of plan for MMCO to facilitate encounter data sharing.

CHAIR BELLA: This is going to -- we are going to make this sort of speed-round answers. It's a really important question, but I also want to respect your time.

MS. HERMAN SOPER: Yeah. I think, very quickly, I mean, I think there just still remains even in the demonstration challenges between Medicare and Medicaid and

which systems process what files, definitions. I guess just at a very high level, there's still even across states and CMS and plans different eligibility categories and services, and codes are called different things. So I think there just still remains a lack of true integration and abilities for systems to speak to each other, just very high level, but in the interest of time.

MR. MONSON: I would say that states do not have the capacity to manage encounter data. Most of them aren't even getting it, as far as I'm aware at this point, from Medicare. And then to be able to ingest that, use it, match it up. and understand where the overlaps are, et cetera, it's doable, but they don't have the capacity today.

MR. ENGELHARDT: A dozen states in their SMACs require that the D-SNPs share encounter data directly with the states. We have out for public comment right now, a rulemaking that would create new and additional and more timely options for states to request, directly from CMS, access to some of those encounter data. So I hope we'll hear from you and the Commission on that as well.

CHAIR BELLA: Did you figure out what Jenny does

for a living?

Do you have any more questions, Jenny?

[No response.]

CHAIR BELLA: Okay. Sonja?

COMMISSIONER BJORK: Thank you. I was wondering if the panelists could speak a little bit about the challenges of D-SNPs in rural areas because of the -- rural and frontier areas because of the small number of potential enrollees and provider network limitations compared to reimbursement levels.

MR. ENGELHARDT: Briefly, the Upper Peninsula Health Plan in Michigan is our -- maybe our very best performer nationally, if not number one, very close to it. They get incredible CAHPS and HEDIS scores, despite all of the challenges of operating in a really, really rural part of the country. So we know it can be done.

We also have to look really hard at their network every cycle because we have to make certain exceptions in that part of the country.

MS. HERMAN SOPER: I would just add that we are really excited to see more and more acceptance and interest in telehealth and keeping some of the flexibilities that

were created during COVID in place more permanently. I think that that is one way -- not the only way, certainly, but one way that some of these plans can best serve populations in those areas.

MR. MONSON: I would just add it's a "will" issue because plans already do it for Medicaid. So it's not exactly the same networks, but similar. So it can be done. It's just a question of how much money you want to spend to do it.

CHAIR BELLA: Do you have time for one more question?

[No response.]

CHAIR BELLA: Okay. Carolyn. It's not me. It's not me. Don't worry.

COMMISSIONER INGRAM: I know. I wanted to throw this in because I'm dying to know, but similar to Melanie's questioning, do you all have the authority you need to work with IHS to ensure that information is exchanged when Tribal members are trying to access care through D-SNPs for these integrated programs?

MR. ENGELHARDT: I'll expose my ignorance by saying I don't know the answer.

COMMISSIONER INGRAM: Okay. We'll work on that. Thanks.

CHAIR BELLA: All right. We will stop with the questioning. We have a little bit of time to talk amongst ourselves.

I would say in closing, we'll continue to stay engaged on the MMP transitions, and we'll appreciate your ongoing partnership on that and if there's a way that we can support efforts.

And then we will have a chapter on SMACs. We talked about SMACs last month. It's unclear yet if there will be recommendations. We didn't really get to a round robin of asking each of you if there were specific things you want to make sure we keep in mind, but that door is always open. We've done a lot of work on understanding what's in SMACs, as you could tell by a little bit of the questioning today. We have some interest in how to make sure states can leverage, actually kind of use the SMACs and that the monitoring of the SMACs is happening. So welcome your feedback on that at any point as we continue work on levers that states have.

And just really want to say again thank you to

the three of you for being here, for being here in person, and for being so willing to put up with our insatiable interest in this area. So thank you all very much.

You're welcome to stay. We'll be talking for the next 10 minutes, but we understand if you also would like to go. Thank you.

All right. Drew, thank you so much.

We're going to open it up just for some reflections from Commissioners, and then we'll call it a day. I have a few, but I'll save it for the end. Comments from Commissioners?

Dennis, would you like to start?

COMMISSIONER HEAPHY: I think Tim Englehardt is a good man, and I'm very grateful, again, to him and to the office for what they're doing.

I think we need -- the council is not going to feel good about this, but really do more -- a further, deeper dive into D-SNPs and to the duals population as we move forward, because it may be a smaller population, but it's a high-cost population. And so I think that's one takeaway.

My second takeaway would be that -- I do think we

need to work towards recommendations, whether it's around the SMAC or Jenny's question. Yeah, this is a brand-new area, and I think we need to track it very closely.

That's it.

CHAIR BELLA: Thank you, Dennis.

Other comments?

[No response.]

CHAIR BELLA: All right. Well, I will make a couple. I think we heard a lot of common themes from the panelists. I think we still -- the recommendation we made about a state strategy with support for developing that still remains, I think, a great need to build that capacity and, as Michael said, the human capital infrastructure.

It sounds like we have opportunities to look at the authority that MMCO has in different areas, particularly as they transition from demonstration on to a permanent platform.

Clearly, we talk a lot about the institutional bias, and that came up several times today and thinking about that for this population.

There were many other things that were raised today, but thinking about the shared savings is no small

issue and just taking one more opportunity to pick on John. Ohio did book savings on this demonstration, and it was a big motivator. And we haven't figured out in any of the models how to have shared savings and whether it's managed care or fee-for-service, which is an important thing. Michael had mentioned ACOs.

So I think we have a lot of work we can do here. I want to bring it back to what Tim said in the beginning, which is like simplification and better outcomes and designing programs that people want. And as Dennis said, to get their needs met is in addition to our overall goal of everyone having access to integrated care. We have to think of all of those other guiding principles.

So the good thing is so many great ideas are now on the public record for future exploration of this Commission, that we just have endless opportunities for how to improve things for duals. So I thank the Commissioners and Kate and Drew and Kirstin and Gabby, and obviously, we're very happy with the panelists.

And we'll wrap on that session unless anyone else has -- any Commissioners have comments, and then we'll open it up to public comment.

Carolyn.

COMMISSIONER INGRAM: One more comment. Melanie, I didn't jump in time when you were asking more comments, but I think the point that Michelle and Michael and others brought up about stars and just the transition and what that looks like and how stars are applied and the flexibility Tim mentioned about being able to navigate those systems when states are trying to do their procurements and trying to hit their timelines and the timelines of Medicare, those are two things we've got to make sure we look at.

COMMISSIONER McCARTHY: The other thing I want to clarify is when we were looking at doing this in Ohio, it wasn't about the savings. What we saw was outcomes that were much, much worse for the duals population than we saw for the rest of our population. We just were looking at how do we try to make an impact, try doing something different than what we had been doing to help improve those outcomes.

And when you were looking at duals, we were looking at things such as the average number of prescriptions for the population we were looking at, it was

something like 12 prescriptions. We were just hearing -- and so it's we were paying for transportation 12 times a month to go to the pharmacy. It's like, why can't we just get those all at once? Just things like that, that we were so focused on, how do we get that to happen?

So that's why I hear what you're saying on the savings, but our view of it was if we could just improve the outcomes, savings probably would come through on the other end.

CHAIR BELLA: Yeah. But when the incentives are aligned, the outcomes are improved and then better experience and ideally savings also comes. But I guess maybe thinking about it as aligned incentives as much as the shared savings, as I think that has to come first.

Tim.

COMMISSIONER HILL: Just an observation. Obviously, incredibly complicated, and I find myself -- I think Angelo made the spaghetti comment yesterday about financing. That's kind of how I feel about this topic when we talk about duals. But what I see lacking -- and I don't know if the Commission can drive some of the conversation around just getting more beneficiary voice into this

conversation, this notion of what does choice really mean? I don't care if I have a thousand choices in Cuyahoga County. I want to know what's meaningful. I don't know how we get it, but trying to understand what the beneficiaries want and what's meaningful to them, as opposed to us forcing on kind of this health policy conversation about all these variable choices, and maybe they're meaningful and maybe they're not.

CHAIR BELLA: Yeah. Last year, which was before you were here -- I can't believe you haven't read all the past transcripts of the last 20 years -- we did do some beneficiary focus groups. But it wasn't necessarily targeted on how do you make choices or how do you choose to be in something or choose to not be in something. And I think that we have gotten pretty consistent feedback that that's a really important area, and so figuring out how we either leverage the work of others who are doing some of that work or do it ourselves, I think, is a really important point, Tim.

And, Dennis, I also wanted to say your point about D-SNPs is an important one. As you know, MedPAC and MACPAC become more intertwined as Congress does more to

foster integration between the two programs and figuring out how we can best work with our MedPAC colleagues to do some things that might be a little bit more on the line of their title is something that we're actively working on as well.

So thank you all. Any more? Any last comments?

Verlon.

COMMISSIONER JOHNSON: Yeah. This panel was amazing. Again, the gift, I think Kate said that was a great Christmas gift or holiday gift for her was great.

I do want to call out that Michael did mention our previous recommendation about a dual strategy for each state, and so I think as we think about all the things we heard today, as we think about some of the comments that we knew we were going to get, if we can really think about, too, how we can make sure that states have what they need to make that come to fruition, it would be a really good idea as well, because that will help us get the outcome we're looking for overall.

CHAIR BELLA: It would be such a small investment that would have to be made in the grand scheme of things.

Michael also mentioned a new title, and I'll

remind new Commissioners that we did work on a unified program. 2020, Kirstin? 2020? 2020. So there's a lot that we can continually look at and remind new folks on Congress, as new folks come in, what some of these ideas might be, including the state strategy.

Okay. Very last call for Commissioners, and then we will go to public comment.

[No response.]

CHAIR BELLA: Okay. Thank you all.

We'll open it up to public comment. If you would like to make a comment, please use your hand icon. I ask that you represent yourself -- sorry -- you give us the name and the organization you represent, and we ask that your comments are three minutes or less, please.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: People are duals-out today. No, not for long. She's ready to go.

All right. We'll give it just a little bit, a couple more seconds. I don't see any hands.

I will remind folks that our next meeting is January 25 -- January 25th and 26th. We are working toward

the March report with some additional -- some follow-up on some previously discussed topics, and we invite you all to join us then.

Thank you, everyone. Thank you to the team. Thank you to Kate. Thank you to our tech team. Wishing you all wonderful holidays, and we are adjourned. Thank you.

* [Whereupon, at 11:43 a.m., the meeting was adjourned.]

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