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PUBLIC SESSION

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10:30 a.m.

COMMISSIONERS PRESENT:

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P R O C E E D I N G S

[10:30 a.m.]

CHAIR VERLON JOHNSON: All right. Good morning, everyone, and welcome to the December meeting of the Medicaid and CHIP Payment Access Commission. It's wonderful to see all of you, and I want to thank you for the flexibility as we shifted to a one-day format for this month, for sure.

So, as you know, we weren't able to convene in October, but rather than focus on what we missed, I really want to focus on what we built together today for our agenda, a really highly focused, timely, and substantive agenda designed to really keep our work moving forward without losing any momentum. As we know, Medicaid does not pause, and neither does the importance of the issues that we have before us today.

So, with that, let us transition to our first session, and for that, I will turn it over to our Vice Chair, Commissioner Duncan. So, Bob?

VICE CHAIR ROBERT DUNCAN: Thank you, Madam Chairwoman.

I'm excited to kick off today with Linn and Ava

giving us a couple of updates on our children with special health care needs transition to adult coverage. So we'll start out first looking at the findings that they've had, looking at the data, and go from there.

So, Linn, Ava, welcome.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) TRANSITIONS TO ADULT COVERAGE: T-MSIS FINDINGS

* LINN JENNINGS: Thank you, Commissioners.

I'm just waiting two seconds to start switching slides.

So, as Commissioner Duncan said today, we are presenting our findings on T-MSIS and our stakeholder interviews on our findings on children and youth with special health care needs on their transitions to adult Medicaid coverage.

And next slide.

All right. Well, I'll continue just giving an overview of what we'll be doing today until I get the permission to move the slides forward.

So today, we'll first start with a summary of the transitions to adult Medicaid coverage and how that

transition may overlap with other transitions, so the waiver transitions from a child-only to an adult waiver and the SSI age 18 redetermination. And then I'll go through our key findings from the T-MSIS interviews, and after presenting those findings, we'll pause so that we'll allow for technical questions and discussion of the findings. Discussion of these findings is also welcome at the end after our interview findings, but we wanted to set aside some dedicated time for those findings. And then Ava will present our interview findings, and then we'll wrap up with next steps.

And next slide. Great

All right. So you might remember this figure from September, and it provides a high-level overview of the transition processes that we are looking at in this work, and so to begin, I'll start with the blue box on Medicaid eligibility. So, as this transition age beneficiary is transitioning to adult coverage, their Medicaid eligibility, starting in that box, they would go through the Medicaid redetermination, usually in advance of their 19th birthday. And states are first required to attempt to do the redetermination on the -- or ex parte

basis, and that eligibility is also determined -- could be affected by your SSI redetermination, and so for children who were SSI eligible as a child, they will go through an age 18 redetermination. And children who are not on SSI may be applying separately as an adult.

So, as a reminder, in September, we went through this in a lot more detail, but if you're in a 1634 state, SSI eligibility confers Medicaid eligibility, and so, if you are eligible for SSI, then you're automatically eligible for Medicaid. And so your redetermination that a state goes through, no action is needed by the state to complete your redetermination.

But in SSI criteria states, individuals apply separately to Medicaid, and so the state has to confirm your SSI eligibility for that ex parte redetermination.

And then in 209(b) states, SSI eligibility does not confer your Medicaid eligibility. So individuals apply separately to Medicaid, and a state would have to determine eligibility in the same manner that they would for all other individuals.

And then going to the green box, the waiver enrollment box, individuals may be enrolled in a child-only

waiver, and if they are, they may also be transitioning to an adult waiver. And child waivers have varying age limits. So this process may or may not overlap with the Medicaid eligibility redetermination.

And the arrows between the waiver enrollment and the Medicaid eligibility just show that -- or are a reminder that you have to be Medicaid eligible to enroll in a waiver, and also, your waiver enrollment may confer your Medicaid eligibility in a specific eligibility pathway.

All right. So now I'll move on to our T-MSIS analysis. Just a little delay here on the slides. Now, it's caught up. Just a second. All right.

So I'll go through the methods first for analysis. So we know from prior research in our first phase of this work on transitions between pediatric and adult care that children and youth with special health care needs, their families, and caregivers can experience challenges with the transition to adult coverage. But there's little research specifically on the coverage outcomes of this transition, and so to address this gap, we examined coverage transitions for transition-age children and youth with special health care needs who are enrolled

in disability-related pathways using 2017 to 2019 enrollment data from T-MSIS.

So for the analysis, we grouped these children enrolled in disability eligibility-related pathways into three groups: SSI-related pathways, so those who are current recipients of SSI; other SSI-related pathways, a much smaller group of beneficiaries who would be eligible for SSI but are not receiving for various reasons; and then other disability-related pathways, so other non-MAGI groups.

And then we also had three primary transition outcomes. One, we looked at those who remain continuously enrolled during this transition period, and then we looked at those who disenrolled during their transition age, so within 12 months of aging out, and if they reenrolled, then if they did reenroll within 12 months, and if they did reenroll within 12 months, that's the churn. And if they didn't re-enroll within the 12 months, then they are considered disenrolled.

All right. So, in this first table, we show the transition-age children and youth with special health care needs who remain continuously enrolled, who disenrolled,

and then who churned.

So, in the far left column, you see the different eligibility pathway groups with all disability-related at the top, the total, and then the second column, the number of transition-age children and youth with special health care needs, kind of the denominator identified. And then in the third column, the share who remained continuously enrolled during that transition period, so 82.4 percent, with variation among the three eligibility groups. And then the share who disenrolled, 17.6 percent, and then the share of those who disenrolled who churned. So of that 17.6 percent, about a third, 33.9 percent, churned back onto Medicaid within 12 months.

So, in this figure here, this is a Sankey diagram that visualizes movement from child eligibility to adult eligibility pathways for those who remained continuously enrolled during this transition period.

In the left column, we see the three eligibility groups that we created and then the percentage of each of that group. So, for SSI-related, you see four percentages that each correspond with an adult eligibility pathway. So 85.9 percent moved to the same pathway.

And then in the right column, we see the adult eligibility pathways that they moved to as adults, and so you see the overall percentage for all children who remained continuously enrolled. So the majority ended up in the same pathway, 77.9 percent, and of those who were not in the same pathway, about half ended up in a MAGI pathway.

This figure is very similar, but instead only shows those who churned. So, again, in the left column, you see the three eligibility pathways and the corresponding percentage who moved to each type of eligibility pathway as an adult, and unlike the other figure, which showed that the majority remained in the same pathway of those who churned, about half went to a MAGI pathway, and only 14.1 percent remained in the same eligibility pathway as they were as a child.

Just waiting on the slide to move.

So we also disaggregated our key outcomes by race and ethnicity groups, and so, each of -- oh, let's see. I skipped ahead too many. There we go. --by race and ethnicity. And so each of these columns shows the percent who continuously enrolled in dark blue, and then in light

blue, the percent that churned, and then in green, the percent that disenrolled. As you see that there's variation in the percent who remain continuously enrolled among race and ethnicity groups, ranging from 82.2 percent for Black non-Hispanic to 94.5 percent for Asian American Pacific Islander, the AAPI.

We also disaggregated key outcomes by states that had adopted different policies, state policies. Just waiting for the slide to move forward. So we disaggregated key outcomes by expansion and non-expansion state.

So, in this figure, again, in each bar graph, you see the percent who remain continuously enrolled, churned, or disenrolled, and so our findings show that continuous enrollment for both those enrolled in SSI-related pathways and those enrolled in other disability-related pathways was higher for those who were enrolled in expansion states compared to those enrolled in non-expansion states, so for SSI-related, 88.3 percent in expansion compared to 78.7 percent in non-expansion.

Then we also measured transitions to the expansion pathways in states that had expanded Medicaid, and as we saw earlier, in those Sankey diagrams, a large

percentage moved to MAGI pathways, and so we wanted to dig in to understand which of those MAGI pathways were these individuals primarily transitioning to as adults.

So, in this figure, we see -- and to the left of the dotted line -- overall of those who were in all disability-related pathways and then in the right columns, broken out by SSI and other disability-related pathways. So we see that 48.2 percent of those who churned re-enrolled in an expansion pathway, and of those who were continuously enrolled during this transition period, 13.1 percent moved to an expansion pathway.

All right. So I know we just covered a lot of findings very quickly. I just wanted to summarize some of our key takeaways from the analysis.

The majority of children and youth with special health care needs remained continuously enrolled in Medicaid when they transitioned to adult Medicaid, so 82.4 percent. However, as you saw across all of these figures, the percent who remained continuously enrolled varied by disability-related eligibility pathway that they were enrolled in as a child, differed by the beneficiary's race and ethnicity, and the beneficiary's enrollment state and

between states that had and had not adopted Medicaid expansion.

Also, the adult eligibility pathway that children and youth with special health care needs transitioned to differed between those who remained continuously enrolled and those who churned. So most of those who remained continuously enrolled remained in the same pathway, and then in contrast, the majority who churned moved to a MAGI pathway.

I'm just going to see if I can get my slides to advance.

All right. Well, I'll turn it back to the Vice Chair so that Commissioners can ask any technical questions about these findings, and then Ava will present the interview findings.

VICE CHAIR ROBERT DUNCAN: Thank you, Linn. I appreciate it very much.

So, Commissioners, Linn just shared a lot of data on what's taking place in the lives of these children that transition. Any questions, comments that you'd like to make on the findings?

Okay. I see Adrienne has her hand up and then

Mike.

COMMISSIONER ADRIENNE McFADDEN: Thanks, Linn, so much for this.

I do have just, hopefully, a quick question for you. I'm trying to sort of reconcile in my mind the individuals who are transitioning who are SSI eligible as a child but not as an adult. Is that mainly because of sort of an asset sort of issue or concern, or is there something else that's going on there, or did we see anything in the data to indicate what that might be?

LINN JENNINGS: Yeah, that's a great question.

I think there are a lot of reasons, and unfortunately, our T-MSIS data can't really get at kind of like the causality, but we do know from other work that in, I think, from SSI, like reports on the age 18 redetermination, for SSI that about half are redetermined as adults if they were on as a child, and then a large percentage appeal and then are later back on SSI. But we don't really know if that is because of assets or income or if it's -- you know, the definitions change from being a child to an adult. So it's possible also that they aren't -- no longer eligible based on -- or like the medical

criteria, but unfortunately, with these data we can't really get at that.

CHAIR VERLON JOHNSON: Thank you, Adrienne. Thank you, Linn.

Mike.

COMMISSIONER MICHAEL NARDONE: Hi. Can you hear me, Linn? Thanks for the analysis.

I just had a real technical question. I was wondering if you can maybe fill in for me the differences in those various categories, particularly, you know, who would be falling into the other disability-related pathway versus the SSI-related pathway. I mean, I clearly understand what SSI-related versus SSI pathway. I just want to understand that a little bit better in terms of maybe by examples of who might fit in one of those categories

LINN JENNINGS: Yeah. So for the SSI, as you said, right, there are specific SSI pathways for those who are current recipients. For the other SSI, they are kind of like other mandatory pathways that states have for individuals who may not meet SSI -- or they meet SSI medical or the criteria but may not meet asset or income.

They're very -- at least from our data, like, very small populations. So it's hard to say exactly what led to them being in that pathway versus an SSI, other than they're not SSI eligible at that time.

For the other disability-related pathways, it could be other -- there are other mandatory disability pathways or optional state pathways. I think also some of the Katie Beckett children may end up in that pathway potentially, and I would have to look back at our list. There are a lot of different pathways that kind of get combined into that, and so I'm happy to share that longer list if that would be helpful.

COMMISSIONER MICHAEL NARDONE: Sorry for my ignorance on this topic.

LINN JENNINGS: No, no.

COMMISSIONER MICHAEL NARDONE: I was trying to understand the other related was a fairly big category in terms of percentage. So I was trying to understand that, and I assume that when -- you know, I don't know if this -- is this part of this analysis or a later point? I mean, one of the questions I guess that I have is, you know, as people -- if people are turning or moving to the MAGI

benefit package, does that mean that they potentially lose services because the benefit package is not as rich as the disability pathway? Is that something that we're -- I mean, that's -- that would be something I would be interested in understanding a little better as to -- they do have coverage, but is the -- are the services the same as they're moving to these different adult categories?

LINN JENNINGS: Thank you.

That's definitely something we can make sure to answer more in January.

I will note that I think some of that also is related to whether they're in a waiver and if they're able to transition to an adult waiver and maintain similar services that they had as a child to the adult pathway -- or adult waiver, but we can definitely look into that as well for January.

COMMISSIONER MICHAEL NARDONE: Thank you, Linn. Thank you, Ava.

VICE CHAIR ROBERT DUNCAN: Thank you, Mike. Thank you, Linn.

Heidi, then April, Dennis, then Patty.

COMMISSIONER HEIDI ALLEN: Thank you so much for

this analysis. I really appreciated the churn, tracking the movement. That was super helpful.

I'm curious for the people who churned back in within 12 months, which looks like a considerable percentage. How long were they uninsured before they regained coverage, and did you see spikes? I mean, I know you haven't probably done this level of analysis, but I think it'd be interesting to see if you see spikes in utilization when they come back that demonstrate that they had gone without care that they needed during that period of uninsurance.

LINN JENNINGS: Yeah, we did look at time for the churn. So on average, it took about four months. I think it varied a little bit based on which pathway they moved to as an adult. I think it was a little bit longer for those who moved to MAGI pathways compared to those who maybe returned to the same pathway, but we didn't look into the utilization. But that's certainly something interesting to think about in the future.

COMMISSIONER APRIL HARTMAN: Thank you for your analysis. The question I had is, you know, I wondered how well we did with ex parte redeterminations. So as the

people who remained continuously enrolled, do we know what percentage of those were done by one of the ex parte ways they had of keeping them enrolled? I'm just wondering how much we learned and how well we did in that category.

LINN JENNINGS: That's a great question. As far as I know, we can't just really get that, whether they were able to remain enrolled because of ex parte, but that's certainly something we could go back and look into. We did look, and I can't remember if this was included in the materials or not, but differences between those who were in 1634 SSI criteria, 209(b) states to see if there were differences in continuous enrollment. Among those states there wasn't much variation between states with those different types of SSI Medicaid determinations.

VICE CHAIR ROBERT DUNCAN: Thank you. Dennis.

COMMISSIONER DENNIS HEAPHY: Thanks. My question is built on some comments made earlier. I'm thinking of you've got Kid A in one state and Kid B in another state, and they have the same challenges, the same needs. So what more information do you think you can get to us about the Social Security information, like what's causing that churn for those kids? What's causing the churn in that

population, and what's enabling those folks to go back into Medicaid after the churn period? Like how do we reduce the churn for that population of kids, because the SSI data is kind of frustrating, that we really can't get more information on it, unless you think you can.

LINN JENNINGS: Thank you for that question. We'll have to go back and see if we can get more on the SSI side. I will say that I don't want to get ahead too much of what Ava will be presenting on the interview findings.

COMMISSIONER DENNIS HEAPHY: Right.

LINN JENNINGS: I think the interview findings actually complement these quite well, and I guess having a kind of mixed methods approach of getting at some of those qualitative questions. So I'll let Ava get to that later.

COMMISSIONER DENNIS HEAPHY: And then there's nothing more you can provide us about the disproportion of folks who are Black and Hispanic and their experiences.

LINN JENNINGS: Yeah. Right. And I think kind of understanding, I guess, the reasons why there is some variation in the materials. We did the breakout by race and ethnicity so that you can look at those who were in SSI-related pathways or disability. But beyond that,

again, the data can't help us get an understanding why there are those differences.

COMMISSIONER DENNIS HEAPHY: Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis. All right, Patti.

CHAIR VERLON JOHNSON: I've got Patti's question, since she lost her voice. She wants to know could we dig deeper to learn more about what works and perhaps look at states with lower rates to learn what didn't work.

LINN JENNINGS: Thank you for that.

COMMISSIONER PATTI KILLINGSWORTH: And it may help to just read the first part.

CHAIR VERLON JOHNSON: Oh, I see the first part. I'm sorry.

COMMISSIONER PATTI KILLINGSWORTH: Sorry. Sorry.

CHAIR VERLON JOHNSON: Everyone out there sees us, this is a little bit different for us. Okay. So she says as it relates to the T-MSIS findings, "I'm stuck by the significant variation among states. There are several with rates of 90 percent plus retaining eligibility. Kentucky particularly had a high rate with 0 percent churn. Do we have any sense of how these states approach these

redeterminations in ways that help children to retain eligibility?" And then she wants to go deeper to learn more about what works and didn't work. So that probably puts it in context.

COMMISSIONER PATTI KILLINGSWORTH: Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti.

LINN JENNINGS: Yeah, thank you for that question, and I guess in our interviews we did speak with states, so I'll let Ava speak to that once we get to the interview findings, and we'll make note to kind of look into that a little bit more.

CHAIR VERLON JOHNSON: Thank you.

VICE CHAIR ROBERT DUNCAN: All right. Any other questions, technical aspects you'd like to know?

[No response.]

VICE CHAIR ROBERT DUNCAN: All right. Seeing none, as Linn teed up, we will move to Ava. She'll talk about the interview findings, and we can see where these match up or where there may be some discrepancies in what the data shows and what the interviews say. So Ava, take it away.

CYSHCN TRANSITIONS TO ADULT COVERAGE: INTERVIEW

FINDINGS

* AVA WILLIAMS: Thank you. Good morning, Commissioners. And we're going to do something a little different the slides, I'll be saying "Next slide" for someone else to advance it for me.

In the next section I will go over the stakeholder interview findings. This section is broken up into factors that affect Medicaid coverage transitions and facts that affect 1915(c) transitions. As a reminder, we conducted interviews with national experts, federal and state Medicaid officials, as well as national and state level advocacy organizations, and the goal of our interviews was to understand how state Medicaid agencies operationalize their eligibility and redetermination policies as well as how they align with age 18 SSI redeterminations and how states operationalize their waiver policies, and any challenges beneficiaries experience with either transition.

From our interviews we identified six key factors that affect the transition to adult Medicaid. In this figure we have organized them by those related to the Medicaid redetermination process and those related to state

policy choices. In the next few slides I will explain each factor in more detail.

States are required to redetermine beneficiaries on an ex parte basis, using available information before requesting additional information from the individual. State officials and national experts describe challenges with conducting ex parte for beneficiaries who are enrolled in a disability pathway or changing between eligibility groups. The reasons for these challenges include insufficient data from the Social Security Administration, such as lack of income or asset information, and some states have separate MAGI and non-MAGI eligibility systems, and their non-MAGI system may be outdated and unable to support ex parte renewals.

Next, as Linn discussed earlier, the outcomes of the SSI redetermination have an effect on beneficiaries' Medicaid eligibility. So if a beneficiary is enrolled in SSI as a child and remains enrolled as an adult, then they often do not experience any changes to their eligibility pathway. On the other hand, if a beneficiary is no longer eligible for SSI as an adult, they will need to be redetermined for a different pathway.

In SSI criteria and 209(b) states, where beneficiaries have to submit a separate Medicaid application, the state may have enough information to complete a redetermination. However, in 1634 states, the Medicaid agency may not have enough information, and the beneficiary may need to provide additional information to maintain coverage.

State Medicaid agencies are required to send beneficiaries notices related to their upcoming age 19 redeterminations, but there are no federal requirements related to how far in advance the notice should be sent if the beneficiary is required to send additional information. States shared that they send notices 60 days to 3 weeks in advance of the end of the eligible period. Advocates shared that beneficiaries may receive a notice too late to respond, after the deadline, or do not receive the notice at all, and noted that these notices may lack clarity on what steps are needed. If a beneficiary does not send the requested information in a timely manner, this can lead to a delay in their redetermination or termination of coverage.

Next, beneficiaries can receive support with

Medicaid and SSI redeterminations from a state Medicaid agency, managed care organizations, waiver case managers, and community-based organizations. However, the amount of support a beneficiary receives can vary depending on the entity providing the support and may not be sufficient to facilitate a smooth transition.

For example, beneficiaries enrolled in a waiver are assigned a case manager to help with waiver transitions as well as Medicaid and SSI transitions, but it is unclear if beneficiaries not enrolled in a waiver receive any dedicated support.

There are mandatory and optional adult eligibility pathways that states can choose to cover, and the available adult eligibility pathways in a state can affect a beneficiary's ability to remain enrolled in Medicaid as an adult, especially if they are not eligible for SSI as an adult. For example, beneficiaries who either were not enrolled in SSI as a child or are no longer eligible for SSI as an adult will need to transition to a different eligibility pathway to maintain coverage as an adult. As you saw on the T-MSIS findings, many of those that transition to a different pathway as an adult move to

a MAGI pathway.

States have the option to extend child eligibility through a state plan option, which four states have done. One state has also extended child eligibility for children and youth with special health care needs through an 1115 demonstration. We hear in stakeholder interviews that extending the child eligibility can help ease the transition process by delaying the coverage transition until after many other transitions are complete.

Next, I will go over the factors that affect 1915(c) HCBS waiver transitions. This figure organizes the factors by those related to the state Medicaid waiver transition process and state Medicaid waiver policy choices.

States are required to have transition planning procedures for age-limited waivers, but there is variation in the robustness of transition planning across waivers and the support received from case managers. Advocates shared that case managers are not always knowledgeable or proactive about waiver transitions, and transition planning may be insufficient to facilitate smooth transitions, leading to delays in waiver transitions.

When transitioning waivers, beneficiaries need to complete a functional and level-of-care assessment, but they can experience challenges with both of these. Advocates shared that case managers do not always inform beneficiaries about the need to complete the assessments in a timely manner, and this can lead to a gap in waiver enrollment.

States have the flexibility to design their HCBS waiver programs to support transitions between child and adult waivers. For example, one state designed their corresponding child and adult waivers to overlap in age requirements to give beneficiaries more time to transition at a time when they may be navigating multiple transitions. Some states have reserved capacity for youth aging out of age-limited waivers to ease transitions between child and adult waivers. Advocates noted that reserved capacity works well and helps beneficiaries maintain needed waiver enrollment and services.

Lastly, many states have waitlists for their adult and all-ages waivers, which can lead to delays in transitioning from a child to an adult waiver, receiving waiver services, and may affect their Medicaid coverage.

Our findings show that state Medicaid programs have a number of flexibilities related to eligibility redetermination process, including covering optional eligibility groups and how they operationalize their waiver programs. In our state interviews we heard many examples of how states have implemented these flexibility to improve transitions to adult Medicaid and support children and youth with special health care needs and their families with navigating these processes.

Additionally, findings from our T-MSIS analysis indicate that the majority of children transition to adult Medicaid coverage without experiencing a gap in coverage. However, our research also identified that even with state flexibilities, some children with disabilities do experience challenges with the transition to adult Medicaid coverage process and may lose or have a gap in their coverage.

In this last section I will summarize the key challenges identified in our work and highlight some of the policies that states have implemented to address these challenges.

Research indicates that the SSI application and

redetermination process can be challenging for individuals, and many Medicaid beneficiaries are not eligible for SSI as adults, even if they were as children. One reason for this is the adult disability and financial criteria are different than the child criteria. Additionally, individuals may meet the adult disability criteria but they may not meet the income and asset limits. If a beneficiary is no longer eligible for SSI as an adult, states will redetermine them on all bases before terminating coverage.

As mentioned earlier, there are mandatory and optional adult eligibility pathways, and states have the flexibility to determine which optional eligibility pathways they offer. Depending on the optional eligibility pathways available in a state, young adults who lose SSI or those who are not enrolled as a child may or may not be able to remain enrolled in Medicaid as an adult.

One of the optional pathways that states can cover is expansion pathway. Our work shows that the expansion eligibility pathway is one of the pathways that many children with disabilities transition to if they remain Medicaid covered as an adult.

Medicaid covered transition aged children and

youth with special health care needs and their families may experience gaps in coverage because of challenges with navigating multiple, simultaneous, or near-simultaneous transitions. The main challenges beneficiaries experience include not receiving sufficient support or advanced notice about the Medicaid redetermination and transition process and not having sufficient time to complete all simultaneous transitions during the given timelines.

States have implemented policies to reduce beneficiary burden with the transition to adult Medicaid, such as sending notices in advance of upcoming redeterminations, extending child Medicaid eligibility for young adults to age 21 and 26, and assigning case managers to children and youth with special health care needs to support transition planning.

For example, states and advocates shared that extending child eligibility to those over age 19 is helpful because it provides beneficiaries with additional time to navigate their multiple transitions and maintain coverage into young adulthood.

Beneficiaries experience challenges with understanding these notices they receive from Medicaid and

SSA about the changes to their SSI eligibility and how it affects their Medicaid eligibility. There are no federal requirements for Medicaid and SSA to coordinate or combine notices related to changes in SSI eligibility and how it affects Medicaid eligibility. SSA sends notices about changes to SSI eligibility, and these notices may include information that says changes to SSI can affect Medicaid eligibility as well as to contact the state Medicaid agency for more information.

There is no requirement for Medicaid to notify the beneficiary about their change in SSI eligibility. The individual would only receive a notice from Medicaid if additional information is needed to complete the redetermination that is triggered by the change in circumstance.

Overall, advocates describe these notices as confusing and difficult to understand and raise the importance of improving these notices to facilitate beneficiary and family understanding of how to maintain Medicaid coverage, regardless of SSI eligibility.

Thanks for listening to our presentations today. Now the staff would welcome Commissioner feedback on any

outstanding questions about the T-MSIS analysis and interview findings, if the evidence presented supports any federal or state policy changes, and are there other factors that staff should consider when developing policy options. Staff will return in January to present potential policy options.

And now I will turn it back to the Vice Chair.

VICE CHAIR ROBERT DUNCAN: Thank you, Ava. And Linn and Ava, thank you so much for today's information, both the T-MSIS data information and interview findings so we can see parallels and then also opportunities. So I will open it up to questions from the Commissioners, and I've got Jami first.

COMMISSIONER JAMI SNYDER: Thanks, Linn and Ava for your work on this topic. I'm curious to learn a little bit more about those five states that have extended child eligibility. To me that seems like a best practice. And I'd love to know more about what the transition process looks like in those states, so we could better understand the benefit of extending eligibility.

AVA WILLIAMS: Yes. Are you asking for the specific names of the states, because I can give that to

you?

COMMISSIONER JAMI SNYDER: Oh, that would be great.

AVA WILLIAMS: The District of Columbia, Massachusetts, Maine, and Florida have extended child eligibility up to age 21 through a state plan option, and then Oregon has extended childhood eligibility for children and youth with special health care needs up to age 26, through an 1115.

COMMISSIONER JAMI SNYDER: Yeah, I would just love it if we could reengage with those states and talk more about kind of, again, what the process looks like, given that they have additional time to work with members around that transition.

AVA WILLIAMS: Yes, I think that's a great question. I guess we did talk to Oregon, and they did explain that their 1115 is working well, but we would still need to do more evaluation.

VICE CHAIR ROBERT DUNCAN: Thank you, Ava. Thank you, Jami. All right. Patti via Madam Chairwoman.

COMMISSIONER PATTI KILLINGSWORTH: I'm going to give this a shot, and if you can't hear me, you can just

let me know and I'll pivot. I just have some thoughts about potential actions that we might consider in the recommendations coming up. You talked, Ava, about notifications, and I think requiring that those notifications are happening earlier, that parents are aware of this transition pretty early on, and that there are early and repetitive notification processes, and that we use a variety of ways of doing that, not just sort of mailing a letter and saying, "Hey, we told them."

I think that states could be required to designate some entity that would assist the parents in helping that youth transition to adult eligibility, and that could be a health plan, it could be a waiver manager, it could be some sort of community-based organization. Lots of options, really leaving that up to states, but saying hey, these are families who are dealing with a lot, and they really need support in navigating this process.

Around the notices, surely, by this time, there are some template or sample notices that have been tested in the population that could be made available. Again, states maybe could tailor those to their own unique programs and eligibility categories. But just knowing that

something has been tested to actually be understandable to the population and always available in their primary language.

And then for kids who are in the 1915(c) waivers, while there is a requirement for transition plans, I don't think that there are any specific parameters for those transition plans. So in this instance it would be helpful if CMS would require really clear processes for how the state is going to assist those youth and their families in navigating that transition from child to adult categories of eligibility.

VICE CHAIR ROBERT DUNCAN: Thank you, Patti, and we heard you well. Ava, did you capture that. Okay. I wanted to make sure. All right, Commissioner Ingram.

COMMISSIONER CAROLYN INGRAM: Thank you, and I just wanted to expand on what Patti brought up to also ask if we could think about considerations for tribal members and people living in rural communities who don't necessarily always get access to this type of information and know about what they have to go through in terms of transitions. And especially dealing with people who may have different forums where they access care in tribal

communities. So thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Carolyn.

COMMISSIONER CAROLYN INGRAM: And happy to expand on that offline if we need to about how that works. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you. All right. John, then Dennis.

COMMISSIONER JOHN MCCARTHY: So I was trying to look at to see if there were any patterns in that data, state by state, and the interviews are very helpful to hear kind of anecdotal information on that. But trying to dig into that state by state. I know somebody already asked earlier if we could dig into that a little more. And one of the pattern I did see generally is that non-expansion states have higher percentages of people who don't come in after 12 months, which makes sense because a number of the people in the other states go into the MAGI group. So is that one of the reasons for it? Is it something to do with childhood eligibility versus, you know, there's not that eligibility group later on.

So if we could just, you know, whenever we ask you for data, you give us data. It's great. But then we

ask you for the next step on it. So I think that's really my request, is can we dig into some of those states that are doing really well and some of the states that aren't doing as well, and some of the ones in the middle, too. Like Illinois, for example, is an expansion state, has a high disenrollment rate, but then a fairly high rate of bringing people back on. Maybe that's an example of some of the things we were just talking about when you're looking at communication and some other things.

So if we could pick a few of those states and really dive into it to see what's working or not working, I think that would be helpful in trying to tease out how much of it is actually just an eligibility issue, you know, versus an operations issue.

AVA WILLIAMS: I can give you some context about the expansion pathway for these individuals. In our state interviews the states that we talked to that were expansion states, they described that the expansion pathway can be very helpful, especially for beneficiaries who may be going through an SSI redetermination, because for various reasons those redeterminations can take a long time, or be very complicated, or they may be denied the first time, et

cetera. So the expansion pathway is a way for these beneficiaries to remain enrolled in Medicaid while they are also going through other transitions such as SSI.

VICE CHAIR ROBERT DUNCAN: Thank you, John. Thank you, Ava. Dennis, then Adrienne, then Sonja, and Heidi.

COMMISSIONER DENNIS HEAPHY: Might it be possible for CMS to require states to work with the Social Security Administration to better coordinate the notices that go to folks as they are doing this transition? Would that be within the scope of something CMS can do? Because it seems that, building on what was said earlier about there is a real need for having templates and timelines and model notices available to folks. And it would also seem that if there was better coordination between Social Security Administration and the Medicaid offices, that also would decrease churn. Thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis. Adrienne.

COMMISSIONER ADRIENNE MCFADDEN: Thank you, and Ava, thanks for that additional context around sort of the expansion sort of use of the transition opportunity. But I

think what I'm interested in, and I think Heidi brought this up earlier in the churn sort of population, is whether or not they were uninsured or if something else was happening in the time between them sort of initially having eligibility, then dropping off, and then coming back on within 12 months.

I'm also interested in understanding the detail on those who don't return. I think the assumption is they are either uninsured or they find some other health coverage. But I really would like to know what percentage is what.

And then the last thing I'll say is I think I'm really interested in sort of minding the gap in sort of effective transitions. And so I would echo sort of the sentiments in understanding the states that are doing this really well, not just in continuing coverage but making sure that the coverage from sort of childhood to adulthood and making sure that the providers that they are utilizing are the ones that they need, so it's not just coverage in name but also getting the actual services that they need.

LINN JENNINGS: I do want to note one thing on your question on where individuals go if they disenroll.

Unfortunately, with the T-MSIS data, we can't see where they go. But in our 2021 analysis we were able to link with exchange data, and we know from that analysis that somewhere between 1.6 and 3.3 percent of children, depending on eligibility pathway, moved to the exchange, and then we don't have any other way of kind of identifying if they moved to dependent coverage or ESI in various places. But I just wanted to provide that context from that earlier work, that we at least know not a lot, at least at that time, or in this time period, were moving to the exchange.

VICE CHAIR ROBERT DUNCAN: Thanks, Linn, for the clarification. All right Sonja, Heidi, then Mike.

COMMISSIONER SONJA BJORK: Thanks. I was wondering for Ava, in the interviews did anything come up about reimbursement methods for the work it takes to help somebody navigate eligibility? So I mean, reimbursement for case management activity or a community health worker. And was that something that helped in any of the states in terms of, you know, a lot of this is just basic hard work. You know, you have to help somebody interpret all the different rules, help them fill out the right applications,

meet deadlines, provide documents. And if there is a reimbursement method for that type of work, I was just wondering if any of the states were experimenting with that and seeing if that helped people keep their eligibility who are eligible. Thanks.

AVA WILLIAMS: That's a great question. And correct me if I'm wrong, but I don't remember states or advocates speaking specifically about reimbursement rates. And we definitely had conversations about workforce and the workforce issues, if workforce is going well what that means for the beneficiaries. But nothing specific to reimbursement. I think we heard that more in our care work about reimbursement, but not specifically in this coverage piece. But, Linn, correct me if I'm wrong.

VICE CHAIR ROBERT DUNCAN: All right. Thank you. Heidi.

COMMISSIONER HEIDI ALLEN: So I just keep coming back to something that has been mentioned a couple of times, which is all of these transitions that are happening to these kids at the same time, often leaving school, and the structure that that provides and the support that that provides. And recognizing that your analysis includes

people that are coming off at different ages, some at 19, some at 21, some at 26, I'm wondering if there is evidence that there is less churn when you come off at an older age, when it's not coinciding with the same age that you leave high school. Because it kind of would support that argument, that it is a lot of administrative and bureaucratic things to navigate at the same time.

And the other thing is, I realize that we are trying to start looking at policy recommendations in January, but I really would be interested to know if the people who come back on, particularly back into the SSI pathways, if they have emergency department or hospitalizations in that first six months. Just wondering if some of the people are getting back on because they go into a hospital, and a hospital helps them navigate it. And also because that would just be such a flag for unmet need and concern. So I don't know how difficult or easy it is.

And then thinking back to Adrienne's question about where do people go, you know, I know that is kind of beyond our capacity and scope, but I really hope that some of these states that have all-payer claims data might have

an opportunity to look more deeply into that, to see if they can track people into different types of coverage after they leave Medicaid.

Anyway, thank you.

VICE CHAIR ROBERT DUNCAN: Thank you, Heidi.

Mike?

COMMISSIONER MICHAEL NARDONE: Yes. I wanted to just echo my support for kind of better understanding and also looking at the recommendations around better coordination between SSA and Medicaid around those notices. That just doesn't really seem to be -- if people are getting those notices late, that is, like, something that we should be able to take care of administratively, and if it helps with those transitions for SSI, I think we should be on the record with respect to that.

I also want to maybe understand a little bit better in kind of putting the data together from both the looking at the data that you presented, Linn, earlier and maybe understand better from the focus groups and the interviews. It seems like a lot of the people who are falling off are those people in that other disability-related category. The SSI related -- or the SSI is

actually less, seems to be less of a churn off of Medicaid. It's really that other disability-related category, so trying to understand that a little bit better and whether or not anything came up around what the barriers are there. Is it -- kind of understanding that so that could maybe inform what recommendations we might want to make, is it a question of in those categories, you know, those are people who are in a child waiver and they're not making the transition to the adult waiver, and that's what's happening there? Or is there some other factors that are leading to that lower percentage that maybe we should be looking at for potential recommendation?

VICE CHAIR ROBERT DUNCAN: Thanks, Mike.

Dennis.

COMMISSIONER DENNIS HEAPHY: Just a question. Linn, do you think we should be looking more deeply into asking questions about waiting lists, folks who are on waiting lists and the impact that has on this population, or is that totally separate? Because it's in the report, in the memo. So I'm curious if we're missing something there -- or Ava.

AVA WILLIAMS: Yeah, we talk to states about

their waiting lists. We talk to states who have longer waiting lists, less waiting lists, shorter waiting lists. I guess I'm trying to think about the information that we heard and how to best answer your question. I guess some context I can give at least for this population, especially in states that have long waiting lists, many beneficiaries and advocates tell beneficiaries to get on these waiting lists as early as possible, even as a youth. So, when they are ready to age out of the child waiver, there could be an opening for adult waiver.

COMMISSIONER DENNIS HEAPHY: And so do we have a sense of the impact of churn on those folks who maybe get further delayed on waiting lists because they lose their Medicaid for a year or six months?

LINN JENNINGS: From the data, we didn't link -- so one of the challenges -- and we did look at some of the waiver data in T-MSIS, but one of the limitations is that we can't really distinguish between specific 1915(c) waivers in T-MSIS. And so we can't really see if they're on a child-only or an all-ages waiver as a child, and there's no way to kind of see if someone may be on a wait list for a waiver. So there are some data limitations

there.

I think, as Ava said, we heard a lot about wait lists in our interviews. I think there were a couple of states -- and Ava maybe can elaborate more on this -- where they shared that if they were on a child waiver and they were unable to get on an adult waiver, some of the waivers would allow them to just remain on the waiver until they could move. So there were a number of different ways that states tried to kind of limit any sort of gap by either extending the child waiver or, as Ava said, getting on a wait list early on.

But I'll let Ava add anything.

AVA WILLIAMS: Yeah. And one more thing, I guess, I would give a context. We heard from states, or one state -- I think it's states -- that beneficiaries who are on wait lists but are still Medicaid eligible are still receiving services through Medicaid. They are just not enrolled in the waiver or getting waiver services.

COMMISSIONER DENNIS HEAPHY: Okay. Thank you. Do you think that's something we need to look further at, more deeply at, as we go on as a Commission, is other folks on waiting lists and the impact on access to services or

medical utilization or something over time, ED use or hospitalization use, and what best practices states have in reducing waiting lists? Because it's a large issue for people, but thanks.

VICE CHAIR ROBERT DUNCAN: Thank you, Dennis.

Commissioners, any other questions or thoughts around policy?

[No response.]

VICE CHAIR ROBERT DUNCAN: Seeing none, again, Ava, Linn, I want to thank you so much for the amazing work that you've been doing on this. As I highlighted earlier, I think having the data, going through that and seeing what that showed, and then interview panelists, information along that is very helpful.

Do you feel like you've got what you need for next steps in January?

All right. Thank you very much.

And with that, I'll turn it over to Madam Chairwoman to go to public comments.

CHAIR VERLON JOHNSON: Thank you. Thank you so much.

Actually, before we open the floor for public

comment, I just want to take a moment to highlight a recent publication that MACPAC released, certainly with MedPAC, which, of course, is the Medicare Payment Advisory Commission. Together, we do this every year. We published the 2025 edition of the duals data book, which really compiles information on individuals dually eligible for Medicare and Medicaid in calendar year for this time, year 2022.

So this annual publication presents some key statistics that will be helpful. It will tell you about dually eligible beneficiaries who qualify for both programs by virtue of age or disability and low income. And so some of the early statistics that we can tell you about from the highlights of the book is that there were 13.6 million dually eligible in our country. Although this is a very small number, a share of the Medicaid population, about 13 percent, they actually account, of course, for 27 percent of all Medicaid spending.

Previous editions have documented a very steady shift toward managed care among duals, and that trend we found in this year also continues.

So, as of 2022, about three-fourths of full-

benefit duals were enrolled in some type of Medicaid managed care plan during the year, and nearly one-third spent at least one month simultaneously enrolled in both Medicare managed care and a comprehensive Medicaid managed care plan.

To better understand service use and spending among this population, we actually, for this year, included two new exhibits focused on full-benefit duals enrolled in comprehensive Medicaid managed care, and this new analysis showed that full-benefit duals under age 65 had lower use of Medicaid-covered institutional LTSS and lower LTSS expenditures than those who are age 65 and older.

We also found that a majority of full-benefit duals in comprehensive Medicaid managed care used no Medicaid LTSS at all.

So we do hope that this data book continues to support a very clear and more comprehensive picture of program spending, enrollment, and diverse experiences of our dual eligible population.

You can, of course, get this information at MACPAC.gov, and we encourage you to do that, and gift it all during this holiday season to your friends and family

as well.

So, with that, we will open the floor for public comment. So, to do this, we're going to invite people in the audience to raise your hand if you would like to offer comments. We do ask that you introduce yourself and the organization you represent, and we also ask that you keep your comments to three minutes or less, if you can, please.

So, with that, let's go to comment.

VICE CHAIR ROBERT DUNCAN: We've got Peggy McManus.

CHAIR VERLON JOHNSON: All right. So, Peggy, the floor is yours.

PUBLIC COMMENT

* PEGGY McMANUS: Thanks so much.

I'm Peggy McManus, and I co-direct Got Transition, which is the national resource center on health care transition. And great congratulations to Linn and Ava and all of you for shining the light on not only transitions in care, but transitions of coverage.

My comments -- or the first one is around taking greater advantage of EPSDT in terms of informing young people about the changes in coverage well before they no

longer are eligible for EPSDT, and also for trying to ensure that they have their current medical documentation. So often that they're getting rejected because they don't have current information and can't access it. I appreciated the comment about using targeted case management.

The second comment I had would be to think about policy research on the impacts of benefit changes on access and health outcomes, including family caregiver responsibilities. Again, from our work, we hear a great deal about what this loss of benefits means in terms of services.

The other comment I have is around definition of disability going forward. There's so many limits around just using waiver and SSI disability definitions, and how can we think more broadly about a more inclusive definition and more consistently.

Finally, I'd be very interested to know about the characteristics of Medicaid-insured youth that were previously Medicaid-insured but became uninsured beyond the four months. Who are they? And, you know, it's a sad story that that's happening.

So, again, thank you.

CHAIR VERLON JOHNSON: All right. Thank you, Peggy, for your comments.

Next up, we have Amy Clawson. The floor is yours.

AMY CLAWSON: Hello. Can you hear me?

CHAIR VERLON JOHNSON: We can hear you, Amy. Thank you.

AMY CLAWSON: Oh, good. Okay.

As a first-timer here on the call today, I just echo what the previous speaker said. This information is so helpful to know that you're all working so hard for our children and adults with special health care needs on a national level.

I'm Amy Clawson. I'm the program coordinator for Ohio Family-to-Family, and we are one of the lucky states to have a very strong relationship with our Ohio Medicaid partners. And they're open to hearing all about children and youth who especially lose coverage, perhaps, when they transition from children to adult Medicaid.

And I know some of you are very concerned and interested in more data and policy on a national level

around that, and that's so encouraging to me because I also have a child with a disability.

But really, I'm here to say on behalf of families like mine and those I support, thank you, and please, let's do more if we can to fill those holes to not allow lapses in coverage. I love the idea of extending child eligibility. So I'm so glad to hear that's on the table, and anything I can do in Ohio would be helpful.

So really, a thank-you and a comment, and I love that idea. So I'm looking forward to hearing more.

CHAIR VERLON JOHNSON: Thank you, Amy. Appreciate your passion and for calling in, and we hope you call in for future meetings as well.

All right. Any other comments? Give it one more second.

[No response.] One more second.

CHAIR VERLON JOHNSON: Okay. All right. So seeing none, I do again want to thank you all for those comments, and I also want to remind the audience that you may also submit any comments on the MACPAC website as well if you think of something after the meeting.

So. with that, we will now take a lunch break,

and we'll return at, I believe, 12:45 noon Eastern. So we'll see you then. Thank you.

* [Whereupon, at 11:36 a.m., the meeting was recessed, to reconvene at 12:45 p.m. this same day.]

AFTERNOON SESSION

[12:45 p.m.]

CHAIR VERLON JOHNSON: All right. Welcome back, everyone. I hope you all had a chance to get something to eat and also to recharge a bit.

So this afternoon, we're turning to the new community engagement requirements, right? So, as you know, these statutory changes raise a number of important implementation questions, including how states will operationalize them and how beneficiaries will navigate these processes.

So today's session is really a very important opportunity for us to understand what successful implementation looks like, to hear from those closest to the work where additional clarity, alignment, or support may be most helpful, and, of course, to consider how states and federal partners are preparing for these changes.

So, with that framing, I'm going to turn it over to Melissa and Janice to walk us through the guidance, what we've learned from some stakeholders, and the considerations emerging states plan for implementation. Then they'll introduce an expert panel to add both a state

and a federal perspective to the conversation.

So, Melissa and Janice, and I meant to say Melinda. Sorry about that, Melinda. Melinda and Janice, the floor is yours. Thank you.

CONSIDERATIONS FOR IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS: FINDINGS FROM STAKEHOLDER INTERVIEWS

* MELINDA BECKER ROACH: Thank you so much, and good afternoon.

As the Chair mentioned, I will be discussing -- Janice and I will be discussing key considerations for implementing community engagement requirements based on findings from our interviews with states and other stakeholders over the summer.

This session is meant to build on the Commission's September meeting where we discussed the history of work and community engagement requirements in Medicaid, described the new statutory community engagement requirement, and heard from an expert panel on considerations for implementing those requirements.

I'm going to advance the slide. I'll keep going and talk about what we're planning to cover today.

We'll start today's session by revisiting the details of the community engagement requirement that was recently added to the statute. Then we'll discuss the implementation considerations that emerged from our interviews and conclude with next steps.

Before we start, it's important to note that this is a fluid and fast-moving policy topic, as evidenced by the new guidance that CMS released earlier this week. We want to provide assurances to the Commission that we've reviewed the guidance and found nothing that conflicts with our overview of the law and the interview findings we're about to describe. We also want to remind you that our interviews were completed at the end of the summer when stakeholders were just beginning to digest the new requirements and consider how they would be operationalized.

While we understand that thinking may have evolved since then and the findings we've gathered represent viewpoints from a discrete point in time, we think this information still holds value for the Commission and its discussion of considerations that can inform the efforts of CMS and states going forward.

Before we get to the implementation considerations, I'm going to briefly revisit the details of the community engagement requirement that was included in the 2025 Budget Reconciliation Act.

The law requires states to implement a community engagement requirement for non-pregnant, non-dually eligible individuals between the ages of 19 and 64 who are eligible for coverage under the adult expansion group or a Section 1115 demonstration that provides minimum essential coverage. Individuals must comply with the community engagement requirement to enroll in Medicaid and to maintain their eligibility. Those subject to the requirement must engage in 80 hours of work or community service or halftime education or a combination of those activities for a total of 80 hours in a given month.

States must implement the requirement by January 2027 unless they receive a good-faith effort exemption to delay implementation. HHS is required to issue an interim final rule to implement the requirements by June of next year.

This slide shows populations that qualify for an exception from community engagement requirements. They

include current and former foster youth, certain parents and caretakers, individuals who are medically frail, individuals who are or have recently been incarcerated, and those who meet SNAP or TANF work requirements as well as others that are listed here.

States can choose to provide short-term hardship exceptions to individuals who have experienced certain events. Hardships include having stayed in an acute care setting, such as in a hospital or nursing facility or receiving care of similar acuity, including in an outpatient setting.

States can also grant hardship exceptions for individuals in areas affected by a federally declared emergency or high unemployment.

Individuals who traveled for an extended period of time for medical services for themselves or a dependent may also be eligible for a hardship exception.

States must determine compliance when an individual applies for Medicaid and every six months, or at least every six months, as part of the redetermination process. They can also choose to determine compliance more frequently.

States have some discretion to decide the look-back period for compliance. That can be one to three consecutive months before an individual applies for Medicaid and one or more months, consecutive or not, before redetermination or other compliance check if the state decides to determine compliance more frequently.

To reduce the need for individuals to report, the law requires states to use existing data where possible to determine compliance and identify individuals eligible for an exception. One way that states can determine compliance through employment is by assessing whether an individual's income is greater than or equal to the minimum wage times 80 hours.

For a seasonal worker, states can assess whether the individual meets that threshold by looking at their average monthly income for the previous six months.

The law provides $200 million for states to establish systems to implement community engagement as well as other provisions in the law that affect Medicaid eligibility determinations and redeterminations. Half of that funding will be awarded equally to all 50 states and the District of Columbia, and the other half will be

awarded according to a formula that accounts for each state's population of individuals affected by the community engagement requirement. The law also provides $200 million for CMS to support implementation.

I'll move now to highlighting implementation considerations that arose in our conversations with stakeholders over the summer.

Interviewees included representatives from CMS, state Medicaid agencies, national associations, beneficiary advocacy organizations, and vendors, as well as subject-matter experts from think tanks, academia, and consulting.

Stakeholders consistently emphasized the importance of CMS engaging early and often with states to support implementation, including the need for guidance before the IFR is due in June.

Some states noted that understanding which topics CMS will address in the IFR or other guidance and which decisions they'll leave to states would help them plan and prioritize more effectively.

In our interviews, CMS acknowledged the amount of work that states have to do in a limited amount of time and the need for guidance before June.

Also relevant to the implementation timeline, states raised questions about the criteria and process for receiving a good-faith effort exemption through which states can delay implementation. Several stakeholders expressed a preference for CMS to be flexible in granting good-faith effort exemptions and noted that whether a state previously implemented similar requirements through a Section 1115 demonstration will likely have a bearing on CMS's consideration of such requests.

The compressed implementation timeline is one of several reasons stakeholders are hopeful that CMS will give states maximum flexibility in operationalizing community engagement requirements. Stakeholders also cited the need for flexibility given the variability of state eligibility and enrollment systems, such as whether state systems are integrated with other human services programs or have the capacity to receive data from other entities to determine compliance and exception status.

Several stakeholders highlighted the important role that community partners can play in effective beneficiary outreach, as evidenced by state experience during the public health emergency unwinding.

Another strategy that proved effective during the PHE unwinding is for states to partner with managed care organizations to obtain more current and reliable beneficiary contact information to support community outreach.

Stakeholders also emphasized the importance of states sending notices in clear and plain language and using multiple modes of communication to promote beneficiary awareness and collect needed information. One stakeholder highlighted the need for clear CMS guidance on the use of text messaging specifically, including through platforms such as WhatsApp.

Stakeholders identified data sources for determining mandatory exceptions as well as data limitations and considerations for accessing data. Medicaid programs are less likely to have data on individuals with no prior enrollment relative to existing beneficiaries. Medicaid enrollment applications could be modified to capture additional information needed to identify individuals who are new to the program and eligible for an exception to the community engagement requirement.

States can also use claims data to identify individuals with certain medical conditions that qualify them for an exception, though there's often a significant lag in claims data that will limit their usefulness in this context.

Stakeholders pointed to managed care data, including encounters and case management data, as a more timely and reliable data source.

Interviewees noted that requirements to verify mandatory exceptions will result in a need for additional information as well as manual processes, which is likely to create more administrative burden for both states and beneficiaries.

Interviewees raised several questions related to the criteria for mandatory exceptions and expectations for verifying those exceptions, which they hope to see addressed in CMS guidance. States were particularly focused on the criteria for medical frailty, given how significantly CMS guidance on the topic will affect implementation.

Other questions relate to the definitions of caregiver and substance use disorder treatment, what will

constitute evidence of compliance with SNAP or TANF work requirements, the use of self-attestation, and the frequency with which an individual's exception status will be reassessed.

Some of the states we interviewed reflected on the short-term hardship exceptions they provided under their earlier Section 1115 demonstrations and emphasized the need to be flexible when considering circumstances that affect an individual's ability to participate in qualifying activities. These states and other stakeholders raised questions about the types of hardships that will qualify someone for an exception and the type of verification that CMS may require.

Stakeholders also noted uncertainty about how states will calculate unemployment rates for the purposes of determining whether an individual in a given area or whether individuals in a given area are eligible for a hardship exception.

I'm going to turn it over to Janice now to continue discussing implementation considerations from our interviews.

* JANICE LLANOS-VELAZQUEZ: Thanks, Melinda.

Regarding the definition of community engagement, stakeholders would like states to have flexibility to further define the criteria for meeting community engagement requirements to reflect the various ways in which individuals participate in qualifying activities. For example, one stakeholder asked if states would be allowed to average an individual's income over a period of several months.

Stakeholders requested further guidance on what activities would qualify as community engagement, including the definition of a work program and the need for guidance to clarify whether that includes job search activities, clarity concerning individuals in supported employment programs, and they would like guidance on the criteria for activities that would qualify as community service. For instance, one stakeholder asked if certain types of caregiving, such as providing unpaid care to an elderly neighbor, would be considered community service.

Waiting for the next slide. You got it. Thanks.

As Melinda described earlier, the law gives states the option to verify engagement in qualifying activities more frequently than every six months. Several

stakeholders raised concerns that states choosing to verify compliance more frequently than required could experience increased disenrollment and administrative burden.

Among the different qualifying activities, stakeholders generally agreed that verifying traditional employment would be least challenging compared to verifying nontraditional employment, such as gig work, babysitting, or community service, or engagement in multiple activities.

The law requires states to verify compliance with community engagement requirements by using available data. To do this, states will need to use several data sources to support verification, which may involve using existing data sources in new ways. For example, states currently use wage and income data sources to verify eligibility for Medicaid, and states would now be required to use the data to determine compliance with community engagement.

And state Medicaid agencies would also likely need to obtain data from other state agencies, such as school enrollment data, and when compliance cannot be determined using available data, stakeholders suggested that states provide user-friendly solutions for beneficiaries or their employers to submit documentation.

For verifying employment, wage and income data were cited as the primary source. The two main data sources mentioned by interviewees were quarterly wage data and Equifax's The Work Number. Quarterly wage data include individual-level gross income data reported by employers in the state, and The Work Number is a database that provides verification services such as employment and income verification for commercial and government entities.

Stakeholders identified several considerations for using these commonly cited income and wage data sources. Quarterly wage data, as mentioned, contain individual-level gross income data, which means that they do not account for deductions. The wages are typically aggregated up to the quarter, which means that state Medicaid agencies would need to perform calculations to ascertain monthly wages. These data are reported on a quarterly basis, and they can lag up to three months.

Some of the advantages that stakeholders cited for this source is that these data are free and they could provide data for a sizable share of individuals. However, some of the limitations noted include that the data are not very timely, they lack detailed information, and though it

could cover a sizable share of the population, that can vary widely from state to state. And lastly, individuals engaged in nontraditional employment are not included in wage data.

For The Work Number, stakeholders noted that it is more detailed income data, and it can't account for deductions. The data can be more timely than wage data, and the data could be real-time depending on several factors, such as the criteria that are used to query a valid response. Some of the advantages cited include that it is more timely and more detailed, but one of the major limitations stakeholders highlighted was the cost of using The Work Number. Also, the timeliness of the data and the share of the population covered can vary, and similar to wage data, individuals engaged in nontraditional employment are not included.

As we just mentioned, stakeholders consistently raised concerns about the cost of The Work Number. For example, The New York Times recently reported that the cost of North Carolina Medicaid's Equifax contract nearly doubled in recent years, going from $11.6 million in 2022 to $22.5 million in 2025. Some stakeholders suggested that

CMS allow states to use The Work Number without charge, even on a short-term basis, as was done during the PHE unwinding.

Individuals who are self-employed or engage in gig work often do not receive conventional pay stubs, which makes their income difficult to verify using traditional wage and income data sources.

Several stakeholders highlighted CMS's piloted Income Verification as a Service, or IVaaS, application as a potential solution to help states address this challenge. However, because IVaaS is still being piloted, there is little publicly available information.

School enrollment data can be used for verifying engagement in education-related activities. A couple of the states that we interviewed shared that they are working with their state education departments to determine which data can be shared, and as mentioned previously, verifying community service will be challenging.

Stakeholders suggested several ideas for verifying community service, such as adopting processes used by state judicial agencies for court-mandated community service or allowing beneficiaries to submit

documentation.

Stakeholders emphasized the need to allow for -- can we go back one? Thank you.

Stakeholders emphasized the need to allow for self-attestation when data are not immediately available to verify their circumstances. This flexibility will be particularly important for new applicants, for whom the state does not have claims or other information to determine compliance and exceptions. Some interviewees noted that because self-attestation is an existing practice in eligibility determination processes, it should be considered acceptable for determining compliance.

Also, states would benefit from guidance on viable data sources and expectations for data recency for ex parte verification.

Stakeholders raised questions such as what data sources will states be expected to use and how recent should those data be for the purposes of determining compliance.

CMS guidance could also identify free data sources that states should check before paying to access other data sources, and clarification is needed on how

states should operationalize the provision, allowing beneficiaries an opportunity to cure.

Stakeholders pointed out that the law does not specify the period of time for which a beneficiary must demonstrate their compliance after they receive their notice of noncompliance.

Medicaid IT system changes to implement community engagement requirements will likely be costly and time-intensive. For example, the Government Accountability Office found that Medicaid IT system changes accounted for over 90 percent of total administrative spending for Georgia's work and community engagement demonstration. The number and scope of system changes will depend on the state's existing Medicaid IT infrastructure; for example, whether a state has a legacy or more recently modernized system or whether it's integrated with other human services programs such as their SNAP or TANF program.

To operationalize determining compliance or identifying excepted individuals, states will need to assess what data they have, what data they need, and the functionality that would be required. These decisions will inform what system changes are feasible by the

implementation deadline and to the extent which automation is prioritized.

Stakeholders shared that states' abilities to maximize automation is affected by the short implementation timeline and limited funding. To help mitigate some of these concerns, stakeholders suggested that states prioritize low-cost data sources that cover a large share of beneficiaries.

And even though automation could help processes be more efficient, stakeholders cautioned that automation could require higher upfront investments compared to manual processes.

Another consideration highlighted by stakeholders regarding the short implementation timeline is that it limits states' abilities to competitively procure systems vendors. Stakeholders suggested that CMS support states in the procurement process. They can do so by leveraging the Advanced Planning Document, or APD process, to establish a range of what system changes are expected to cost and by streamlining the APD process to expedite processing and alleviate time and resource constraints.

Stakeholders would like states to provide

beneficiary supports to assist them in meeting community engagement requirements. Support could include enrollment assisters, enhanced call center capacity, and accessible application locations. Stakeholders expressed concerns that the law does not require states to address barriers to compliance such as lack of transportation. This is an area where CMS could establish expectations as they did under Section 1115 demonstrations, where they asked states to describe their strategy for helping beneficiaries to achieve compliance. States raised questions about whether federal matching funds will be available for beneficiary supports.

CMS shared that they intend to monitor various aspects of community engagement implementation and that they are using lessons from PHE unwinding to inform their process. For example, they noted reviewing all data that states currently submit to identify any gaps and to determine what new data might be needed.

Stakeholders generally agreed that CMS should closely monitor implementation of community engagement requirements, and several expressed concerns that the law does not require additional monitoring.

Stakeholders emphasized that monitoring is important because it helps identify trends that may indicate the need for adjustments. They also conveyed that timely, high quality data and meaningful metrics are important for effective monitoring.

Several stakeholders and CMS pointed to the experience with reporting during the PHE unwinding as a useful model for the development of metrics for monitoring. During the PHE unwinding, some states made additional data publicly available, including through the development of public-facing dashboards, and states used those data to identify issues and adjust their outreach and other strategies accordingly.

Stakeholders suggested several metrics that could help monitor implementation and track beneficiary outcomes after rollout. They identified some metrics already available through existing data sources, such as the monthly performance indicators that report on call centers, applications, renewals, and Medicaid enrollment. They also proposed measures to track outcomes such as the effects on new enrollment, health outcomes, and appointments.

Several of the proposed metrics would require

collecting data specifically on individuals subject to these new requirements, and because the requirements have not been in place before, most states have not historically reported information on this population, and as a result, these metrics would be considered new and would need to be developed.

Another proposed monitoring metrics related to individuals subject to community engagement requirements include tracking beneficiaries subject to community engagement requirements, and within that population those who qualify for an exception reported in aggregate and reporting on those identified through ex parte processes. They also expressed interest in tracking beneficiaries who lose coverage due to noncompliance with the requirements, further stratifying that data by beneficiaries who aren't compliant because they didn't meet community engagement requirements or they aren't compliant because they didn't submit evidence of compliance

And lastly, they suggested tracking beneficiaries satisfying community engagement requirements, reported in aggregate, and stratified by each type of qualifying activity, that is, tracking the number who are satisfying

their requirement through employment, through school, or community service, and also stratifying the verification methods, whether it was via ex parte or via manual processes.

A final consideration highlighted by states and stakeholders is regarding technical assistance. Stakeholders shared that in addition to the ideas for topic-specific technical assistance, states would benefit from multistate online forums that enable cross-state learning on topics such as beneficiary outreach. Stakeholders cited some CMS approaches during PHE unwinding as helpful models. One state Medicaid official said that this type of sharing of what works and what doesn't was particularly helpful during PHE unwinding.

For our next steps, we have an expert panel that is following this session which will further discuss considerations for community engagement implementation, and in January we will return to provide more information about opportunities for monitoring.

But for today, based on what we presented, we welcome your feedback on the considerations presented and the direction of the Commission's work on monitoring.

Specifically, we are interested in whether Commissioners would like us to emphasize or elaborate on any of the considerations raised by stakeholders when we draft our June chapter, do Commissioners share the view of stakeholders we interviewed that CMS should monitor enrollment changes that result from community engagement implementation, and are there any specific monitoring principles that the Commission thinks are important for us to consider, such as the frequency of monitoring, transparency, and actionable metrics.

And with that, I will pass it back to the Chair. Thank you.

CHAIR VERLON JOHNSON: All right. Thank you both. That was very helpful. We do have some time here to have some of those questions answered, right? Melinda, we have a little bit of time before the panel begins. So with that, let me open it up for Commissioner questions or comments. All right. Great. I will start with Jami, then go to Heidi and Doug. So with that, Jami.

COMMISSIONER JAMI SNYDER: Thanks, Verlon, and thanks for this overview, in particular, of the stakeholder interviews. I just wanted to reiterate, you know, during

unwinding managed care organizations, providers, and stakeholders were so critical to the states' success in being able to engage members. So I would love for us to do additional research on the role that various parties can play in supporting the states in not only documenting compliance but also documenting any exemptions, in particular, those that are more difficult to document, and are they straightforward. So just would love for us to continue to look at the role of partners such as managed care organizations.

And Melinda, I know that CMS released some guidance this week. Can you elaborate a little bit on what that guidance stated in terms of the role of MCOs, because I know there have been a lot of questions around what MCOs can and can't do in supporting the states.

MELINDA BECKER ROACH: Sure. The informational bulletin that CMS released earlier this week restates the provision of the 2025 Budget Reconciliation Act, which prohibited managed care plans from making determinations as far as beneficiary compliance with the work requirement. But it does underscore the role that managed care organizations can otherwise play in supporting

implementation and conducting beneficiary outreach and some of the functions that you mentioned. And CMS notes that that is a topic on which they plan to provide further guidance.

CHAIR VERLON JOHNSON: Thanks. Heidi.

COMMISSIONER HEIDI ALLEN: Thank you so much for this. I just want to stress what I feel like is the importance of maintaining a state-by-state ability to compare the infrastructure and policy decisions that states are going to be making, to try to understand, as this begins, kind of where people are and what levers they are pulling. It's so complex, and yet the fact that they are all doing it together to me signals an opportunity to try to really understand what's working well and what's not. And whatever detail we can get about each state and their processes I think would be really helpful.

And then the second thing I'm curious about is, you know, reflecting on the unwinding, there were several times that CMS paused a state's process because of indications that something might be going wrong and that disenrollment was higher than expected. Do you think that there is any appetite for MACPAC making recommendations or

if CMS indicated that they are thinking about something like that, if we start to see unexpectedly steep drops in enrollment that vary significantly by state?

MELINDA BECKER ROACH: CMS has not provided any indications as far as their appetite for doing something like that in the context of community engagement implementation, at least to our knowledge. And I think as far as whether that's an area that the Commission would want to weigh in on, it's something that we can take back for further discussion.

CHAIR VERLON JOHNSON: Thank you. Doug.

COMMISSIONER DOUG BROWN: Thank you. I want to make sure -- well, I want to make this comment first. It seems to me that the biggest challenge is going to be the IT infrastructure within states to be able to manage work requirements. And I know that there is money set aside, $100 million divided by the number of states, so each state is going to get about $2 million, and there are other additional funds that are appropriated from that point.

With those funds, can states still use that money and then get a 90/10 match on that, but use the $2 million, they can still draw down up to $20 million to do the

infrastructure development here? Is that part of this? Does that still exist in the way this is set up?

MELINDA BECKER ROACH: The guidance that CMS released earlier this week does confirm the ongoing availability of enhanced matching funds for certain activities related to a state's Medicaid IT assistance.

COMMISSIONER DOUG BROWN: Thank you.

CHAIR VERLON JOHNSON: Thank you. Adrienne.

COMMISSIONER ADRIENNE MCFADDEN: So I want to just add my exclamation point to a couple of points that have already been made and make a third. I think we learned a lot from the unwinding and the importance that partners have played as far as some of the successes that we saw towards the end there, including sort of the MCOs and the community-based organizations, and hope that we can reflect that in the chapter.

The second is I agree with Doug, that I think the IT is super important and cannot be stated enough times.

And then the third piece, it's hard for me not to make the connection between the last sort of session we just had with children and youth with special health care needs and some of the folks that were ineligible for SSI

and then who kind of churn and went over to expansion as a bridge to maintain coverage. So I think that -- you know, I hate the saying that the devil is in the detail, but the detail will give us all the answers when we start to define some of these exceptions. And I do think there is an opportunity for us to be informative and helpful in coming up with sort of definitions that will not create more gaps for particular subsegments of the population that really do need coverage under Medicaid.

CHAIR VERLON JOHNSON: Thank you, Adrienne. Carolyn.

COMMISSIONER CAROLYN INGRAM: Thanks. One of the questions I had was, in your interviews, if the issue of consent ever came up, and adding that to the application process. And the reason I ask is it seems like a lot of the problems around notifying people, like whether it's through texting or email, and getting hold of people could be taken care of if we have permission and consent from people to text or email them information.

Likewise for gathering pay stubs and other information, there are a number of kind of newer companies out there that are operating off of platforms that are much

more efficient and faster, with all the new technology, that can gather this information together. But again, we'd probably need consent from members to be able to do that.

So I'm just wondering if your -- and I'm not sure if that's totally true, but I'm thinking it is -- if that whole issue of consent ever came up when you were discussing what states are looking at doing with their application processes to make things a little bit easier. Thank you.

JANICE LLANOS-VELAZQUEZ: So the issue of consent did come up when it came to income verification specifically, where some stakeholders shared that there are some consent-based systems that could help facilitate income verification. It didn't come up specifically in the context of adding it to the Medicaid application or in the context of beneficiary outreach. But Melinda, correct me if I'm wrong on that.

MELINDA BECKER ROACH: No, I think that's right, Janice. I don't have anything different to add.

COMMISSIONER CAROLYN INGRAM: Yeah, that may be something we want to dig a little bit into, but also just think about in terms of our recommendations, for states or

CMS to recommend to states that they figure out a process for that. Again, I think a lot of these problems, like looking at the whole issue about how to gather pay information, how much it's going to cost from Equifax. A lot of that can be overcome if we have permission, as states, to gather the information from individuals, from other sources.

So I think it's worth it for us to consider that recommendation. Thanks.

CHAIR VERLON JOHNSON: Thank you. Mike.

COMMISSIONER MICHAEL NARDONE: Thanks, Melinda and Janice, for this work. As I was reading some of the materials and this presentation you really highlighted a lot of the issues that I'm thinking about as we look to implement community engagement.

I guess I wanted to just put a point maybe on a couple of those things. I mean one, I think, is, you know, the advantage of doing the community engagement through 1115s is you do have a monitoring and evaluation framework that's kind of built in. And we learned a lot from, I think, the examples of unwinding as to how important monitoring can be to kind of be timely, knowing what's

happening on the ground. I think Heidi and others have mentioned that, and I just kind of want to reinforce that. It's really important that a framework is put in place to do effective monitoring in a timely way.

I think it's also important to be able to look at this maybe longer term, in terms of evaluation and in terms of how effective this is in terms of actually helping people get on the road to employment and positive outcomes with health care. I think that's something that would be helpful to have that evaluative framework to perhaps be able to answer some of those questions.

Echoing other points that people made about IT. I think one of the things I'm going to be looking to hear about is what type of flexibilities or what type of prioritization will CMS allow with the APD process in terms of, you know, will these get expedited given the time frame that states have to implement this? I would expect to hear from Lindsey from NAMD that this is kind of an all-hands-on-deck work activity for the next year. So I think that some flexibility to overcome some of these IT hurdles will be particularly critical.

And the other thing I'm just wondering, as I'm

thinking about kind of the capacity question, is whether or not your interviews, or stakeholder engagement, stakeholder feedback indicated kind of how states were handling this workload or thinking about how they would handle this workload beyond the IT issues, Because I think that this is a significant workload. And I am concerned about what are some of the opportunity costs of this over the course of the next year in terms of the Medicaid program.

CHAIR VERLON JOHNSON: Thank you, Mike. Dennis.

COMMISSIONER DENNIS HEAPHY: I wanted to ask about really the reporting requirements. And I'm wondering, you mentioned that states have, the criminal justice system often has work requirements. Are there states that have best practices in reporting that we could look at, to get a sense of what states are actually doing already in reporting this information?

And then my other question is regarding the digital divide. I think it's really important to track which populations may not be reporting data properly or timely or in the manner required, to see if there are folks falling through the cracks because of the digital divide, if states are going to rely on technology reporting. So

I'd like to see more about both of those things. Do you have thoughts on that, Melinda, regarding what best practices might be out there? And you mentioned the memo. I don't know if you mentioned states that had best practices. I don't recall seeing it.

MELINDA BECKER ROACH: Dennis, would you mind clarifying your interest in best practices with regard to reporting?

COMMISSIONER DENNIS HEAPHY: Sure. So there are states that have reporting systems that have high levels of compliance or high levels of engagement with folks that are required to be employed. Let's say if someone is on parole, the rate of folks on parole who lose their parole status because of not meeting work requirements. That sort of thing.

MELINDA BECKER ROACH: I think that's something we can take back and think more about and try to incorporate more of that type of information into our work going forward.

COMMISSIONER DENNIS HEAPHY: Because I think that probably states would do a good job, if they've got work requirements for people in collecting that data and working

with populations, low-income populations. So yeah, thanks.

CHAIR VERLON JOHNSON: Thanks, Dennis. April.

COMMISSIONER APRIL HARTMAN: I guess my question is more around any innovative ideas that there might be out there that doesn't put the impetus for reporting on the individual. We know that they have a very difficult time accessing these systems, reporting this data that needs to be reported. And I'm asking this because recently I heard a presentation that used data from the Distressed Communities Index, which looks at people between 25 and 54 years old, and the economic opportunity in their community. And in a state like ours that has -- and I'm from Georgia -- but a state like ours that has a lot of rural areas, there may be a lot of people who are unemployed, but the unemployment rate doesn't reflect that. There's just not a lot of opportunities, and people have become disengaged.

So I'm just wondering if there are any innovative ideas where segments of the population who would qualify, instead of qualifying them individually can be qualified based on some other metric other than them having to individually report on their qualifications.

CHAIR VERLON JOHNSON: Thank you, April. Any

other questions or thoughts?

[No response.]

CHAIR VERLON JOHNSON: All right. From my perspective I appreciate all of the Commissioners' thoughts and questions, particularly around the IT systems, knowing how important that is in this particular initiative.

The only other question I had was more around exceptions categories. I mean, obviously they are very important and they are going to be complex, for sure. And just as we go down this path further, just to get more insights around how states are thinking and identifying and handling exceptions that they have in place would be helpful.

And with that it looks like John has a question.

COMMISSIONER JOHN MCCARTHY: Not so much a question but it's a statement thinking about this as we go forward. So, Melinda, not too much for you to be looking at right now, but incentives for managed care plans is to get people enrolled into the program and keep them enrolled. So one of the issues that I know came up even for redeterminations is once a person falls off the program, the managed care plan, because of the marketing

rules, can't reach out to that person or cold call them, both because of what's in statute in Title XIX plus CMS rules and state rules. I think that's something for us, as the Commission, to be looking at.

And those rules made sense pre-community engagement requirements but, you know, if we're going to be looking at this, this is the law now, looking into this going forward, would that be something that MACPAC should be taking a look at, and should those rules be changed so that managed care plans could be doing outreach to individuals who aren't enrolled, helping them to become enrolled by helping them get work. Because per that CMS guidance letter that we talked about earlier, moving forward if you don't have one of the qualifying conditions you will have to be doing some type of community engagement, either one month, two months, or three months, before you become eligible.

So again, how can we use other entities to help people get employed, or be working in some type of community type of setting that qualifies and then move forward? So again, this isn't so much a question but something for us, as a Commission, I think to be thinking

about, another area to look at, is how to help people become qualified for the program. Thanks.

CHAIR VERLON JOHNSON: Thank you, John. Any other questions or thoughts?

[No response.]

CHAIR VERLON JOHNSON: All right. Melinda and Janice, I know our panel is supposed to start in about 15 minutes or so. So if there are no more questions then, let's see, do we want to just take a break then? Would that be helpful? All right. Let's do that. So we'll take a 10-minute break and be back in 10 minutes. Thank you all.

* [Recess.]

CHAIR VERLON JOHNSON: All right. I'll turn it back over to you, Melinda and Janice, to kick us off for the panel. Thank you.

EXPERT PANEL ON IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS

* JANICE LLANOS-VELAZQUEZ: Thanks, Verlon.

Good afternoon. We're so glad to have Caprice Knapp from CMS and Lindsey Browning from the National Association of Medicaid Directors, or NAMD, to reflect on

the considerations we heard from stakeholders and to provide insight into how states and CMS are implementing of community engagement requirements.

Dr. Caprice Knapp is the principal deputy director of the Centers for Medicaid and CHIP Services, and Lindsey Browning is the deputy executive director of programs at NAMD. Commissioners can find their full bios in the meeting materials.

I'll start the conversation by posing several questions to the panelists, and then I'll turn it to the Chair to facilitate Q&A with Commissioners.

Caprice and Lindsey, thank you so much for joining us today.

Commissioners just discussed key considerations that arose in conversations with states and other stakeholders over the summer about implementation of community engagement requirements. How do those considerations align with the questions and considerations you are hearing now from state Medicaid leaders?

Caprice, would you like to start?

* DR. CAPRICE KNAPP: Sure. Thanks, Janice, and thank you to the Commissioners and to MACPAC for inviting

me to come and talk about community engagement.

What's, I think, very interesting is how aligned what you all heard as Commissioners with what we heard.

So we have spent the last several months talking to every state who is subject to community engagement requirements, but one, and we have a planning meeting set up with that state. But anyway -- and Lindsey and the team at NAMD helped us facilitate those. Sometimes they were one-on-one meetings; sometimes they were group meetings. But the good news is we heard almost very aligned with what you all heard, concerns as it relates to timelines, IT, how things are defined, how the data will be used, how verification will happen, and as you all have so nicely laid out in the document, the pieces.

The one piece we did not hear from that I thought was new is the last piece at the end where you have the table, where it's, you know, metrics. I understand that was put forward, some ideas. That will be a second phase for us as we go through and talk to states, but again, alignment, which is good because we are hearing what you are hearing. I think you can -- the way I would describe it is an evolution of what we are hearing.

At first, when we started having these conversations with states, it really was about the timeline and IT, and we understand that because that's the heavy lift to do in terms of what your IT system is. Do you use what you have? Do you bring in new vendors? How do you pull that together? But the great news is I think now states, even if they haven't solved that problem, are moving on to ask more policy questions. And we are getting really good feedback out there, both at the high level, which you all described, and then some really good nuances.

So, Lindsey?

* LINDSEY BROWNING: Yeah. I would just plus-one to a lot of that. And just for context for folks, the National Association of Medicaid Directors, you know, we are supporting all 56 Medicaid leaders and their teams across the country, and it's sort of from that vantage point -- and particularly from the vantage point of supporting key senior leaders in the program, finance, policy, eligibility, et cetera, that we are engaging with our CMS partners in this, in this moment.

So, really, the big considerations, like Caprice said, are outlined in what you all heard. It's really that

robust engagement with CMS on kind of the policy and operational matters, early and often, and thrilled that that has been happening through those small-group listening sessions, through NAMD's affinity groups and CMS folks coming to that, and through kind of an ongoing series of calls with state leaders and CMS to really hash out some of those questions, surface some of those questions.

IT systems, another huge area of focus and thrilled that we'll get to dig into that a little bit today, but really kind of digging into understanding what's needed, you know, what solutions are out there as far as systems, and kind of estimating what the cost will be of that build.

And states really see this as an opportunity to disrupt that first dollar model of spending, where every state is paying kind of first dollar costs, even when some of these vendors are implementing similar solutions or changes in multiple states.

And then member engagement is really key, and I see a lot of attention focusing on that now of how do we build the foundation and build a strong plan to engage Medicaid members, both in the upfront policy design but

also throughout the arc of implementation, so folks leveraging their MACs and BACs to be able to do that, learning from their SNAP colleagues, and the work, you know, that we know has been ongoing in SNAP around community engagement, and leveraging that infrastructure and relationships built during the unwinding that have really upped Medicaid's game and upped the capacity to do effective member engagement.

JANICE LLANOS-VELAZQUEZ: Thanks.

So it sounds like based on what you've shared, there is a lot of alignment between what we learned through our interviews and through what you're hearing and what you're hearing from states as far as considerations for implementing these requirements. Are there any considerations we haven't addressed that are important to highlight?

I know, Caprice, you had mentioned them, but we can start with you, and then we can turn it to Lindsey.

DR. CAPRICE KNAPP: At a high level, no.

I do think when you get down to the details in terms of, you know, particular pieces of the policies, implementation, and operating it, I think we'll end up

hearing more from the states.

Just as an example, on education, for example, there's been discussion, and you all noted in some states, about how they can link up to their higher ed and the data stream there to try and verify. And so the states are asking us another question, even at a layer below that, which is, suppose I get the information, I'm really looking to see, is this person part-time attending, you know, higher ed, but what happens if they're not but they have three hours? And so how do we convert those hours if it's semesters, if it's quarters? How does that conversion work?

So, again, I mean, I think you all have the broad categories in there, which is great. We're just starting to get the next layer and the next layer down from that, which is great, which says people are really putting a lot of thought into this. And we are taking -- well, we're obviously taking all those questions as well. We have an email that we've set up, medicaidreforms.com, and I'll make sure that I put that in the chat so that people have access to that. And again, we're getting one-off questions that are, again, a layer or two deeper.

LINDSEY BROWNING: Yeah. And I'll just wrap around with three things.

I think, first, at the highest level, we're still seeing that there's not great understanding in the landscape around the differential impact of the bill's policies, particularly on expansion and non-expansion states. In particular, I've had a couple of Medicaid directors say to me that they've been on the receiving end of large community campaigns around work requirements and community engagement, and there's just not -- again, not understanding that it doesn't apply to certain states. So I think that's important.

The second is the operational reality that eligibility policies in the bill need to be sort of looked at and taken together, knowing that the more frequent redeterminations, the changes to retroactive coverage periods, et cetera, come online at the same time. So I think a deep appreciation that Caprice and Anne-Marie and the team at CMCS are thinking about it in that way, and states are as well, but I didn't see that surface as much in the findings.

And then the third and most important one that I

would flag is that consideration of community engagement implementation alongside a provision that doesn't go into effect until 2029, and that is the change in Section 71106, which limits CMS's ability to use a good-faith effort around certain audit findings, right?

So currently, if PERM audit findings are above 3 percent, there's a process in place for those overpayments to be returned or for there to be financial implications, but traditionally, CMS and states have worked through a good-faith effort process to resolve excess errors there.

That flexibility or ability to use that pathway goes away or is limited starting in 2029. So what that means for now in the current moment is that as states are implementing these policies, they are keeping an eye towards making sure there's a clear paper trail, that things are auditable so that there isn't financial risk on the back end if PERM errors go up.

So happy to talk more about that, but I do feel like that's a piece of the policy picture that maybe isn't getting as much attention in the current moment.

JANICE LLANOS-VELAZQUEZ: Thanks for raising that.

So, Lindsey, what are some specific areas in which state Medicaid agencies are looking for additional guidance or support from their federal partners as they work toward implementing community engagement requirements?

LINDSEY BROWNING: Yeah. So, first and foremost, what I would say -- and this was in the findings from your all's interviews -- is really the importance for states in getting those early signals from CMS, and all states subject to community engagement are really appreciative of CMS's efforts to have those early conversations, send signals when they can, knowing that June is very late. So that's at the highest level.

I think, broadly, Medicaid leaders are really looking for clarity on where CMS intends to be specific in its policy and those areas where CMS intends to provide more flexibility and state option around implementation.

But digging in kind of from that a little further, I think continued desire and conversation with CMS partners around timelines, particularly timelines for sort of outreach to those first cohorts of folks who are subject to community engagement or have the renewals early in 2027. I think better understanding from CMS around what a minimum

viable product for the IT solutions might look like, and again, ongoing conversations there.

I think an interest in understanding what a glide path might look like for more automated processes or connecting to data feeds, particularly as Caprice said, around the volunteer engagement where it feels like we collectively are at a more nascent stage, kind of how do we move towards the goal of more automation.

I think new data reporting expectations, as you all are interested in, is an area where having that clarity, having that conversation with CMS will be really helpful so that those can be baked into the systems changes.

And then the last two, I think the overlay of those other eligibility policies that I mentioned with community engagement is an area where there will be questions way down deep in the weeds where eligibility experts will surface things, and I think having those opportunities will be important.

And then, finally, you all talked about this a little bit in the last session, but the role of managed care organizations and what is within bounds and out of

bounds for the role that they can play in supporting their state partners in implementing this.

JANICE LLANOS-VELAZQUEZ: Thanks, Lindsey.

Caprice, we've seen that CMS has started to issue some guidance through informational bulletins recently, but what topics is CMS planning to address through guidance or technical assistance before the IFR is issued in June?

DR. CAPRICE KNAPP: I appreciate the question, Janice.

And I want to say I misspoke. It's medicaidreforms.cms.hhs.gov. I just want to clarify that, and anyone can use that, and again, we're using those questions as we think about building out documents.

So, to your point, we understand that the IFR that comes out in June is way late in the game, and just to make sure that everyone in the audience understands the difference between an IFR and a notice of proposed rulemaking, for example, when the IFR comes out, we'll take public comments, but it won't be like typically what happens where we have a notice of proposed rulemaking. We take public comment, final rulemaking. But in the IFR process, there still will be an ability to put in public

comment.

Again, understanding that June is too late or puts too much pressure on states, the administrator has been, I think, incredibly helpful at trying to push for letting us get out some regulatory guidance earlier than June. So, on Monday, like you mentioned, we published two things. One, we published a Center information bulletin that is on community engagement, and we published a slide deck that's associated with that. So, as you were talking about, you know, what are states asking for, I think the CIB really does a good job of outlining when there are decisions that are state decisions that we are not involved in, and states can go ahead and make those decisions.

So, for example, I think you all noted about the short-term hardship exemptions. States can decide whether they want to take those up. That's not our choice.

The second choice, for example, another example would be about the renewal period or the look-back period, and so, for example, when you start doing community engagement, the state can choose one, two, or three months to do a look-back period to determine if that individual has met the community engagement requirements. That's a

decision states make.

So the CIB, I think, really tried to point out where areas were state decisions, where areas where CMS would be providing guidance, and a lot of that spelled out in the bill.

And again, thinking about all the avenues in which we have to do this, Lindsey hit on the minimum viable product. We have been talking a lot with states and vendors about that minimum viable product, about what our expectations are there, just to make sure that everyone is on the same page, and so we've outlined some of that minimum viable product.

So I think you'll see from us, in an iterative fashion, that sub-regulatory guidance and trying to get to the point of so that, obviously, we're not waiting until June, and we're trying to send signals ahead of time.

We started our Friday calls again, and we've started all-state calls again, and so information is being pushed out that way to the Medicaid directors and their staffs, and NAMD helps us with that. We also have, again, our all-state calls. So that's another venue where we'll be sending signals and describing some of the policy

decisions as we get closer.

JANICE LLANOS-VELAZQUEZ: Thanks, Caprice, and thanks for sharing the email address.

Lindsey, we've heard a lot from states and other stakeholders about the parallels between community engagement requirement implementation and the public health emergency, or PHE, unwinding. What are some key lessons from the end of the PHE that could help inform state efforts and the way that CMS and states engage around community engagement requirements?

LINDSEY BROWNING: Yeah. I think there's a lot of lessons learned, but I think maybe just to start off with one important difference, which was during the unwinding, the work between CMS and states was really to understand the application of an existing body of policy, established policy. So I think important to keep in mind, we're sort of at a point in time where there isn't that body, right? This is new policy that's being developed and worked on.

So, setting that aside, I think there's incredible lessons learned and incredible foundation of progress made during the unwinding that'll be really

essential to operationalizing community engagement.

The first and the biggest leap forward that I think we all saw during the unwinding were efforts to better automate eligibility processes. In particular, we saw ex parte renewals, a massive focus on how do we increase that rate of ex parte renewals, and saw that play out in the data.

I think in the most recent report from CMS, the August 2025 enrollment report, 50 percent of individuals up for renewal were renewed on an ex parte basis. That's as compared to 34 percent that were renewed ex parte in September 2023. So I think clear progress in linking to different data sources and strengthening those ex parte processes that we know are consumer friendly, right, because there's less sort of touches involved and effort involved, but also help maximize the capacity of the state eligibility workforce at a time when there will be an increasing workload there.

The second key lesson learned, I think, is the maturation of member engagement structures and various ways of engaging community partners in doing the work of outreach and articulating changes that are coming in

Medicaid and what action is needed on the part of consumers, and we saw this through various focus groups leveraging the member advisory committees that were already in existence in some states and whatnot.

And then, finally, I would say really leveraging the infrastructure that's been built, and that's infrastructure as far as outreach modalities. You know, the beginning of the unwinding, very few states were doing text messaging. Now it's pretty ubiquitous in Medicaid, leveraging, you know, AI to help assist eligibility workers in doing reviews, leveraging relationships with new partners, community partners, schools, et cetera, to reach folks. So I think it's really setting states up to be in a much better position to move quickly to implement because of the work during the unwinding.

JANICE LLANOS-VELAZQUEZ: Thank you.

And, Caprice, is there anything you'd like to add as far as lessons learned from the PHE unwinding, particularly given your experience as a Medicaid director in the lead-up to that period?

DR. CAPRICE KNAPP: Yes, a couple of things. I think Lindsay did a great job of covering the things that

we learned.

I think for us, we went to the legislature, and just for clarity, I was a Medicaid director in North Dakota for the years during the PHE and the unwinding. And one of the things that we did was make sure we went to the legislature to secure outreach dollars. We actually had an outreach campaign. We worked with public health. They are experts in outreach and doing public campaigns.

And so, as you read the community engagement statute, it talks about states, you have to do three months of outreach before you start. So that's a requirement. But, I think what we learned is that that outreach needs to be frequent.

So what we've talked about at CMS is that -- again, the three months of outreach is going to be -- that's part of the statute, but we're encouraging states to often, even after that three months, that's right. So, again, that was a lesson.

Managed care, how you use your managed care organizations, how you partner with them, and really being -- Lindsey talked about text messaging, et cetera. The plans can do that as well. The plans have great outreach

into the communities, great CBO partners, community-based organization partners, and the plans can be just a fantastic player in this.

And then the last thing I'll say is vendor engagement. You know, I have -- obviously I was not at CMS working during the unwinding, but I know one thing that's been very critical to the Administrator is to engage with vendors early in this process, and so we have done that. We have reached out to traditional enrollment eligibility vendors, new vendors that we're seeing, to really have conversations with them from the beginning about expectations of their role in this, because again, it is going to be a very significant role.

And I think -- and then communication. Obviously, CMS, I think during the unwinding, again, we had constant communication coming out. We had calls, and on some of these calls -- you know, sometimes you go to an all-state call, nobody says anything. That was not the case. We would have calls during the unwinding, and lots of people asking lots of questions. And so, we hope that is the case going forward as well about communication requirements and we'll have those similar opportunities.

JANICE LLANOS-VELAZQUEZ: Thank you.

And the final question we have for the moderated portion is, in a lot of our conversations with stakeholders, one of the topics that came up a lot was the importance of monitoring implementation of community engagement requirements. The Commission is interested in better understanding the type of information that CMS already collects from states and whether additional data or information might be needed to provide insight into how state implementation is going.

Caprice, can you describe the approach that CMS intends to take toward monitoring state implementation of community engagement requirements?

DR. CAPRICE KNAPP: Sure. So what we have planned for calendar year 2026, anytime that states submit to us an advanced planning document, or an APD, around an IT system build or an IT system upgrade, there are continual checks in with the state. What is the progress of that? How is procurement going? What is the testing looking like?

So we're gonna build off of that framework in 2026 to have monthly meetings with states. What we're

going to add on to that -- so, again, that's a structure that we have in place about the IT systems, and it works quite well.

Our data systems group has folks that are assigned to different states. They know the folks at the states. They have good relationships with them.

So, again, as they're doing those monthly meetings, we're looking at how ready are you? How ready are you, and where are you in the process? What we're going to layer on top of that, though, is an operational piece to that, which is about the policy, right, and about training and staff, because we understand that this just isn't an IT exercise. You also have to write the policies. You have to go to your legislature, get appropriations authority. Your eligibility staff need to be trained. You might have redesign happening.

So the goal is to meet with states every month to get updates on that. And DSG has a format that they already use for that so that we will have a good idea by June, July, August where people are in that process.

The other thing you mentioned, Janice, is about data, and we're in the middle. We've got some small work

groups going. We haven't made decisions yet. Again, it was great to see that table at the end of the report about the types of outcome measures that people are thinking about. So that part, we haven't made decisions about yet. We're still iterating on that, but understand that that is a critical part of the IT build, right? We need to make sure that you have the reporting in there.

And we have learned quite a few lessons from our colleagues down in Georgia about some of the outcome measures and thinking about how those are structured. So, an example that we learned is if we get to the end and someone, for example, is coming up for renewal and it's decided that -- or through the verification, they're no longer enrolled, well, it could be that they're no longer enrolled because they're above income. It could be that they're no longer enrolled because they -- through that process, there was a different part of Medicaid or a different category of eligibility. And so, what we learned in Georgia is that just at the end to say this is the number or the percentage of people that were no longer enrolled really doesn't provide you with the granularity of data that you need to understand what happened.

So, we're going to be taking lessons from them and, again, looking for input from states and understanding that there's a balance there between everybody is going to want to know what happens, but we can't have 65 measures to review, so thinking about sort of the burden on states to report versus what is really, really critical to know and understanding that there's gonna be an iteration to this over time.

So just like with lots of measures, it could be that there's a core set of things that we want to know and understand from now until perpetuity, but it could be that there are additional things that come up or trends that we're seeing that we want to ask states about.

So that's the approach that we're taking and happy to talk more about that if folks are interested.

JANICE LLANOS-VELAZQUEZ: Thank you.

And, Lindsey, what are some key considerations related to monitoring that are important for states and CMS to keep in mind?

LINDSEY BROWNING: Yeah. I think just building a little bit on what Caprice said, having a reasonable number of measures and having those baked into the systems build

are really critical from the state perspective.

And I think also, to the extent possible, what are the existing universe of data and measures that we have, like you guys kind of mapped in the analysis, and how can we build on those? I think that's really key.

But going to the broader question of monitoring, how's implementation going? Where are there road bumps? I think it's really key to have this collaborative approach that we're seeing play out between states and our CMS partners to be able to have kind of candid conversations around what issues are coming up, what's not going well, where are we running into roadblocks? And I think the ability to do that in a very collaborative way is key, and those bi-weekly calls are a great example of that.

And then being able to spot issues kind of early, early and often as the work moves forward.

And then, I think as Caprice mentioned, kind of leveraging existing sources of information and reporting that states may already be doing, like the APD process, is really key to try to make sure that maximum state capacity and effort can go to the implementation work rather than kind of new reporting burdens.

JANICE LLANOS-VELAZQUEZ: Great. Again, thank you both so much, and I will now pass it to the Chair to moderate further discussion. Thanks.

CHAIR VERLON JOHNSON: Yeah. No, thank you again, Caprice and Lindsey. This was very helpful to all of us. We've been looking forward to it, so really happy you're able to join us today. You have some really good insights for us and a lot to think about. And also Janice for moderating and Melinda too as well.

So, we do have some time now for the Commissioners to follow up on some of what we've heard. So, we definitely want to open up the floor for some questions to our panelists.

I will start with one, and it may be too soon. So just because you just released the guidance, additional guidance on Monday -- and I know that you all had these amazing checkpoints that you're doing, but just curious. So maybe with the new federal guidance that's now released, are you hearing anything yet from states about their initial priorities as they really begin planning for implementation for this? You know, maybe some including how they may be thinking about sequencing, you know, what

comes now versus what comes in 2027.

DR. CAPRICE KNAPP: Thanks, Verlon.

CHAIR VERLON JOHNSON: Yeah.

DR. CAPRICE KNAPP: I think obviously the IT, the minimum viable product, is top of mind for everyone, and then the next big chunk of decisions, I think, that are really critical that we've been focused on is qualifying events, your work, your jobs programs, your volunteering, and your education, thinking through what is the structure for that, what are the expectations, what does verification look like, same thing with exemptions, exceptions and exemptions, and then thinking about within those exemptions, a lot of interest in medical frailty.

We've had several small group conversations on medical frailty. I'm happy to talk more about that.

And then the timelines. I do think that the bill is maybe confusing a little bit about the timelines and thinking about when states actually again have to do that three months at outreach. Then they're going to choose their one to three months of look-back, and then they're going to start. So, you could be thinking about a whole six-month process before actually there's a go-live, and so

trying to get a feel from states about what their expectations are, we have some states that want to go early, a handful of states. And so that's a good opportunity for us to get in and learn exactly what you're talking about, which is what's top of mind and what's gonna be difficult for them.

I think the renewal timeline is one of those where there's still questions about, because the statute talks about states have the option of how frequent they want to check verification, but again, we'll still have to work through that and think about what states' choices are and how that impacts operations and implementation.

CHAIR VERLON JOHNSON: That's really helpful.

Lindsey, anything else to add?

LINDSEY BROWNING: Yeah, I would just add from kind of a state policy lens, I think there's this orientation to, particularly, the employment pieces and income verification and then the education pieces, knowing that that's likely the bulk of individuals and qualifying activities, and recognizing that the volunteer piece, again, is a little more nascent as far as what data sources we have, how we can automate those processes. So, I think

really trying to prioritize what are the strategies we can pursue to capture the bulk of the population and then build on those moving forward.

CHAIR VERLON JOHNSON: That's very helpful. Thank you.

So, I see my Commissioners. There are many hands up. I'll start with Anne.

COMMISSIONER ANNE KARL: Thank you so much for being here today. It's really helpful to hear this.

I've heard a lot about minimum viable product and iterating. These are great concepts when you're talking about testing a new social media app. I have some concerns about thinking about that in the context of a situation where people will lose access to Medicaid coverage as a result of technological challenges.

I think, Lindsey, your comments on how something like volunteering, which is in the statute, is just much harder to track.

So, with that in mind, it feels like there needs to be some way to understand at what point a state has done enough to actually be able to knock people off of coverage or at some point where their technology is so poor that it

is honestly violating people's constitutional rights to not be able to maintain access to coverage because of the limits of the technology.

So, I wanted to understand how CMS is thinking about whether there is like a readiness review. You wouldn't let a state launch a new Medicaid managed care plan without having done a readiness review to make sure that the plans can take that on. Will there be some type of readiness review to make sure that state systems are operating effectively enough?

And then related to that, completely hear and agree, we do not want to bog states down with so much reporting that it's taking away from their time to be able to implement effectively. But I do also wonder if this degree of technological functionality, if we need to be checking that so that as we start to be monitoring enrollment changes and you see, oh, there's a group of states that's losing more people than others, is there a way to crosswalk that with the technological features? Like, oh, they're all using one vendor, or, oh, the high performing states all have cracked the code on education linkages or volunteering.

So, it's sort of two things. Like, will there be a readiness review and, then what's the plan to be monitoring the technological variations across states so we can match that up against the enrollment changes?

LINDSEY BROWNING: I'm happy to -- do you want to jump in first, Caprice?

DR. CAPRICE KNAPP: No, actually you go ahead, Lindsey.

LINDSEY BROWNING: Okay. I was gonna jump in on the technology piece in particular. I see a clear interest from Medicaid leaders in wanting to make sure the technology works and delivers an effective platform consumer experience and, again, automating as much as possible. And I think Medicaid leaders are really building in that timeline, that time for testing, right, which is part of why there's that urgency to make decisions around the technology path now to be able to do the testing and training of staff.

I think there's a shared interest in working with the federal partners in a very transparent way to get results from the technology and, quite frankly, to get better results than we've seen in the past, right? I think

this is why this is an opportunity to disrupt the norm in some of the technology challenges we've seen in the past, so I think an eagerness to do that in a very transparent way.

The other thing I would say -- and I think this is a lesson learned from the unwinding -- is sometimes when implementation timelines are short, you end up sort of wrapping around the technology with manual processes until you can automate. And I think that's going to continue necessarily to be a piece on the table as states think about implementation and how to achieve -- you know, how to make it work for the numbers.

DR. CAPRICE KNAPP: And just quickly to add on, yes, we're going to have a readiness review process -- I talked about that -- in 2026. We will meet monthly with states to do both IT readiness review and policy operations readiness review.

And I do think on the tech side, I really liked the way that Anne said that about that crosswalk. One of the things that I think has been confusing when we've talked to people about this is it's not just one system. You have your enrollment eligibility system. That could be

great for those of us that have integrated eligibility. Sometimes we don't. Sometimes SNAP and TANF live in other places than Medicaid, but you have your enrollment eligibility system.

And then either you're going to go with your traditional vendor and infuse into that system your community engagement requirements, but you could also do a mechanism where you've got enrollment eligibility. Then you have community engagement as a module which would interface with your enrollment eligibility system, and so it's different amalgamations of what states have and what they're going to go forward with.

And then there's a third piece to this, and this, I think would be in the future. It would be great if states could get there right out of the gate, but there's a third piece to this where that then wraps around in a closed-loop referral to those community-based organizations that you have, right? So, it would be great. We know that the plans have great experience doing that already, but again, I think of it as sort of layers.

And I love that idea of crosswalking, and that was the goal of doing these monthly readiness reviews.

CHAIR VERLON JOHNSON: Thank you.

I see Sonia and then Jamie.

COMMISSIONER SONJA BJORK: Thank you.

I was hoping either or both of you could opine a little bit on all the information we're receiving lately that AI is going to change the game and help beneficiaries get through this process, meaning that a lot of different tech companies are developing things and offering products that they hope are going to help in this new era. And I was just wondering if you see any prescriptive actions by either federal agencies or state agencies giving guidance on what should or shouldn't happen or if it is okay for us to engage and see what rises to the top in terms of the best types of apps or portals or et cetera that can interface with all the eligibility programs.

I'm sure you're getting a lot of the same pitches that certain companies have the solution for one and all, but right now there's just so much going on about that. So, I was just wondering what you're hearing.

LINDSEY BROWNING: I'm hearing both a healthy degree of skepticism but inquiry and interest in what those solutions might be, and my colleagues who support our CIO

affinity group are having those active conversations among states to compare notes and be able to ask critical questions around what's really realistic and what is maybe not quite there yet.

I think we have some experience from some Medicaid programs who've started to adopt AI to support eligibility processes and document review in particular, so some real tangible and concrete places where I think we have a body of evidence to support that it can work and be helpful and then those areas where we need to better understand and test before we can say for sure.

DR. CAPRICE KNAPP: And really quickly, I really appreciate our partners. NESCO and CHCS put on two recent events for your states and for your Medicaid directors, and both of these were to showcase the vendors in the states. One was CHCS, it was a Zoom-in. Vendors did an hour of a demo. There were lots of vendors that participated. And states could come in, come out, and hear the pitches. And sometimes that's good because sometimes thinking about procurement rules and who can come in your office and give you a demo. So, we tried to set that up. The other thing is we were thinking about not everyone can travel. We

needed access to the information on that Zoom-in day.

And then NESCO had, on November 12-14, an in-person event where, again, we had vendors there. They had vendors there, states, and their team could come in and really have that experience. I don't see CMCS writing to AI in the rule, but it would great. We think we're going to learn a lot from states. And again, it could be iterative. It could be the first year, like Lindsey said, you're really just trying to get the minimal viable product and make sure that you've launched the program. Next year maybe you have some functionalities you want to add on. So we're interested to learn from states, as well, and did learn quite a bit from them in the unwinding.

CHAIR VERLON JOHNSON: Great. Thank you. Jami, and then John.

COMMISSIONER JAMI SNYDER: Thanks, Lindsey and Caprice, for joining us today. This has been a great conversation. Lindsey, I really appreciate your reference to the intersection between community engagement requirements and the limitations that each or one imposes around good faith waivers for the PERM process. And, of course, it can't be top of mind for any state these days.

I mean, I know they're dealing with the sort of immediate issues of standing up a CE program.

But I'm curious to know what states are discussing in terms of protections that might be offered around eligibility determinations that are tied to community engagement, given some of the limitations around those good faith waivers that states have historically been able to take advantage of.

LINDSEY BROWNING: It's a great question, and I'm glad you raised this. Maybe just for those who aren't as attuned to the PERM process, I think a really good analogy or rough comparison is what we're seeing in SNAP right now, where if a state has a relatively higher error rate, there is a financial impact to the state on the SNAP benefit side. So, I think similarly, once this policy goes into effect, if there's a higher error rate the financial implications for states could be quite significant.

I think the way that I hear folks thinking about it now is how can we make sure there is appropriate documentation, particularly in those area where there is policy flexibility, appropriate kind of CMS documentation of kind of signing off on the options that a state may

choose so that when the PERM audit comes around there's a clear paper trail and clarity that how the state operationalized it was appropriate and within the bounds of federal policy.

CHAIR VERLON JOHNSON: Great. Thank you. John.

COMMISSIONER JOHN MCCARTHY: Hey, guys. Thanks for coming, like everyone said. One of the questions I had, and you touched on this a little bit, Caprice. But on the IT system side, I know you talked about the iterations in getting there, but what about the procurement side? I know you guys have been working on some things there, to help states possibly go quicker on procurement, more importantly to save money. Right? We heard Dr. Oz and Dan Brillman both talk about this at NAMD. Not everyone on here was at NAMD.

So can you talk a little bit about what is CMS doing to help states keep down the costs on these, especially in the IT administrative side cost of things?

DR. CAPRICE KNAPP: Thanks, John. So, lots of information to come, but we'll say again the administrator has been working on meeting with the vendors for quite some time, and will continue to. And the idea is to have those

conversations and thinking about pricing, because again, you've got 51 folks who are trying to implement a system, and we don't really want to pay 51 times for the same system. So really talking to the vendors about how can we work collaboratively there.

Second, procurement is an issue. And I think, my hunch tells me that we are going to see some states go with their traditional enrollment and eligibility vendor, because of that process. Sometimes it can be very timely at the state level. Many of you have contracts in place. We know some states are already working and moving forward with their traditional vendors and building out the code.

The other thing is thinking about how we work with those vendors to lay down expectations, to get feedback from them, about what is a core product versus what are things that states might want flexibility on.

So again, the more that we can get standardized helps bring down the cost, and the more that we get vendors to commit to working together with us, and working with states, and making those prices transparent.

The last thing I'll say that we've made clear to the vendors and that we've told states is we expect that

the dollars are separated. And the reason why that's really critical is when you have your APD and you're asking for dollars for your system, you can also include dollars to help train staff. You can think about dollars you might need for notices and call center. It's pieces all around. It's not just the community engagement module. And to Lindsey's point, you're going to do six-month renewals in there. You've got lots of other things happening.

So, what we said to states and vendors is our expectation is that you separate and present to us what the community engagement costs are, so we actually have a better idea of where the dollars are going. And sometimes that's an easy process and sometimes it's not. I understand, though, that procurement is an issue, and that is one thing we're going to be talking about in these readiness reviews.

LINDSEY BROWNING: I would just add two things onto that. I think the first is we've seen the IVaaS tool that was developed by the federal government, the Income Verification as a Service. And I think lots of interest from states in, again, in future years -- knowing the timeline we're on -- are there other solutions like that,

that can be developed and shared among states?

The second piece that I would add is knowing that the systems cost is the upfront build, but also the ongoing costs of needing to tap into various data sources. So, I think there is a real interest from states in partnering with the federal government to explore how do we get more value from those data sources, that all states who are getting community engagement, or nearly all, need to tap into.

CHAIR VERLON JOHNSON: Thank you for that. Carolyn, and then Heidi.

COMMISSIONER CAROLYN INGRAM: Thank you. Thanks, Caprice and Lindsay, for joining us. Caprice, it sounds like you all have put together lots of plans already around IT and communication. And I'm wondering if, in your conversations with states, if you or Lindsey have heard them talking about consent at all and adding that to their application process? It seems like a lot of the problems people are raising could be taken care of in that regard. So being able to automatically pull payroll and work information to check somebody's eligibility before they even come in could be managed as long as the person

consents to it, in terms of some application process.

So, I'm wondering if states are starting to look at how they can, I guess, allow for that consent during their application process, if they started to think about that yet.

DR. CAPRICE KNAPP: So, I think what Lindsey just mentioned really dovetails into that. That is the reason why a lot of states use Equifax, because the consent is not needed. On the IVaaS tool you need consent. But the great thing about IVaaS is it's going to help push some of those holes that you have even from Equifax, from gig economy, from sources that you wouldn't normally get income information on.

To your point, though, I think we haven't had states bring to us this idea of, you know, can we think about different ways of getting consent? Can we say on the application that, yes, I agree to this? I think it's interesting. I think it's worth looking into. And I think that's really going to push the hierarchy of the data sources states use for income.

So, for example, in Georgia we saw a definite shift in the data sources they went to, one, because of

cost, two, because of completeness, and three, thinking about consent and what's easiest on members.

But it's a good point, and we will get to that place if it's something really critical. I don't see that coming through in the rule, but I do think if there's a way to think about this that would help all states, we are certainly open to that and interested in that discussion.

LINDSEY BROWNING: Yeah, I think that's a really intriguing idea. You know, consent is a big challenge, and one idea we've heard is could there be sort of multiyear consent or one-year consent, something like that. But we've heard the idea of like the how of getting consent. So, I think it's definitely an interesting area worth exploring.

COMMISSIONER CAROLYN INGRAM: Thank you. Yeah, I think it could help lower the costs. I think what we're hearing is that Equifax kind of has a monopoly on that and is charging states quite a bit of money to gather that information. So I'm excited to hear about that IVaaS tool and that it allows for other sources, and maybe it's something MACPAC can even look at, about recommending to states as they think about a consent process. Thanks.

CHAIR VERLON JOHNSON: Thank you. All right, Heidi.

COMMISSIONER HEIDI ALLEN: Thank you both so much for being here. Kind of building on the previous comment of potential MACPAC recommendations, one of my questions is are there areas that you think that MACPAC could be helpful in thinking, particular, you know, because this is an 1115 process there's not the same level of evaluation built into the system. It's a new policy. Are there things that we could do that would be helpful to CMS or NAMD about making recommendations on how this could be evaluated and tracked?

And then my second question is for Caprice. Thinking about previous times where you've implemented by technologies like, in particular, the implementation of the ACA. You know, we had some states that wanted to have their state-based marketplaces and the technology made that difficult. We know that Marketplace itself had some technological issues. And I'm curious if the law gives CMS the ability to put a pause on a state's process if they see numbers that are really unexpected.

I know, with Georgia, the enrollment numbers in their expansion is lower than anticipated and that there

are efforts to try to figure out why that is and what's happening. But recognizing that there will be such complexity and potentially new technologies employed across all of these states, if you identify a state where enrollment is dropping precipitously, do you think that CMS will step in and say, wait, let's just hold off for a minute until we can figure out what's happening? Or is there a mechanism for that? That's my question. Thanks.

DR. CAPRICE KNAPP: Do you want to take the how can MACPAC be helpful, and then I'll take the second?

LINDSEY BROWNING: Sure. Happy to. Two areas I think I would call out. I think the first is around measuring outcomes, and I think there's a real opportunity for the Commission to surface kind of what would a small set of meaningful measures be that CMS and states could consider, again, early in the staging process?

I think the second is around recommendations around that member outreach. You know, we talked a lot about how there are similarities from the unwinding, but one big difference is the reality that community engagement implementation affects a subset of the population, and trying to, I think, articulate and communicate to members

who is impacted, who is not, and what is required is going to be a really critical and challenging exercise. And I think MACPAC surfacing recommendations, surfacing best practices for that could be incredibly helpful.

DR. CAPRICE KNAPP: And to your point, Heidi, which is good one, which is something goes wrong, right. Something always goes wrong when we do these big launches. We understand that. One of the things that we are working on are states that want to go early. We understand that you can go early if there is an 1115 process or a state plan amendment. But there are some states that want to go early, and actually did quite a bit of this work in building out their systems before COVID.

So, what we're working on with those states, one, that will be great for us in terms of lessons learned, and as we work with them, and as they go first. And what we are working on with those states is a hold harmless period, whereby if they go early and they start before everyone else, we want to make sure that for a certain period of time that they have the opportunity to not disenroll people if they choose to. So, to your point, yes, we're trying to work with those early starters, learn as much as we can

from them, and then give them a hold harmless period.

For the folks that start on time, of course, you know, things happen, and we do have the ability, I think, through the APD process, through our data systems group, to have let's pause, let's time out. And it could be, I can think of a couple of scenarios where one could be, obviously, we start, things go wrong, we need to put a pause, but the other thing could be that I've filled out the minimum viable product, but maybe perhaps I haven't finished notices. So maybe that's not completely built out in my system yet, but maybe I can send 30-day notices through a different system. I can print them up over here. I can make sure that's being taken care of.

So, we're definitely going to work with states where, you know, again, it could be 75 percent is done, 80, 90 percent is done with that system, and then like Lindsey said, they might have different processes that they're using just to bridge them over. So absolutely, I think you make a great point, and a lot of lessons learned at CMS about some of these big IT launches.

COMMISSIONER HEIDI ALLEN: Thank you.

CHAIR VERLON JOHNSON: All right. Let's see,

Mike.

COMMISSIONER MICHAEL NARDONE: Hi. Thanks, Lindsey. Thanks, Caprice. Thanks for taking your time out. I know you've got a lot of things going on with this. And it's good to hear kind of the balance that you're looking for in terms of the monitoring of this program as it kind of unfolds. And I think we all share the concern that if people have a reason to be exempted from the work requirement because they meet those criteria, making sure that they are able to kind of meet the exemption and not be thrown off for some paperwork type reason.

So, I appreciate you working on that, and it sounds like there is some openness to maybe MACPAC helping you with some of those monitoring metrics. That would be helpful.

I think maybe Heidi stole some of my thunder a little bit in terms of, you know, I am hoping that this will be, when we do kind of set up some metrics, that there will be some transparency around this, and that's something we can use to continue to refine the program. And that's certainly what I'm hearing from you.

I'm wondering, do you have kind of a timeline in

terms of when you think you might be thinking about what that monitoring plan might look like? It sounds like you're in the process of thinking that through now, and you're hoping for feedback from MACPAC. But I guess that might be something a little bit later in the process?

DR. CAPRICE KNAPP: Yeah, I mean, I think what we're trying to prioritize now is, again, that minimum viable product build, and then those big, huge policy decisions that you still need to push forward to get your system built. And definitely measures for reporting are critical for building that system. We haven't gotten to that yet, but again, we have small groups working on that. I think I might have lost the end of Mike's question.

But again, we hear you, we understand that, and definitely that's now one that we know can wait until June, for sure.

COMMISSIONER MICHAEL NARDONE: Thank you. I had a more technical or just a process question, kind of what implementation actually looks like on January 1, 2027. I'm assuming that all states will have to have in place a process for new people who are coming into the program, to determine whether or not that they are eligible for

benefits, or that they're meeting the community work experience requirements.

For people who are currently on the rolls, do you envision a rolling process in terms of when they would have to demonstrate that they meet the community work experience requirement, or is the expectation that everyone has of January 1st, who was already on the program, will meet those requirements, or the state will have been through everybody on the rolls?

Am I being clear with my question? I don't know. Or I guess is there a process over the six months where those redeterminations happen, once that program gets underway?

DR. CAPRICE KNAPP: Okay. I think I'm following you. But remember, I'm sure everybody on the Commission remembers that January 1st is when the six-month renewals start, as well. And so now you're going to have a situation, to your point, Mike, that they will be new enrollees, and we're working with states about different processes for those new enrollees.

For example, if you're an existing enrollee and you think you might be exempted because you have a SUD

diagnosis, and that was included in the statute, you might have claims. A new enrollee is not going to. So, we've been working with states to think through how do those processes look different for new enrollees versus existing enrollees.

I think what you're asking is you're going to have your new enrollees, which obviously that's what the three months of outreach is really trying to make sure that it is widespread, that it is broad based, because again, you're trying to communicate to the public. Because we don't know who is going to show up. Then, for the people that are coming in for renewals and they're going to start the six-month, so presumably it could be that twice in 2027 that they are going to come in for renewal. And what we do with renewals is typically 90 days before the renewal we start to send notifications. We send forms. And that's where, I'm sure, states are going to communicate to them, there's this new requirement, and here are the pieces that you're going to need to meet. That's typically how we do renewals. And also looking in that renewal process, if there has been a change in circumstances, that might impact folks, as well.

So not 100 percent sure that I'm answering your question, Mike. There are different considerations for new versus existing. And we certainly understand that. We can't expect someone who is completely new to the system to have that information that the existing enrollees have.

COMMISSIONER MICHAEL NARDONE: Yeah. I just wanted to be clear that people will have a period. January, there will be some people up for renewal in January. There will be some people up for renewal in March.

DR. CAPRICE KNAPP: Sure. Yeah, absolutely.

COMMISSIONER MICHAEL NARDONE: So not everyone who is currently enrolled come January 1st will have been through that redetermination process, and that will be over a six-month period, because they all have to be done within six months.

DR. CAPRICE KNAPP: Correct, with one exception, and that is that we don't dictate to states in the renewal period how frequent they are going to verify. So, it could be that you have a state that says, "I want to verify every month of that six months." That's a state option for us. Understand that's, you know, that's a lot of money and a

lot of time there. I'm not sure at this point what states would want to do that.

But to your point, if you're going to use multiple months in that renewal, the individuals need to know that, and they need to know that the expectations, if I'm using the last three months, that you have met the CE requirements in each of those three months. So again, that is a state option.

COMMISSIONER MICHAEL NARDONE: Thank you.

CHAIR VERLON JOHNSON: All right. Thanks, Mike, for all those questions. All right, Adrienne, and then Dennis.

COMMISSIONER ADRIENNE MCFADDEN: Thank you both, as others have said, for being here. This has been really informative. Lindsey, you mentioned something about ongoing costs, which triggered a question in my brain. I've had the, we'll call it a pleasure, of living through large IT implementations in just about every professional phase of my life. So, I have grown to know that the go-live date is just one date of many dates with the IT implementation, and just one sort of large cost, and one of many large costs.

So, my question, I think, is mainly for you, Caprice, which is, as states learn more in the initial phases or rollout of their minimum viable product, it's plausible, I would think, that they will have larger day one and day two enhancements to go from that MVP to more of a high-functioning, valuable product. Is there any consideration or potential for additional federal support to the states as they iterate beyond the MVP phase?

DR. CAPRICE KNAPP: So, I want to understand what you mean by federal support. We already paid 90 percent of those bills. We are going to provide technical assistance. We have got two groups that can do just-in-time technical assistance. And so, what do you mean by would we provide additional technical assistance?

COMMISSIONER ADRIENNE MCFADDEN: More of those dollars in addition to the technical assistance, because it seems that, in my experience, and this is different from what's happening with the states, is that you have a large cost up front to get to that first sort of V.1, V.0, however you want to call it, for that first product, and the day one and day two items are almost as costly sometimes to get to sort of the point of functionality that

you need to do. So that initial infusion of monies I think will be helpful, but certainly I think it's plausible there will be some major enhancement that will be just as costly or almost as costly as the initial phase.

DR. CAPRICE KNAPP: No, yeah, I understand. So yes, again, the APD dollars that we provide 90/10 on the design, development, implementation, and then 75/25 in the maintenance and operation. But also, I want to flag for the group that the statute calls out two pots of money that is also available to states. One is $200 million that will be split up evenly among states, and then there is another pot -- and that could be for any eligibility activity. It doesn't have to just be for community engagement. It can be to help with six-month renewals. And then there's another pot of money to be split up for states just because it relates to community engagement.

So, we are taking the number of folks that are subject to community engagement requirements, and then we will divide up that pot of money proportionally. So, there are some extra dollars there. But again, to your point, we still offer the 90/10 for design, development, and implementation, and that would be, in my mind, a new piece.

So, we have opportunities for through that through the APD process.

CHAIR VERLON JOHNSON: Dennis.

COMMISSIONER DENNIS HEAPHY: Thank you. This is really helpful and informative. My question was really for MACPAC staff, I guess, as well as for you both. And that is how might all the work that was done on the unwinding, all the information that's been gathered, been used to support and inform what's being done now with this new requirement? Can you take all that data that's been gathered, states' data, best practices, reduced risk of harm, optimized engagement, all those sorts of things, but apply it directly to this process? I was just wondering if that might be useful, helpful, to you, Caprice, but also if that's something that folks think would be doable. Because all the work that was done, it just seems like there's an opportunity there to use it on this.

LINDSEY BROWNING: Yes, from our perspective, absolutely. I think we're combing through all the lessons learned from the unwinding and we welcome, you know, I think the Commission's insights there, as well, and recommendations of what were some of those best practices

that emerged. But yeah, we learned an incredible amount. I mean, even something as simple as like how to stay connected to Medicaid members and have more up-to-date addresses, how to deal with returned mail, those sorts of things. So, I think there's an immense amount we can learn and glean.

DR. CAPRICE KNAPP: And I heard you say, Dennis, that you were asking that of MACPAC, so I won't answer for them. But lots of lessons. One of the things that really helped set us up nicely; in unwinding we had a special session. We worked with the legislature. We talked to them up front about some of the flexibilities we would need in procurement, in contracting. And someone brought that up earlier, that sometimes procurement is difficult.

And that is one thing. The legislature was also, I think, really fantastic for making sure that we had the preparations that we needed, that we weren't constantly having to come back and ask for additional spending authority.

So again, I think it was not just working within the Medicaid system but also with our partners externally, and making sure that we had alignment there. But Dennis,

asked the staff.

COMMISSIONER DENNIS HEAPHY: I didn't want Kate yelling at me by putting forward this suggestion. That's why I said staff. Kate, don't yell at me for bringing that forward.

CHAIR VERLON JOHNSON: No yelling. No yelling, Dennis. You're good. You're good. All right. Any other Commissioners with questions? We have about four minutes, so I want to make sure that you're able to use that if you need it.

[No response.]

CHAIR VERLON JOHNSON: Okay. And I know we all know where to find both of you. But thank you so much for coming on today. Again, we were looking forward to this conversation, and it definitely gives us what we needed. So thank you, Caprice, thank you, Lindsey, for your time out of your schedules to join us. And also thank you to Melinda and Janice for pulling this all together. We are always appreciative of your efforts too, as well.

With that, we will actually take a quick break, and we will return at 3:15 Eastern time, for some additional Commissioner discussion around community

engagement. So thank you all.

* [Recess.]

CHAIR VERLON JOHNSON: All right. So welcome back everyone.

EXPERT PANEL ON IMPLEMENTING COMMUNITY ENGAGEMENT REQUIREMENTS: ADDITIONAL COMMISSION DISCUSSION

* CHAIR VERLON JOHNSON: After break, we're now going to go into a conversation with our Commissioners on what we heard today during the community engagement discussion. I'll just say I thought it was a very rich discussion. It really gave us a good foundation of what we needed to know in terms of what we thought we needed to consider for our next steps, and so I think as we reflect on today's sessions and what we've heard, let's really think about some of the key themes that we heard from the discussions that really feel most important for the Commission to keep in mind as states move toward implementation.

We also want to think about, like, what are some of the opportunities for MACPAC to add some clarity, to elevate some lessons learned or support states for sure, and then just think about, too, are there any approaches or

insights from the panel that you heard that could help shape future Commission work in this area as well?

So, with that, I'll turn it over to the Commission for their reflections as well. Unless, Melinda or Janice, do you have anything else you want to add as well before we kick it off? Okay. All right. Perfect.

So, Commissioners, the floor is yours to talk. First up, let's see Tim Hill.

COMMISSIONER TIMOTHY HILL: So thanks, Verlon. I thought it was, as you said, a really rich discussion. I'm glad that CMS and folks came, and I think the information that the staff brought up is informative and incredibly helpful.

I can't help, honestly, feeling a little bit of deja vu from some of the previous big, large-scale implementation efforts at CMS around health care, whether it's the ACA or other implementation efforts.

So, in that regard, given our role, right, I like the conversation that we started to have around evaluation and monitoring and understanding how things are going, and I think it would be really good for the staff, for the Commission to be thinking about -- and this kind of gets

to, I think, the question that Mike was asking is -- when are we going to -- like, implementation dates, it's not like there's one implementation date. There's a series of implementation dates, and there's a series of dates that are going to affect people differently.

From a data and monitoring standpoint, what are the things we want to know and when? Right? Is there a roadmap that we can create that says, on January 1st, we need to know this; on April 1st, we need to know that; on May 5th, we need --just a series of milestones that we can know early if things are on track or off track or wobbly.

Obviously, the implementation effort is one between states and the federal government, but from our perspective, to be able to articulate those early warning signs, those early warning evaluation monitoring metrics that we want to see and understand to know if things are going well or not, I think would be time really well spent and something I think we could add a lot of value to in the conversation.

CHAIR VERLON JOHNSON: Thank you, Tim.

I think Adrienne had some similar thoughts too from her past as well when it came to implementation big

projects.

Patti?

COMMISSIONER PATTI KILLINGSWORTH: I'll keep this pretty brief. I do think it's really important that the exempted categories are -- that there's monitoring around that to make sure that that's being implemented consistently and that the requirements aren't being inappropriately applied.

I really liked Lindsey's recommendation that MACPAC could come up with a set of metrics, recommend a set of metrics that could be collected and reported on by all states to measure on an ongoing basis how things are going.

I honestly feel like it's probably a little bit late for that, just because having those designed and baked into systems are so critically important in order to be able to do that reporting with ease, and it's very important that everything is so precisely defined so that everybody's reporting it in the same way. But if it hasn't been done, it needs to be done so that we really do have some agreement on how and make sure that the data is available to really be able to monitor and evaluate.

And then the other thing I would say is that

where states have flexibility, which is great, hopefully, somebody will catalog that, right, so that we can compare the impacts of these various policy decisions that states make on the impact that that has on people being able to both attain and retain eligibility for the program.

CHAIR VERLON JOHNSON: Thank you, Patti.

Dennis and then Mike.

COMMISSIONER DENNIS HEAPHY: Thanks.

For me, the reason I raised that, what we learned from the unwinding, is really are there ways we can actually measure based on what we found in the unwinding, how things are progressing with this new undertaking?

And I guess my own bias is I keep thinking do no harm, and so how do you ensure that they are implementing the work requirements in a way that's going to support folks who are doing the right thing and doing no harm to them and also holding folks accountable that aren't working and aren't doing what they should be doing. But it's like that do no harm piece of it, and how do you measure that? I don't know. But I think for me, the starting place is what we learned from the unwinding.

CHAIR VERLON JOHNSON: Thank you, Dennis.

Mike?

COMMISSIONER MICHAEL NARDONE: Yeah. I was just going to say that I thought that they really seemed to like, Janice and Melinda, your chart on the data points and metrics. It seemed like maybe you had helped -- you know, you maybe were a little bit out ahead in terms of like actually looking at what might be easily collectible versus more challenging to be collected.

I think that kind of finding that right balance, right, between what is the information that you really would like to have and need and would be important to evaluate in the program, without, you know, overwhelming the states as they're trying to, like, implement this new policy, I think is really something that, you know, maybe we can help with.

And I think, you know, your chart that kind of showed, well, here are things that we're already collecting, they're already in the system, they're not a new implementation burden, I think those would be -- you know, I think that that's helpful. And I think kind of keeping kind of the effort around, you know, having a monitoring plan and evaluation plan, I think, would be an

important place for MACPAC to be.

I thought also just a couple of things that I heard from my fellow Commissioners that, you know, I think are worth more exploration is, I think Carolyn's point around consent was one that I think clearly resonated, I thought, in the discussion.

And then also, you know, some of the points around, you know, John and Jami's points around how can we -- you know, how have we been able to use our MCOs and other partners to really do the appropriate -- to do good outreach? And what are kind of some of the lessons learned, and are there things we need to explore to make sure that MCOs can be a good partner in this as they were with the unwinding?

CHAIR VERLON JOHNSON: Thank you, Mike.

John?

COMMISSIONER JOHN McCARTHY: Going back to what Mike was saying a little bit, we had heard, you know, on MCOs and how to engage with them. One of the things we heard at NAMD, Melisa Byrd brought up and the Medicaid director of DC and outgoing president of NAMD had asked everyone there to really get outside of our Medicaid box,

right, and look at the SNAP program, because now they are so intertwined in what's going on between the two.

So, in this new Medicaid world, we have the same issues with people finding jobs, and jobs programs in the states may not be up to snuff, you know, may not be -- they may be overwhelmed. They may be under-resourced, all those other things there. So, again, what can we do to help in those areas through managed care, Medicaid, whatever it is, to help people find jobs in a system that might be broken or not funded correctly or for whatever reason?

I know in Ohio, my issue was -- we had the Ohio Department of Job and Family Services when we were there. There's 88 counties, and they do these things 88 different ways, and some are better than others. And, you know, how do you work through those issues?

I just want to bring up, Verlon, that once again, you know, it's like, what do we need to look at going forward of what laws and rules, changes need to be done so that Medicaid can help people find, you know, any type of community engagement they need, whether it be doing, hopefully, in my opinion, jobs to help support themselves, but whatever that -- you know, whatever that takes on that

one.

CHAIR VERLON JOHNSON: Thank you, John. Good call-out.

Any other Commissioners? Carolyn?

COMMISSIONER CAROLYN INGRAM: Yeah, I think Mike brought this up, so I don't want to belabor it, but the whole issue that is puzzling to me is if Equifax is the only company that, you know, checks payroll stubs and things, because they made deals with those companies that have that information. It's just kind of a no-brainer that we start thinking about consent so that other platforms can be used to check those areas, because then it saves the state's money. It also helps the member, you know, with time.

That's the thing about all the new technologies that's out there. There's a lot of companies now just self-populating applications. So, you don't have to do things the old-fashioned way anymore. So, it just seems kind of like a no-brainer for us to make that recommendation.

It would also help with the ease of texting and email, that type of thing, if there is a general consent on

the application.

All right. I'll pause. Thanks.

CHAIR VERLON JOHNSON: Thank you, Carolyn. Appreciate it.

Adrienne?

COMMISSIONER ADRIENNE McFADDEN: I actually just wanted to say I hope we don't lose sight of Anne's suggestion around the technology laddering up to sort of how we're monitoring for those states that are doing things effectively. I thought that was a particularly prescient sort of recommendation and certainly don't want to lose sight of that as we think about how MACPAC could maybe formulate or help inform some measurement and monitoring frameworks.

CHAIR VERLON JOHNSON: All right. Thank you.

Jami?

COMMISSIONER JAMI SNYDER: Yeah. I'm going to go back to something that I asked about during the panel discussion. Lindsey brought up the idea of the intersection between community engagement requirements and some of the limitations imposed by H.R. 1 around the PERM process, in particular, really limiting states' ability to

use that good-faith waiver process to avoid some of the financial penalties.

I do think it would be worthwhile to look further into the implications, the potential implications for states, and think about what states can do to mitigate risk, understanding that the PERM requirements don't go into place, the new PERM requirements, until 2029, 2030, but they need to be thinking now. States need to be thinking now about, to Lindsey's point, documentation protocols, for instance, so they can avoid penalties when the changes to the PERM process are implemented down the line.

And, you know, I mentioned, too, potential protections that we could offer to states, given that for most states -- not all, but most states -- this is the first time that they will be incorporating community engagement compliance into their eligibility determination and renewal protocols.

CHAIR VERLON JOHNSON: Thank you, Jami. Good point.

Any other Commissioners?

[No response.]

CHAIR VERLON JOHNSON: I'm seeing none. Bob, am I right? Keep me honest. No one else has a hand up?

All right. Okay. So, thank you, Commissioners. I do look forward to future conversations around this topic, for sure.

So, Melinda and Janice, do you have everything you need in terms of your next -- Jami, you have your hand up again or -- okay. All right.

So, do you all have everything you need for your next steps? Is there anything else that you need to ask or clarify?

MELINDA BECKER ROACH: I think we have everything we need. Thank you so much for the robust conversation and the feedback.

CHAIR VERLON JOHNSON: Of course.

JANICE LLANOS-VELAZQUEZ: Thank you.

CHAIR VERLON JOHNSON: Of course, I just saw Mike's hand go up. Mike, are you good, or do you have another question?

COMMISSIONER MICHAEL NARDONE: I'm good. I was trying to thank Melinda and Janice for the great memo and putting together the panel, but instead, I raised my hand.

I was trying to clap.

CHAIR VERLON JOHNSON: He was trying to clap. We'll teach him. We'll teach him technology.

COMMISSIONER MICHAEL NARDONE: Thank you.

CHAIR VERLON JOHNSON: No problem.

But again, thank you all so much. We appreciate it.

Okay. So we have our last session. Now we're going to go and turn our attention to states and federal tools for ensuring accountability of Medicaid and managed care organizations, and so we brought up the slides. We'll bring up the team as well.

I mean, as we all know, managed care continues to play a very central role in Medicaid. The majority of beneficiaries are enrolled in MCOs, of course, and so we really want to make sure we understand everything we can to make sure it's a good experience for all involved. So that, of course, makes oversight, meaningful, actionable oversight very essential for this, and so today's conversations is around the tools associated with making sure that that's happening.

So I'm going to turn it over to Holly and Chris

to facilitate the discussion and the findings, so over to you all.

STATE AND FEDERAL TOOLS FOR ENSURING ACCOUNTABILITY OF MEDICAID MANAGED CARE ORGANIZATIONS (MCOS): INTERVIEW FINDINGS

* HOLLY SALTRELLI: Great. Thank you, Verlon, and good afternoon, Commissioners.

Today Chris and I are going to present an update on our work in managed care accountability, as Verlon mentioned.

Next slide. Thank you.

First, we'll walk through background on Medicaid managed care accountability and provide a reminder of the oversight requirements at both the federal and state level. Next, we will present findings from stakeholder interviews and share our analysis of the Managed Care Program Annual Reports, or MCPARs. Finally, we will discuss next steps and areas where Commissioners may want to consider policy options.

Next slide. Oh, I can do it. Sorry. One back, please. Thank you.

Managed care is the predominant Medicaid delivery

system in most states. Almost three-quarters of Medicaid beneficiaries are enrolled in a comprehensive full-risk managed care organization, or MCO, and managed care capitation payments account for more than half of Medicaid benefit spending in fiscal year 2023.

States contract with the MCOs, selecting them through a competitive procurement called a Request for Proposal, or RFP, or a noncompetitive application process.

MACPAC has done related work on Medicaid managed care oversight in several areas. Our 2022 study on procurement found that CMS defers to state Medicaid agencies to procure MCOs, but opportunities do exist to assist states and MCOs during readiness reviews.

Our study on managed care external quality reviews, or EQRs, resulted in the Commission making three recommendations intended to improve the usability and transparency of EQR findings.

Additionally, we examined the monitoring, oversight, and beneficiary experience of the denials and appeals process. The Commission made seven recommendations that include requiring external medical review of denials, conducting clinical audits of denials, and making denials

and appeals data publicly available.

Continuing the Commission's examination of Medicaid managed care oversight and accountability, last December, MACPAC staff provided the Commission with background on the use of full-risk comprehensive managed care organization contracts, as well as findings from an environmental scan of the types of state accountability tools included in procurement and contracts.

To help remind ourselves of the scope of this work, here are the policy questions we are examining. First, what tools, for example, sanctions or incentives, are available to states to ensure MCOs comply with contract requirements and meet performance expectations? What tools do states actually use, and do states need additional tools? What tools are available to CMS to ensure state managed care programs and their contracted MCOs comply with regulatory requirements and meet performance expectations? And to what extent does CMS use their existing tools, and does CMS need additional tools?

So, first, we will review the federal and state oversight requirements we identified in our initial work. States are primarily in charge of managing their

procurements. Federal requirements are minimal when it comes to procurement. Oversight is limited to conflict of interest safeguards, and verifying contractors are eligible for at-risk contracts.

CMS does have some direct oversight responsibilities. They must approve states' actuarial rate certifications with MCOs, and they must also review and approve state Medicaid agency contracts with MCOs to ensure they include all the requirements specified in federal regulations.

CMS has authority to deny federal match on capitation payments for noncompliance with federal requirements and can deny federal match for new enrollees upon recommendation from the state Medicaid agency.

CMS denial of federal payments for new enrollees does automatically trigger denial of state payments to the MCO for those same enrollees.

Finally, CMS does have authority to independently perform any of the enforcement functions normally assigned to the state under the denial of payment process and may refer such cases to the Office of the Inspector General, which may impose additional civil monetary penalties on the

MCO.

Section 1932(e) of the Social Security Act specifies that states may not enter into contracts with MCOs unless the state has established a process for intermediate sanctions. States must establish intermediate sanctions for specific instances in which the MCO acts or fails to act. However, imposing sanctions is entirely within the state Medicaid agency's discretion. States also have authority to impose additional sanctions under state law or regulation to address noncompliance.

This table shows the intermediate sanctions listed in federal regulations that states can impose on Medicaid MCOs. These options include civil monetary penalties, appointment of temporary management of an MCO, granting enrollees the right to terminate enrollment without cause, suspension of new enrollment, and suspension of payment for enrollees.

The individual reasons for sanctions and the limits are defined in regulations, and I won't read them all here, but in many areas, there are limits on the amount of monetary penalties that can be imposed for each violation, and the limit ranges from $25,000 to $100,000

depending on the violation.

As for incentives, they are limited to 5 percent of the capitation rate. That is, total payment under incentive arrangements may not exceed 105 percent of the capitation rate under actuarial soundness standards. And these incentives must be for a fixed period of time. They cannot renew automatically. They must have similar terms across contractors, and they must align with initiatives under the state's quality strategy.

So, with those requirements in mind, next, we'll present our findings from the stakeholder interviews conducted with the assistance of our contractor.

These are a summary of our findings from 18 stakeholder interviews conducted between December 2024 and May 2025. We interviewed state Medicaid agency officials and MCO representatives from six different states. We also interviewed stakeholders from Medicaid health plan trade associations, relevant federal agencies, and national experts and organizations.

We organized the interviewee feedback into three domains that support MCO accountability: procurement and contract requirements, use of accountability tools, and CMS

oversight and guidance.

Next slide. Thank you.

We heard from our stakeholders that the procurement process provides an early opportunity for states to identify high-performing plans and establish performance expectations. States often use the procurement process to understand past performance of bidding MCOs, reviewing this information to ensure MCOs were compliant with the terms and prior contracts, and to be aware of any issues that bidding MCOs have had.

However, some stakeholders mentioned that state procurement rules can limit how past performance can be used in the procurement process, sometimes prohibiting such information or forbidding the use of publicly available information about MCO performance from other states to validate MCOs self-reports.

Besides using past performance in the bid evaluation process, some states also use this information to proactively monitor for potential performance issues by revising or adding new reporting requirements.

For example, upon learning during the procurement process that one MCO had a prior record of high rates of

service authorization denials, one state created a monthly reporting and monitoring process to track and compare MCO service denials.

All state Medicaid agencies interviewed engaged in regular meetings with MCOs to proactively identify and address performance issues. Both states and MCOs noted that maintaining ongoing communications and relationships is important for addressing and resolving issues before they escalate to formal accountability tools, such as sanctions, when possible.

States vary the use of accountability tools based on the severity and duration of the contract violation or performance issue. To determine which accountability tool is most appropriate, some states rank contract violations and performance issues by severity and how quickly the plan resolves the problem.

All six states interviewed set thresholds that automatically impose a serious penalty, such as a fine or enrollment suspension, for violations or performance issues that have immediate consequences for enrollees.

The interviewed states varied in how and when they impose formal sanctions, and some lacked documented

criteria and policies as to what triggers escalation.

Stakeholders generally preferred incentives over penalties for motivating improvement in MCO performance and behavior change. Many interviewees mentioned that incentives like bonus payments, auto assignment, and capitation withholds were more effective in fostering competition among MCOs to achieve improvement targets.

States do use sanctions, but they can be more challenging to administer. Some interviewees noted that sanctions can be hard to impose because MCOs frequently appeal such enforcement actions, which lengthens the time it takes to resolve the issue.

Additionally, the extent to which state Medicaid agencies use available accountability tools can reflect the priorities of the executive or legislative branch. A few state officials mentioned that MCOs lobbied the state legislature or governor's office to obtain relief from their sanctions.

All state officials, national experts, and federal officials recognize public reporting as a tool to promote transparency and accountability, though states vary in the information released in their reporting methods.

For example, four of the six interviewed states post corrective action plans, or CAPs, and monetary penalties on state websites. The other two publish quality measure performance only. One state official noted that public disclosure often motivates the plans to resolve issues, so public reporting is seen as one of their most effective accountability tools.

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While CMS has broad authority to ensure that state Medicaid managed care programs are structured to be compliant with federal requirements, it has fewer tools to directly address specific MCO deficiencies. CMS can defer federal matching funds only for the entire amount of the capitation payment made to the plan.

In practice, CMS rarely uses this authority because withholding funding for the entire capitation payment can disrupt the financing of all beneficiary care provided through the managed care plan, not just the particular issue that needs to be addressed.

Federal officials noted that CMS lacks some of the oversight tools available in fee-for-service, such as imposing formal CAPs on states or deferring a share of the

federal match for capitation payments in proportion to the severity of noncompliance.

Additionally, while state Medicaid programs have broad authority to manage their MCO procurements within the bounds of state procurement law, some interviewees suggested that CMS has an important role in providing tools and practical information to state Medicaid staff to fully leverage the MCO procurement process.

Several interviewees also suggested that there is an opportunity for CMS to help states by developing a national database of MCO contract violations and sanctions. They noted that CMS and states are already collecting the data, but it is not publicly available in a comprehensive or user-friendly format.

MCPARS do contain information on sanctions, but as we will present next, there are some limitations to what has been reported to date.

Next slide.

To supplement our interview findings, we also analyzed the Managed Care Program Annual Reports, or MCPARs.

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States are required to post MCPARs on their state Medicaid website, and CMS posts MCPARs from states in a central repository on Medicaid.gov. The MCPARs include information on sanctions and CAPs that states imposed on their MCOs the previous year.

For this analysis, we reviewed MCPARs submitted for performance year 2023, which spans from September 2023 through August 2024, from 34 states that were available on Medicaid.gov. Our analysis focused on the types of sanctions, amount of financial penalties, reported reasons for the intervention, and time to remediation.

Overall, we found that the MCPARs echoed interview findings that states are more likely to take intermediary steps, such as CAPs, before levying monetary penalties. Twenty-five different states used CAPs as a tool versus 11 states that reported civil monetary penalties and 10 states with liquidated damages. Only 12 of 359 CAPs, 3.3 percent, had an associated financial penalty. Additionally, the amount of financial sanctions imposed varied, but the most common value reported was less than $5,000.

We categorized the topics reported as reasons for

the intervention and found that average sanction amounts vary by intervention type, with sanctions related to beneficiary rights and communications as the least costly for MCOs.

Additionally, we found that the majority of reported sanctions, close to 55 percent, were remediated within 90 days and only 3 percent took longer than 360 days to resolve. Based on the number and type of sanctions reported in MCPARs for the states examined in this study, it is likely that states are not reporting all sanctions in MCPARs.

For example, Florida did not report liquidated damages as MCPAR sanctions. According to their state's website, Florida's managed care compliance actions totaled $33.8 million in liquidated damages in fiscal year 2023-'24 and one sanction of $2,500. The MCPAR data only includes the one $2,500 sanction and failed to capture the liquidated damages.

The MCPARs are in the first couple years of being reported, so it is possible that these data will improve as states become more accustomed to the reports. However, our initial findings raise questions about the current

usability of such reports to track the actual use of these accountability tools and to provide a full picture of MCO performance.

In summary, stakeholder interviews indicated that states generally have sufficient tools through sanctions and incentives to oversee MCO performance and ensure that plans are meeting performance expectations. Most states take an incremental approach and use regular check-ins to identify and address performance issues before issuing formal sanctions, which may be one reason there are not many sanctions reported on the MCPARS.

Stakeholders generally agreed that incentives and sanctions that have a substantial impact on plan revenue are more effective, such as changes to auto-assignment algorithms.

Additionally, many stakeholders thought that the public reporting of MCO performance, such as information on frequency and type of sanctions, could be a useful tool for oversight and future procurement decisions.

While the existing tools are generally sufficient, some stakeholders suggested there may be opportunities for CMS toolkits or other guidance that could

help states design more effective procurement processes or sanction policies.

Federal officials and national experts commented that CMS does not have the same authority to oversee and address issues in managed care that they do in the fee-for-service program, and they were interested in equalizing the tools across the delivery systems.

Staff would appreciate Commissioner feedback on the interview findings and areas for potential policy options. We outlined some discussion questions here that Verlon will lead us through, and if Commissioners are interested in pursuing policy options, staff will return to present the policy options at the next meeting.

Thank you.

CHAIR VERLON JOHNSON: All right. Thank you so much, Holly. That was very clear and a comprehensive overview and really appreciate that very much.

As Holly indicated, we do have a list of questions that we'd like you to think about as we move forward on further analysis of this area for sure.

So, with that, you'll see that the first one is really about research and really getting some more feedback

about the potential policy options that are there, and let me go ahead and open up for questions for the Commissioners now so they can give us their thoughts.

Sonja?

COMMISSIONER SONJA BJORK: Holly, can you say a little bit more about the reporting gaps? Because, you know, I'm in California. There's a lot of sanctions, and so I know even just in California, for measurement year '23, there was over $3 million worth of sanctions, you know, to 20 different managed care organizations. And so it just doesn't feel like it's reflected properly, and you already acknowledge that. But what do we do? We don't have the right info here. Because when it says there's an average of like $5,000 sanctions, boy, that'd be a great level. You know, there's really so much more going on in sanction land. So how do we get a view of that across the nation? Do you have any ideas about that?

CHRIS PARK: Sure. I'll jump in, Sonja.

So I think that's part of the findings is that people point to MCPAR as a potential way to, you know, have this information made public and have that kind of transparency as to what's going on in a managed care

program, but as you can see, that particularly during these first couple of years of reporting, it doesn't seem like the information is complete. And, you know, we're not sure, particularly what the reasons are. Some of it may be definitional, like Florida didn't consider liquidated damages to be sanctions per se. So they didn't report them, and there's quite a significant amount of liquidated damages in Florida.

Some of it might be particularly, like, when reports are cut and as to what point in time the sanctions are in terms of, you know, if they're being appealed, then should they be reported until, you know -- like, until they're finally resolved. And so we did see, as Holly mentioned, a few of those sanctions, at least with the reported dates on the MCPARs, it took over a year to resolve. So, you know, I think there's some of those -- may be issues potentially.

But, yeah, I think that's part of the findings and the interest in, you know, maybe either through MCPARs or, like, refining them or, like, just trying to get them in better shape to make this a better tool that could be used both by states in procurement so that they have a way

to kind of view plan performance across states as well as, you know, potentially for beneficiaries to be able to use in terms of, like, oh, this plan had a particular issue on provider networks, and maybe, you know, I'd want to think about whether I want to enroll in that plan versus another plan.

COMMISSIONER SONJA BJORK: And I'll just add

HOLLY SALTRELLI: Yes. And these are --

COMMISSIONER SONJA BJORK: Oh, just one sec, Holly.

These are common, you know, when there's a new template or reporting that different entities have different interpretations, and then sometimes there's technical assistance calls or, you know, like, how does clarity or how will clarity on definitions and things like liquidity, things like that? What's the pathway to get everybody on the same page so that the reporting is more accurate?

CHRIS PARK: So, certainly, I think that's where some of the stakeholders, like, thought that CMS could have a bigger role in terms of providing guidance and maybe clear definitions.

And am I frozen?

HOLLY SALTRELLI: No.

COMMISSIONER SONJA BJORK: No, we heard you.

And, Holly, I'm sorry to interrupt you. I didn't mean to cut you off.

HOLLY SALTRELLI: No, I was just going to add to Chris's point about beneficiary use. These are located in individual PDFs deep on the Medicaid.gov website. This isn't like a searchable database that, you know, we think of when we think of the star ratings, for example. This is within a PDF, not even necessarily like anything searchable, and each individual one corresponds to one plan package for that state. So it's not exactly accessible in addition to not collecting necessarily the right data.

CHAIR VERLON JOHNSON: All right. Thank you.

Tim and then Patti.

COMMISSIONER TIMOTHY HILL: Thanks. This is helpful and I think a really good topic for us to keep digging in on. In terms of accountability tools, I just want to iterate, reiterate the need for CMS to have some sort of intermediate financial sanction, right, the fact that the deferrals are broad on the managed care side, it's

very much a nuclear option. It's very hard to target a specific financial accountability tool on a state, given the way that the regs are written. So providing CMS with that authority to defer sets of capitated payments to particular plans I think would be incredibly helpful, like they can on the managed care side.

The other point, and maybe this is a little beyond what you guys were looking at, but I think when we think about compliance and accountability and the measures and the tools that we're using, I would encourage us to continue to think about ways that we can involve beneficiaries in these conversations. I mean, all too often the accountability and compliance tools we use are based on the data that we have, which doesn't always take into account beneficiary experience and understanding about what it's like to interact with a plan. So continuing to push CMS and ourselves to think about how we interact with beneficiaries and collection information from them directly about plan behavior and compliance I think would be important, and I think add a lot to the conversation. Thanks.

CHAIR VERLON JOHNSON: Thank you, Tim. Great

comments. Patti.

COMMISSIONER PATTI KILLINGSWORTH: First of all, with regard to the fact that it's such a small percentage of CAPs ultimately results in some sort of a financial sanction. I think it's a good thing. If we think about sort of progressive sanctions, and you're really starting with identifying an area where corrective action is needed, and you're building in an accountability mechanism, the hope would be that that's sufficient to correct issues without then having to sort of take that next step towards financial sanctions, just trying to sort of put that in context.

As someone who was in a state for a couple of decades, and I think a state that really utilized both incentives and, in particular, sanctions, really, really well, there are many tools available to states. I think that sometimes states lack maybe -- I don't know if I would say capacity, but really in this sense, of sufficient staff, to be able to oversee health plans at the level that we might like, especially in states that have larger numbers of health plans. It really does take a close working relationship to have your finger on the pulse of

what's happening and be able to use those tools well.

I will say, I probably respectfully disagree a bit with my colleague, Tim, on CMS's oversight authorities. See, when I think about how the fee-for-service program is overseen versus the way that states oversee managed care, my guess is there are far more sanctions assessed in managed care than there are in fee-for-service. But that would be an interesting look at data, to actually see how CMS is using the sanction tools that are available to them on the fee-for-service side.

I continue to believe that sort of the order of that relationship is CMS to states, and then states to their health plans, and that CMS has all of the leverage that they need to really oversee states, and states have the tools that they really need to oversee health plans. But I'm certainly open to additional discussions on that, going forward.

And then I would say, too, I completely agree with transparency in data. I would be hesitant to add additional reporting. We have the MCPARs. Let's try to make them what they're sort of intended to be. I do think that very consistent data element requirements is key in

sort of making sure that's clearly communicated, and that that's happening before we think about adding to.

And then I would just caution us in terms of putting things in context. We were a state who tended to assess sanctions more than other states, and our health plans didn't love that because, you know, from their perspective that looked sad on us, when another state might not assess the same sanctions.

Every state sort of approaches oversight differently. I do think it's powerfully important when things are important in a program to be able to build an accountability mechanism and work with health plans to be successful while also holding them accountable for making sure that the program is implemented as the state intends. Thank you.

CHAIR VERLON JOHNSON: Thank you, Patti. John.

COMMISSIONER JOHN MCCARTHY: Just a lot here on this one. This is one of those areas I agree a lot with what Patti said on this one.

It is so complex that just breaking it down to these three areas I think is really hard. You know, I was reading through the memo last night. There's a lot of good

information in there. Some of it is just the fact of you're taking all that information and boiling it down to these three points right here.

I do want to say, should CMS have the same authorities, overseeing the fee-for-service program, the managed care program? Sure. I think many of us would say yeah, that's a good way to go. But then the question becomes, like, what does that mean and what does that look like? And obviously having the ability to do more than just we're going to withhold all payments from a state, you know, that just doesn't work, so it's like what can you do around some of these things?

But I want to hit on this. This program has just kind of started. We're getting information on it. It will lead to new questions, that type of a thing. But I would caution us, as MACPAC, to be jumping forward on things, like helping states or telling them how this should be used in procurement, for a whole bunch of reasons. Some of them include just because a plan is not doing well in one state does not mean that it's doing poorly in your state. So if you're doing a procurement and you're holding that against a plan, and a procurement, like, oh well, you have these

sanctions in this other state, but they're doing great in your state, with no sanctions -- how does that hold up in procurement process, or even court, if you go to court?

Likewise, if you've got a plan that's not in your state, but they do have sanctions in another state, then you would be using that against them. So again, it makes it difficult to look at that.

Also, somebody brought up in there, the implicit information doesn't show up in Stars report. Well, I mean, it probably does in some way, shape, or form in creating the Stars report. So if you have a report card for a state, I'm sure, at some level, like for Ohio, for instance, this information went into creating our report card for the plans. It just you didn't see it. And the reason is because when we showed enrollees the report cards, if you gave them more than like two or three pieces of information, it's just overwhelming. Just like us. Like if I'm looking at buying a policy off the exchange, you can't show me 65 different metrics and expect me to pick from it. People just want to see an A, B, C, D, and not even like by certain areas. They just want to see it overall. So how does that fit into things?

Now, could you make it more transparent? Sure. Everything can be. But there's just so much information here on this one that it makes it tough to use.

So I think it's a great start to some work here, looking at these things. I agree with Sonja. We have to kind of wait to see how this falls out. And again, it's 51 different programs, so I don't know if we necessarily, on this one, need to say, hey, everything has to look exactly the same when it comes to these things, because as Patti said, states do this oversight in different ways. And also, just if you're looking at it, two different programs might have, as you guys know, as Medicaid Director in D.C. and Ohio, you can't have the same dollar amounts for sanctions because the plans are so much smaller or larger. So there's a big issue there, too.

Anyway, a lot of good work. We need to keep moving on this. But I just caution us on some of these areas as we move forward.

CHAIR VERLON JOHNSON: Thank you, John. I just need to ask a question related to what you just mentioned about procurement rules. So Chris and Holly, from your interviews, do states even express interest in having more

flexibility, to use past performance, and if so, do they have different examples of approaches that helped them work within those kinds of procurement rules where they have them? I'm just curious.

CHRIS PARK: I don't think it was like a need for a federal requirement for past performance or anything like that. It was more about like the availability and transparency of data. You know, in certain cases they're relying on the plans to self-report the information, and there could be questions as to whether they're getting complete information on what that would be. Or it's a burdensome process and so if that information is already available in MCPAR maybe you don't need to go through that information. Or ones they got something differently than another state, so there may be some state variation there, like on the MCPAR, that could be useful.

To John's point, I think there is also variability in how states use the past performance. You know, often it was assigned some points, but we heard from states that wasn't like the deciding factor. So it was just one part of a broader set of considerations as they were making their bidding decisions. There was some

recognition, particularly for new entrants in the state, like how does that compare to the incumbents and how do you evaluate them consistently and appropriately with the past performance?

So I don't think there was necessarily a need to require past performance in the procurement. For the most part, the procurement process is handled by the state. It's just having more information readily available that could be used to the states that want to use that information.

CHAIR VERLON JOHNSON: All right, great. Thank you. Mike.

COMMISSIONER MICHAEL NARDONE: Thanks. Thanks for this analysis. I mean, I think I tend to agree with the comments made previously around, let's look at MCPARs and see how can we make it better. You know, we're already collecting this data. It sounds like it's a little sporadic, not fully fleshed out, in certain aspects. And maybe part of this is, rather than kind of thinking about a new tool or seeing if we can make what we have better, to provide the information that we need to kind of assess managed care.

I also was wondering about where QRS systems kind of fit into this, in terms of, you know, that's another thing coming down the pike around managed care. That will help to assess the quality of Medicaid services. So I wonder if we don't have kind of the tools in place, and our goal really needs to be making sure that those are providing the type of information that we need on managed care plans to make sure they're doing the jobs that they should be doing.

I would say that one of the thoughts, as I was thinking about this, it's also important to kind of keep in mind to the extent that we're assessing the performance of plans, that there are differences based on the populations that are served. So if you're looking at an MLTSS plan, you might have different quality goals that you might like to see. So I think maybe it's a little off topic, but it does feel like if you are doing an assessment of how managed care is working you need to take into account what is the population that's being served and what are some of the differences, in terms of the population being served.

I do think that there is some additional work, as Tim and others have mentioned, around the sanction

authority at CMS. You know, I was in the role of being in charge of managed care at CMCS, and we did have situations where we had to face a situation where we felt that we would like to assess a financial penalty, but the size of it, it was a nuclear option, and it was a bridge too far. So having some sort of intermediate authority would have been helpful in those instances. But I think Patti and John make a good point as to you want to make sure it's kind of consistent with what you see on the fee-for-service side.

And along the lines of kind of using tools that are already in place and making sure that they're achieving the job, one of the things that CMS does do is, in addition to oversight of actuarial soundness, it also is reviewing contract terms for all the MCO contracts. And I think that's been somewhat of a more rote process, and I wonder if there are things that can be built into that process that, as CMS is reviewing contracts that they could have some input on achieving the goals that we're trying to achieve in those contracts.

CHAIR VERLON JOHNSON: Thank you, Mike. Chris or Holly, anything else related to Mike's comments at all.

All right, okay. Dennis, you're up next.

COMMISSIONER DENNIS HEAPHY: Thanks. I've been involved with Medicare Advantage procurements, looking at the model of care, and really diving deep into that model and assessing the quality of it. And even though with the consumer engagement folks, it's not binding. It can affect how the contracts are written. So I just share that. It's been frustrating having been on a couple of those committees that you can see past performance, and know that past performance does not match with what they're presenting in the proposal, but you're not allowed to use that information.

It's also frustrating when, if a plan that's presenting, let's say, utilization management strategy, and you know that in other states the utilization management strategy leads to reduced access to services because it's just out there. The information is out there.

So I think there is merit to looking at past performance and looking at performance in other states, if not performance itself, looking at what's underlying the performance, like what led to the sanctions, what led to the low quality measure ratings.

And the other piece, going back to what Tim said in the beginning -- and thanks, Tim -- is providing people with the information they need to make decisions about which plan they join. And you can do it very simply. Like for an LTSS plan, what are the approvals? What are the denials? What approvals are overturned and which ones are upheld? So I do think that's really important, like what are those categories that are important to people, so they can make a decision. And the Star ratings doesn't include HCBS and LTSS services, so consumers need something to augment what's lacking in the Star rating system.

I appreciate everything that was in here, and I think that the engagement with consumers, beneficiaries at the start, at the lower level, like more base levels, can actually lead to reduced need for MCPAR insufficiency reporting.

CHAIR VERLON JOHNSON: Thank you, Dennis. I see April.

COMMISSIONER APRIL HARTMAN: I would also encourage talking to providers, and the reason for that is looking at some of this data that's out there is really not representative of what we experience. For instance, one of

the biggest things is access. And the way it works is as a provider, I've split my time between three different clinics, what happen is because the managed care plans have to assign a primary care provider to each member, they're going to assign a certain number of people to me at each practice that I go to, regardless of how much time I spend there, or even if I'm capable of seeing that number of patients.

So what happens is you get a bunch of patients assigned to you. Then can check their box saying that they provided access as a primary care provider. But in reality, there is not someone there that has the capacity to take care of those members.

So when I'm looking at this data that's out there and they're checking the box saying, yes, we have met this within a certain number of miles, there's access, in reality it's a lot different. So also taking into consideration the fact that a lot of providers are part-time or work at multiple practices. Like a lot of things, the number of patients that get assigned to us is sometimes just -- we can't handle it. We can't see that many people.

CHAIR VERLON JOHNSON: Thank you, April. That's

a good perspective and I'm glad you were able to share that with us, for us. Are there any other Commissioners that have additional thoughts or questions? John.

COMMISSIONER JOHN MCCARTHY: I just want to clarify some things from my statement before. I'm not saying that this information shouldn't be used to look at past performance. I think Dennis had said something to the effect if like, well, I should be. It should be for that plan in that state, because obviously if you're an underperforming plan it should be used in a procurement for that plan. Where it could be difficult is where you're looking at that past performance in another state, and if you've got conflicting information, as in your state your plan is doing well, you don't have any sanctions, and things are good, but in another state they have poor performance. When you're using that in a procurement it's difficult to score that.

So I just want to make clear that this is good information, and it can be used, and it should be used in the state. Like I used it in Ohio and D.C. It's just how do you use it is. I was reacting to our bullets on this page, along with some of the things that were said earlier,

of how can we tell states to use this. And I'm saying I don't know if we should be just telling states to use this, because there are so many nuances in there. I just wanted to get a clarification on that.

CHAIR VERLON JOHNSON: Thanks, John, for that clarification. Any other comments? Okay, we have Mike.

COMMISSIONER MICHAEL NARDONE: I was just going to ask, one of the recommendations or one of the questions was around providing additional information to states around procurement processes or sanction policies. And I'm just wondering, was that a recommendation or something that came out of state stakeholders? The reason I'm asking is because so much of that is state-specific. The procurement process is a more centralized function, and they kind of are in their own space, outside the Medicaid space. And so I'm just wondering, was that something that states recommended, or was it just, you know, kind of a question that you are raising based on some of the conversations with other stakeholders?

CHRIS PARK: Yeah, it's --

CHAIR VERLON JOHNSON: Go ahead, Chris.

CHRIS PARK: Okay. I was going to say, it's a

little bit of both, in the sense that we did hear from a few state interviewees about it would be nice to have a little bit of guidance, I think, in terms of almost like, or toolkits, almost like best practices of this is how some states have designed an effective procurement process, particularly around thinking about the past performance and things like that.

I don't think there's any suggestion that certain things should be required, because there is a recognition that this is largely in the state's purview to control their procurement process, and a lot of it is subject to state laws and regulations. But if there were federal guidance or toolkits, there might be places where states would want to change their own procurement laws to kind of maybe fit into some of these suggestions.

And then we also kind of mentioned sanctions policies, and there are a couple of statements from the states, particularly on the appeals process, and if there is any clarification or guidance as to what maybe states would be allowed to do in terms of structuring what the appeals process looks like when a plan appeals a sanction. They thought that would be helpful, as well.

COMMISSIONER MICHAEL NARDONE: Thanks.

CHAIR VERLON JOHNSON: Thank you. All right, so one last call for Commissioners.

[No response.]

CHAIR VERLON JOHNSON: Okay. Well, hearing none I want to thank the Commissioners for your thoughtful reflections, and also very much thankful to Holly and Chris for the excellent work and the presentation. And Chris and Holly, do you have everything you need in terms of your next steps from us?

HOLLY SALTRELLI: Yes. Thank you very much for your time.

CHAIR VERLON JOHNSON: All right. Thank you so much.

CHAIR VERLON JOHNSON: All right, this is our final session, we will now open the floor for public comments. In order to do that we are inviting people in the audience to raise your hand if you would like to offer a comment. Please make sure you introduce yourself and the organization you represent. And we do ask that you keep your comments to three minutes or less.

[Pause.]

CHAIR VERLON JOHNSON: We have two. All right.

So, Arvind, your mic is now open to comment. Arvind?

PUBLIC COMMENT

* DR. ARVIND GOYAL: Can you hear me all right?

CHAIR VERLON JOHNSON: We can hear you now.

DR. ARVIND GOYAL: Thank you, Madam Chair, for the opportunity and thank you Commissioners and staff for your excellent work on this topic as well as many others that you constantly discuss and hopefully improve.

I want to say that there are probably good people on both sides, both sides meaning the government as well as the Medicaid agency and the MCOs. However, all of us have been in various schools and I've never been promoted without some sort of a quiz, some sort of a test, some sort of a performance evaluation. And I think that should be a minimum when we are trying to serve people who are really, really vulnerable, and I say that for each state, not just my state in Illinois.

I am the medical director for Medicaid program in Illinois, and previously, a few years ago, I served as Chair of the National Medicaid Medical Directors Group.

So I would suggest that there'd be some sort of a national metric for evaluation, frequency to be defined based on your recommendation to a CMCS, and I would include the basic queries that should be made of managed care organizations, the network adequacy, care coordination, care management, case management, the claim processing. Somebody mentioned earlier, satisfaction by population served as well as the provider's complaints, the MLR ratios and so on.

And I think that if it was prescribed, if it was required, it will increase the accountability. It will increase the quality of the work, and it will be measurable. If you don't measure it, you just assume that everybody's performing as expected. So I would suggest a toolbox with metrics defined at a national level and then you get a report that can be compared, can be looked at and can be improved.

Thank you very kindly.

CHAIR VERLON JOHNSON: Thank you very much. Always good to hear from you.

Next up, we have Tricia Brooks, our former MACPAC Commissioner. It will be good to hear your voice, Tricia.

TRICIA BROOKS: Well, I missed you all, and I wish I was there to have this conversation and be not limited to three minutes.

But I want to comment on two specific things. One is that there's been a lot of chatter about more specific details on work reporting requirements that were shared with states at NAMD, and it's a slide deck. And we would really like to call upon CMS to be true to what the Secretary has said about radical transparency. Where are those slides? Because there are details in there that I think the stakeholder community really needs as in the same timeline that states are getting it.

The second piece I want to talk about is the data. I think we set some measures up for unwinding that lend themselves to further granularity for work reporting requirements.

So, for example, we would want to know of those who suggest that they report that they're working, how many ex parte reviews confirm that, right, versus how many times did people have to send in information? And you need that on not only when you're reporting work, but if you're reporting an exemption, if you're reporting community

engagement or education, we need that granularity on each of those.

But I think there are some other ways to evaluate. Obviously, we can watch enrollment in the Section 8 group as it begins to drop.

But I certainly hope that CMS will come out with data requirements. I don't think they need a law. We know that under unwinding, the Consolidated Appropriations Act reinforced what CMS was saying states needed to report, and they attached a financial penalty to that. And they required CMS to report the data. I don't think CMS needs that authority individually for this, because they have all of that in the approval of the enhanced funding for systems. So I think it's really important that that get built in. It's a statutory and regulatory requirement that these systems be able to produce the transaction data and the performance indicator data that's necessary to monitor the program.

So thanks a lot, and I am more than happy to share more of my details on my data wish list with staff.

CHAIR VERLON JOHNSON: That would be great. Thank you, Tricia.

Any other comments? Give it one second.

[No response.]

CHAIR VERLON JOHNSON: Looks like none.

Okay. So thank you for the comments we did receive. I do want to remind you that if you do have additional comments that you think of after this meeting, you can feel free to submit that to the MACPAC website.

So, as that was our last session and we did the comment period, I do want to now thank you, thank the Commissioners, the staff, and everyone who joined us today, and as we close out the year, I do wish you all a warm and peaceful holiday season. I want you all to take good care, enjoy time with your families, and we look forward to seeing you all at our January meeting.

This meeting is now adjourned.

* [Whereupon, at 4:26 p.m., the meeting was adjourned.]