PUBLIC MEETING

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COMMISSIONERS PRESENT:

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

KATHERINE MASSEY, MPA, Executive Director

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P R O C E E D I N G S

[1:32 p.m.]

CHAIR BELLA: Okay. Kate, I think we'll go ahead and get started, if that works for you.

I'll just make a few introductory remarks. I want to welcome everyone to a special session of MACPAC. Our charge is we have three groups who we are responsible for advising or making recommendations to, those being Congress, the states, and the administration, and all three are busy working on any number of things related to the PHE.

Because MACPAC had a little bit of a break in our schedule, yet things were moving quickly on the PHE front, we decided to take this opportunity to have a virtual meeting to sort of take stock of where everything is and to help inform our work going into the fall. And so today's focus is on the public health emergency, unwinding activities by states and others, and so we're going to start off with a presentation by Martha and then have some Commissioner discussion and leave time for public comment at the end.

Kate, would you like to add anything?

MS. MASSEY: No. That was a great intro. Thanks, Melanie.

CHAIR BELLA: Okay. Martha, welcome, and take it away.

MEDICAID AND THE PUBLIC HEALTH EMERGENCY (PHE)

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

As part of MACPAC's ongoing monitoring of the public health emergency, or PHE, we're here today to provide a brief update on where things stand. The Commission has been closely following CMS and state preparations for unwinding the continuous coverage requirements, particularly focused on the potential risk for eligible individuals inappropriately losing coverage, as well as state administrative capacity given the magnitude of the task ahead.

Given the uncertainty of the timing of the end of the PHE, the potential fiscal implications for states when the enhanced FMAP ends, and the fluidity of the pandemic and economic situations, we did some further research over the summer, including speaking directly to some states, and are updating you today on what we've learned.

So I'll begin with some quick background before discussing enrollment growth and fiscal implications associated with the PHE and then provide a state update before concluding with next steps and turning it over for Commission discussion.

The Families First Coronavirus Virus Response Act provided states with a temporary 6.2 percentage point increase in the FMAP if they met certain conditions, including a continuous enrollment requirement for most Medicaid beneficiaries who were enrolled in the program as of or after March 18th, 2020.

The PHE remains in effect until at least October 13th, 2022, but once the PHE ends, states will resume the process of the redeterminations and terminating coverage for ineligible people. Given that the administration has promised 60 days advanced notice, we should know in mid-August whether or not unwinding will commence in the fall.

Federal and state Medicaid officials have been planning for the resumption of redeterminations for some time. CMS has released guidance and a number of resources for states and is continuing to provide ongoing technical assistance. CMS is also holding monthly calls to help

advocates, beneficiaries, and other stakeholders prepare for the unwinding and held one just earlier today.

States have also been taking steps to prepare for the resumption of normal redeterminations, including considering the timeline for unwinding, communicating with beneficiaries, addressing staffing constraints, and facilitating transition between coverage sources.

Policymakers, state and federal Medicaid officials, and beneficiary advocates have all raised concerns regarding the return to routine operations given the number of redeterminations to process. Moreover, the uncertainty about when the PHE will end has made it unclear when this process will begin.

So stepping back to provide a bit of context for these areas of concern, between February 2020 and February 2022, enrollment in Medicaid and CHIP increased by 24 percent. Estimates suggest the vast majority of this increased enrollment was due to the continuous coverage requirement. Given the growth in enrollment, the volume of redeterminations states must undertake is substantial. Furthermore, while extending the PHE allows for additional preparation and beneficiary outreach, it also means

enrollment will likely continue to grow, further increasing the number of redeterminations that states have to process.

The number of individuals who will disenroll at the end of the PHE is highly uncertain, with estimates ranging from 5 to 14 million. What happens depends on state processes, enrollee responses to inquiries related to renewing coverage, and how long the PHE lasts.

Many of these individuals may be eligible for other sources of coverage. For example, one study found that of the children losing Medicaid, almost 60 percent would be eligible for CHIP, and an additional 10 percent would be eligible for premium tax credits on the exchange. However, whether they will be connected to coverage and successfully enroll is unknown and may depend on states' ability to facilitate these transitions.

The enhanced FMAP was intended to offset the state cost of maintaining coverage during the PHE, and to date, this has been the case. According to a recent analysis, looking at fiscal years 2020 through 2022, states will have received approximately $100.4 billion due to the enhanced FMAP, more than twice the state spending on increased enrollment. However, the share of state spending

that is covered by the increased FMAP ranges widely across states, about equaling additional spending in New Hampshire, Nevada, and Colorado, compared to roughly six times the amount of additional spending in Alabama and Mississippi.

In response to the large anticipated revenue declines at the beginning of the pandemic, the enhanced FMAP was also designed to provide some fiscal relief to states beyond the cost of the continuous coverage provisions. However, the pandemic-induced downturn lasted just a few months, and in fiscal year 2022, no states were reporting midyear budget cuts due to revenue shortfalls, and almost half reported midyear spending increases. State revenues have also continued to perform better than expected earlier in the pandemic, and state rainy day funds have continued to grow. Additionally, in fiscal year 2023, governors in 30 states are proposing decreases in taxes.

At the end of the PHE, state Medicaid agencies project enrollment and total spending growth will decline or slow. They also project that state's share of Medicaid spending will increase with the end of the enhanced FMAP.

So, during prior Commission meeting discussions

and through other research, several concerns regarding the timing of the end of the PHE, the continuous coverage requirement, and the enhanced FMAP have emerged. So to investigate these concerns, staff reviewed prior work and conducted interviews in five states and with a national advocate to hear directly about the steps they are taking to unwind the public health emergency and their concerns. These states represent a range of criteria specific to the unwinding, such as the timeline, as well as geographic and political diversity but may not be representative of all states' experiences.

Some have expressed concern that the uncertainty of when the PHE will end hampers states' ability to plan for the end of the continue coverage requirement. The states we spoke with noted that they have had the time needed to develop a plan for resuming redeterminations and that they feel prepared to begin the unwinding. Most of the states noted that they have continued to process cases during the PHE, although have not been terminating coverage, which is consistent with CMS guidance and other research and will likely alleviate some of the backlog once the PHE ends.

A number of states we spoke with described using the time during the PHE to implement broader changes to the renewal process. For example, one state put in place a streamlined renewal package and modernized the online portal. Another state described IT system upgrades to increase the number ex parte renewals.

The advocate noted the potential for coverage losses and that their primary concern is ensuring as smooth an unwinding as possible. The advocate also noted that some states are better positioned to process renewals, given their systems and staffing, but that the unwinding will likely be challenging for all states.

Many states reported that they have been working with plans, providers, and community-based organizations to inform beneficiaries about the unwinding and to update contact information. States have also shared their unwinding approach during stakeholder meetings and posted presentation slides.

Some states have or plan to publicly post their full unwinding plans, but it's unknown how many states ultimately will do so or when.

Others have noted that the uncertainty of the end

of the PHE affects states' ability to notify beneficiaries and engage community partners. For example, providing notice to beneficiaries regarding the end of PHE is complicated by the lack of a clear timeline. One state official noted that continually notifying beneficiaries of the upcoming unwinding when they do not need to take immediate action may desensitize them to the situation. Some states and the advocate noted that starting and stopping preparations if the date shifts consume state resources.

So there are several factors that make it difficult to predict the end of the PHE. The nature of the COVID pandemic has changed over time with fluctuations in cases, illnesses, and deaths hitting various parts of the country at different times. With the advent of vaccines and new treatments, the severity of the pandemic has subsided in many locations, but uncertainty remains with the emergence of new variants and the relaxation of most public health measures such as indoor masking.

There are also many policies that are tied to the end of the PHE. For example, the optional eligibility group for COVID testing and treatment ends with the end of

the PHE as do the Section 1135 blanket waivers for providers.

Some have discussed that decoupling the continuous coverage and FMAP provisions from the PHE writ large could allow for addressing the uncertainty without affecting other policies tied to the PHE. For example, one state noted that decoupling would allow them to begin processing renewals but would allow some provider waivers to continue.

Some have suggested that HHS provide more advanced notice beyond the promised 60 days to give states additional time to prepare. For example, in a February 2022 letter, the National Association of Medicaid Directors along with Medicaid plan and provider groups requested 120-day advance notice prior to the end of the continuous coverage requirements and the enhanced FMAP. Others have suggested having a date certain for the end of the continuous coverage and enhanced FMAP provisions would allow states and other stakeholders to prepare for the unwinding with a more concrete operational timeline.

In our conversations with states, they did not endorse the need for additional advanced notice. Several

states noted specifically that 60 days was sufficient to start the process and what they had been planning on receiving. If they were given additional notice, there might be other activities they might pursue. For example, one state noted that there are other changes related to the eligibility and enrollment system such as reinstating batch processing runs that were caused during the PHE. One state noted that 90 days would be preferred, but it could work with 60.

States we spoke with had mixed views on the usefulness of having a date certain. Some of the states and advocates we spoke with agreed that the repetitive "hurry up and wait" is wearing on everyone, and that having a date certain would be helpful for creating a sense of urgency for state staff, beneficiaries, and other stakeholders.

One state also commented that having a date certain may help with hiring temporary staff. However, this sentiment was not universally shared.

States may be in different places when it comes to their preparations for the unwinding and have varying needs in terms of notice and certainty. It may also be the

case that the extended time period over which the PHE has lasted has provided states with enough time for preparation.

States also noted in our conversations that the extensive guidance, tools, and technical assistance from CMS has been useful in their planning.

The FMAP increase is available through the end of the quarter in which the PHE ends. At the end of the PHE, states must complete redeterminations for all individuals within 14 months and must initiate all renewals within 12. The majority of states have indicated that they will take the full time and, therefore, will be processing redeterminations and covering some ineligible people at their regular matching rate for at least 10 months.

Concerns regarding the fiscal implication for states of these provisions have been raised by Commissioners, states, and beneficiary advocates. For example, at our October 2020 meeting, two state officials noted that consideration should be given to continuing the enhanced FMAP until states can get through their renewals. At the time, state revenues were down, and states were facing fiscal pressures to move quickly through

redeterminations.

So approaches for addressing the misalignment have focused on extending FMAP over the unwinding period, either at the full 6.2 percentage point increase or in a step-down fashion. States we spoke with said that their budget situations were not currently dire and that financing was not a driver in their decision making for their unwinding strategy. While several of the states we spoke with also noted that extending the FMAP may be useful to stave off pressure to work through the caseloads quickly, they were not concerned about this in their own state.

Similarly, the advocate we spoke with noted that states could use the end of the enhanced match as a reason to accelerate the process. However, they had not seen any information or analysis from states making such an argument.

Several states noted that the timing of the end of the enhanced FMAP would be important. For example, two states noted that ending the PHE early in the quarter would allow for the maximum amount of time for the enhanced FMAP to be available. Another state noted that knowing when the

FMAP would end in advance of their legislative session would allow the state to budget accordingly.

The states we spoke to did not view an extension of the time frame for the FMAP as necessary. States also acknowledged that other states may face fiscal constraints and have different needs. For example, one state noted that they were not "in the red," but also that others may be facing different fiscal situations, and extending the FMAP period or stepping it down may be the "equitable thing to do."

It may also be the case that if the broader economic conditions change and the PHE continues, state budget health and the need for continued relief may change.

As it cannot be known at this time how the resumption of routine redeterminations will actually play out, ongoing transparency in state operations and monitoring implementation and data will be important to understand the effects of unwinding. Staff will continue to monitor CMS and state actions and provide updates in anticipation of potential start to unwinding in the fall.

And with that, I will turn it back to you for discussion.

CHAIR BELLA: Martha, thank you. As always, you did a great job walking us through this and putting together all this information for us.

Just a couple comments to kick us off. I think that we went into this thinking we might hear calls for more time or a date certain or more money or glide paths or any number of those things, and I want to be careful to say that we are not suggesting that the group of states we spoke with is representative of all states, but there was pretty common -- pretty common themes coming from the states we did speak with, that perhaps those aren't the areas of the greatest need.

And things move quickly in this arena, right? And everybody has fatigue from this. So I think for the Commission, certainly welcome the conversation around those things but also would like to suggest that perhaps we start talking about what post-redetermination world looks like and we sort of thread the needle for what we want to be talking about in the fall as we have opportunities to continue to address this issue. And some of those things might refer to some administrative procedures that states have. Like, how are states doing on ex parte, for example?

How are we looking at transitions if we know there are people who can be transitioned to CHIP or to the marketplace? How will we know if those transitions are working smoothly, and how do we think about what's going to be reasonable and appropriate in terms of data and transparency, recognizing that there is going to be a lag in some of what we know and when we know it?

But if, ultimately, the Commission's responsibility is to ensure access for beneficiaries, like how are we thinking about that going forward? And it may be that we have a greater chance to make an impact thinking about kind of turning our attention to what happens once these restart.

Again, we have this opportunity to talk about any number of things, including those that Martha mentioned and including those that we want to tee up for our upcoming work cycle.

So, with that, I am going to open it up for Commissioner comment. Who would like to kick us off? Tricia?

COMMISSIONER BROOKS: Thank you, Melanie. Thanks, Martha. This is helpful and interesting,

considering how the conversation has evolved since the last time we were all together.

So I want to talk about two things. The first is transparency in the state planning process as well as in the data. I mean, eventually, when we look back on this a year after it's done, we'll have a lot of data that will tell us what happened. The problem is we're not necessarily going to be able to access that data in current time in order to hit the pause button if too many people are losing coverage for procedural reasons, and so I'm very worried about this as yet CMS has not committed to releasing the data that they will be collecting from states either in the renewal distribution report or in the data that they're collecting in addition to the ongoing performance indicator data that's been collected since 2014.

So, you know, they believe, they understand that transparency is important, and they certainly are encouraging the states to be transparent, but I think transparency has to occur at both the federal and the state level. And more needs to be done for data to be released in real time so that there is an opportunity to take action

before too much damage is done.

The second point I want to make is in regard to the great work that the Commission staff did on the churn analysis, and I've just recently gone back to that for a couple of presentations.

In 2018, only 4 percent of people losing Medicaid transitioned to the marketplace, and 70 percent of them had a gap in coverage. Now, that was before we had enhanced premium tax credits, but that's a dismal -- a dismal statistic to look back on, and therefore, I think more needs to be looked into as to how proactive states or the federal government can be using navigators and certified application counselors to proactively reach out to people as they're losing coverage to help them transition to other options that may be available to them, and those other options often involve CHIP for children. The majority of children will remain eligible for CHIP, and yet the MACPAC churn analysis shows that there are also gaps in transitions between going from Medicaid to CHIP and from CHIP to Medicaid. So I think we have to think out of the box a little bit about how we get real-time consumer assistance to folks that are losing Medicaid.

Thank you.

CHAIR BELLA: Thank you, Tricia. Darin?

COMMISSIONER GORDON: I have not raised my hand. I am still thinking about what my comments are, so just give me a minute. Sorry.

CHAIR BELLA: Martha, go ahead.

MS. HEBERLEIN: Okay. I just wanted to follow up with Tricia. I didn't mention this, but we did ask each of the states we spoke with whether or not they were going to make their plans public and whether or not they were going to release data publicly, and they all noted that they were planning on that but the timing was unclear at this point. And in terms of the data, they weren't sure whether or not it would be the full CMS required dataset. They did say that they were ready to submit that to CMS. But whether or not they were going to post those data specifically on their website or if it was going to be a subset or a dashboard or something else, they were still just in discussions within their state about that. But they all had plans to post both their plans and their data publicly. So I just wanted to reply to that.

CHAIR BELLA: Tricia, is it on this?

COMMISSIONER BROOKS: Just a follow-up there, because, quite frankly, there are three or four pieces of data that I think that are most revealing. The first is called center statistics, which are the canary in the coal mine. If people aren't able to get through, to get assistance, that is certainly a big problem.

The second is the share of renewals that ended in a procedural disenrollment, because those are the folks we don't know if they are eligible or not. And given any number of challenges, you know, that piece of information could be a trigger, if you will, for, okay, it's time to slow down the process and take a look at what's going on and what more a state might do to encourage or to increase their response times.

You can do some proxy stuff with enrollment data, but you are not necessarily going to arrive at the same kind of precision that you would if you had the datapoints that I mentioned previously.

I don't think we have to advocate for every performance indicator or every piece of renewal data that is on the new reporting form, but I think there are some critical data that are desperately needed for us to assess

the impact.

CHAIR BELLA: Thank you, Tricia. Rhonda?

COMMISSIONER MEDOWS: I just wanted to add my two cents in. I really would love to be able to focus solely on the impacts to the beneficiaries, to the people who are dependent on this care, but I also think that we need to continue to track what is happening in the states we did not talk to. If they fail the transition to move away then we will have people impacted in ways that we can only imagine. I just think that if we are not able to get input from other state Medicaid programs, aside from the ones who have already spoken with us, then perhaps we can get some information from them, and if there is a change, if they are seeing something that is happening. Because I think that is part of our responsibility to anticipate what is going to happen in those states and what is going to happen to those beneficiaries. Just my two cents.

CHAIR BELLA: Thank you, Rhonda.

Kate, did you want to say anything to that?

EXECUTIVE DIRECTOR MASSEY: Sure. So as Martha had highlighted in her next steps, MACPAC's plan for the duration of the summer, going into the fall meeting

schedule, is to continue to monitor all publicly available and transparent plans for PHE unwind as well as to continue conversations with states -- Rhonda, to your point that we have not already spoken with -- as well as beneficiary advocates. And we plan to have another PHE unwind-focused conversation for the September meeting, to make sure that our focus on these activities persists.

CHAIR BELLA: Thanks, Kate. I think you are also in close touch with NAMD, so that's a good point as well. Darin?

COMMISSIONER GORDON: Thanks. Yeah, I think as you all have pointed out well, there is just a wide range of where states are on the different issues that are out there so it's hard to think about a uniform policy that would address everyone's needs.

But one thing that I've heard, and I know you have probably heard as well, is this continued desire for reducing this FMAP cliff dynamic that exists currently, as it is currently structured. You know, and I've heard that where -- and I lived it, actually, in a state -- when you have that added financial pressure with that FMAP going away and you have rolls at an all-time high and you're

trying to get through that process, there is just going to be some added pressure on those states to get through that, maybe at a pace faster than they would otherwise. Clearly, I think everyone wants to make sure that they come back into compliance at some point, but I think there are different perspectives on how quickly a state feels they can get there, some quicker than others.

So, you know, I would like some -- and maybe, Martha, you can just give some of the perspective from your conversations -- I would like us to think about making a recommendation around a phase-down, you know, to have a slope. I don't know what the right time period is. I heard from states it was, you know, over a year. I've heard some say even six months would allow for a more smooth, orderly transition. But I would love to get your thoughts, just from the conversations you all have had, and your perspective on that idea.

MS. HEBERLEIN: Sure. You know, I think nobody is going to turn down money, is how I would start with that, and I think that states, to varying degrees, felt like it would be helpful for budgetary reasons. One state we spoke to noted that they had sort of planned ahead and

knew what was going to happen to their budget, and so they put it in a lockbox, for lack of a better word. So they're like, "We can use that money for something else." So that was one state's perspective.

Another state was thinking about what they could ask their legislature for going forward, in anticipation of the FMAP going away.

You know, I think that the timing of it was what was most important, and I think the way that the current PHE renewal schedule falls out is those renewals happen at the beginning of a quarter, and I think that would give states the most FMAP time. And there was one state that noted specifically that if they got that one full quarter, then they could cover the caseload for the rest of the year.

So I think you are right. It totally depends on states and their fiscal health, how they budget, what their budget timeline is. So I think the phase-down or the extended FMAP for the duration is something that we could give some more thought to, or you could give some more thought to.

I think the other thing that we have noted in the

past, specifically in the CHIP discussion, was that cliffs are generally bad and that providing a ramp-down, that was part of the discussion in the CHIP reauthorization debate a number of years ago. So there is a precedent for the Commission looking at that and you could recommend that. So we can definitely do more work.

COMMISSIONER GORDON: One other area -- and that is helpful -- one other area. I have heard some discussion around the, was it the 12 months or the 14 months to come back into compliance, on reverification. So you have like the financial pressure that we talked about with FMAP going away, and then you also have that time frame. Again, I believe states are well intentioned. They want to get through that process in an orderly and as quick a time frame as they possibly can.

But I also have heard some states feeling that that 12 months was tight. And again, I am not, by any means, suggesting it was the majority of states or it was half the states, but I have heard that in my daily job.

So I would be curious. Have you heard any discussion or have you had any sense that that compliance window could be extended a little bit larger, again, for

the state who feels they have the fiscal ability to do so or they have the need, you know, they feel the need to maybe take, even if it's just one quarter more? I am just trying to understand what the flexibility is there.

MS. HEBERLEIN: We did not hear that in the states we spoke with. When they described their plans a couple of them noted that they were sticking with the original renewal date for individuals. And so if somebody is supposed to be renewed every 12 months, that original renewal date is sort of a natural way, an existing way to spread out the work over the 12-month period. There were other states that were taking different approaches to renewals, you know, starting with folks that they hadn't heard from and focused on that population. Other states were thinking about a risk-based approach that took into account individuals' care needs and those services that they were using.

So there were definitely different approaches by the states we spoke to, and I think, as Kate said, we have been trying to pull down plans and PowerPoints and other presentations that states have been putting out about their plans. But the states we spoke to didn't speak to needing

an extended period beyond the 12 months. Some thought they would be through the bulk of their renewals in a 9-month period, but that there would still be some folks that they hadn't been able to get in touch with over a longer period of time.

So I think it really depends upon the states' plans and whether or not, as most of the states we spoke to, have already been processing renewals during the time period, so pushing people out if they were still eligible. So I think they had a fairly good sense of how much work was in front of them.

COMMISSIONER GORDON: That's great. Very, very helpful. Thank you.

CHAIR BELLA: Thank you, Darin. Other Commissioners? Verlon.

COMMISSIONER JOHNSON: I was actually trying to look through my notes but I decided, Martha, you are the expert. You can help me answer this question.

While I'm thinking about the notion of decoupling the end of the dates of the continuous coverage with the FMAP provisions and the PHE, during that conversation was it more about extending the date for someone's

flexibilities or was it an opportunity for us to look at these flexibilities as something that we may want to recommend or we may want to consider as a permanent option at some point?

I say that because I think we have had a lot of conversations over the last year about the opportunities that the pandemic has actually presented. You know, we've had more of an increase focus on health care disparities. We are putting more thought around direct care workers. And, of course, we also enhanced -- we have a lot more use of telehealth and things like that.

So I was just trying to get at kind of like the spirit behind that particular one as well, just to see if there are some other options we want to look at in the future as we continue this conversation.

MS. HEBERLEIN: Making things permanent was not part of the conversation, but that doesn't mean it can't be going forward. I think at this point it was this idea that there are so many other things that are tied to the PHE, and I think oftentimes we are so focused on the continuous coverage requirements -- I speak for myself -- that you forget all the other things that are tied to the PHE. So

it was this idea of, well, it's not just that you would be asking for a date certain for all of that, would you just be asking for a date certain for the unwinding?

So there is certainly work that we could do looking at some of the other provisions that we might want to look at going forward to make permanent, but that was not the discussion that we were having.

COMMISSIONER JOHNSON: Okay. Well, I definitely think we should think about that as Commissioners, as well. Thank you.

CHAIR BELLA: Thank you, Verlon.

Martha, while folks are gathering their thoughts can we talk a little bit about ex parte? And first, can we make sure, like everyone on the Commission, like thumbs up, thumbs down, do you feel like you are well versed in what it is or what the requirements are, or would you like a little primer on ex parte? Thumbs up if you want a little primer.

It's really hard to see thumbs. Martha, just can you give a little bit of context and then let's talk about what do we know, do we think it's going to be an important tool, and how can we learn more about it, if so?

MS. HEBERLEIN: And Tricia can jump in if I get things wrong. Ex parte is the requirement that states start with data available to them to renew coverage for individuals, and if they are unable to do that then for the MAGI populations they need to send out a prepopulated renewal form, and for the non-MAGI population they have the option of doing so.

The survey that Tricia does with the Kaiser Family Foundation has ranges of which states, the caseloads that they process through the ex parte process. So there is some data out there that sort of looks at where states are now in terms of their processing and how many cases ex parte represents. I think there is some question about what data do they use, are they tapping all the data sources that they could use, and whether or not they are getting a high percentage of their caseload renewed in sort of that administrative fashion.

I think some of the states we spoke to commented quite clearly that they had used this time during the PHE to improve their ex parte processes. One was talking about a systems build. Another was talking about connecting with the other sources they hadn't connected with in the past.

So I think there are some things we can dig in, in more detail, about what states have done to improve that process over time.

I will also note that the advocate clearly said, in our discussions -- and this has been reiterated in other forums as well -- that the ability for states to process their renewals in an ex parte fashion will make it much easier, both on the beneficiary and on state staff, to get through the number of redeterminations they need to do.

So I don't know, Tricia, do you have other things to add?

COMMISSIONER BROOKS: Yeah. Just I think it's important to point out that states improving ex parte shares is really critical, not just during the unwinding but on an ongoing basis. It is administratively efficient and it helps to reduce procedural disenrollments. It's pretty simple. So it's really time that we live in the digital era where all this access to data and these high-performing systems are available to us.

But states make choices in terms of the data they will use, how old the data can be, and some states have actually said, you know, definitively, "I am not letting

the system make a determination. I am going to have a human body review that and confirm it."

I think there is a lot of room to move forward on ex parte. You saw, in the churn analysis that MACPAC did, that states that have higher shares of ex parte rates have lower rates of disenrollment within 12 months. So it is clearly, clearly a procedure and process that is beneficiary- and state-friendly. It is win-win as far as I'm concerned.

And I am glad to see the intense focus on this, because it has been in place since 2014 as well, as we still have a handful of states that aren't doing anything on an ex parte basis.

CHAIR BELLA: Thank you, Tricia and Martha. Kisha?

COMMISSIONER DAVIS: Thanks for this, Martha. I wanted to talk a little bit more about the transitions to other plans. You know, a lot of folks will come off of Medicaid but many will be transitioning to CHIP and to the exchanges, and you touched a little bit on this earlier.

But are there anything states are currently doing or can be doing to be more proactive in that process for

lining folks up for a glide path to get them linked up to exchange programs and CHIP and other insurance products?

MS. HEBERLEIN: Sure. I think there are some things, and I think it is likely easier in a state-based exchange situation rather than in a federal exchange situation. But definitely, in some of the work we have looked at in terms of what states are doing, one thing that comes to mind is in California, for example, they had a law, in 2019, that directed Cover California, which is their state-based exchange, to automatically enroll individuals who lose Medicaid coverage and become eligible for subsidized exchange coverage. So that is one approach and that is specific to the exchange.

And then another thought is that Kentucky and Oregon are more recently looking at the basic health program. That is for individuals who are ineligible for Medicaid but with incomes below 200 percent. And it was part of the ACA but only adopted in New York and Minnesota, and they kind of converted over existing coverage into a BHP.

So they've been talking about this as sort of filling the gap. We heard that premiums in the exchange

can be unaffordable for families, so this provides them maybe another option. Those are a couple of things that come to mind, but that is also something we can spend more time looking at and coming back to in the fall.

CHAIR BELLA: Okay. I am going to see if we any other initial comments. I am going to go to public comment soon, so we get that in, and then would like to make sure -- we need to give Martha and Kate and others clear direction on what we are interested in focusing on, particularly as it relates to September. And if there is something that you feel strongly about, we should be doing before September, that needs to be brought up today so that we can understand where the Commission is.

So are there any thoughts, comments? Dennis.

COMMISSIONER HEAPHY: Yeah. I'm wondering, maybe, to show, Martha, are there any data points we should be looking at in terms of to get a better understanding of the impact on beneficiaries and across all states? And if there are disproportionate impacts on certain populations, if there's a way we could say hold on, let's reevaluate what's happening or at least get a better understanding of what the impact is?

I really like Darin's ideas on the FMAP, making it a slope rather than a cliff, and then maybe states have plans in place that seem maybe going to work but in reality, are not going to work out, and then maybe just disproportionate harm that happens.

So what bytes of datapoints that we can look at and say from the start, here's the things we should consider as we're seeing states transition folks out of the Medicaid coverage.

Does that make sense, Tricia? Martha?

CHAIR BELLA: Looks like heads are nodding.

Tricia, did you have a comment?

COMMISSIONER BROOKS: Yeah. I mean, I will just say that CMS has provided a lot of guidance in terms of how states might engage managed care plans, not only in updating addresses but reaching out to people who are procedurally disenrolled, reaching out to people who are losing coverage for ineligibility to assist them with a QHP. So a little bit of that requires an (e)(14) waiver. It's not complicated because CMS has provided an expedited path to doing that, but the more that I -- you know, the managed care companies have the vested interest seeing

their -- retaining their members, whether it's in Medicaid or in QHP. And I think that's a good source to have extra hands on deck.

COMMISSIONER HEAPHY: I think it would be more like an outcome as opposed to the processes because the plans definitely have a vested interest in this, but like what outcome should we be looking for in terms of data points?

COMMISSIONER BROOKS: Well, I think the procedural disenrollments are a big thing here, that we would know that their eligibility was never fully redetermined, and having that data disaggregated by eligibility group or geography or age, you know, would be helpful in starting to pinpoint whether there are specific groups that are being impacted more than others. That's the piece I would certainly be looking at.

COMMISSIONER HEAPHY: Thank you.

CHAIR BELLA: Okay. I am going to turn to public comment. We're going to come back. Darin, when we come back, I'm going to ask you about the cliff work, is that something -- I'm going to ask you to think about it. Are you asking us to do, take some action before September, and

if so, what action are you putting on the table? And if not, what do you want to -- what do you want Martha to bring back to us for that discussion? So I'll just ask you to think about that.

And I think the other things, we're obviously -- Martha indicating interest in data and transparency, and procedural disenrollments. I do think it's really important to understand ex parte and where states are and what they understand about their current requirements, and then transitions is a theme that I'm hearing come out of this conversation as well.

Okay. We are going to go to public comment. I'm going to invite folks in the audience to use your hand icons if you would like to speak. I will ask you to state your name and the organization you're representing, and public comment is limited to three minutes, please. And there are a lot of you on the call today, so we will actually be policing the three minutes. But if you would like to make a comment, please indicate as such now.

PUBLIC COMMENT

* MS. HUGHES: Molly Collins, you need to enter your audio PIN, which I just sent you, in order to make a

public comment.

So we'll move on to Noella. It looks like she just moved down in order. Maybe she changed her mind.

Let's go with Zina. Zina, you've been unmuted, and you can unmute yourself to make a comment.

[No response.]

MS. HUGHES: Zina, you are self-muted. If you could click the little microphone icon under the orange arrow to unmute your line.

[No response.]

MS. HUGHES: All right. Melanie, let's go ahead and move on to Joe. Joe, you've been unmuted, and you can unmute your line to make your comment.

MR. THOMPSON: Thank you. Joe Thompson, head of the Arkansas Center for Health Improvement.

I would encourage the Commission to consider advice or at least attention to disparities in the redetermination process that explicitly have performance indicators on the proportion of minorities that successfully reenroll or potentially have enhanced disenrollment experiences going through the redetermination process.

CHAIR BELLA: Thank you very much. That is high on our list. I think as we talk about what data will we get and how will we get it and how can we break it down into observable trends, that that one is a really important one. Thank you, Joe.

MS. HUGHES: All right. Molly Collins, you have been unmuted on my side. Go ahead and unmute to make your comment.

MS. COLLINS OFFNER: Great. Thank you. I'm Molly Collins Offner, the director of Policy Development with the American Hospital Association, and we thank the Commission for their efforts to focus on the challenges for Medicaid and CHIP coverage once the continuous eligibility requirements end at the conclusion of the PHE.

The AHA has been working for the better part of a year with our member hospitals, hospitals with provider-based plans and our state hospital association partners to get ready for the unwinding of the PHE COVID-related coverage. We've conducted webinars and prepared tools and resources, focused on the role hospitals can play.

In addition, the AHA is participating in various CMS stakeholder workgroups on the unwinding process. We

hosted a webinar just this week, and the issue of transparency came up in terms of being able to publicly access state unwinding plans. So we very much support the Commission's work in this area.

And just to conclude, hospitals have a unique role in the caregiving community to help ensure patients and their families stay connected to health care coverage, and we stand ready to support our hospitals and health systems with that redetermination effort. And we're pleased to be a resource and partner to the Commission, CMS, and other stakeholders in the coming months.

And, again, we thank the Commission for their work in this critical national effort. Thank you.

CHAIR BELLA: Thank you, Molly.

MS. HUGHES: All right. Kaleema, you have been unmuted. You may make your comment.

MS. MUHAMMAD: Yes. Hi. Can you hear me?

CHAIR BELLA: Yes.

MS. MUHAMMAD: Good. There was a statistic that Tricia Brooks referred to earlier.

CHAIR BELLA: Kaleema, can you -- for the record, can you please state the organization you're representing?

MS. MUHAMMAD: I work at the Centers for Medicare & Medicaid Services.

CHAIR BELLA: Wonderful. Thank you.

MS. MUHAMMAD: So there was a statistic that Tricia Brooks mentioned earlier regarding the gaps in coverage during redetermine process. Tricia, what's that statistic again? Especially given that we're getting ready to go into unwinding soon, it would be nice to focus on ensuring or trying to mitigate individuals having the tragic gaps in service that you referred to.

COMMISSIONER BROOKS: So the Commission staff notes this. In April, I believe the presentation that was done that updated some of the churn analysis has showed those gaps in moving between the coverage sources. So, if you go to the MACPAC website and look at the meeting materials from April and look at the presentation, you'll see the data there that talks about all the numbers I rattled off and hopefully got right.

CHAIR BELLA: And Kaleema, you can also send an email to info at, I think -- is it "info" or "comments"? Which one is it? Sorry. Kate? Comments@MACPAC.gov and with your email information, and we can send you the link

to the meeting that Tricia is talking about as well as the recent report that has the data on churn, the churn analysis, which I think might be interesting as well.

MS. MASSEY: That's right. Because in July, MACPAC issued two issue briefs. One related to churn, as we've been discussing, and then another related to transitions in coverage, which include Medicaid to other public programs including the exchange as well as CHIP.

So when Tricia has been making those references and interweaving them into her comments, I think she's pulling from recently released data. It's available on our website, but we're more than happy to provide that to you specifically Kaleema.

CHAIR BELLA: Thank you, Kate.

MS. HEBERLEIN: All right. Zina, you are self-muted. So you may unmute your line and make your comment.

MS. GONTSCHAROW: Thank you. Apologies for earlier. Appreciate the opportunity. Zina Gontscharow with the American Nurses Association, or the ANA. We appreciate the opportunity to comment, and we are happy to see the Commission focus on all of these challenges as all of the public health emergency provisions start to unwind.

Expansion of Medicaid coverage during the PHE was really critical to ensuring patient access to care, and we continue at ANA to support efforts to ensure that patients can obtain appropriate health care coverage that allows them to access needed services and providers of choice, including and especially advanced practice registered nurses.

ANA represents over four million registered nurses, including the APRNs or the advanced practice registered nurses such as certified nurse midwives and certified nurse anesthetists and nurse practitioners.

The APRNs provide primary care, maternal health, and other key services that are relied on by patients that are critical to fill access gaps, in rural and in other underserved areas.

ANA urges MACPAC to keep these clinicians in mind as this work continues and looks forward to opportunities to partner with the Commission in the future.

Thank you.

CHAIR BELLA: Thank you, Zina.

All right. It looks like we have no one else who would like to make a comment.

So, Darin, I'm going to circle back to you for some thoughts and then kind of get a thumbs-up from the Commission if they also -- if there is consensus. It seems that there is consensus on the glide path in particular. Darin, your thoughts on -- is that action you are proposing we take before we are together again, and if so --

COMMISSIONER GORDON: Yeah. I -- you know, Martha and the staff, I'd love it like if we were saying, yeah, can you interview every state and get their perspective on it? But, obviously, that's not manageable.

But what I would like before the September meeting, if you could maybe engage with the NAMD and find out what the latest perspective, what they're seeing from their members with regard to that so we have a sense? Because, obviously, I know they're engaged on this issue, but it would probably be a one-stop shop. And I'm just not really clear where they are as an association in representing their members' interests on this issue, but I think it would be helpful for us so that we could have a productive meeting in September and maybe come to a recommendation.

CHAIR BELLA: Thank you, Darin.

Martha?

COMMISSIONER CARTER: One of the points that was made on the slide resonated with me, and that was -- I don't think we know what state it was that talked about needing a date certain, that the ramp-up to the disenrollment -- I'm sorry -- redeterminations.

And then sort of the "hurry up and wait," I think is the term that was used. That really resonated with me, and I was curious if there was more uptake on that idea. Was that just one state? Were there several states, or states just sort of resigned that that's not possible, and so we're, you know, just planning for the time that we have?

Martha, is there any more information you have about that? It just seems kind of wasteful that people are having to ramp up and then back down. So I'm surprised there wasn't more -- didn't seem from what you reported there was more support for that position.

MS. HEBERLEIN: I think the support was mixed, I would say. You know, I think there's been some other -- you know, there was a NAMD webinar earlier in the summer that had Iowa and North Carolina, and, you know, Iowa noted

that having its work sort of framed around -- they called it an "anchor date" and then having to shift and rework when the PHE was extended. And then I think North Carolina was also on that webinar and raised similar issues.

I think with the 60 days, I think that was less of a concern. I think we also heard that sort of early on in the processing when, you know, there were a couple -- you know, very early in the pandemic, some of the extensions happened with just a couple days' notice. So I think that also was where some of that concern had stemmed from, and so I think it was definitely mixed. And we've heard different opinions that sometimes knowing a date can, you know, sort of light a fire and get you -- if you have a deadline, you will respond to that deadline. So we heard that from some states, and we've seen that in other venues. But it was not consistently voiced among the states we spoke with.

CHAIR BELLA: Thank you.

Tricia?

COMMISSIONER BROOKS: So one thing that I would be interested in is hearing a little bit more about the challenges in states that use county-based administration

of eligibility.

Additionally, there are a number of states that have a sister agency that does eligibility for Medicaid, and the Medicaid agency doesn't actually do it. And I've certainly heard concerns about county-based administration. I've heard concerns about Medicaid agencies whose sister agency isn't as into transparency as they should be. So I think those two distinctions might be helpful.

And the other comment, I don't think this is as much in the Commission's bailiwick, but in response to Dennis comment, you know, the frontline providers are going to be a wealth of information here, and having effective feedback loops where we are getting a flow of information from providers into their state chapters or associations that can help to compile and assess that data to identify any recurring problems or system glitches or bottlenecks, I think all of that is really important. And I would hope that CMS is really talking with national associations and having it trickle down to the state chapters who can gather that information, and it's not just -- you know, pediatricians, family physicians, community centers, hospitals, all of those are a key piece of the puzzle if we

can't get the actual hard data.

CHAIR BELLA: Thank you, Tricia.

COMMISSIONER HEAPHY: I guess, how do you track continuity of care as those transitions are taking place? Is that even possible? That's a question I would have for Martha. How might you actually track that across states?

CHAIR BELLA: Martha, I think that's going to be a really important part of the work we're doing in September in thinking about focusing on some of those issues as you put together the panel and any prep work or any kind of diligence you're doing between now and then.

It does feel to me we're shifting, not entirely, from pre to post, but we are starting to think about what happens once this restarts and where is the appropriate role for the Commission in looking at access and continuity and beneficiary protections and all of those things.

So we did -- hopefully, we gave you -- before we wrap up, other Commissioner comments?

[No response.]

CHAIR BELLA: Kind of a quiet group today.

But hopefully, I think we did give you some concrete things. There's kind of one thing I feel like

came out of the pre-discussion, which is continued focus on the glide path and thinking about -- as you noted, MACPAC does have a precedent for not always being comfortable with cliffs. And we've seen cliffs in a couple of different areas and so thinking about that, but then a lot of discussion around procedural disenrollments and what are we going to know and when are we going to know it and how are we tracking that and what is the impact from a disparities angle and all of those things. Transition. So it feels like we're looking much more into the procedural and the monitoring side in addition to or maybe a little bit heavier than some of the procedural on getting ready to actually start the process.

So I think -- what else do you need from us in terms of direction or clarity?

MS. HEBERLEIN: I think that's all really helpful. Thank you.

MS. MASSEY: Martha, I was going to say the same thing. I think that through today's conversation, we've been able to identify additional themes to drill down on, and so we'll kind of take this back and make sure that in September, we're prepared to dig into these issues in

greater detail.

CHAIR BELLA: And if you can manage to talk to all the states between now and then, like bonus points, that would be amazing, or maybe some proxies can do it with us or on our behalf. It's not like the states are sitting around waiting to have other people to talk to either, but nevertheless, it's always helpful to hear from the people doing the work. And we'll make sure that we get the beneficiary voice -- it's never lost in that either.

But thank you for the work that you've done. Commissioners, thank you for making yourselves available today, and we will look forward to reconvening in September unless there is some other amazing opportunity for us to have another special session between now and then.

Thank you. Thanks to the MACPAC staff, and, Martha, thank you again.

We are now adjourned. Thanks, everybody.

* [Whereupon, at 2:30 p.m., the Public Meeting was adjourned.