PUBLIC SESSION

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P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Good morning, everyone. Welcome to the January MACPAC session. We are going to get started with Denials and Appeals in preparation for voting on these recommendations that are coming back to us, and I'll turn it over to Lesley and Amy. Welcome.

DENIALS AND APPEALS IN MEDICAID MANAGED CARE

* MS. BASEMAN: Thanks, Melanie, and good morning, Commissioners. Amy and I are back today to review the recommendations and present the draft chapter on denials and appeals in Medicaid managed care.

We'll start with a brief background, highlight the current federal requirements, and elaborate on the state role. We'll then quickly review the challenges before turning to recommendations, additional considerations for states, and end with some next steps.

We are going to move quickly through the first part of the presentation as you have seen this material before.

Until recently, little was known about denials in Medicaid managed care. The Office of the Inspector

General, OIG, released a report last summer that shed light on denials. The found that 12.5 percent of prior authorization requests were denied by Medicaid managed care organizations, MCOs, a rate higher than in Medicare Advantage. Additionally, approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with denial rates greater than 25 percent.

Few denials are appealed, and little is known about the beneficiary experience. Additionally, media reports, including stories in California and Texas, have highlighted instances of MCOs inappropriately delaying or denying care.

Federal rules lay out requirements for service authorization and appeals processes. At a high level, MCOs may deny or limit services. Beneficiaries have a statutory right to appeal denials, and MCOs are required to have an internal system to review appeals. States are required to collect and monitor data related to appeals, work with external quality review organizations to conduct MCO oversight, and submit key metrics and data annually to the Centers for Medicare & Medicaid Services, CMS.

States have some flexibility to modify the

appeals process. For example, some states require MCOs to resolve appeals faster than in the timelines indicated in federal rules. States have the ultimate responsibility to monitor and oversee MCOs to ensure beneficiary access to care. Some states conduct more robust monitoring beyond federal requirements. For example, some states voluntarily collect denial data from their MCOs.

Our work highlighted four key challenges in the appeals process. We discussed these in greater detail in November, but at a high level, beneficiaries expressed both a lack of trust and a general frustration with the MCO appeals process; the appeals process is also challenging and burdensome for beneficiaries; denial notices can be late in the mail, and the content is often unclear; and beneficiaries encounter multiple barriers in accessing continuation of benefits.

We also found three key challenges with monitoring, oversight, and transparency, as discussed in September. At a high level, federal rules do not require states to collect data on denials, continuation of benefits, or appeals outcomes. Federal rules also do not require states to assess clinical appropriateness of

denials. And lastly, federal rules do not require that states publicly report information on denials and appeal outcomes.

We will now turn to the seven recommendations and discuss the rationale and implications for each.

The first recommendation reads, "To bring independence and improved trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent, external medical review process for beneficiaries who have exhausted the internal managed care organization appeals process. As part of the rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services should allow states the option to establish automatic external medical reviews. This process should not impede a beneficiary's right to a state fair hearing."

Our findings from interviews and focus groups suggest that many beneficiaries lack trust in the MCO appeals process. Adding an external medical review would introduce a step in the appeals process that would be both independent, that is, not conducted by a provider

associated with the MCO, as well as clinical, done by a clinician rather than an administrative law judge.

Beneficiaries and advocates noted the importance of reviews that are both independent and clinical. Currently, 14 states offer external medical review as an option for Medicaid beneficiaries, and data from the OIG suggests that appeals to these external reviewers were fully or partially overturned in favor of the beneficiary nearly half of the time.

External medical reviews can also be a tool for oversight and performance improvement. States that offer this option are required to report data annually to CMS on the number of external medical reviews and their outcomes.

The Congressional Budget Office, CBO, estimates an increase in federal direct spending of less than $500 million over a ten-year period for this recommendation. States may see an increase in administrative burden to establish this program or align existing programs with federal rules. Beneficiaries may see an increase in access to care. Some MCOs may revisit authorization processes and see increased costs.

Lastly, providers may experience increased

administrative burden, as their documentation may be needed for external medical review, but they may see more requested care approved.

The second recommendation reads, "To improve the beneficiary experience with the appeals process, the Centers for Medicare & Medicaid Services should issue guidance to improve the clarity and content of denial notices, share information on approaches managed care organizations can leverage to fulfill their requirements to provide beneficiary assistance in filing appeals, and clarify how Medicaid funding may be used to support external entities, such as ombudsperson services."

Our findings suggest that the content of denial notices can be difficult to understand, and that the reasons for denials often do not include why medical necessity is not met. Guidance from CMS should help states and MCOs improve the denial notices to more clearly explain the denial. CMS can also help identify strategies for improving the readability and understandability of notices, for example, with model notice language.

Our findings also suggest that the appeals process can be challenging to navigate. CMS should offer

states and MCOs guidance on how they can better support beneficiaries in navigating the appeals process. This guidance should also detail how Medicaid can ensure that assistance from trusted external partners, such as ombudspersons, is available for beneficiaries.

CBO estimated no changes in federal direct spending for this recommendation. States may choose to implement CMS guidance and improve how beneficiaries experience the appeals process. Beneficiaries may have improved access to the appeals process, and more beneficiaries may choose to appeal denials. States may require MCOs to make changes to denial notices, and MCOs may also implement CMS strategies to better support beneficiaries in the appeals process. Providers may need to supply documentation for a greater number of appeals, but their administrative burden may be lower if the notices are more clear.

The third recommendation reads, "To ensure beneficiaries receive denial notices in a timely manner, the Centers for Medicare & Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice, in

addition to the mailed notice."

Written notices delivered by mail can be inadequate for some beneficiaries. Mail delivery can be delayed or delivered to the wrong address. Multiple modes of communication help to ensure that beneficiaries receive important information in a timely manner.

CBO estimated no changes in federal direct spending for this recommendation. States may need to amend managed care contracts and monitor MCO compliance with new requirements. Electronic delivery could improve timely access to notices for beneficiaries, making the appeals process more accessible.

MCOs would need to update electronic systems to identify delivery preferences of beneficiaries and generate these electronic notices. We do not estimate that there is any direct effect on providers.

And now to Amy.

* MS. ZETTLE: Draft Recommendation 2.4 reads, "To improve beneficiary access to continuation of benefits, the Centers for Medicare & Medicaid Services (CMS) should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering

tools, such as model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service."

In our research we identified three major barriers to beneficiaries accessing their right to continue services through an appeal, and this recommendation aims to address those three challenges.

First, beneficiaries lack time to file for continuation of benefits. By extending the minimum of 10 days to make this request, access may increase for beneficiaries. There was also limited awareness of this benefit for those who qualify. Model notices and other tools from CMS could improve notices to make this information more accessible and prominent.

Lastly, we heard that the threat of repayment can be a barrier for beneficiaries. CMS should clarify that

MCOs are only allowed to pursue recoupment if the state allows repayment under fee for service, and therefore denial notices should only describe recoupment if it is allowable in that state.

This recommendation would not have a significant effect on the federal budget, according to CBO, and states will need to implement this recommendation by ensuring that MCOs offer this extended timeline to beneficiaries. More beneficiaries may become aware of this benefit and gain access to continue services while they appeal, and providers would be able to continue to provide these services throughout the appeal.

Plans would change their timeline to follow CMS rules, and may improve communications following the CMS guidance.

Draft Recommendation 2.5 reads, "To improve monitoring and oversight of denials and appeals, the Centers for Medicare & Medicaid Services (CMS) should update regulations to require that states collect data on denials, beneficiary use of continuation of benefits, and appeal outcomes, and use these data to improve the performance of the managed care program. Additionally, CMS

should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities.

This recommendation aims to address the current gaps in monitoring requirements at the federal level. The importance of collecting these data fields became evident in our conversations and interviews with states, who many use this information to assess whether beneficiaries are experiencing challenges in accessing care. Requiring states to monitor these key metrics will provide greater insight into denials and appeals and the outcomes.

CBO estimates no change in direct federal spending for this recommendation, and similar to other recommendations, states would see an increase in administrative burden to implement this requirement or to align existing monitoring with federal rules, and MCOs would need to submit additional data to the states once this requirement is in place.

The goal is that this improved monitoring would result in beneficiaries receiving improved access to

appropriate medically necessary care.

Draft Recommendation 2.6 reads, "To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare & Medicaid Services (CMS) should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the results of the audit."

Clinical appropriateness audits have shown to be effective at identifying inappropriate denials of care, but they are currently not required in Medicaid managed care. We heard from states throughout our interviews that this type of audit can be helpful in identifying inappropriate denials, and OIG came to a similar conclusion, recommending that this type of audit occur regularly. Similar audits

already happen in Medicare Advantage.

CBO estimates that this recommendation would increase federal direct spending by less than $500 million over a 10-year period. Similar to previous monitoring recommendations, we expect that states and plans would see an increase in their administrative burden to implement or align these requirements with the new federal standard.

Beneficiaries could see improved access to medically necessary care and a reduced administrative burden if the audits reduce inappropriate denials over time.

Draft Recommendation 2.7 reads, "To improve transparency, the Centers for Medicare & Medicaid Services (CMS) should publicly post all state Managed Care Program Annual Reports to the CMS website in a standard format that enables analysis. Reports should be posted in a timely manner following states' submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a health plan."

Currently there is little transparency on MCO

approvals and denials of services, limiting what is known about beneficiary access to medically necessary care. This recommendation would leverage managed care annual reports and quality rating system websites to improve accountability and ensure that beneficiaries can easily access this information.

CBO estimates no change in federal direct spending for this recommendation. For states, these transparency efforts would add a modest administrative burden. Beneficiaries would have greater insight into the extent to which services have been denied and then overturned through the appeals process, and transparency may encourage plans to improve authorization and appeals processes.

So after our recommendations in the chapter we discussed some additional considerations and also what is next.

Following these recommendations, we discussed how ultimately states have a responsibility to oversee managed care plans and their programs and ensure beneficiary access in their states.

Current federal rules allow states some

flexibility to modify and improve these processes. Independent of federal action to adopt these recommendations, states could take some steps to improve these programs such as adding external medical review or the clinical audits, and states should use tools available to them to respond to any issues that arise from these activities.

Okay, looking ahead. So next, tomorrow, we will vote on these seven recommendations. Following that, Lesley and I will finalize the chapter for the March Report to Congress. We will also review the recently released rule on interoperability and prior authorization, and MACPAC staff is contracting work to look at prior authorization in Medicaid in more detail.

We will continue to monitor state websites for the MCPARs and investigate any additional work that we could do based on this newly available information.

So now I will turn it back to the Chair.

CHAIR BELLA: Thank you very much. You got through that very efficiently. There is a lot here, and I appreciate that we have had several meetings to discuss this.

I'm going to open it up to Commissioners. Usually we would sort of go recommendation by recommendation, but we don't necessarily need to do it that way. So as Commissioners speak if there are certain recommendations you want to weigh in on with support or concern, please do so, but don't feel the need to comment just to comment because we have had several opportunities at this.

I see Patti, then Bob.

COMMISSIONER KILLINGSWORTH: So first of all, Lesley and Amy, just excellent work on a really complex process. It is at the intersection of law and health, so that makes it incredibly complicated. But it is also incredibly important to those that we serve, and really at the heart of our statutory charge of access because these are people that we know are in circumstances where they are experiencing a challenge in accessing care that they may need. So we want to be sure that we are incredibly thoughtful about this.

I have mixed feelings about Recommendation number 1. I do think there is value in having some sort of availability of an external process. I do think that to

the extent this recommendation moves forward that clarity is really important to make sure that it is clear that it is a process that a state would make available at the request of the beneficiary and is not required to automatically make it available to all beneficiaries.

I also wonder if the clinical appropriateness audit in Recommendation 6 is maybe an appropriate first step before also adding a requirement for an independent review process. It seems like both of those are kind of addressing the same issue, and maybe there is a stepwise approach to try one before the other.

The other thing I would say is if the recommendation moves forward, at least in the regulatory guidance, CMS should make clear that states can, at their discretion, integrate that independent external review as a part of their state fair hearing process, but it doesn't have to be distinct so long as the fair hearing process is allowed to move forward.

And I would suggest that we make it clear that data from any sort of independent medical review is collected, report, monitored, and actually used by health plans, states, and CMS to identify and address potential

issues with denials or access that rise to the top through the appeals process.

Should I go on to Recommendation 2, or see if other folks want to comment on Recommendation 1?

CHAIR BELLA: You can go on with your comments and then we'll circle back around.

COMMISSIONER KILLINGSWORTH: Okay. So with regard to Recommendation 2, I would just -- I think I talked about this before, but I would like to see included in the -- at least in the chapter, if not in the recommendation, that CMS and/or MACPAC further investigate the beneficiary support system requirements in 42 CFR 438.71 for MLTSS and how those have really been operationalized by states' awareness and experience of beneficiaries in using those systems and then how any of those lessons learned might be brought to bear in helping inform improvements in the managed care appeals process more broadly, not just limited to MLTSS.

I have no comments on Recommendation 3.

On Recommendation 4, I would like to see us make clear that the additional time for continuation of benefits is really to accommodate adequate time for receipt of mail

notices. When we say that CMS should issue guidance offering tools such as, I recommend saying "including" other than "such as," because I want to be sure that model notice language is a part of what CMS moves forward in doing. I think that would be a tremendous benefit.

And I would include and underscore the importance of engagement with beneficiary states and key stakeholders in crafting that guidance and especially that model notice language.

I also have a question related to continuation of benefits. Because we speak to what a state allows under its fee-for-service program -- and some states have no fee-for-service program, and so how does the repayment issue work when a state operates only under a managed care program?

With regard to Recommendation 5, I just want to be sure that we note that it is imperative that there are standardized definitions of data in order for that data to provide meaningful comparison and oversight.

And I'll give you an example from one of the first slides that were in the presentation about comparing denials of service in Medicaid to Medicare Advantage, and

the problem is that there's really broad discretion in terms of what a health plan chooses to prior-authorize or not. And so if you're just doing apples-to-apples comparisons of raw denials, they really mean nothing unless you know how sort of the breadth of services that a state is placing under prior auth -- or a health plan is placing under its prior authorization processes. And so we really have to know and define things pretty specifically in order for that data to be useful to people.

And then again with Recommendation 7, I would just note that data is meaningful only to the extent that it's standardized; there are definitions that are developed and implemented. Really, transparency is only beneficial if it provides a true picture for those for whom the data is made available. So data tells a story, but if we don't really understand the context, it may tell the wrong story. So we want to be sure that we're making that data clear if we really want to increase transparency.

That's it for me.

CHAIR BELLA: My head is spinning.

Patti, just to -- no, that's a good thing. It sounded like the actual edit -- there was an edit on

Recommendation 4, which you wanted to change "such as" to "including." Did you have -- and you wanted to make sure some things were clear, which you said could be done in the recommendation or the chapter. Did I miss any other specific wording changes?

COMMISSIONER KILLINGSWORTH: I really want to see the -- if Recommendation 1 moves forward, I really want to see change in the language to Congress that is more clear with regard to that being available at beneficiary request and not automatically.

CHAIR BELLA: Okay. Other than that, though, Recommendation 4 had the word change --

COMMISSIONER KILLINGSWORTH: Correct.

CHAIR BELLA: -- and the rest of your comments were clarity and information for the chapter.

COMMISSIONER KILLINGSWORTH: Correct. Perfect.

CHAIR BELLA: Thank you very much for that thorough review.

Bob and then John and then Tricia.

VICE CHAIR DUNCAN: Thank you.

Again, Amy, Lesley, great work, and to my fellow Commissioner, Patti, you asked a couple of my questions in

yours, and so I want to go to 2.5, as Patti highlighted, around the data. I want to make sure that we're getting specific.

So I'd like to see language around either demographics or populations so that we can compare apples to apples versus looking at things holistic, because holistically, it may look like denials are low, but there may be certain segments of the population that have a higher denial than others. And so in being able to understand that and address that, I think is important.

And the next question is in 2.6. For me, it's just clarity. When we talk about clinical appropriateness, are we including EPSDT in that component of that? It's just it's not called out, but I just want to make sure that that is understood in the clinically appropriate services.

Thank you.

CHAIR BELLA: Thank you, Bob.

John?

COMMISSIONER McCARTHY: I think I brought this up the last time we looked at it, and again, great work, as everyone has said.

The part that we didn't have in here was a part,

for me, around incentives, and then how these things are enforced. And so while we have recommendations in there for CMS to do certain things, collect certain data, there's no, as we've talked about in other areas, enforcement mechanisms for those things. And so then what is the incentive to do some of those?

A part of what I would like for us to look at in the future is how to tie some of these policy ideas to incentives to incentivize states to do better, because I would argue that states want to do better, and they're trying to do better. And there's a lot of other things, and when we vote tomorrow, I'll have more to say on some of those. But I think that's one area of lacking in our recommendations.

CHAIR BELLA: Incentives and penalties or just incentives?

COMMISSIONER McCARTHY: You can look at them either way. I would just say incentives are -- can be in both directions.

CHAIR BELLA: Okay. Thank you, John.

Tricia?

COMMISSIONER BROOKS: So I understand when we

make recommendations, Congress, CMS get to pick and choose what they want. I'm a little struck by 1 and 6 because they both have a $500 million price tag. Is it implied that we're suggesting states do both? Right? Do we go through a clinical audit and we do external review? It feels like we're piling on a lot.

And then, you know, it makes it harder for anything to happen. So I'm wondering if -- how folks feel about, you know, if we were to start with clinical reviews and gather data from those, see what comes up, whether then taking -- because for me, going external, is sort of a -- you know, the last step -- right? -- that we could do. Whereas, I just feel like this is an awful lot to be throwing together in recommendations at one time. So I feel some tension between 1 and 6.

CHAIR BELLA: Thank you, Tricia.

Heidi?

COMMISSIONER ALLEN: So I just want to congratulate the staff for putting together such a comprehensive package, and I know that work started on this last -- I think almost this time last year, and it reflects a lot of care and thoughtfulness and a lot of beneficiary

voice, which I think is really important. And I think that when we ask for beneficiary voice, this is a really good chance for us to honor it, and I feel like that is reflected in these recommendations.

I don't have the same conflict, Tricia, as you do, because one process -- they're very different. One is at the beneficiary request, and it has an impact on the beneficiary. The other is a retrospective, I would assume, random sample of audits. And because we know that so few people appeal at all and then so few people appeal even up, I think that the audit serves a really important perspective, because it takes out the beneficiary requirement that they have to navigate a system. Whereas, the external review is really important to get that person's care taken care of, which isn't done in an audit. So I think I see these is very complementary.

I really think Recommendation 1 is very important. I think very few people will use it if we look at the data, but for the people who do, the statistic that 46 percent are overturned is really compelling. And I think that somebody that the state hires has incentives too. Just like mandatory arbitration, we know it often

rules in favor of the company and not the individual. We know that probably that this could reflect a conservative state perspective of also wanting to be prudent about costs and that it really does represent unmet beneficiary need that then gets met. So it's really, really important for not only trust but access.

I had a couple of, like, minor edits. One is a little bit more conceptual with Recommendation 4. We talk in the chapter about this idea that you might have to repay for any care that you use when you exercise your right to have a continuation of benefits while you're going through the process of appealing. That is such a shadow, and in the report, when we've talked to stakeholders, they say, like, "We haven't even heard of this happening." But when you include it in the language, I think recognizing that it puts a threat and it's an unknown threat. Even as a person who studies U.S. health care, I would not be able to put a dollar amount to what that represents for almost anything.

I wouldn't be able to say, am I talking -- I could end up having to pay $100, or is this $10,000? Low-income people who have to navigate circumstances with such fewer resources, if you hear that, you're going to go like,

"Oh, it's not worth it," when it very much could be worth it for your health. And so I think if there's some way we can reflect in the language that language needs to give some sense of the probability of that actually happening.

Like, very rarely will the managed care, you know, company -- just something -- that states should have to kind of quantify that or give people a way of trying to find out what that means. But just saying they could, I think could have an enormous impact on something that is not real. And you reflect that in the chapter, but I'd like to see it in the recommendation, if possible.

And then the second thing is in Recommendation 5, we say to collect data on denials, beneficiary use, and dah-dah-dah, and then we say, "And then use it for performance, and then they report it," I would like to call out, if possible, by making a couple simple word change: require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes, end of sentence, that states use this data to improve. So, like, you put "report" with the "collect," and then you're talking about how they are going to use it, which is the next two sentences. So I think that would

make it clearer rather than it's just implied now that because they -- they're requiring the data fields, and it's in the template, and they should have it in there. I'd like to just have that language be more stronger.

That's it for me.

CHAIR BELLA: Thank you, Heidi.

Angelo and then Rhonda.

COMMISSIONER GIARDINO: I just wanted to comment a little bit on some of the points that have been made.

First of all, I think the fact that you're looking at appeals and denials is incredibly important. It's an important domain or pillar of a program, and you've done a really good job at demonstrating that we don't have the data that we need to see if that denial and appeal process is having the desired result. So I think this is really, really important work, so thank you for that.

A couple things. One, I'm really concerned about this less than 500 million. That is a half a billion dollars. The people that I interact with on a daily basis in Utah think a half a billion dollars is a lot of money, and it's not a rounding error, and it's not pencil dust. So we have to be careful about our relevance with these

recommendations because that is such an enormous amount a money to people in the fly-over country, that they will not overlook this recommendation. So I'm really concerned about that being an acceptable band to look at cost.

In terms of the recommendations, there's seven of them, and I think the last three are about transparency and putting a feedback loop into the system, which to me makes the Medicaid program better. And that's why we're all here. We all believe that Medicaid is not broken. We believe that it can be improved, and we can make those recommendations.

The middle three, 2, 3, and 4, are all about best practice and giving the consumer a voice, and I completely support that, and we all know that makes Medicaid better.

But No. 1, to me -- No. 1 may or may not be the right thing. So I've heard the number; 46 percent of the 14 states that do this overturn. Well, that means 54 percent don't. So 14 of the 50 states have a trend of 54 percent. So if you added another 14 states to that analysis, that number could completely change. And if you added 28 states to that, that number might disappear statistically.

So I don't think we're ready to say that No. 1 is something that we should potentially add and add a half a billion dollars to the Medicaid program. So states have that option now, and it sounds like in this jointly funded federal-state program, 14 states have used their autonomy and have decided to add that. That's fine. We have a jointly funded federal-state program, and I don't believe MACPAC is here to federalize Medicaid. So I think 1 is premature.

I support 2, 3, 4, 5, 6, and 7, because if we have the data in a couple years and 1 is the right answer, I will vote a strong yes on that, but it's not time yet. That's premature. That's a policy decision that's made on a trend of 14 states, and as Patti alluded to, the data that we're looking at has a lot of footnotes to it. If we do 5, 6, and 7, we'll have strong data, and we can make a strong policy argument, and then we can suggest to the nation to spend a half a billion dollars on something.

Thank you.

CHAIR BELLA: Just to clarify for the record, especially for folks in the audience, it's zero to 500 million over 10 years on a, like, almost $9 trillion

program over 10 years. So it is, Angelo, not intended to be something that we think is frivolous, but it's important to put it in context with the total spending of the program and that it's over a 10-year period. And it could be zero. It could be 10. It could be up to 500.

COMMISSIONER GIARDINO: No, I understand, Madam Chairman. But I think it's -- 5, 6, and 7 are absolutely fundamental to get this program to work. Right? So I would spend up to $500 million on that.

Number 1, I don't believe that you have the statistical power to tell me that really is worth as much as 5, 6, and 7.

CHAIR BELLA: This is why we are all here to share our voice. Thank you, Angelo.

Rhonda, then Dennis, then Carolyn.

COMMISSIONER MEDOWS: Okay. I will I will speak to the opposite.

So I understand really, really well how the Medicaid program works, how denials and appeals works, and I understand really well how Medicaid managed care plans work.

And I heard -- I've been listening really, really

well, because I've heard a lot of really good comments and a lot of good information. It still comes down, to me, when I say that I support 1 through 7 -- and specifically 1 -- that no matter what that dollar amount is -- and I get the Medicaid program has limited funds. I know it. I ran the programs. I know what the finances look like, but I do believe that the individuals who are being served in Medicaid deserve that extra protection of an external review by medical professionals. I think it needs to be independent. I think it needs to be watched and monitored as well as what the managed care companies are doing.

So I'm going to speak in favor of 1 through 7, specifically because I will tell you what the loss of a child, the loss of a parent, the loss of a senior, the loss of anybody, because we just couldn't get our arms around agreeing to have an independent review, and we think more data is needed? I can't agree.

And I think that a lot of times, we get paralyzed with all the analysis. We wait long to have perfect data, and I think there's enough information already present.

And I realize that some of you will disagree with me. I think the beauty of this group is that we can have

different opinions, and we can share our rationales. And so thank you.

CHAIR BELLA: Thank you, Rhonda.

Dennis?

COMMISSIONER HEAPHY: I think we should support all these recommendations.

But for me, Recommendation 1 is extremely important. There is a tremendous amount of distrust of the MCO system, and I think the distrust is actually increasing. And that is, in part, due to increasingly opaque utilization management policies, the use of artificial intelligence to make decisions that really cannot even be understood by the people making the decisions in the plan, let alone the beneficiary. So they can't even really learn how to appeal a process.

So in order to have that fairness in the process, you need someone who does not have a conflict of interest to help make that decision. So I don't understand why we're -- why we want to deny some of the folks on Medicaid that we're providing to folks in Medicare Advantage. And maybe I'm oversimplifying that, but if this is available to folks in Medicare Advantage, what's the difference with

folks on Medicaid? Why shouldn't they be provided that same right as available to folks in Medicare Advantage, particularly given the stats and people's experiences based on your interviews with people? Like, why is this an issue?

CHAIR BELLA: Thank you, Dennis.

Carolyn.

COMMISSIONER INGRAM: Thank you.

I appreciate hearing all of my colleagues' feedback. It's very helpful to think about how to put things in terms based on different experiences that we have, and I appreciate the work by the staff as well.

I'll speak first to 1 and then some of the other changes. I think in 1, we are just adding more cost and more complexity to the system for members. Members already have an option to pursue a denial process inside managed care. They have an option for a fair hearing outside of managed care.

What I've seen, both from sitting on both sides of the table of having run a program and then also having participated in these types of appeals representing members of my family, is that it's confusing to members, and we

want to try to make this simpler.

The graphic that we have on page 7 or 8 really shows that adding that external quality review entity is just making it more complex. So I would ask that that be modified, Recommendation 1, to make that independent clinical review part of the fair hearing process an option for states to have that under their fair hearing process if that's the pursuit that we want to move forward with. But I can't support the recommendation the way it's currently written.

Going down the line, the other recommendations that ask for data and information, I want to support what Patti put forward in terms of really being clear with the definitions. One of the failures of the OIG report was that it looked at how managed care companies self-reported denials. And going back to one of my colleagues, there's a number of processes that managed care companies go through to determine what's going to be something that's prior authorized or not prior authorized. And so we're not comparing apples to apples in terms of those or in terms of the programs that OIG looked at.

They also didn't look at the fact that sometimes

a denial might occur for a service, but then a step-down service or an alternative benefit is provided that meets the person's needs. And so I do think us gathering the data and the transparency in the recommendations around 5, 6, and 7 are really important, but we have to make sure that we're defining exactly what we mean by a denial of service so that we've got something to compare back to.

I think the data we have right now is very flawed, even the data that looks at the turnover rates that have happened in those states, and so that's another reason why I just can't support 1.

But I do support moving forward with getting that information as long as we make it clear what is meant by a denial exactly so that we're all comparing the same definitions, and then that will give us the tools that we need to determine whether you're a regulator or whether you're a managed care entity or whether you're CMS, what's really happening in the system and how we can make improvements and make it easier to run and operate these programs.

Thank you.

CHAIR BELLA: Thank you, Carolyn.

I have a few comments, but let's see who else.

Dennis and then Verlon.

COMMISSIONER HEAPHY: I think the comment about clear definitions is important because from a beneficiary perspective having a modification is a denial, even if something is offered instead of. If someone requests, let's say, a wheelchair that's got a reclining system on it, or a tilt system, even if they are offered this chair without those things that initial request is a denial. And so it is important to catch that denial information, because what was requested by the person was not provided, and that may be really important. And then having that independent entity, we examine that modification, and in fact, seeing it as a denial of the initial request is very important.

And so a lot of denials get lost under the umbrella of modification, so I think that's got to be part of what we're looking at here is recognizing modifications are a denial.

CHAIR BELLA: Thank you, Dennis. Verlon.

COMMISSIONER JOHNSON: Yeah, no, this has been a very helpful conversation, and I really appreciate the

comments from all the Commissioners. It really helps to kind of form the idea of what we are really trying to achieve here. And I really want to thank you all for all the work you've done on this. I told you earlier that it was very exciting to read how far we've gotten into our research and all of our discussions.

I love that implication chart that you all put together for each of these areas because it really emphasizes the important partnership that we need to have as we think about improving health care for Medicaid beneficiaries. And with 72 percent of people enrolling in managed care it is important for us to start here, and so I really appreciate how we've really focused on that.

So to me, our recommendations, I'm really supportive of all of our recommendations, especially Number 1. I really think that it is pretty fundamental in terms of what we are trying to achieve and what we're trying to do. When we think about this, this is really a health care equity issue. We have 72 percent of beneficiaries enrolled in managed care, and that first recommendation really hits hard on the importance of making sure that they have a voice in all of this, that they have someone else as an

advocate that can really help them move this needle further on addressing appeals.

I agree with Heidi that, you know, it's very true that the current data may say that they may not use this process, but if we look at what we have in the other recommendations, I believe in 2 and 3, I think we can see where we can actually get that a little bit further. So for that reason I really think it's important for us to really look at approving all of these seven recommendations. I think that they're worth probably some good tweaks along the way, from other Commissioners, but I just wanted to make sure that you all knew that I am very supportive of this particular step that we have moving forward. So thank you.

CHAIR BELLA: Thank you, Verlon. Kathy?

COMMISSIONER WENO: I too want to say that I support all seven of the recommendations. I do have some concerns, like Patti, about an automatic review there. I was an ombudsman for a while, and I represented beneficiaries in all of the stages of the review process. And there are some times where I can think where a beneficiary would not want a review, or it wouldn't be

helpful to the case.

So I think, like Patti, having something in there where you say it's not an automatic review if that beneficiary requests would be helpful, so to be clear about that in the recommendation.

And I also want to just highlight Heidi's thoughts about the repayment threat. It is a true chilling effect among beneficiaries. If they read anything on their denial notice about the possibility that they're going to be on the hook for that they will not. You need to have a good conversation about that with your client when you are doing these appeals. So if there is some way we could discuss that a little more in our recommendations I would appreciate it. Thank you.

CHAIR BELLA: Thank you, Kathy. John.

COMMISSIONER McCARTHY: I just had a question on Draft Recommendation 2.2, and it was going back to something Kathy just said and something I did in D.C., where on one hand we're saying CMS should improve beneficiary experience by issuing guidance on denial notices and sharing information, right, which is one piece. And then we tack onto it at the end there, and then also

how they should support external entities.

I just want to, for a second, pose the question, should we really break that into two recommendations, and the first one being that it should issue guidance and clarity on that, and then the second one as a separate recommendation about the ombudsman program?

The reason I bring that one up is because they are, at some level, two different ideas. And in D.C., when I brought up our ombudsman program, it was super useful in this area to help people navigate that process in doing some of these things.

So I just want to pose that as a question, of could Recommendation 2.2 really be separated into those two different pieces.

CHAIR BELLA: Now is a fine time to ask. Kidding. Kidding.

All right. We are going to wrap this up, so I'm going to attempt to summarize and make a couple of comments.

The discussion for me around Recommendation 1 was really helpful. I think where I get stuck is making sure that we don't add another step that makes it more

complicated. But the amount of folks that seem to be availing themselves to a state fair hearing also seems low, and so I don't think that we are at risk of doing that. This is already a complicated process, and I'm very persuaded by the fact that it exists in Medicare. But Medicare doesn't have these other things either.

So we're making important recommendations today, and we are using these are an opportunity to collect a lot of data, and I do hope that we will continue, as we get information in, to continue to ask ourselves, have we improved the process? What can we continue to do to make the process better? Should we look at something with state fair hearings down the road?

Carolyn, I think it would be hard to shift Recommendation 1 to what you suggest, but it doesn't mean that it can't be mentioned in the chapter, that one Commissioner would have preferred to see this be incorporated in state fair hearings. We could handle it that way. It does seem to be an important opportunity for beneficiaries to have at their disposal.

We got some relatively minor edits from Patti and Bob and Heidi that should be able to be accomplished.

Heidi and Kathy, the point about repayment, it might be difficult to get the words in the recommendation, but there is a clear commitment to making sure that it is very, very clear and overstated, I think, in the chapter, but the team will take that back. And John, that Kate and Lesley and Amy will take back what you just asked as well, on Recommendation 2.

So with that I think we are a wrap on this until tomorrow morning, unless anyone has any last comments, or Amy or Lesley, unless you need anything else.

MS. ZETTLE: No, thank you.

CHAIR BELLA: Dennis?

COMMISSIONER HEAPHY: Yeah, it doesn't have to be within the recommendations, but in the chapter, to talk about moving towards plain language in the denials notices, because that's something I actually worked on in Massachusetts. There is a cover sheet that is written in very simple, plain language, with the contact information of someone who they should call about the denial. But simple, very plain language that says this piece of your request was denied for this reason. So I think noting that in the chapter would be really helpful.

CHAIR BELLA: Yeah, and the one thing that you already heard several times, but the importance of clear definitions, which was raised by several folks, and is obviously very important.

All right. Well, for seven recommendations you made it through with relatively few edits. Congratulations, team, and we'll look forward to having you back in the morning to take a vote on each of them individually. Thank you very much.

All right. Thank you, Commissioners, for your engagement.

CHAIR BELLA: We are going to now continue our discussion of data collection, focused this month on disability data. And Linn is going to join us for that, and Bob is going to lead it.

[Pause.]

VICE CHAIR DUNCAN: As Madam Chairman said, data has been the topic of the early part of the conversation, and it will continue. As you know, Linn has been doing a lot of work around self-reporting of Medicaid data. I think she is finding there's some inconsistencies in the process, and so Linn comes forward today to ask us about

some key considerations.

So, with that, Linn, it is all yours.

MEDICAID SELF-REPORTED DISABILITY DATA COLLECTION

* MX. JENNINGS: Good morning.

So during this work cycle, we are presenting on the availability of Medicaid primary language, LEP, SOGI, and disability data, and for purposes of measuring and addressing health disparities and access and health outcomes. And so today I'll present findings related to Medicaid disability data.

And so I'll start by covering the definitions that we're using for this work, and then I'll present an overview of health disparities experienced by people with disabilities, the federal priorities, and methods and modes for Medicaid disability data collection. And then I'll present as well, the considerations for collecting these data, a summary of findings for all three types of demographic data that we've covered thus far, and then next steps for this work.

So there are many definitions of disability, and some of these definitions are narrow, such as those based on specific types of disabilities or to determine

eligibility for benefits, and others are broader and more inclusive of individuals with different types of disabilities. And given that our work is focused on using data for purposes of measuring and addressing health disparities, we use a broader definition of disability and focus on self-reported disability information that are collected as part of demographic data collection rather than in definitions that are used for determining Medicaid eligibility.

And so we define disability using three broad categories: functional disability; intellectual disabilities or developmental disabilities, ID/DD; and serious or severe mental illness, or SMI. And so we also acknowledge that there may be overlap between these categories. So I'll provide more information on these later on in the presentation.

When disability data are collected, they can be used to measure health disparities, and research findings indicate that compared to those without disabilities, people with disabilities are more likely to report poor health and chronic conditions, unmet medical and dental care needs, and poor provider experiences. And these

disparities can be even greater for populations who have disabilities and other intersectional identities. For example, Black and Hispanic adults with ID/DD are more likely to report poor health compared to those who are white. and sexual and gender minorities with disabilities are more likely than their counterparts to report poor physical or mental health.

The collection and use of disability data can support the monitoring of compliance with civil rights laws that protect individuals with disabilities from discrimination and measuring and addressing health disparities experienced by these populations, and so there are several federal priorities related to measuring and addressing health disparities and achieving health equity for people with disabilities.

In 2023, CMS revised their framework for health equity, and two of the priorities are related to disability. And so one of these priorities focuses on the standardization of demographic data, and the other focuses on increasing accessibility to health care services and coverage and improving the enforcement of accessibility requirements.

Additionally, in September of 2023, individuals with disabilities were designated as National Institutes of Health population with disparities, and this launched agency-wide efforts to fund research to measure and advance health equity for individuals with disabilities.

Medicaid disability data are collected in a number of ways on the Medicaid application, and in federal and state surveys. There is some inconsistency in how these disability measures are used across these modes of data collection. So this means the type of information and data granularity may differ.

For eligibility and enrollment data, state Medicaid collects disability information for screening and eligibility purposes and can get these data from many sources, including the state Medicaid application where states are required to include screening questions related to disability and long-term care needs.

States are also required to develop a supplemental or separate application for non-MAGI populations to collect additional information necessary to determine eligibility.

States may also receive information from SSA

about -- but these data are often limited, and that the state Medicaid programs may only receive information on whether someone is eligible for SSI and in some cases the date of onset for the disability.

Medicaid claims can also be used and include many types of data, including diagnosis codes that can be used to identify individuals with disabilities. For example, ICD-10 codes can be used as a proxy for disability to identify individuals with ID/DD, physical disabilities, and serious mental illness. But some of these populations -- some other populations may not be identified using this approach.

And some federal and state surveys ask self-reported disability questions, and there are many validated measures to identify adults and children with different types of disabilities. There are also many categories that are used to group individuals with disability based on the type of disability or dimensions related to impairment, activity limitation, and participation restrictions. And so for the purposes of our work to assess survey measures and data availability, we categorized survey questions based on whether the questions could identify individuals

with functional disability, individuals with ID/DD and SMI.

And so in our review of 13 population health surveys, we found that 10 surveys include one of the two most commonly used functional measures, disability measures, which are the ACS set of six questions and the Washington Group short set, and the ACS measures are the same as those that state Medicaid programs can submit to T-MSIS.

And findings from our literature review and interviews with disability experts demonstrate that there are concerns with the validity of ACS and the Washington Group short set and whether they accurately identify the intended populations.

Additionally, in 2023, the U.S. Census Bureau proposed changing the ACS disability questions for the 2025 survey administration and would change them to the Washington Group short set questions. But these changes have been postponed until additional work is done to engage key stakeholders in this process.

In our review of population health surveys, we also identified three surveys that include questions to identify individuals with ID/DD. I do want to note,

though, that there are no established standards for administering surveys to ID/DD populations or for identifying these populations in national surveys.

And in our review, we also identified six surveys that include screenings for SMI, which include the Kessler-6 scale and the PHQ-9 assessment.

So this figure may look familiar. We've used it in our other two presentations on language in SOGI data, and these considerations reflect those that are identified in prior Commission recommendations regarding collection of race and ethnicity data and prior Commission discussion on demographic data collection. And so these key considerations are specific to disability.

State Medicaid programs primarily collect disability information to determine eligibility, but they can also be used to determine what services a person is already using and if they have additional service needs or accommodations.

Regarding research purposes, most states did not report that they're considering collecting these data, these additional demographic disability data, and were unsure of how they could use these for analytical purposes

at the state level.

Interviewed researchers and advocates emphasize the importance of collecting these data to ensure that individuals with disabilities are counted and included in research and to supplement clinical and eligibility data. However, in these same interviews, they also acknowledge the limitations with existing disability measures and the need for more research to develop measures that address the current limitations.

States reported challenges with updating state data collection and reporting systems, and regarding the updates to the application, states reported challenges with the CMS approval process for application updates. States that choose to modify the model application or develop an alternative application are required to seek CMS approval.

They also discussed applicant understanding the purpose of the questions. Applicants may require further explanation of the application itself as well from assisters about how this information would be used and how it differs from eligibility information collected. For example, in the Medicaid application, they include these questions in a separate demographic section and include

clarifying language about the purpose of these data.

Regarding the written oral translations, state Medicaid applications have to be made accessible to individuals with disabilities, and so any additional questions would be translated and provided with all written and oral translations.

States also share that applications can be long. So additional questions may increase the individual's burden.

Regarding the data systems, T-MSIS includes disability type, and this data element aligns with the current ACS disability questions, and states were required to begin submitting these data to T-MSIS by December of 2023.

During our interviews and in state survey responses, states reported more generally across all these data that any update to the application, there are challenges and administrative costs with updating the data system used to store and report state Medicaid eligibility and enrollment data.

Regarding the data quality considerations, self-reported data are considered the best method for collecting

information that reflects an individual's identity. And as with other data that are collected on the Medicaid application, these data may be completed by the individual themselves but also may be completed by the head of household.

Disability status can also change over time, and in particular, for children. So providing individuals opportunities to update this information can help ensure that their disability status, specific service needs, and accommodations are accounted for.

There are also many validated measures for collecting disability data that are used on federal surveys and administrative forms, but there is inconsistency across these sources, and this can limit comparability.

A data collection method should also allow for data to be generalizable to the Medicaid population, and this is inclusive of people with disabilities. And currently, survey data are limited by sample size and rarely have a representative sample of ID/DD individuals.

And then for data privacy, there are federal protections to ensure data privacy and protect individuals from discrimination on the basis of disability, and state

Medicaid agencies can only use beneficiary and applicant information for purposes that directly pertain to the administration of the Medicaid state plan.

So findings from this work, which includes findings on language, SOGI, and disability data indicate that most states are collecting the demographic data that they need for their state programmatic purposes, and that these data are often sufficient to meet those needs.

So, for example, with primary language, we heard that states almost exclusively use these data to ensure language access for individuals with limited English proficiency, and for disability data, we heard from states that they almost exclusively collect these data for eligibility purposes.

Regarding data that the majority of states do not collect, states were primarily interested in collecting SOGI data, and they were not sure how collecting LEP or demographic disability data would benefit their program or be used for analytical purposes.

States also can collect LEP and disability data and report them to T-MSIS, and so states did not report needing guidance on collecting these data.

For SOGI, states were interested in collecting these data but expressed concerns with developing these questions without guidance from CMS and without knowing how they would have to report them to T-MSIS. However, in November of 2023, CMS published guidance on collecting these data in the Medicaid and CHIP applications, which addressed this primary concern, and CMS expects that states will be able to report these data to T-MSIS by 2025.

So given these findings, we don't anticipate Commission recommendations related to language, SOGI, or disability data collection.

At the April Commission meeting, I'll present a draft chapter for the June report to Congress. The draft chapter will include considerations for collecting primary language, LEP, SOGI, and disability data.

So today would be most informative to receive Commissioner feedback on the key themes and messages to highlight in the chapter and on the considerations presented today and whether there are any other factors to include.

So I'll turn it back to you.

VICE CHAIR DUNCAN: Thank you, Linn. Again,

thanks for all the work that you've put into understanding what we're getting and what we're not, and as we highlighted in the first session, it's important for us to understand the populations that we're serving to make sure we're providing the programs that need to be provided.

So with that, any thoughts on what has been presented as we prepare for a report in June?

Patti?

COMMISSIONER KILLINGSWORTH: First of all, thank you, Linn.

Some incredible statistics in the conversations that we've had and the information you've provided, this gap between what eligibility data reveals versus what self-reported disability supports. Eleven and 43 percent I think is the information that we got. Clearly, there's a gap, and it's not easily explained. I think it points to the need for better information, and yet states indicate that they're not really focused on collecting additional data on disability. And we find that more than two-thirds of T-MSIS data on disability is unusable. So there's a need to do something.

I think in terms of considerations, what I would

like for us to really focus on is the why, the purpose for the data collection. What is it that we are wanting to support? Is it primarily programmatic? Is it primarily research? I think as an access Commission, right, we really need to be focused on those things that impact people's ability to access the services they need.

So what does it tell us about health inequities? What does it tell us about people's access to the appropriate accommodation? It's that form follows function. This isn't a building, but understanding what we want to do with the data in order to help us identify the kinds of data that are really needed and then the most efficient way to be able to collect and use that data.

I do worry that there are types of disability data that we are not collecting well, whether -- and it's really primarily those related to cognitive disabilities, whether developmental in nature or occurring later in life. Even when I looked at sort of those broad definitions of disability in that initial listing, I didn't really see cognitive limitations there. And I understand it's because we're looking for the cognitive to impact the functional, but I think it's easy for us to miss sometimes the nuances

of disability that people experience that can impact their ability to both access and benefit from the health care services that they receive.

Just one note from my own experience is that it is not at all clear to me why everyone who receives long-term services and supports should not be identified as having a disability, because we know there's a functional requirement to access those benefits, whether or not it's reported or reflected by their Medicaid eligibility category. And yet there's even a fair gap between people who are identified as receiving LTSS and having a disability. So there are some rational assumptions, I think, that could be made in disability data specifically.

VICE CHAIR DUNCAN: Thank you for your thoughtful comments, Patti.

Any other Commissioners?

Yes, Heidi.

COMMISSIONER ALLEN: I would like to highlight related to this topic in our chapter, reminding Congress of the recommendation to have a beneficiary survey and how that would be such a wonderful opportunity to be able to ask some of these questions that are being captured through

administrative data.

And, in particular, we don't -- I think it would be important to get information about mental health conditions that are not just depression and anxiety in that survey.

But I do think this is really important for a variety of reasons, and I think that's -- you speak to it well, but just the number of -- when we do have the information, the degree of health disparities that we observe in the population is so high that the idea that we could improve targeted services and come up with specialized approaches to serving Medicaid enrollees with different types of disabilities, I think seems so critical.

And thank you for your work on this.

VICE CHAIR DUNCAN: Thank you, Heidi.

Dennis.

COMMISSIONER HEAPHY: Thank you for the report. It's really good.

I'm on the task force that you've mentioned in the report, one in Massachusetts, and this stuff is really challenging. I think the first thing is that we should not be just using it for eligibility, but for states to

understand the composition of the populations that comprise the Medicaid population, they need to understand from a self-reported perspective how beneficiaries identify themselves and what their disabilities are.

While imperfect, I think the ACS is a good starting place as it currently exists. There's a lot of -- there's some resistance in the disability community about the change to the Washington survey. But with that, I would say the ACS, not to put a burden on states, but it's a very binary question, yes/no, that maybe having a Likert scale if people say yes, like somewhat, very much, or whatever.

And then in addition to that, to frame this in an equity perspective. This is really about equitable access to services and looking at discrimination against folks with disabilities where the presumption is people are unhealthy because they have a disability as opposed to people are unhealthy because of social determinants of health and lack of access to services.

I can share more information with you, but I think that what you've started here is really helpful.

In terms of folks with IDD and folks with SMI, we

have a long way to go to get adequate and appropriate questions, to capture what the needs of these populations are, and that's why even though I put forward the ACS, it's inadequate. And so perhaps states could start with implementing the ACS with the option of adding additional questions, but at least CMS putting a requirement for baseline set of questions out there, because states need to collect equity data anyway. So they should be part of that equity collection of data.

VICE CHAIR DUNCAN: Thank you, Dennis.

Yes, Adrienne.

COMMISSIONER McFADDEN: Linn, thank you again for the work. In addition to the comments that my fellow Commissioners have said I would just add that it would be nice to sort of bring in the piece around having these data around the demographics of the beneficiaries is also really informative to program administration when it comes to understanding the skill sets and accommodations that the provider community would need to have in order to appropriately provide true access for these beneficiaries. And secondarily, it also helps the states to understand some of the benefits that may be needed to sort of be

reevaluated and offered in the future for the program, to better reflect the needs of the beneficiary population.

VICE CHAIR DUNCAN: Thank you, Adrienne. Jami.

COMMISSIONER SNYDER: And just to tag on to Adrienne's comment, I also think the collection of this type of data is really essential from a network development standpoint, ensuring that you have an adequate network to serve the membership. In particular, in Arizona and in Texas, we faced a number of challenges related to serving individuals with intellectual and development disabilities who also had high-level behavioral health needs, sometimes individuals with serious mental illness. So I think the collection of this data is just really critical to informing states' efforts to ensure network adequacy for members with more complex needs.

VICE CHAIR DUNCAN: Thank you, Jami. Dennis?

COMMISSIONER HEAPHY: That the data be cross tabulated to better understand how disability disproportionately impacts folks of color and whether there is access to services that are equitable or not, because we know that there is data out there that's showing that African American and Black folks have less access to HCBS,

et cetera. And so we have to make sure that data can be used with SOGIs as well as other populations, because that is the model of the population that we're looking at.

VICE CHAIR DUNCAN: Thank you, Dennis. Anyone else?

[No response.]

VICE CHAIR DUNCAN: So Linn, I think you heard the importance of collecting this data and how it would improve access and services to those. Do you have any other questions or need anything else from the Commissioners?

MX. JENNINGS: No, thank you. This is very helpful. I appreciate all your comments.

VICE CHAIR DUNCAN: Thank you, Linn. And with that we go to break, or to questions.

CHAIR BELLA: Yes. Thank you, Linn. Thank you, Bob. We will open it up to public comment now for the first two sessions from this morning. If there are folks in the audience, virtual audience, who would like to make a comment please use your hand icon. We ask that you introduce yourself and the organization you are representing and that you keep your comments to three

minutes or less please. We will open that up now.

All right. We have one. Sarah.

PUBLIC COMMENT

* MS. PFAU: Yes, hello. My name is Sarah Pfau. I am in North Carolina, and I am a public health and health policy consultant.

It is my understanding that some of the challenges in any of the states' already extensive waiting lists for services, and I know that waiting list isn't the most P.C. term. We call it a "registry of unmet needs" in North Carolina, and here we have over 17,500 individuals waiting for HBCS waiver services.

So I do feel as though if there is a reluctance to collect data or analyze data at the state level, I do believe that there is a concern about identifying the needs and identifying the voluminous numbers of individuals who do, in fact, need services. And that, ultimately, leads to a need for state appropriations for the match in the services provided. And I do think that funding is, unfortunately, a fundamental issue in access to services, even when the need for access is identified.

Thank you so much.

CHAIR BELLA: Sarah, thanks for joining us and for your comment.

We'll give it just a second, to see if anyone else would like to make a comment.

[Pause.]

CHAIR BELLA: All right. I don't see anyone else at this time. We'll have another opportunity for public comment in the afternoon.

Is there anything else from any Commissioners, Kate, before we take a break?

EXECUTIVE DIRECTOR MASSEY: No.

CHAIR BELLA: All right. Well, you burned a lot of energy on these discussions. It's time for lunch. We will take a break. We will be back at 1:00 Eastern time, and be ready to engage again. We'll get started with transparency and financing.

So thank you all, and we'll see you back at 1:00 Eastern.

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

AFTERNOON SESSION

[1:00 p.m.]

VICE CHAIR DUNCAN: Welcome back.

Next, we have Policy Options for Improving the Transparency of Medicaid Financing with Rob Nelb. This has been a topic that we've been working through for many months, and in December, we talked about being able to find policy options to increase financial data transparency.

So Rob is going to share with us several policy options, and we'll need to provide input on our preferred options that the team can then take back for translatable recommendations to come forth for our June report.

So, Rob, thank you for the work and look forward to the report out.

POLICY OPTIONS FOR IMPROVING THE TRANSPARENCY OF MEDICAID FINANCING

* MR. NELB: Thanks so much.

So, as Bob mentioned, following up from our discussion in December, I'm going to be discussing some policy options to improve the transparency of Medicaid financing.

I'll begin with some background about financing in general and then zoom in on the existing requirements

related to transparency and then talk about some policy options to build on those requirements in the areas listed here.

Finally, as a reminder for why transparency is important, I'll review some of the new data we've actually collected from Texas, which has begun reporting provider-level financing data, and I'll show how that type of data can help inform assessments of payment adequacy.

The presentation will then conclude with a discussion of next steps. Today we'll be looking for your feedback on which policy options you'd like to bring back for a vote at a future meeting.

At this time, we're planning to include a chapter on Medicaid financing in MACPAC's June report to Congress, which means that the Commission would vote on options at our April public meeting. However, if you would like additional time to discuss any of these recommendations or if the Commission would like to consider any additional approaches, we can come back at the March public meeting and talk about them then.

So first, some background. As you know, the Medicaid statute permits states to finance the non-federal

share of Medicaid spending from a variety of sources, including state general funds, health care-related taxes, and IGTs or CPEs from local governments.

The Commission has previously recommended more transparency around the provider contributions to the non-federal share in order to enable analyses of net payments to hospitals and nursing facilities. These recommendations have not yet been implemented.

In this report cycle, we're considering ways to expand upon MACPAC's prior recommendations and also provide more detail about how these recommendations should be implemented.

Some questions to consider are whether the new data should be collected by states or providers, whether the Commission should expand its recommendation to include all types of Medicaid payments to providers and all types of Medicaid financing, and finally, a question about whether additional state-level data would be helpful to either validate provider-level data or just provide more context about Medicaid financing overall.

So, under current law, there's very few transparency requirements for Medicaid financing methods

and amounts. States are required to answer a set of five funding questions every time they make changes to their payment methodologies in the Medicaid state plan or in a managed care-directed payment. However, responses to these questions are not publicly available.

In addition, it's worth noting that for provider taxes, for some of them, states do need to provide some more provider-level information on them, but that information isn't required to be updated after the tax has been approved.

In terms of financing amounts, states are statutorily required to submit information on provider taxes, and this is done through CMS Form 64.11. This information is for informational purposes, and according to our analyses, the information collected appears to be incomplete.

At the provider level, there are no existing reporting requirements. States can choose to report some provider tax amounts when they submit upper payment limit demonstrations, which are used to determine supplemental payments fee-for-service; however, they're not allowed in the UPL demonstrations. They don't include information

about IGTs or CPEs, which also affect the net payments to providers.

CMS does occasionally -- they do have the authority to request more information on financing at the provider level as part of a financial management review, but that's really only done when there's a known compliance problem and isn't a regular part of routine monitoring.

So, given these limitations, let's talk about some options to fill in the gaps.

Based on your feedback at the last meeting as well as feedback we've been hearing from the stakeholders we have interviewed, including states and providers and federal officials and other experts, we developed a set of policy options for you to consider today. For each option, we've evaluated them based on the three policy criteria listed here.

First is usefulness. We looked at whether increasing transparency of this data would be useful for enabling analyses of net Medicaid payments, which is what the Commission has previously recommended.

Second, we looked at comprehensiveness and specifically whether the transparency method would provide

a comprehensive perspective on all types of Medicaid payments to providers.

And, finally, we examined administrative burden and asked the question of what option has the least administrative burden for states, providers, and CMS.

Because all these options are building on existing requirements, there will be some administrative burden associated with them, but the goal is to minimize that so that resources can be used most effectively.

So let's dive in. First, looking at options to improve transparency of state Medicaid financing methods. Here, we looked at two options, first requiring CMS to make its existing funding questions publicly available, and the second option was requiring states to submit a new comprehensive report describing all of their Medicaid financing, which would also be made publicly available.

Based on these criteria, we thought it would be more useful and comprehensive to develop a new report rather than just make the existing questions publicly available. This is because states submit the funding questions for every single SPA and directed payment they submit. So there's multiple that are submitted each year,

and it's hard to use them to get a full picture of Medicaid financing. A comprehensive report would provide an opportunity to bring all that together in a format that's more useful for policymakers.

There is a little more administrative burden with creating a new report, but as we'll discuss, there may be opportunities to reduce that.

So with any recommendation when we do these reports, the Commission has an opportunity to describe its rationale for the recommendation and also highlight potential design considerations for policymakers to consider if they adopt the policy, which, of course, we hope they do.

The design consideration section is an opportunity for the Commission to elaborate more on what specific types of information would be useful for CMS to collect. This slide has some examples of potential ideas we could discuss more in the chapter, and in your memo, it discusses how some of these sort of relate to the existing questions that CMS is already asking.

Another design issue to consider is how some of the new reports should relate to what CMS is already

collecting. Obviously, CMS has to balance its oversight requirements with transparency. However, there may be opportunities to reduce reporting in the future. So, for example, if in this new comprehensive report, CMS is already getting information about a certain financing method, it may not need to ask about that again when a state submits a SPA or makes other changes.

The next area we looked at were opportunities to improve transparency of state financing amounts. The two options we considered were building on the existing form, the 64.11, to include IGT and CPE financing as well as the provider taxes that are already being reported. This recommendation would also call for more data quality controls to improve the quality of the data that's being reported.

The second option to consider is putting the financing information on the CMS-64 expenditure reports, which states use to draw down federal funds for Medicaid expenditures. The CMS-64 reports have the advantage that they are more detailed in terms of what categories of Medicaid spending the funding is going towards. However, when we talked to states and providers, we realize that a

lot of folks don't actually track the financing in that way, and so doing so would be administratively burdensome. And so it seems like the first option of just building on the existing report best fits the Commission's criteria.

If we go with the first option, an important design consideration is what steps CMS should take to improve the accuracy of the data submitted. As we've heard, when we asked why the current report isn't being filled out completely, most interviewees noted that CMS hasn't prioritized state submission of this data, and again, it's just for informational purposes. So it’s sort of a less pressing priority than other data that it collects.

Another thing that came up is the fact that CMS kind of has few enforcement mechanisms to ensure accurate data. So if a state doesn't submit complete data, the current option is to withhold your federal funding, which is a pretty large penalty that doesn't get used very often.

In thinking about internal controls, we learned during our interview process about some steps that CMS took in the early 2000s when it first implemented the five funding questions. Specifically, they created a national

institutional reimbursement team of analysts that would help double-check the information that states were providing by checking other state budget documents and other things. And that process seems to have worked pretty well.

Last but not least, I want to talk about improving transparency of provider-level financing data, which, of course, is why we're all doing this to get better analyses of net payments to providers.

Here, we examined three different policy options. The first would be to collect information from the providers. This would be done through a provider cost report. However, it could probably only be done for large institutional providers that already submit cost reports, and so it wouldn't be quite as comprehensive. In addition, it would be harder to get information -- we know that cost reports include information on taxes, but it's not really clear how local government contributions are counted.

The second option we looked at was getting the information from the states and building on some new provider-level supplemental payment reports that Congress has recently acquired and CMS has begun implementing. The

second option was one that CMS had proposed in the MFAR regulations a couple years ago. One of the downsides of this, again, in terms of comprehensiveness, is that it would only include financing information for supplemental payments and not for base payments.

Finally, the third option that we considered, and the one that seems to best meet the various criteria here is requiring states to complete a new report that would include provider-level data but wouldn't require them to track it, again, to sort of which category of service it was but would include both information on the financing of base and supplemental payments.

This approach has actually recently been implemented in Texas, and so as we think about design considerations, we can hopefully learn from the Texas experience. Some of the benefits of the way that Texas is reporting the data is that the data, the provider-level data, includes identifiers that can be linked to other publicly available data, such as Medicare cost reports, to understand the characteristics of hospitals that are receiving -- that are financing different parts of Medicaid payments.

It's important to note, though, that this Texas report didn't require some administrative investment to implement. So I think in 2019, the state legislature had required the state to report data, but they didn't provide them any resources, and the state wasn't able to fulfill that request.

Later in 2021, the state legislature did allocate approximately $4 million a year to help support this activity, and the state has used that funding to help finance -- help support about 18 staff and also invest in an IT system to collect the data. And that result has been much more successful, and so in their recent reporting period, 99 percent of the 1,200 local government entities who had to report were able to submit that information.

Texas may be an outlier in terms of the complexity of their financing. There's quite a number of providers, and it's a local tax that then goes from the local government to the state. So in other states that have a more simple tax or IGT arrangement, it may be less administratively burdensome for the state to collect that information.

So the Texas financing data is pretty helpful,

but there, of course, are some limitations as with any data. One thing, for example, to note is the timing. So sometimes the time when someone submits their tax payment or IGT is slightly different from the timing when the supplemental payment was made. And so the Texas report kind of clarifies those differences in timing, but it's just important to keep in mind interpreting these data.

Also, one of the notable things about the Texas data is that it tracks administrative fees. Again, this is a locally administered tax. It goes to a locality. The locality retains an administrative fee for processing it and then sends that money on to the state, and in the new report, some of those administrative fees are tracked, which is helpful to get the full picture of financing.

So once we get this data, the question is, how would we use it? And so to inform those discussions today, we've linked some of that Texas financing data to information we have on Texas's managed care-directed payments in 2022. And for illustrative purposes, we chose a public hospital that finances payments with an IGT and a private hospital that finances the payments through a tax.

Some caveats about the data. First the managed

care-directed payments are projected, and so actual payments may differ from what was projected. The Commission has already recommended collecting data on actual directed payments, but we used what we had.

And then another piece to note here with directed payments is that a pretty large share, about 6 percent of the directed payment, is actually retained by the managed care plan as an administrative fee. So of the $4.7 billion in directed payments that we looked at, about a quarter of a billion were retained by the managed care plan. So those are just important, again, to get a sense of where all the money is going.

And then in this example, we're just focusing on one of the eleven supplemental and directed payment programs in Texas. So there's quite a lot, and there's more information in the back of your materials about how they all interact.

So let's dive into the data. In this first example, for a private hospital, the base, this looks at their payments compared to the Medicare payment rate. And so on a gross basis there, the base managed care payment rate was about 65 percent of Medicare, and then the managed

care-directed payment helps boost payments above that to a total of 152 percent of the Medicare rate.

This is permissible in managed care because, as we've reviewed, although in fee-for-service, the supplemental payments are limited to what Medicare would have paid, and for directed payments, you can actually go up to what the average commercial rate is or a bit higher if you -- anyway, but yeah, this Texas one would go up to the commercial rate, so that's the limit here.

With taxes, there are two different ways you could consider calculating the net payments to the provider. One way, which is the way used on UPL demonstration reports, is to subtract the Medicaid share of the tax cost. So, in this case, it's a tax on total patient revenue, and if in this case, you know, about 20 percent of the patient revenue comes from Medicaid, you could just subtract 20 percent of the Medicaid -- of the tax cost to calculate net payment.

However, another approach and the one if you talk to providers that I think they would prefer to use is to subtract the entire cost of the tax from their payment. And when you do so, in this case, you find that the net

payment to the provider after subtracting the full tax cost is below what Medicare would have paid.

And this helps illustrate how, you know, whether you count financing or not, you get different perspectives of Medicaid payment adequacy.

Next, let's look at the example of a public hospital in Texas. Here, the base rate in managed care is about 42 percent of Medicare. It's a bit lower than the private hospital, and then to offset that, the state has actually what's called a "passthrough payment" in place, sort of recognizing the fact these public hospitals don't have as much leverage to negotiate with health plans. They allow them to kind of guarantee a minimum rate that the health plans pay them. And so adding in that pass-through payment, sort of the Medicare base rate, I guess we could say, would be about 88 percent of Medicare. And then the directed payment is on top of that.

In this case, the public hospital finances the non-federal share of both the pass-through payment and directed payment, and again, you can see after subtracting those costs, although the net payment is below what Medicare would have paid, again, illustrating how these

data give you different perspectives of Medicaid payment adequacy.

So, with that, I'll turn it back to you all. We're really looking for your feedback on the policy options presented, specifically figuring out which options we should bring back and whether there's any additional points we should consider.

Also, if there are any additional options we should consider, now is your chance to raise them or forever hold your peace. So we welcome your thoughts and ideas, and as I mentioned, we'll try to pull all this together for the June report.

To help guide your conversation, here's a quick summary of all the options, and I'll turn it back to the Chair.

VICE CHAIR DUNCAN: Thank you, Rob. I appreciate it. And I just want to go on record saying how much I appreciate your persistence in trying to understand Medicaid financing and revealing the transparency of it. I think the information you have shared not only today but in previous meetings shows the complexity of it all, and thank you for working through that.

With that I will open it up. Jami?

COMMISSIONER SNYDER: Thanks so much, and thanks so much, Rob, for your work on this important topic.

In terms of the policy options that you offered up, under the state financing models arena I would recommend, in line with your Recommendation 1B for consideration because states do have the data available, readily available, and the idea of trying to pull all of the state plan amendments together I think is just kind of an unmanageable task. So definitely 1B on the state financing models component of the discussion.

Around the state financing amounts, again I'm in agreement with your general recommendation around 2A. I like the fact that it would include all types of financing for Medicaid payments. I don't think 2B is feasible for certain states, quite frankly. And I do like the idea of kind of looking back to the committee that was formed, the NIRT, and using that as sort of a platform, maybe reestablishing that committee to provide technical assistance and guidance to states to ensure data accuracy.

On the provider financing amounts item, I too would go with 3C. I like being able to sort of build off

some of the learning from the Texas work that has been done. I like the fact that it includes base and supplemental payments. I think that is critically important.

I do think with 3C it is important to note while it is less administratively burdensome, it's not without an administrative burden. And so it does impose some level of lift for states that I just think we need to acknowledge that.

And the other thing I just wanted to say is I think like you did in your analysis of some of the Texas work that's been done, it is really important to kind of pull out that administrative component of directed payments. I thought it was really enlightening looking at both on the managed care side and the local entity side. That was really helpful.

VICE CHAIR DUNCAN: Thank you, Jamie. Melanie, then John.

CHAIR BELLA: Thank you, Bob. Can we go back to Slides 14 and 15, please? This is really fun because I was Medicaid director when those five questions were introduced, and this is bringing back glory days.

I just want to make sure that we all understand the analysis here on both of these slides, especially, Rob, if there's anything else you would want to say to us about how it might influence. Because I lean exactly where Jami was, but I didn't know if there was any more color, and I wanted to make sure the Commissioners understand kind of what's on both of these slides and see if there are any questions there. Because this is the best example we have.

I have questions that aren't necessarily yours to answer about why the administrative fee is that rate, and how does Texas consider when you're looking at 140 versus, you know -- but I don't know that that is relevant to our work as much. But I don't want to leave these two slides without making sure that we all fully understand what's on them. Does everybody feel good about the analysis and understanding the two different ways we can look at it? And Rob, is there anything else you'd say that you learned, that you would think about differently?

MR. NELB: Yeah. I mean, I think the purpose of the data is to raise questions, and that's why we went into it. And the Commission hasn't said you should assess payments on the gross basis or a net basis. But we talked

to people, and some people say they're getting paid too much and then other people say they're not getting paid enough. And this sort of helps explain the two sides of the coin and how you can be both above Medicare and below Medicare at the same time. You know, it's like a paradox that is the reality of how this works.

You know, perhaps as we continue work in this area in the future this could raise some policy questions you could think about. So for example, the question of when you calculate costs on a DSH audit or in a UPL do you count the tax or the IGT currently. The middle option is what's done on taxes and then IGTs aren't counted at all. So it has sort of a disparate impact on public providers that tend to finance through that method versus private providers that tend to finance through taxes.

Yeah, more questions than answers, but that's part of our rationale, is that we think people should be having these discussions and see where it leads us.

VICE CHAIR DUNCAN: Any follow-up?

CHAIR BELLA: No. Tim may have had a question on this.

COMMISSIONER HILL: I had a question but John was

first.

VICE CHAIR DUNCAN: Okay. John, then Tim.

COMMISSIONER McCARTHY: So I am always, from my old world, worried about, from the state perspective, how much additional work that you have, but I also am a big proponent of transparency and getting those things out there. So, Rob, my question is, if we went with just 3C, wouldn't we be able to get what we were looking for in 1A and maybe 2? Like instead of saying, hey, do 1 and 2 and 3, if we just said 3, new report, like Texas, we would theoretically, on that report, I'm guessing, be able to get what, because it's a new report, what are IGTs with our taxes. Am I reading that correctly or incorrectly, or is it a possibility, I should say?

MR. NELB: Well, you know, we're presenting them in one order, but probably again, the most important for what we're trying to do is that net payment data, which is the third option there. But I can walk back and show kind of what additional stuff we would gain throughout the report.

The Texas report just includes provider contributions to the non-federal share, but a full report

on financing could also include state contributions, like the state general fund, to get the whole picture of the pie of where it all comes from.

CHAIR BELLA: Could we go to Slide 17, please? Sorry, so everyone can see it.

COMMISSIONER McCARTHY: But couldn't we include that in the report in 3C?

MR. NELB: Let's see. Yeah, but it would be kind of an addendum to the report because it wouldn't -- I mean, we can figure out exactly the right format or things, but yes, there is certainly a way. Yeah, you could submit it as one report rather than two different ones, or we say that we want provider-level financing amounts and the state general funds. Or if you really want to know if there is an interagency fund or those sorts of things.

When GAO did a survey, which is sort of what we were basing the second option on, they asked states to report on all of the taxes financing, and so that's the piece that would be added there.

And then when we get to the first option about methods, there are some specific things that you don't get just by looking at the numbers in terms of the context

about, for example, the tax, understanding what the tax rate is. You know, and these are maybe less important for analysis of net payment but might be relevant for other future analyses and Medicaid financing policy.

So for example, there have been efforts in the past to sort of change -- there's a safe harbor threshold about how high the tax can be as a share of revenue. But whenever Congress considers it's like there's no data actually to know how many people are at whatever threshold. So that kind of thing might be useful.

And, you know, the thought, I guess, that this first thing -- and again, I guess these all could be like one big report, right. So you would have this first part with the methods and your notes and caveats before you get into the numbers, but giving you that context. And then primarily getting that provider level data but then also filling in, okay, what is the state share as well.

Yeah, we are presenting them as three options, but they could certainly be rolled into one big report that would give the information we need for analyses in the right context for everyone to interpret it.

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

John. Tim?

COMMISSIONER HILL: So a bunch of stuff. In terms of why we're doing this, I think, well, two things. One, because we're an Access Commission, I think it is also important when we think about financing methods, particularly taxing methods, to have an equity conversation. We talked about this a little bit last time, that there are providers that do not have taxes available to them, HCBS in particular. When we think about financing the Medicaid program, in some respects it is an advantage to some providers to be included in that list while others are not, and what does that mean for the program and how it's funded? I think that would be important to kind of consider.

I also know we're talking about provider-level understanding and evaluation, but I was a Fed so I'm going to say it -- I think trying to determine an effective or actual FFP, when you consider all the financing methods and how it's washing through, and thinking about what that means for the federal share I think is important.

A couple of considerations. One, I guess to the recommendations, and I'm not sure I have views on any of

the individual ones other than to say, which you kind of just led to, my view would be a de novo report, new, not based on something that exists -- just my understanding about how stuff is working at CMS and kind of how incrementalism just makes it very hard to make things -- I would just think a new report that can get reported on the things that we think are important, are important.

And I also think that what's not talked about in here, thinking about and being sure to capture data under 1115 waivers. That has always been an issue, the 64 doesn't always report that, and making sure we have that.

And then if you can go to Slide 14, and I don't know, again, we're talking about net provider payments, but the disappearing revenue there goes somewhere. And so having an understanding about how is the state using that disappearing revenue. Is it going to other hospitals? Is it been propping up a waiver? I don't know. But like that more policy-level conversation of it's not like a state is retaining that to build roads. We stopped them from being able to do that. It's got to be going back into the system. Is there an analysis that can tell us how they're using those taxes or IGT revenue, that's not going to this

particular hospital but it has to be going somewhere in the system.

So if you could just get all that done by March it would be great.

VICE CHAIR DUNCAN: Thank you, Tim. I said that he was persistent. I don't know if he's that persistent.

All right. John.

COMMISSIONER McCARTHY: I just leaned over to Jami and said, "Wow, I actually agree with Tim on something" which, in the 25 years we've worked together probably one of the first times. Not bad. Yeah. Besides haircuts and facial hair.

I did want to go back to what Tim's last point and question was, which is a really, really good one, but I didn't think that that chart that you showed necessarily shows that, which is Tim talked about the disappearing taxes or IGTs, which, for instance, I'll just give you an example, and I'll just use my example from Ohio. Ohio taxes hospitals. There is a tax. They get the money back. The state keeps some amount of that -- let's just say it was $250 million. That $250 million doesn't go back to hospitals in the form of increased payments, but Medicaid

did use that to finance the rest of the Medicaid program. So there's that.

That chart there doesn't really show that, right? That one just shows that -- and I just want to make sure I have the math right -- that they paid, I'll make it $100 in taxes to get that 87 percent. And so all we're doing is subtracting off that $100 in taxes to get to the 65 plus 24 percent, right? On that one. That's not counting administrative fees or others.

MR. NELB: Yeah. This is from the provider perspective, and from what we understand in Texas most of the tax paid is passed back to the providers, the IGTs. There is another issue, potentially, where then the providers, maybe just to beat the fund themselves, which is not in here, but we think most of it's going back. But there are other states that we've been interviewing that the tax is used to fund their Medicaid expansion or other things in general, and so it doesn't always sort of go back to the provider. Or some of these admin fees that are retained by the managed care plan or other entities would be there.

I think the way to maybe interpret, from the

provider level, to see if that's happening or not, is to sort of look at the payments that they were paid compared to the amount that they contributed. And so if it's a simple example of a 50 percent FMAP, normally if you put in $100 you get $200 back. If the provider is putting in $100 and only getting $150 back, that means there is sort of like $50 that is not going back to them, but it is going somewhere else in the program.

And so we have asked questions, is there a good way, at the state level, to really track where it all goes? And it was hard to tell because it kind of goes into one pot and it's hard to see where it goes. But I think in some ways, actually, on this provider graph, if you interpret it the right way it can help illustrate to what extent is the tax being paid back to providers, that finance is paying versus to what extent it is going to providers in other parts of the program.

So hopefully that helps.

COMMISSIONER HILL: Can I just, one addendum, and another thing that John and I will probably agree in, because we talked about it here and I meant to mention it. I am all for collecting the data and creating a new report,

but I don't think we should be, you know, rose-colored glasses here. There are more people, based on what you just said, working in Texas on this, so they're probably, at CMS, working on providing financing, right, if there are 18 people in Texas.

So, I mean, there is a real issue, both at the state level and at the federal level, with collecting more data and doing more work that perhaps may not get done well or get done sufficiently because there's just not resources to do it. I don't know what we can do about that, but it is an issue.

MR. NELB: And this has been part of why we would like to make the data publicly available so that it's not just up to CMS to analyze it. But if it's available then other people can look at it too and come to their own conclusions.

VICE CHAIR DUNCAN: Thank you, Tim and Rob. Sonya, then Jami.

COMMISSIONER BJORK: Thank you. What a great discussion about transparency. Thanks for all your work. I always want to balance it with the administrative burden part, so that's why I favor 1A and 2A, because on 1A making

something that already exists public, and then on 2A adding to the form. That's not as administratively burdensome.

But of the 3's, I think 3C is a good option because we already have the Texas example that we can follow, and I think if we follow 3C we're going to have to allow some time for states to accomplish this, because I think a lot of the states aren't going to have the data to be able to complete it. And you mentioned in there the concern that the burden of it rolls all the way down to providers, and it can be a lot if you are already taking 18 staff at the state and doing a whole new IT software system in order to track all this. All these things take time to get into place, so maybe a staggered rollout or something like that. Thanks, Rob.

VICE CHAIR DUNCAN: Thank you, Sonja. Jami.

COMMISSIONER SNYDER: Thanks so much. So I really like the idea of a new standalone report. I think that is definitely something we should explore. I wonder, however, if transitioning to kind of a new comprehensive report, if that really results in any sort of less of an administrative burden for states, sort of decreases the administrative burden for states. So I think that's just

something we should take a look at.

And Rob, remind me, have you been talking to state financial officials within Medicaid agencies? So it might be worthwhile, just from a technical standpoint, to have that conversation with them.

MR. NELB: The conversation about the admin burden of a new report? Yeah. So, I mean, they didn't think, actually, that 1B would be too much. They often will maybe do a report like this for their state legislature or different things. I mean, it's like the data is there and it's pulled there.

I'm wondering about making this all one big report so that all the notes and caveats sort of follow along with the numbers and can interpret it. So we can think through that.

And then, yeah, when you think about 1A it might be worth looking in the appendix of your material that has these are what the actual funding questions are. Some of them are useful. Some of them sort of refer to old policies that aren't really particular relevant today. So it's just something to think about.

VICE CHAIR DUNCAN: All right. Angelo, then

John.

COMMISSIONER GIARDINO: Rob, you've been talking, obviously, to people and interacting with folks from Texas. So would you say that your conversations are trending towards that this was worth the investment that they're making? Is this turning into something valuable for the Medicaid program and the Medicaid recipients, or is this just being done?

So what's your sense? Like what's the value of doing this?

MR. NELB: Sure. I want to be hesitant there. I mean, the program folks we talked to and other folks to get a sense of it. I mean, the state legislature, I think, has certainly seen value in this, and it might be part of the complicated way that Texas is financed is that these local -- they're kind of almost like, with the federal government, where we don't know what the states are doing. The state government in Texas sort of didn't know what the localities were doing in terms of raising these local taxes, and so there was sort of the state legislators' impetus to create this new report. And I think they found it valuable and important enough to invest the resources in

it, even when they realized it was going to be a little more or less than they thought.

It's just been two years of the reporting so it's unclear how it's changing policy or things. But, I mean, I think we can see from the discussion today that this type of information does have some use in getting a fuller picture of the payments. I mean, we certainly hear from the providers that they kind of feel like, you know, in some of these discussions, you know, you look at Texas and billions and billions of dollars going out in these directed payments. It looks on the surface like all the providers are getting paid sort of too much. But then when you net out the payments it's a different perspective.

So I think from the provider perspective they would value people seeing both sides of the coin.

COMMISSIONER GIARDINO: Thank you.

VICE CHAIR DUNCAN: All right. John?

COMMISSIONER McCARTHY: I was thinking about my comments earlier. So I do want to clarify and especially after Sonja brought it up.

I think 1A is like the least we can do, right, just to make that public, and I do -- I think that's where

we could like make -- whatever you have, make public.

And I wanted to go back to that last point that you just said and the importance of this, and it's -- for me, as a policymaker and looking at things is we've been seeing more and more reports coming out of various providers being overpaid for things. And it's like, oh my goodness, now entities are making money off of Medicaid and those types of things. But then when you dig into it, it may not -- that's not the story, because it's the whole like, "I gave you a hundred, and you gave me $101 back. Okay. I have an extra dollar." But, you know, it wasn't that. So to me, that transparency and importance of seeing what are providers really getting paid is really important, especially when we talk access.

I know Jami and I were talking a little bit earlier about, in Medicaid, as the Medicaid director, one of the biggest areas around access is payments and what you can pay providers, and you see that happen.

We saw it in Ohio during the implementation of Affordable Care Act when primary care rates went up to Medicare, but we didn't see additional providers join Medicaid. What we saw was those providers in Medicaid saw

more Medicaid patients, because their payment rates went up, and when they dropped back down, you saw that a percentage of people seeing go back down. So this is an important area to understand and how those things interact.

And then back to what Tim said, at some level, there is a bias of who can use these funding mechanisms, which provider types can use these funding mechanisms and which can't. So it's really important that we find these things out.

MR. NELB: And stay tuned for more on physician payment and access after the break.

VICE CHAIR DUNCAN: Coming soon.

[Laughter.]

CHAIR BELLA: All right. Melanie?

CHAIR BELLA: Yeah. I just have a slight difference of opinion with John. Having done the five questions, making those public is like theoretically providing transparency, but no one's going to be able to make sense of those. It's like making public the D-SNP models of care. That's a theoretical thing, but it would require a great deal of translational ability to really try -- I think, unless people's answers have become a lot

clearer to be able to do that. So I do think we need to provide a new report that is actually understandable by the majority of people whom we think want this transparency.

And I guess, Rob, I would like to -- you know we love graphs, like we love focus groups and panels with states. I would like to just make sure at some point, we do have the graph of all the different funded CPE, IGT, DSH, directed payments, blah, blah, blah, blah, blah, blah, and we're making sure that like whatever -- whether we're going to add on to an existing report or create a new report, we understand which things would be covered in each of those if they wouldn't all be covered in one of those, so that we can make tradeoffs about what we know and what we're willing to not know because of some good or bad reason as we move forward.

And then I'd also just like to remind us like right now, sort of like on our directed payment work, we're going on like a fact-finding mission, right? We're not making value judgments about where extra money is going and whether that's good or bad. Like, first, we're just fine trying to find out what in the world is going on, and then I think it will -- I won't be here, but it will set the

stage for wonderful conversation about -- from you all about how to make sure it's properly going in the right directions.

But it would be really helpful for me if -- and you probably have. We've probably seen a graph like that, but some of these things would get at more checks in the box than others. And I think our goal is to get to as much as we can, even if we can't get there on day one.

So thank you for all of this.

VICE CHAIR DUNCAN: Thank you, Melanie.

Anyone else?

Jenny.

COMMISSIONER GERSTORFF: So I have concerns with the accuracy of the data and so expanding CMS 64.11, and you mentioned that CMS hasn't prioritized reporting for that, and also, they have limited enforcement mechanisms. So kind of revisiting CMS's authority to enforce these pieces with something less than withholding entire federal share would be important.

MR. NELB: Yeah. And we can think through -- I mean, so for an example, a potential approach, you know, that's been done with the 90/10 funding and I think also

with the recent unwinding report is just to withhold a portion of the admin thing as opposed to your full amount. And so we could think through that if you want us to come back with that option or something.

COMMISSIONER JOHNSON: Thank you, Jenny.

Anyone else?

[No response.]

CHAIR BELLA: All right. Seeing none.

Rob, do you feel like you got enough work between a pie chart, combining all the options, and creating new ones?

MR. NELB: More than enough. Thank you, but I will be back for more.

VICE CHAIR DUNCAN: All right. Thank you, Rob, for the work that you've done. Extremely important.

With that, I'll turn it back over to Madam Chairman, Melanie.

CHAIR BELLA: Thank you, Bob, and thank you again, Rob.

All right. We are moving on to one of our favorite acronyms, SMACs, the state Medicaid agency contracts for D-SNPs, and Drew is going to join us to talk

about what we heard with some interviews with stakeholders. No, Kirstin and Drew. Wow. Bonus. Welcome.

STATE MEDICAID AGENCY CONTRACTS (SMACs): INTERVIEWS WITH KEY STAKEHOLDERS

* MR. GERBER: Thank you all. We're happy to bring back the topic of state Medicaid agency contracts, or SMACs, and we'll be walking through some of the findings from our interviews with key stakeholders to that process that we conducted back in November.

To begin, we'll briefly go through some background on Medicare Advantage dual eligible special needs plans, or D-SNPs, and the SMACs that they must hold to operate. Then I'll describe the interviews we conducted with stakeholders in the SMAC process, before outlining the key themes we heard around contracting considerations, SMAC authority, data and reporting, monitoring and oversight, and performance improvement and enforcement. Finally, we'll end with some questions to kick off the Commission's discussion and next steps for staff.

Medicare Advantage dual eligible special needs plans, or D-SNPs, are a type of special needs plan designed to provide targeted care to dually eligible beneficiaries.

D-SNPs differ from other Medicare Advantage or special needs plans because they're required to contract with state Medicaid agencies, or the SMAC.

As a reminder, the level of Medicaid-Medicare integration in a D-SNP can vary, and I'll touch on that in a little bit. But in 2021, briefly highlighting some new Duals Data Book numbers, which you'll hear more about at the end of the day, 54 percent of dually eligible beneficiaries enrolled in Medicare managed care were enrolled in a D-SNP. However, we know the majority of these beneficiaries are enrolled in coordination-only D-SNPs, which typically provide minimal levels of integration.

Federal law sets the floor for what's required of D-SNPs in a SMAC. Minimum requirements for coordination of Medicaid benefits were established for D-SNPs by the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA, with additional requirements, including those defining designations for higher integration plans, included in the Bipartisan Budget Act of 2018.

States may include requirements in their SMAC that go beyond what federal law requires in search of

greater levels of integration or to better tailor how D-SNPs serve their Medicaid populations.

Current federal requirements are minimal and include such requirements as information sharing regarding care transitions. For a more fulsome list, Commissioners may refer back to their meeting materials for other federal minimum requirements.

Back in November, we presented to the Commission on commonly included SMAC provisions. In order to better understand how states design their SMACs as well as oversee and enforce the requirements included in those contracts, with the help of a contractor, we conducted a series of interviews with key stakeholders.

We selected five case-study states on the basis of several criteria. First, each of these states contract with plans and require higher levels of integration. These include highly integrated dual eligible special needs plans, or HIDE SNPs, which are required to cover either long-term services and supports, or LTSS, or behavioral health, either directly or through an affiliated Medicaid managed care plan under the same parent organization.

States may also require a FIDE SNP designation. A

FIDE SNP is a D-SNP that, well, as of next year, is required to cover LTSS and behavioral health under one legal entity.

And then in the case of California, coordination-only D-SNPs, which qualify as something called an "applicable integrated plan," meaning they cover a range of Medicaid services through an affiliated Medicaid managed care plan, use an integrated appeals and grievance process, among some other requirements.

A second criterion we used to pick our case-study states are that these states include requirements in their SMACs that go beyond federal minimum requirements.

Finally, we chose states that conduct some level of monitoring and oversight of these requirements.

In the interview process, we interviewed state Medicaid officials in each of the five case-study states, federal officials at the Centers for Medicare and Medicaid Services, as well as health plan representatives for two D-SNPs operating within case-study states.

Our interview surfaced key themes across several domains, contracting considerations, SMAC authority, data and reporting, monitoring and oversight, and performance

improvement and enforcement.

Beginning with contracting considerations, CMS requires a SMAC for D-SNPs to operate, but states are not required to contract with every plan. In our interviews, we heard from state officials that they appreciate this authority over contracting, as it allows them to prioritize contracting with health plans that further state goals. For example, states consider whether contracting with a D-SNP would strengthen Medicaid and Medicare alignment.

All five of our case-study states require the use of exclusively aligned enrollment, which means that D-SNPs may only enroll beneficiaries that are enrolled in the affiliated Medicaid managed care plan under the same parent organization as the D-SNP.

States as well as health plan representatives described the benefits of plan alignment to us in our interviews, and of course, the topic has been the focus of recent federal rulemaking as well.

In our interview, states also said they prioritized limiting disruptions for beneficiaries in regard to plan enrollment. For example, California has staggered its rollout of its exclusively aligned enrollment

requirement. California currently requires new D-SNPs to operate with exclusively aligned enrollment. However, unaligned plans do exist and are currently allowed to continue operating with frozen enrollment.

By 2026, all of their local Medi-Cal -- or Medicaid plans will be required to stand up a D-SNP and operate with exclusively aligned enrollment.

We heard that states also rely upon feedback from health plans as they consider SMAC requirements for the coming contract year. State staff said they meet regularly with D-SNPs to solicit feedback on plan changes, which both state officials and health plan representatives said contributed to a strong working relationship.

While health plan representatives described some state-specific feedback they've provided, across states, we heard health plan representatives note that SMAC approval timelines can be difficult to reconcile with Medicare deadlines.

Turning to the SMAC authority, CMS officials emphasized in our interviews that states are free to include any requirements in their SMAC as long as they do not conflict with federal law or Medicare requirements for

D-SNPs. Officials told us that they could not recall an instance in recent history where they prohibited a requirement that a state wanted to include in their SMAC.

However, we heard from state officials that they were mixed on their perceptions of the level of flexibility that the SMAC afforded them, and they may benefit from more CMS guidance.

Currently, states do receive technical assistance from the Integrated Care Resource Center, which has published a series of tip sheets on SMAC design.

States also noted certain factors impose operational limits on what they could feasibly require in their SMAC. We heard repeatedly that staff capacity was an issue across states, which I'll touch on more in a moment, and state staff mentioned that a lack of Medicare knowledge plays a role in two ways --- staff may be unclear on what Medicare already requires and seek to avoid conflicting with or duplicating those requirements, and staff may struggle to identify what Medicare data or information is meaningful for state purposes.

Looking at data and reporting requirements, all of our case-study states required data and reports from D-

SNPs related to appeals and grievances, provider networks, care coordination, and enrollment and disenrollment. Of course, some of our case-study states require other data as well, such as financial reports, information on marketing activities, or Medicare Part C data.

States also said their relationships with D-SNPs allowed them to request other data that's not required in the SMAC on an ad hoc basis. For example, officials in the District of Columbia described to us working with their D-SNP to collect information on contract status and claims adjudication of home- and community-based service providers, as that was a time-limited and pressing priority for the state at the time.

In our interviews, we did hear health plan representatives note challenges in meeting data reporting requirements set by states, noting that due to delays in guidance from state officials, there were challenges as well as the potential for administrative burden from state-specific operational requirements and unaligned enrollment.

In particular, both state and federal officials said that care coordination data were useful in assessing program health and plan performance. These data include

information related to health risk assessments, individualized care plan completion rates, care transitions, and discharge planning.

CMS requires D-SNPs to submit a variety of data and reports for purposes of Medicare oversight as well. These data have the potential to be useful for states in evaluating D-SNP performance and for care coordination purposes. However, states must require in their SMACs that these data be reported in order to receive it.

Several case-study states do require Medicare Advantage encounter data to be submitted, which allow state officials a fuller picture of service utilization for dually eligible beneficiaries, but currently, state capacity to use these data is limited. However, in our interviews, officials did express interest in building this capacity to leverage encounter data.

On the topic of monitoring and oversight, CMS and states have separate but complementary oversight duties. CMS oversees compliance with Medicare requirements, while states primarily oversee delivery of Medicaid services, primarily LTSS. States use data and reports to monitor and oversee D-SNPs. However, we heard in our interviews

that due to limited staff capacity, these reports are frequently checked only for timeliness, completion, and accuracy.

Again, staff capacity places a limit on what data can be used for oversight, and states are reluctant to include additional requirements without the sufficient staff capacity to oversee them.

In the case-study states we examined, D-SNP oversight was primarily conducted by small core teams in coordination with support from other teams across departments and agencies, and staff members often wore multiple hats.

In conducting oversight, state officials said data on appeals and grievances and care coordination were most commonly used to spotlight problems with planned performance.

Then finally, the topic of performance improvement and enforcement. Monitoring and oversight activities inform performance improvement and enforcement of the SMAC requirements. States described a number of enforcement mechanisms available to ensure health plan compliance. These mostly consisted of penalties, most

commonly corrective action plans, but also fines and monetary damages.

Two states, California and Idaho, plan to publicly release data dashboards of plan performance, which some state officials said may motivate plan compliance on certain measures where other enforcement mechanisms may fail.

Few states currently include financial incentives for D-SNPs, citing a lack of resources and clear quality benchmarks.

One case-study state, Minnesota, does use quality withhold payments to incentivize plan performance; for example, on health risk assessment completion rates.

CMS noted in interviews that enforcement tools should be included in the SMAC itself in order to be most effective rather than in the state's Medicaid managed care contract or separate policy documents. Federal officials said that tools outside of the SMAC may be less likely to be used, and one state we spoke with confirmed this view, noting that officials said they would be hesitant to use enforcement mechanisms not explicitly tied to requirements within the SMAC.

So, as we turn to next steps, we prepared a few items for discussion to guide the conversation among the Commission today, areas where we would appreciate your thoughts and feedback as we're in the process of developing policy options to return to the Commission with in March.

So to begin, items for discussion include: What are the considerations for states in terms of monitoring and enforcing SMAC authority? What burden do additional requirements place on states? How should states build upon care coordination requirements included in the D-SNP model of care? And finally, do Medicare Advantage encounter data provide enough value to states, given limited state capacity?

And in order to kick off the conversation, I pass it back to the Chair.

CHAIR BELLA: Thank you, Drew. Thank you, Kirstin.

I was thinking we should start every dual session off with a quiz on certain acronyms related to this program. Maybe we'll do that next time, because we know we'll keep talking about duals.

This is really helpful. Thank you for bringing

back more color as we look at SMACs. I think one of the things we talked about last time was there's one thing to have a SMAC and there's another thing to actually be able to do something with the information that's in the SMAC, and so you really gave us color there.

So I'm going to turn it over to the Commissioners to take some comments, and then we will lead towards some next steps to bring this work back.

So who would like to kick us off? Patti.

COMMISSIONER KILLINGSWORTH: I know this conversation is about D-SNPs, and so I want to stay with that conversation, but I just -- I can't resist when I hear us talk about the complexities of ensuring access to care for beneficiaries who use both Medicare and Medicaid and how difficult it is when we are working across these two separate federal insurance programs. It's difficult for them to access. It's difficult for states to figure out how to manage and enhance their experience and ensure accountability. And the fact that we're even asking about the value of encounter data for a dually eligible beneficiary is mind boggling to me.

So if nothing else, it speaks to a -- there's got

to be a better vehicle than the train that we're riding on. But it is the train that we're riding on, and so let me talk a little bit about that.

I do think state capacity is just such a key issue here. One of the things that makes -- SMACs are great, and there's tremendous flexibility to use them to do all kinds of things that will advance integration at least as much as you can, again, within these two very disparate insurance programs. But as a practical matter, CMS only monitors what CMS requires.

So if you as a state are electing to add coordination requirements, you are responsible for monitoring them. Even if you are adding specific enrollment restrictions, you are responsible for monitoring them. CMS does not. It puts a lot of burden on the state, and I think a lot of times states weigh at least the perceived value that they may not fully understand against the burden and limited capacity that they know they have and just decide not to go down that path, because requirements that aren't enforced are pretty useless data that is collected and not used. It is pretty useless, and so why do all of those things? So I think there has to be

an effort to really invest in state capacity.

I actually had this conversation over lunch with a colleague that we are 10 years down the road, and we still have roughly the same couple handfuls of states who are really engaged in this work around duals. And part of that is, I think, that states don't understand the why it really matters, and the other part of it is even if they understand, they lack the capacity to go there in the midst of a thousand other competing priorities. And so we have to solve those two issues.

A part of that means really understanding both from the beneficiary level, how this impacts them, but also understanding from the state level, including the financing level. I wonder, how many states really fully understand how much money in total they are spending on dually eligible beneficiaries for their Part D, for their Medicare cost sharing, and premiums for the benefits that they're wrapping around, especially in the LTSS program?

I know for me in Tennessee, over 90 percent of the individuals who were in our MLTSS program for older adults and adults with physical disabilities were dually eligible beneficiaries. So the bulk of hundreds of

millions of dollars was being spent on that relatively small subset of the population, and I don't know that states have the wherewithal to sit down and really understand their own data to know, how many of my members are in aligned arrangements? How much money am I really spending? What are the things that I could really do to both improve quality and experience and also better manage those expenditures? I could go on, but I won't.

I will say that along with that need for capacity, then comes the need for enforcement mechanisms, right? So if I have the capacity to monitor it, what do I do when I find out that the requirements I put into place aren't being met? And it's another one of the challenges with SMAC agreements.

In my own state, these were -- because you have a separate Medicaid contract, these were no-cost agreements. Well, it's very difficult to put financial sanctions in a no-cost agreement, and so I had one hammer, short of corrective action plans, and that was, well, I just won’t renew your contract next year. And you can only wield that hammer so many times before people start going, yeah, you're not going to do that.

So I think helping states think through enforcement opportunities and what that might look like, I think there is some value in bringing that SMAC together with the Medicaid contract, because then you do have greater ability to leverage financial sanctions, because those are certainly not no-cost contracts. They are worth millions, if not billions of dollars, and so maybe looking at the relative advantages versus disadvantages of an integrated contracting strategy versus purely separate contracts. I think part of the challenge there is aligning the cycles of those two things, because the state Medicaid agency contracts with D-SNPs operate on very prescribed federal timelines.

All of that to say it's a really important topic. We still, I feel like, are at the very beginning stages of really being able to make really substantial progress in this area, but it's really important that we do so.

So thank you for your time on this.

CHAIR BELLA: Carolyn?

Thank you, Patti.

COMMISSIONER INGRAM: So thank you. I also appreciate the work that we're doing on this because it's

one of my favorite topics. It's so confusing to work with members or consumers or people out in the community, elders in Tribal communities, to try to actually integrate these two programs. It's just a ton of work, and we spend so much time and money and energy on the health care side trying to get these pieces to work together, and it's just such a waste as a country. So it's something we need to do better on.

I'm wondering, to that end, in terms of getting answers to your questions, if we could try to pull together more information on what the state strategies are for integrating care.

Patti mentioned one remedy. You just don't sign a SMAC agreement if people don't adhere to it. I certainly did that and probably wasn't very popular at the time in my state when I did that. So I think there's got to be some thought towards additional authority if we're not going to fully integrate these programs, which I think is actually the preference.

Then starting to look at what is the state strategy to build out those care coordination requirements. So does a state -- some states know who has got D-SNPs in

their state, who has got lookalike plans, who has MA-PD plans, and they're actively trying to work towards integrating the care amongst those products. But others don't have that information, and so maybe if that's something we could pull together to try to start sharing more widely so it's known what has to actually happen to have the care coordination occur, because I think there's some models that do it really well in certain states that we're going to find, and others don't.

And then, finally, in terms of the encounter data, that's obviously key to the money, and the only product we had in the past that fully integrated the money, the MMP product is now going away. So states do have to start working with that encounter data to fully get a clear picture of the dollars being spent on the Medicare side and on the Medicaid side.

Most states use an actuary -- Jenny can talk more about that -- to do that work for them, because they don't have that capacity in-house, but I think if we could start to put our arms around some of those strategies that states are implementing, what's actually out there by state in terms of what the products look like, it will show us how -

- probably how confusing it is to consumers and the need for a bigger plan.

So I think we should continue with that work and try to pull some of those pieces together to complete the picture. Thank you.

CHAIR BELLA: Thank you, Carolyn.

Jenny?

COMMISSIONER GERSTORFF: Drew, thanks for this chapter. I thought it was really insightful and a lot of good information from the states that you interviewed.

I noticed -- and you mentioned at the beginning of your presentation -- that your selection criteria for interviewing states was -- included they're all using some level of their authority in SMACs. So if you could talk about that, and if you have plans for expanding that to states that are not using that authority, and understanding some of those barriers from that perspective?

Then I'd also be interested to know if you know from these interviews or if we can look into whether states can include penalties and incentives in coordination-only D-SNP SMACs.

And then if you've heard from any states using

their SMAC incentives or penalties for indirect savings initiatives? So you kind of mentioned having the plans -- having the Medicare plans cover supplemental benefits that would have savings for the Medicaid side, but other indirect things like establishing a rebalancing target for the long-term care populations and having some nursing home diversion activities and benchmarks.

And then my final comment on the encounter data, I know states have limited capacity for using that, but I think it can be really important and possibly insightful to understand claims adjudication and how plans are managing coordination benefits between the Medicare and Medicaid. There could be issues with attributing more to the Medicaid side than maybe should be, but we wouldn't know that without the encounter data.

CHAIR BELLA: Thank you, Jenny.

Dennis.

COMMISSIONER HEAPHY: I'm trying to think where to start. One of the things that's been on my mind, reading this report, was just capacity and Medicare, understanding Medicare policy and how it's so lacking in states.

But something else that I was wondering is, how much concern do states have about actually being able to create strong SMACs if they're so reliant on these plans to provide services for the populations and the plans can just say, "No, we don't want to do that"? So is there any states where there are large, maybe national plans that dominate the market? How challenging can it be to negotiate a strong SMAC?

I'm thinking with the decoupling of the MMPs of the Medicare and Medicaid. So how much more challenging is it going to be over time to actually be able to create some strong SMACs? Is this going to become a too-big-to-fail scenario? And how do we prevent that?

I can talk about the other things and all that stuff, but for me, what's really on my mind is what authority or power the states have to leverage with the SMACs.

MR. GERBER: Thank you, Dennis.

So I think it's a good concern. In general, I would say states are still fairly new to adding in requirements to their SMAC and going beyond federal minimum requirements. CMS officials did tell us that they are

starting to see more and more of this happen. States are beginning to develop SMAC expertise. I think particularly states that did have MMPs were able to lean on that experience and leverage that in their SMAC.

I would say among the case-study states that we spoke with, I don't think there was a major concern about plan dominance over the contract negotiations. In fact, we heard from health plan representatives that they did not view the SMAC conversation as a negotiation. It was more an opportunity for them to provide feedback on what the state had already decided and highlight any areas where there may be operational challenges on the plan side that the state may not be aware of and try to ameliorate that.

I would say that we did hear that in other states, trying to generalize beyond the states that we spoke with, smaller, more rural states may have difficulty, as they already do in terms of attracting plans, to cover small, maybe more difficult-to-cover populations. So I think that could pose a challenge. I think that's why we see a diverse patchwork of D-SNP marketplaces across the country right now is that they are dealing with different markets, different populations.

But I would say based on what we've heard so far, states, especially those who have had a few years of experience or more implementing some state-specific requirements, have not felt that there's any concern about losing access to plans, even though I think we do know that there are just a handful of national plans that sort of dominate the D-SNP marketplace.

COMMISSIONER HEAPHY: And just to follow up with Patti's point, that's the oversight capacity. Is there anything that can be done to help CMS push or provide more capacity to the states? Not just in their knowledge, but the oversight, really. Because the oversight piece is so challenging.

MS. BLOM: I think that's something we've been struggling with for a while, Dennis, and as someone -- I think it was Patti -- said, CMS doesn't enforce requirements that they don't levy. So state capacity is kind of an ongoing issue, and we've made a recommendation in the past about supporting states in that way, so kind of a perennial issue.

CHAIR BELLA: It might be time to bring that recommendation back.

COMMISSIONER HEAPHY: Yes.

CHAIR BELLA: Thank you, Dennis. Dennis, do you have any additional comments?

COMMISSIONER HEAPHY: No. It just seems untenable that states are required to do this without having the tools they need to do it, and it harms their budgets, and it harms beneficiaries.

MR. GERBER: Yeah. I think in bringing these questions to the Commission, we were trying to be sensitive to limited state capacity in terms of focusing on what we heard from both CMS and states as being areas of priority for them, whether that's care coordination or potentially Medicare Advantage encounter data. With the limited ability to conduct monitoring and oversight, where are these states, some of which are more experienced are dealing with plans that have higher levels of integration, where are they finding the juice is worth the squeeze in terms of oversight. Given that, I think there is the challenge of states cannot oversee requirements they do not have staff to oversee.

COMMISSIONER HEAPHY: And these are wealthier states, I’m guessing?

MR. GERBER: California. So the list we included had -- you know, they've participated in demonstrations, and they've, I think, had more experience with managed care and with D-SNPs.

COMMISSIONER HEAPHY: So I think someone said it would be great to hear from states that don't have that capacity, that have smaller budgets.

MS. BLOM: Right. I think one note, though, is that even the states with the higher budgets or with more experience, we are hearing some issues around capacity; for example, to use the MA encounter data. So I feel like a lot of states, even maybe most states, are kind of at step one on that.

CHAIR BELLA: Sonja, did you have a comment, or were you just smiling overall?

COMMISSIONER BJORK: I was just smiling, because when we talk about difficult-to-serve areas or populations, rural always comes up, and so that's a big concern as we roll out the big plan in California for all the Medi-Cal managed care plans to offer D-SNPs. But we're all working hard at it, so stay tuned.

CHAIR BELLA: Thank you.

John?

COMMISSIONER McCARTHY: I had two comments. One was to the rural piece, and there's a state that we've worked with in the past where they're all fee-for-service. They're a very rural state. There is no managed care. To integrate with D-SNPs is difficult to do.

But the second comment comes to something, Drew, you had said around the MMP programs, and I feel as a policy, this is one of the areas, Melanie, that we're not hitting on here, but the Feds are getting rid of the MMP program. And having been in a state -- and so I was in D.C. before we had those SMACs, and that was all done after me. They did an amazing job in doing that. But having run an MMP program, the advantage was when we were meeting with the plan, CMS was there also. So it was three of us together talking about these issues and enforcement, and then talking to states that don't have MMP programs, it's you talk to the plan. Then the plan turns around talks to CMS. You're not having the same conversations on enforcement, and the plan is at an advantage from that standpoint, because they could say, "Well, that's not what CMS said." And you don't know what -- so you kind of go

back and forth.

One of the recommendations I would have liked to have seen in here was -- and I know it's probably too late, but not getting rid of the MMP programs or having something that goes in that alignment that with the SMAC, CMS has to have representatives as a part of those meetings with plans. So if it's actually not a three-way contract, okay, but is there any way you can get Medicare to participate with the state? Because that is what I found the most beneficial about it is that, yes, my state staff, we all were learning about Medicare. But because Medicare participated in our meetings, we had the Medicare experts there too, and they could explain some of those things to us like, okay, how would this work versus this work? And that helped quite a bit when it came to the enforcement side and penalties and things like that.

Just the area that we're going to, I think it's just going to be even more complicated to be able to do some of this enforcement.

CHAIR BELLA: I don't think it's too late. I mean, that is something that could come back for discussion in March. That's a very concrete piece of getting --

trying to -- I mean, nobody has to follow our recommendation, but at least signaling the importance of having CMS and the state involved together as part of the oversight is very germane to the discussion.

Jami? Oh, Drew?

MR. GERBER: Just on that point, this doesn't come from the interviews for this project, but for our MMP monitoring, we did hear from CMS that for at least the demonstration states at the time, that while there would no longer be that three-way contract in that level of interaction, that CMS, specifically MMCO, would be interested in continuing participation with states in their conversations with plans, having their regional representatives be involved in those conversations. So I think CMS is open to and understands that there was value in that three-way conversation with plans. So it's not something that we've discussed with these states, but it is something we've heard in our other conversations.

COMMISSIONER McCARTHY: It's great to hear that they're saying that. It's easy to say it now, but with any agency, when you get pulled in 50 different directions, that would -- it concerns me that that would be one of the

things that may just fall off or not the right people in the room to make decisions, but that's good to hear. It's good to hear that they acknowledge it.

CHAIR BELLA: That doesn't mean we can't memorialize it as something of interest.

Jami?

COMMISSIONER SNYDER: I really appreciate the conversation around the lack of state resources. In my experience, I've always found that when a state lacks resources for a specific initiative, it's because they fail to see the tie to their overarching strategy for the program or the organization, whether that's federal level or state level.

And one of the things that in Arizona, I think, my predecessor did a really wonderful job of was tying our work around duals integration to our larger integration strategy. So we could see how our investment would help us from an outcome standpoint, from a cost savings standpoint. And that really kind of incentivized the team to coalesce around this work.

And so I do think it's worthwhile to spend some time. I don't know if it's MACPAC's role, but to spend

some time thinking about how the work we're doing in the duals arena even connects to federal-level officials' priorities around access, diversity, equity, and inclusion, because there's a clear tie. It's one of the most vulnerable populations that Medicaid programs serve, but I think part of that discussion around investment really needs to go back to tying it to some of those overarching goals.

CHAIR BELLA: Jami, Arizona had dedicated resources, correct?

COMMISSIONER SNYDER: One.

CHAIR BELLA: One is all it takes, right? Okay.

I have a few comments, but I want to see if anyone else has any final comments.

[No response.]

CHAIR BELLA: Okay. So specifically -- first of all, thank you, as always.

Specifically, just to comment on your specific questions, I think it's really important to keep in mind this issue of when a state has a SMAC and what a state can do with a SMAC and what resources are there to support states and when states don't have the ability to take

advantage of those resources. So the Integrated Care Resource Center, funded by CMS, and the State Data Resource Center, funded by CMS, both exist to hit these very types of things.

The ICRC is constantly trying to shine light on best practices around care coordination and other SMAC requirements, but I think what we hear is that it's one thing for somebody to hold up like this would be a great thing to drop in your SMAC, and it's a whole other thing to understand how that furthers your strategy and what you're going to do with it.

Same with the State Data Resource Center. The State Data Resource Center is there to help states take Medicare data to use for their duals to improve care coordination, and the ability of states to actually take advantage of that resource and use that data -- and I don't think that encounter data is there. And MACPAC is on record for the most recent proposed rule as supporting giving states advanced access to encounter data.

But where I'm feeling like part of this is going is to have -- wait for it --- not a panel, but a roundtable, where we bring together the State Data Resource

Center, the Integrated Care Resource Center, CMS, and some states and we understand is there a way to combine forces to actually be able to use those resources. It's not going to magically make state capacity appear, but we have to keep beating the drum on state capacity as well. So that's what I would like to see us consider specifically, in addition to some of the policy options that you heard discussed today.

But I do want to step back and just say it's not unnecessary to keep repeating the need for us to recommend a state strategy. We can do all of this work on SMACs and MMCO oversight, and for those of you who don't live and breathe this stuff, people are now talking about having a SMAC requirement for ACOs in a state. And so if we don't have the capacity to use SMACs for D-SNPs, like adding that isn't actually going to make care for dually eligible people better in a state necessarily.

And so if people are starting to pick up on this concept, we have to step back and frame it in an overall understanding of what the state strategy is to drive better care for this population. So it's kind of a plea that we think about the state strategy again and the support for

states.

But I think going to where Patti and Carolyn were going, I think before we made that recommendation, assuming that states would understand, we kind of lay out ideas for them. Here's some D-SNP levers. Here's some of these levers. But I actually am not convinced -- and I think this is what they were saying and what others have said -- that states understand exactly where their duals are today.

So I would also like to ask that when we're talking to MMCO or the ICRC or NAMD or Advancing States or any of the organizations that support states, we find out if somebody actually has a baseline snapshot of where the states are today so that we can help them understand what their options are if they would put together a bigger strategy.

So these are very important things, but I don't want them to lose sight of the overall -- our overall goal, which is to have every dual in the country have access to an integrated product and not forget the importance of reminding Congress that a tiny little bit of support on a 400- or $500 billion annual program might be helpful to states.

Ta-da. Done with the soapbox. Any last comments? Dennis, any additional comments?

COMMISSIONER HEAPHY: The options are great, but if the capacity is still not there, then even knowing your options is not going to be the answer. So I think pushing the capacity piece and maybe asking CMS for guidelines on -- or putting forward maybe potential guidelines for how we'd like to see CMS work with states and developing SMACs as a work on the SMACs would be helpful, because otherwise, you have all these options. But you can't afford any of them.

CHAIR BELLA: Thank you both. We'll look forward to talking about this later this spring.

MS. BLOM: Great. Thank you.

CHAIR BELLA: Oh, lucky for you all, we're taking a break. We're going to take a break, and we're going to come back and talk about a roundtable we did on the effects of payment changes on access to physician services. So come back in 15 minutes, please.

Oh yes. Sorry. I thought we were doing public comment at the end. Let's take public comment now, and then we'll take a break, and then we'll come back. I'm

sure there are many people in the audience that want to comment on duals. We'll open that up for public comment now. If you would like to speak, please raise your hand. Introduce yourself and the organization you're representing, and we ask that you keep your comments to three minutes or less.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Well, we have no public comments. So we are going to go into a break. Thank you all. We'll see you back here at 2:45 Eastern time.

* [Recess.]

CHAIR BELLA: All right. Welcome back, everybody. We are going to hear about our roundtable on payment and access, and welcome to Melissa. I think this is your first time with us. We welcome you and Rob. And we'll turn it over to whoever is going to start.

FINDINGS FROM EXPERT ROUNDTABLE ON EVALUATING THE EFFECTS OF MEDICAID PAYMENT CHANGES ON ACCESS TO PHYSICIAN SERVICES

* MS. SCHOBER: I am. Thank you.

Good afternoon, Commissioners. Today we'll be

presenting on evaluating the effects of Medicaid payment changes on access to physician services. I'll begin with background information on access to and payment for physician services in Medicaid, followed by recent policy developments and findings from our literature review. I will then turn it over to Rob to discuss key themes drawn from the expert roundtable, held in November 2023, before concluding with our planned next steps and opportunities for future work on payment and access.

The availability of providers is a key factor affecting access to care for Medicaid enrollees. Physicians are less likely to serve patients covered by Medicaid than those with Medicare or private insurance. MACPAC's 2017 analyses of national electronic health records survey data found variation in Medicaid acceptance rates by practice type and geography, with higher rates of acceptance by obstetricians and gynecologists and lower rates by psychiatrists.

The same 2017 analysis found that physicians affiliated with faculty practice plans, practices with higher Medicaid caseloads, and practices with more mid-level providers were more willing to accept new Medicaid

patients than practices below average caseloads. Although physicians were less likely to accept new patients insured by Medicaid, beneficiaries report similar levels of unmet health needs as other low-income individuals.

States have considerable flexibility to set Medicaid payment rates. State Medicaid programs typically establish base payment rates based on the resource-based relative value scale, a percentage of Medicare's fee, or a state-developed fee schedule. State officials adjust these rates based on factors such as provider type, geographic location, and service complexity.

In 2019, the fee-for-service base payment rate for office-based physicians was about 72 percent of the Medicare rate, but there was significant variation in the Medicaid-to-Medicare payment ratio, ranging from 37 percent in Rhode Island to 111 percent in Montana.

Over 85 percent of Medicaid beneficiaries are now enrolled in some form of managed care. Managed care organizations have flexibility to pay providers differently, but they have historically based payments rates on the fee-for-service rate. States can make fee-for-service supplemental payments and may direct MCOs to

pay providers according to specific rates or methods. In 2021, 28 states and the District of Columbia made such payments.

FQHCs and rural health clinics are paid a rate based on facility costs, adjusted for inflation. Medicaid payment policies for FQHCs and rural health clinics were outside the scope of this project. However, it is important to note that FQHCs are a major source of primary and other care for Medicaid beneficiaries.

Policy developments have affected Medicaid payment rates. The Affordable Care Act required all states to increase their Medicaid payment rates for primary care services to 100 percent of the Medicare rate in calendar years 2013 and 2014. More recently, in 2022 and 2023, CMS approved Section 1115 demonstrations in six states that require these states to ensure that average payments for primary care, obstetrics, and behavioral health services are at least 80 percent of the Medicare fee-for-service rate.

Although all states with approved Section 1115 demonstration programs must submit evaluation plans, none of the currently available evaluation plans for these six

states address minimum payment requirements. In May 2023, CMS simultaneously released two notices of proposed rulemaking. While the proposed rules take several steps to address the Commission's prior recommendations about the need to ensure access to care, including improving monitoring of access by beneficiaries, increasing payment rate transparency, standardizing reporting, and promoting beneficiary engagement, MACPAC's comment letters highlighted the lack of alignment between the proposed fee-for-service and managed care requirements and raised concerns about the implementation timeline.

Next, I'll discuss a review of the literature.

In considering the context for this work we note that physicians often cite low payment rates as the reason for not accepting Medicaid or taking new Medicaid beneficiaries, but that the available evidence on the relationship between payment and access is mixed. Our work continues to explore the broad policy questions of the relationship between payment and access, framed by the three domains the Commission included in its 2022 recommendations for a new access monitoring system. We incorporated these recommended domains in our conceptual

framework, which I will discuss next.

To guide the literature review and roundtable discussion, we developed a conceptual framework that reflected the Commission's 2022 recommendations on a robust access monitoring system. The framework considers how Medicaid payment policies and non-financial factors affect (1) measures of the potential access, for example, the number of primary care physicians who participated in Medicaid; (2) measures of realized access, for example, rates of preventative care visits or cancer screenings; and (3) beneficiary experience of care, for example, difficulties with scheduling a specialist following a referral.

The framework also considers contextual factors that affect payment and access, such as the total supply of physicians, provider characteristics such as past experience about providing care to Medicaid beneficiaries, practice type or specialty, payment rates from other providers such as Medicare and commercial insurance, and beneficiary preference for specific services and care setting.

With the conceptual framework as the guide, the

literature review considered studies published since 2013, most of which relied on public fee schedules to measure payment rates, and used cross-sectional analyses conducted at a single point in time. Six quasi-experimental studies of the ACA primary care payment increase found mixed results. One found no significant change while two found an increased in-service use and better self-reported health.

Of the very few studies that addressed administrative burden, one, published in 2021, used all-payer data to estimate the administrative costs of claim denials and resubmissions. The researchers estimated that physicians lose about 18 percent of the contractual value of a typical Medicaid visit, much higher than the rate estimated for Medicare, at about 5 percent, or commercial insurance, at just over 2 percent.

Next, I will turn it over to Rob to begin with the discussion of the expert roundtable.

* MR. NELB: Thanks, Melissa. So to better understand these issues we convened a roundtable of experts, including representatives from federal agencies, academic, and researchers who work with states to evaluate

the state Medicaid programs. Through that roundtable we identified a number of themes, listed here, that I will go into in more detail.

The first and most fundamental was this real tension that we heard about different goals of Medicaid payment policy and really getting at some of the findings that Melissa was talking about, how trying to make sense of this with the contradictory results that the fee increase didn't really bring more providers into the system, but it instead improved access among providers who are already participating. And as a result of this dynamic, that helps explain a lot of the effect that a small share of Medicaid providers serve a large share of the patients, sort of the concentration that we see in our safety net.

And at the roundtable we discussed the pros and cons about whether this result was desirable, and it ultimately came down to different goals that policymakers may want to achieve. On one hand, if there are fewer participating providers it limits beneficiary choice about where to go. But on the other hand, if the goal is just access to care, perhaps safety net providers such as FQHCs may actually be better equipped to support the unique needs

of Medicaid beneficiaries. An example is some of the enabling services that might be available to a safety net provider that may not be available at a typical provider that doesn't serve many Medicaid patients.

And roundtable participants ultimately discussed the tradeoffs that states face in allocating their limited resources. If you only have a set pot of money you could choose to distribute it to all providers or you could focus it on those safety net providers that are serving more patients. And in discussing these they highlighted the fact that there is currently not a really good evidence-based framework for states to use when weighing these different options.

The second theme that came up was around data and research challenges. We've talked a lot about T-MSIS, which we always seem to do in these conversations, but really looking forward and thinking about how T-MSIS might be able to help fill in the gaps, especially around areas of provider participation, realized access, and payment rates. Some of the researchers noted in some fields there is a need to validate, especially work on provider types and sites of care, that hasn't been a focus of past

research. But there is some potential. And especially with managed care payment data isn't available to all researchers but it is available for us at MACPAC, so it could be an area where we could look into that data a little bit more.

Roundtable participants also discussed the potential of using all-payer claims database to enable better comparisons to private coverage. And as Melissa mentioned, those all-payer databases were used, for example, in that recent study on Medicaid denials, showing that they were much higher than other payers.

However, researchers noted that even with better data there are always going to be methodological challenges with interpreting the relationship between payment and access because payment changes often occur concurrently with other changes. And so, for example, we heard during the roundtable that those new minimum payment requirements are not currently being evaluated, and the reason for this is that the net change in many of these states is relatively small, and was probably not likely to see a statistically significant effect, based on the way the requirement was set up and what data might be available.

Given these challenges, though, we obviously tried to focus in on what we could do to better learn about some of these factors that came up in the lit review, and one of the key areas we highlighted first was practice characteristics and really diving into this fact that we learned that care for Medicaid beneficiaries is concentrated among a small number of providers, but there is limited research into those characteristics of those practices and why it is that they're willing to serve more Medicaid patients.

So participants highlighted the potential for more research on FQHCs and the unique role of Medicaid's special payment model for those health centers, and then also highlighting the need for more research on roles of practice ownership and consolidation. As more and more physician practices are being part of larger health systems, the decision to accept a new Medicaid patient or not doesn't really rely as much with the individual physician but is a decision that's made as part of the larger organization.

Participants also talked about the fact that participation rates vary by region and specialty, some of

the data that we shared before, and there might be opportunities to better understand the causes of that variation. One might be shortages in the overall number of providers in a region. So when we looked at low participation with behavioral health, there is just sort of a shortage for all payers in terms of the number of providers there in that area.

We also talked about expanding the scope to look beyond just physicians and considered the role of mid-level providers to help fill access to care when there are few physicians available and willing to serve Medicaid patients. And this is consistent with our finding before that practices that have more mid-level providers tend to accept more Medicaid patients.

Next another area we are hoping to dive into more is the role of managed care. I highlighted before the relationship between payment rates and access to managed care isn't well understood because folks haven't really had that data to understand what payment rates are in managed care, and most research has been based on fee-for-service rates. So as we have some of this T-MSIS data we might be able to dive into that and add to the research there.

Another potential area to look into is the role of managed care in helping to reduce administrative barriers to payment that might deter provider participation, and this gets at the findings that we've seen about denials and the fact that according to this one study the rate of denials actually had just as much of an effect as payment rates on providers' decision to participate. And it used what is called remittance data, which we do have in T-MSIS, and so could potentially look at, within a state, which plans are having higher denial rates and what the implications of that might be on access and other measures that we are interested in.

Finally, all these discussions about managed care really raised some questions about network adequacy and what's the best way to evaluate it. As you know, traditionally people have evaluated networks based on time and distance, so sort of the number of providers that will accept patients, but don't really look at the volume of patients that providers accept. And given the findings that we've had that most access is provided by that core set of safety net providers; it raises questions about how you should really be thinking about network adequacy and

what that means for the patient.

In terms of future data sources here, Congress passed some legislation requiring new reports and provider directories that could enable future analyses, but most of the participants thought T-MSIS actually might be a better source because it would show not just who is participating but actually how much they participate, to see if they are really serving a high share of Medicaid patients.

And as I discussed, thinking about different measures of network adequacy here as well, which gets into this broader final theme here about refocusing on beneficiary needs. And I think one of the key themes at the end, taking away from the roundtable, is that a lot of the research so far as focused on the share of physicians participating in Medicaid, but that is sort of an imperfect measure. For one, when we compare Medicaid to private insurance, one participant noted the fact that we often don't consider the fact that people with private insurance can't access every single physician who accepts some form of private insurance. And so to the extent that you are going to compare to private coverage, do that for a specific plan or something rather than putting it all

together in the aggregate.

The policymakers also discussed the importance of considering other measures that were in our access monitoring framework, that we have already put out, around realized access and beneficiary experience. Of course, there are limits here on the fact of not having beneficiary surveys and other things, but really interested in thinking about what we can do with available data.

And so as suggestions for future work, some participants suggested that it might be better to sort of drill down on a specific subset of Medicaid beneficiaries with unique needs, and then work from there to follow them through the system and really see where the gaps in access might be. For example, if we started with children with behavioral health needs, such as those receiving psychotropic medications, you could really think about what does this population need and where are they accessing care, you know, whether it's in a school or in an office-based physician, or FQHC, all those different settings. That is the access side.

And then from the payment side could really think about what are Medicaid payment policies for these

different types of care. So we have certain payments for FQHCs, certain payments for schools, all these different pieces, and try to fit it together to answer sort of a bigger question of basically are we using our limited resources most effectively to ensure, from the patient's perspective, access to the care they need, in the right setting, at the right time. Not a small question but an important one.

All right. So that concludes some of the key themes from the roundtable. Our next steps are to publish an issue brief summarizing some of these findings from the lit review and themes. For today's discussion we have allocated an extra bit of time here and really hope this can be an open discussion to really think about where to go next. This is obviously a big topic of the Payment and Access Commission to talk about payment and access, but it could be a good opportunity to really think about where you want to go and what we should prioritize in our future work.

To facilitate your discussion we have highlighted the five themes that we talked about and have just identified some initial ideas for potential work. Again,

these are just ideas, and we really welcome your feedback to think about how we can improve it and use our resources most effectively to answer these big questions.

Thanks.

CHAIR BELLA: Thank you, Melissa. Thank you, Rob.

This is what you've all been waiting for, exactly what our acronyms are like at their core.

So Tricia and then Heidi.

COMMISSIONER BROOKS: Yeah. Thank you for this.

I just have a question, not so much about the roundtable, but in our past work. And forgive me if I've forgotten. Do we know which states have automatic adjustments in place for provider rates? Have we ever researched that?

MR. NELB: We do have a compendium of physician payment policies. It's just for fee-for-service. They're not for managed care. We haven't updated it as recently, but it is something we could consider. But yeah, some update either based on the Medicare updates or others have their own schedule, and then others aren't updating it as frequently, and that's the concern that people hear, where

the rates aren't updated over time and sort of effectively becomes a bit lower.

COMMISSIONER BROOKS: And so in conjunction with that, for the states that have something in place for fee-for-service, do they also require managed care to at least cover the minimum of that, and what's the relationship there? It just would be really helpful to know, because recently heard from state advocates saying their state has not increased pediatric service rates in 20 years -- 20 years. Hello. It's a long time.

Thank you.

CHAIR BELLA: Thank you, Tricia.

Heidi and then Rhonda.

COMMISSIONER ALLEN: I'm sorry. I'm not on camera. My university enforced a mandatory update. All I see is an apple with a bite out of it.

I'm so excited about this work. I think this is just absolutely critical, and it's so hard when you don't know anything to say what the problem is.

A couple of things that you mentioned that I want to just highlight and pull out is, one, the claim denials in Medicaid impact providers in a different way than claim

denials and private insurance, because they can't go after the person for the balance. And that is so important for understanding why providers don't want to participate in Medicaid is because they end up losing this money. They saw the patient. They did the thing, and then they didn't get paid for it. And they can't do anything about it.

And I think that we just want to always keep that in perspective when we're comparing denials across insurance type, that it means something different for providers than in private insurance.

The other thing is I want to just say related to the fee bump; I hear it often discussed that the ACA fee bump shows that increasing prices isn't meaningful for provider participation. But I want to just always stress that that is two years. They were time limited from the very beginning. The logic model of that is that, oh, providers hear about it, and now they're going to go through the process to become enrolled in providing care for Medicaid. But why would they go through this really arduous process when they know it's time limited, it's a short duration?

So I don't know that the experiment shows us that

some studies found no increase, some studies showed minor increases. I think that that's very different than an enduring increase in rates.

But I do agree that you'd have to have a pretty big fee bump in order to get people who aren't participating to decide to participate, but you know what we talked about earlier, how it shifts the percentage of Medicaid patients that people see when they have a payer mix and they already participate is meaningful.

I also think it's very hard to find out how much you will get paid for Medicaid, particularly for things like mental health. In a school of social work, we're training mental health clinicians. We're numerically the biggest mental health provider in the United States, and I always talk to students about whether they plan to take Medicaid. And often they say, "Well, no, I hear that they don't pay anything." "How much do you think they pay?" And they have no idea.

And when I talk to clinicians about why they don't take Medicaid, they say the same thing, "Well, they pay so little," and I'm like, "Well, what's the -- what do you think they pay?" And they never know.

And then I thought, okay, well, I'm going to look it up for people in my state so I can tell them what Medicaid pays, but I couldn't find it. I really think that when you're having a conversation from a therapist perspective if you were making $20 less an hour, would that deter you, if you were making $10 less? What is the breaking point that you would decide to take Medicaid? If you don't know the answer, it's just always very vague.

So anything that you could do in managed care, because we -- as researchers, we just never -- we can't get that, and so we can't even look at it. So whatever MACPAC could do in that would be such a contribution.

And then I do think that being able to use claims data with managed care data to assess provider networks would be a huge leap forward over assessing network adequacy from provider directories, which will say that a clinic accepts Medicaid when one provider out of 20 accepts Medicaid. It has people in there who've retired. It's just such a poor measure. So just actually seeing where people are getting care, that's your provider network.

And then also for realized access, I think looking at measures for which we have standards of care and

establish recommendations, because we should never expect that people in the same demographic compared to private insurance should have less utilization on recommended care than people on Medicaid. Like, there's no reason to believe that they have fewer needs.

I think our assumption is always that people on Medicaid have higher needs. So if you know that the recommendations for this age category is to have these vaccinations and you see fewer in Medicaid, that tells you something.

Looking at overall utilization is hard because some people in private insurance have access to care that's not beneficial, and we don't want to compare that because that's not necessarily in the person's best interest.

But we do have standards that we can use, and to that extent, I think if you want to focus on looking at a subset, I would -- I think looking at adult mental health is clearer than looking at children's mental health because of the school, because you can't really see what's happening in the school and what kind of care the people are having in the school and because schools aren't billing. And it's under this weird process.

But I think that adult mental health is a lot clearer, and that's another case where I would say you shouldn't expect fewer mental health benefit utilization in Medicaid than you would for commercial insurance. You would expect, based on the burden of disease, for it to be higher. And if it's lower than that, that is probably an access barrier.

CHAIR BELLA: Thank you, Heidi.

Rhonda, then Adrienne, then Angelo, and Patti.

COMMISSIONER MEDOWS: I have just a quick question. When the stakeholders that you were interviewing were talking about refocusing on beneficiary needs, did they give you any examples for the pediatric group as opposed to the adults? And was there any specialty where there was a shortage across the board? I was thinking anesthesia and mental health, but what did you hear?

MR. NELB: Sure. So this was a roundtable rather than interviews. So we weren't -- we heard the idea but weren't able to go in as depth on it. But we continue to ask, certainly, and open to hear. Behavioral health is key, and then access to specialty and Medicaid more generally, I think that, to Heidi's point, we're trying to

-- as we develop this work, trying to think about areas where there is a sort of standard of care. For example, with psychotropic medications, people need to go get a certain visit or metabolic monitoring, or there's certain things you can actually monitor.

But, Melissa, can you think of anything else to add?

MS. SCHOBER: Yeah. the specialty that came up the most was behavioral health, generally, and again, this was limited to physicians, though during the roundtable discussion, apart from psychiatrists, behavioral health generally was noted as a major area of shortage for both pediatrics and adults.

In terms of specific measures of beneficiary access, I think consistent with the Commission's earlier recommendations, a beneficiary survey on experience of care was something that came up repeatedly by members of the roundtable.

COMMISSIONER MEDOWS: And then if I -- Madam Chair, if you don't mind, if I can just also ask -- when you were thinking about the different measures that you're going to be using and you do beneficiary experience, can it

be how long it takes to get an appointment, not just simply whether or not somebody is accepting patients? Right?

MR. NELB: So there is hope to look at wait times. That's one of the areas that's been proposed in the managed care rule, and so we're waiting to see what's finalized and what data might be available. And it was just wait times on managed care, but it's still a step forward.

CHAIR BELLA: I'm hearing some good air time for the beneficiary survey today.

Thank you, Rhonda.

Adrienne?

COMMISSIONER McFADDEN: I think mine is more of a comment than a question, but it was mentioned in the materials around the nonphysician clinicians as part of the scope of things that have happened in the past. Part of my perspective is that the diversity of types of clinicians that are available for access for Medicaid beneficiaries -- and actually all beneficiaries, whether Medicaid, Medicare, or commercial -- it's really important to have that diversity of practitioners, particularly I'm thinking about the OB-GYN space. We think about midwifery and birth

centers and other things that are outside the traditional scope of OB-GYN practices.

So I'd really like to see sort of the scope expanded to the non-physician practitioners.

Heidi also mentioned behavioral health. A very significant number of practitioners who are non-psychiatrists, so very important to understand that dynamic as well.

CHAIR BELLA: Thank you, Adrienne.

Angelo.

COMMISSIONER GIARDINO: Melanie, if the duals are your passion, this one is my passion. So thank you for this work.

Just a couple questions. As we try to navigate through theme number one, could you share a little bit about how you're going to get the consumer voice? My bias is I would like Medicaid recipients to have access to every practice, just like someone on private insurance has every -- you know, like you said, within the limit of who is in the participating network. But people with private insurance tend to have a lot of options.

I'd like to know if the Medicaid recipients share

that view, or are they quite pleased with having access to service locations that have a lot of ancillary services that are useful?

MR. NELB: Yeah, definitely. The idea of further work on theme one would be to develop a more robust conceptual framework that sort of links, like a mega framework that links our payment and access framework into one thing.

And the idea actually is that it really would be centered around the beneficiary. So the idea of picking a certain subpopulation or whatever you want to do and then look at them and where they get their needs. Again, rather than just focus on physicians or hospitals or something, you're focusing on people with a certain condition and then seeing where they go in terms of different sites of care, which could be physicians, or it could be clinic, or it could be midlevel or all those different things.

And then the framework could be a way to introduce the types of questions you might want to do to analyze on that first domain of access, potential access, whether it's sufficient, and so things like, how far away is that provider in terms of distance? To what extent do

they offer certain enabling services that are maybe more important for certain high-need populations? What's the quality of care of those providers? A various set of things that -- you know, it's obviously up to each beneficiary to make their own choice among which provider they want to go. Maybe continuity of care, obviously, if they were seeing a person before or whatever. It could be a set of questions, but we'd ask them from the perspective of the beneficiary rather than from the provider perspective of why isn't this person coming to my clinic or whatever it would be, from that beneficiary perspective, where do they want to go? And then, how can -- on the payment side, how can we support the payment to make sure that where people want to get care, they're actually accepting and able to get that care?

So that's the grand theory. But we could sketch it out, and it will be all these frameworks, a lot of lines and arrows and circles or something. But maybe it will all make sense at the end, and we can continue that conversation.

COMMISSIONER GIARDINO: I'm thinking there's going to be focus groups coming on some of that.

MR. NELB: Yeah. And that's a great idea actually to -- yeah, perhaps convene folks and ask them, what -- as you're deciding between different sites of care, what -- or, you know, levels of provider and things, what are the factors that go into your decision-making?

COMMISSIONER GIARDINO: And then perhaps building on Dr. Allen's point, there are data sets that emerge in locations around the quality indicators. Obviously, I'm a pediatrician, so I'm most focused on HEDIS and primary care, and I'm wondering, did any of the experts talk about how to harmonize that data with some of this access data? Because I would be fine with people having a lot of access to a limited number of sites that are meeting their needs, along with the fact that they're meeting or exceeding national benchmarks that are well known, well used, pretty much validated.

MR. NELB: Yeah, quality definitely came up. So I think, you know -- one, a Dr. Polsky at Hopkins came up with five, five different goals or something you could think about like choice, access to care, access to good care, continuity of care, maybe something else, but there are -- it's a choice or something to think about. Do you

just want to see any provider, or a higher quality provider, but you might have to wait longer for them? And some of those different tensions that might come up.

MS. SCHOBER: Yeah, I think a couple of the folks on the roundtable raised some variation on what do we know about people who are driving past a provider that could ostensibly treat their need to seek out a different provider, and why is that? What drives them to seek that other care provider? Is it those ancillary services? Is it beneficiary experience? Is it something we haven't thought about yet? But thinking about how to look at that in the future.

COMMISSIONER GIARDINO: Okay. And then --

MR. NELB: One other dimension, I think, concordance, so the extent to which it's a culturally competent care.

COMMISSIONER GIARDINO: And then just two more things. Speaking as a provider, I tend to think of buckets, right? So there's the primary care bucket, and then there's the specialty bucket. And access to those tends to be thought of differently.

So I'd love to understand if we'll incorporate

any of that lens, and then I have one other comment.

MR. NELB: Yeah. I mean, you guys are the ones setting the framework so we can incorporate it however, and yeah, I think get beyond -- obviously, the -- we use physician service as like one of the categories in the statute, but when someone's accessing care, they're not like checking the box to say this is -- I would this benefit. They just want care, and then someone else later figures out what bucket it goes into.

So I think if we reorient towards that beneficiary perspective, we could follow people across the continuum. And also, perhaps a part of the framework is -- and there's been like research in the past, for example, that people who receive care at an FQHC have lower -- we pay more for the services there. But if you look at their cost overall, like with hospitals and other things, they have lower overall costs because you're avoiding hospital use and other things, so access and lower, more efficient sources of care. There's certainly ways we can think about specialty or sort of avoided institutional care or other types of measures.

COMMISSIONER GIARDINO: Okay. And then finally,

I'm channeling all of my physician assistant and nurse practitioner friends, one of whom I'm married to. They don't like "midlevel" as an expression. So they would prefer being called "advanced practice provider." So if we could kind of adopt that, I think that's really respectful of their training and truly the emerging role that they have in the health care system, because we will not be able to meet the needs of the people that we want to serve in Medicaid without the advanced practice providers being colleagues, not subordinates. So thank you.

CHAIR BELLA: Thank you, Angelo.

Patti, Jami, Kathy, Sonja, Dennis.

COMMISSIONER KILLINGSWORTH: It's another one of those topics we all care a lot about.

I'm so glad that the conversation came up around quality and also around cultural competency. I know we're having conversations just sort of about minimum access, if you will, but I think when we talk about other measures of network adequacy that really matter, part of what matters is the ability to receive culturally competent care and to receive care that produces high-quality outcomes for people.

So it needs to be a part of the framework somewhere, right? It may not be the first thing that we go to, but ultimately, we need to be able to measure and make sure that both of those things are happening.

Kind of in that vein, I wonder how much we've looked into opportunities to really leverage alternative models of care. Some of the things that we learned from the public health emergency to really expand access in rural areas or where specialty providers may be less available, to be able to both fill those gaps, but also to be able to accommodate needs and preferences. It is much easier to have a provider who speaks a native language that can access people in many different locations than to try to get all of those people to come to that one provide, and so really thinking about how to leverage those alternative care models, I think is important.

I do want to just note community standards of care are real. We may not like them. We may wish that there were more providers available in certain areas, but we can't hold Medicaid to a higher standard than we can what is available to the general community. We can all work together to try to expand that access for sure.

I do think there's tremendous value in looking at realized access versus potential, but I also have some trepidation around reliance on that sort of utilization encounter data, because what it doesn't tell us is what are the socioeconomic factors that really impacted that access and utilization, right? So it's not necessarily always about payment, the payment wasn't enough. There are a lot of reasons why people may have access and not take advantage of that access, and so it's a point for us to research and really understand better.

And the last thing I would say is when we talk about subpopulations, we have to include, among those subpopulations, people with disabilities, and especially, I think, people with intellectual and developmental disabilities who may have some of the greatest challenges in terms of accessing high-quality primary care and specialty care.

I would venture to say that there are few states that actually offer payment that incentivizes or acknowledges the additional expertise and work and time that may be involved in providing really good high-quality care to that population, and so I think that would be an

area worth digging into.

Thank you all.

CHAIR BELLA: Thank you, Patti. Jami?

COMMISSIONER SNYDER: Sure. So I think when we talk about access and payment policies, I really like the idea of looking into the characteristics of practices that are willing to serve more Medicaid members, and in particular, FQHCs. And I know we all want to say it is all about the payment, and certainly payment is a piece of it with FQHCs, but I don't think it's the whole picture. And I do think it would be kind of interesting to see what resources do they have to offer that other providers don't, what are they doing differently that makes them more attractive to members or easier to access for members.

And then I think if you really wanted to kind of dig in around that research with FQHCs, I think it would be interesting to look at states that pay the PPS rate versus that pay on an alternative payment model basis, to see if there are distinctions between FQs and those two kind of situations.

CHAIR BELLA: Thank you, Jami. Kathy.

COMMISSIONER WENO: Jami kind of prepped mine. I

would say having spent most of my career in rural areas trying to find access for patients there, number one is discussed a lot in big cities, but when you get to Medicaid professional shortages areas there is no choice. You are going to the FQHC or you are going to the rural health clinic. So if you want to talk about access in rurals that is pretty much what you're talking about.

And, of course, I would be remiss if I didn't mention that dental is a huge player in this problem, and if you are going to do work in access and you don't look at dental access, we have all of the same issues here. And I recognize that this project was not focused on dental care or dental providers, but if there is a way that we could expand the project to include them I think it's really necessary.

CHAIR BELLA: Thank you, Kathy. Sonja.

COMMISSIONER BJORK: Thank you. Boy, Jami did a real thorough job of covering lots of topics, but I too want to focus on number 3. And I was just wondering, from our panelists, what ways, besides what was already raised, comparing states that have APM versus regular PPS rate, are there other ways we can further explore payment policy, or

are those the main two?

MR. NELB: Yeah. So certainly better understanding the dynamics of the PPS rate and how it's changed over time. Also one of our panelists at AHRQ mentioned that they're having new research that might come out this year kind of looking at a potential intersection that states with low office-based physician rates may actually have more care in FQHCs but are paid the PPS rate, versus states with higher office-based payment rates have more access in different settings. I think this kind of could help inform discussions of that tradeoff and realizing a lot of the research relies on the sort of Zuckerman fee-for-service index, which is just based on office-based physicians, but realizing that that office-based payment rate happens in context, the FQHC rate can maybe help explain different dynamics there.

Regarding the PPS, there have been concerns over time that the cost-based rates that were set in the '90s hasn't really kept up over time, and so to the extent we do more work in FQHCs and you see value in that setting we could think about ways to update payment rates or with alternate payment models or other ways to do it with

quality in mind and other things. So just the start of another long set of discussions but an important one.

And yeah, but I think our first steps was just sort of really covering the bases of payment methods and payment amounts, and then eventually we'll get to the third part of our payment framework which is the outcomes related to payment.

COMMISSIONER BJORK: Thank you. And you know the formula that you had earlier in the slides, one of the key factors was the availability of the workforce. So of course that is an overarching concern, no matter what we learn out of all of these. If we don't have good availability of workforce then that can cancel out all our efforts.

MR. NELB: Yeah, and that actually came up a little at the roundtable, that FQHCs in trouble recruiting people. They are opening their doors to everyone, but if they have trouble recruiting their own workforce it is hard to serve as many people as they want.

MS. SCHOBER: Yeah, recruiting and retaining workforce came up among a couple of roundtable participants, particularly at very high-volume FQHCs.

CHAIR BELLA: Thank you, Sonja. Dennis.

COMMISSIONER HEAPHY: Yeah. Just building off what Angelo said earlier abut specialists, and looking at subspecialties as well. And there is a population of people served by an MCO. Is that reflected in that work adequacy requirements, with specialists and subspecialties, which is a segue into folks who are turning 22 on the IDD population, medical complexity, who are seeing the same primary care provider they had when they were 2, and they're 40 years old. So when we think about that population that's really important.

Another one, which Kathy talked about, is oral health. What percentage of folks are actually seeing a dentist as opposed to a dental student? Because it seems that such a high percent of the folks are going through dental schools. It can be a real barrier to access for folks. I know people who have complex oral health needs, and every time they go to the doctor or to the dental school there is a new student there. There's a constant cycle of new students, and it is very discouraging so they just don't go back, and then their condition gets worse.

And another one is just a general stigma and how

does that impact a provider's willingness to actually take folks on Medicaid. I don't know how you get at that. I guess stigma but also administrative burden. Is there higher administrative burden for folks who will take Medicaid rather than commercial plans? So is there a way to reduce that administrative burden for providers?

CHAIR BELLA: Thank you, Dennis. Jenny and John.

COMMISSIONER GERSTORFF: You mentioned the old compendium of fee-for-service fee schedules and methodologies, and I would say I loved that when you first released it. It has gotten a little bit stale. I think if you were to refresh it, which I think could be beneficial.

It would also be helpful to note in there which states are managed care states or the prevalence of fee-for-service payments versus managed care payments for those types of services. I think that just helps in understanding the relevance of the fee schedule.

And then on the T-MSIS evaluation, I'd love to see more work there, number 2, the data challenges. And given that the T-MSIS data that MACPAC can access has that managed care payment, I think there are a lot of insights that you can pull by state and by the different provider

types, just showing maybe as a percent of Medicare fee schedule, you know, what the payments look like on the managed care side.

CHAIR BELLA: Thank you, Jenny. John.

COMMISSIONER McCARTHY: Just to add to your work, Rob, I mean, you picked the hardest topics I think there are. There are so many different little pieces. Even you say physician payments, right. It's so complicated of what we are even looking at in physician payments.

One of the things, just to jump on what Jenny had said about the compendium, it would totally be great if that got updated. And I think back to what she was saying about managed care. One of the things you can ask the states -- if they don't know you can then ask them to ask the plans -- is, on average, what percentage do the plans contract at a percentage of fee-for-service. In every state that I have worked in it's usually different, but, you know, there is often the state will know something to the effect of like, "Oh yeah, it's at 105 percent of fee-for-service," or 110, or maybe 97. Again, just ask them. You can ask what that is. And so if you can get that from the state, that will help.

My real point I was going to try to get to of what to look at going forward, and this issue around access, in many states we're starting to see more physicians give up their independent practices and they are joining systems. And when they join those systems, they then can bill a facility fee, thus you have an increase in the amount of reimbursement going for that visit. And I was trying to think of, while I was sitting here, how to incorporate that into this analysis, because that becomes important to try to figure out how this works.

And one of the benefits of that is as physicians become employed, not in all cases but in entities I've worked with, for the physician then they no longer have any incentive of who they see. They just see whoever is coming through. So that issue around how many Medicaid beneficiaries are we seeing goes away at that level of the person. Now there may be something different, the systems, but just for that person. So are we increasing access -- is there any way to see if we're increasing access as physicians have moved?

Now, of course, this is probably highly dependent on what percentage of Medicaid payment the fee-for-service

payment is. Like in Ohio, where I was, unfortunately while I was there, we only paid 52 percent of the Medicare rate, on average, and that was just on average. So you could imagine some of them were probably like at 35 percent because we're averaging all of those codes.

So if there was any way you could be looking at some of the data, state by state, to see do we have any correlations between access in any system versus independent versus, for no better measure, HEDIS scores. Like are HEDIS scores better where you have higher payment, just so we can get some idea of some data, of like is there a direction we can go or need to look at any of these.

MR. NELB: Yeah, all really good points, and I think to the extent we do update a compendium we could look at whether states are having site neutral payments or not. And certainly as we think about the range of extra characteristics, when we say office-based physicians sort of distinguishing between independently owned versus hospital-based ones could be a useful distinction. The data in AHRQ has been doing some new work to better classify those health systems, and to the extent to which they are part of a DSH hospital or other things, you know,

it's all there.

I believe the research on consolidation we can kind of look back more. Obviously, there is concern, like in Medicare and other places, that as these practices are consolidated the costs increase for Medicare and things. But my understanding, at least on the Medicaid side, is that actually, as you note, after these practices are owned by the health system, they tend to actually accept more Medicaid patients. That wasn't really a key point we talked -- it didn't come up in our literature, but it's part of the other literature available on provider consolidation. I think there is some stuff there, and we can maybe see about including that in our brief, if it's relevant.

COMMISSIONER McCARTHY: And then just to turn back to the previous work you did around supplemental payments, because we are starting to see more physician-directed supplemental payments coming also, and what impacted, positive or negative?

MR. NELB: Yeah, and the vast majority, I think we said $8 billion in these physician-directed payments, and even the fee-for-service ones, they're pretty much all

targeted to academic medical centers, and so physicians affiliated with that. I think in our prior work there have been questions, like to what extent is that payment going for the physician care versus supporting overall care for the hospital. But at least the stated quality goal, when you look at the directed payment, is to improve access, especially on specialty care.

And so one of our Commission recommendations around directed payments was to better evaluate them, and so one of the pieces is to sort of see to what extent, when you are putting a lot of this money in, does it improve access to specialty care or other measures.

COMMISSIONER HEAPHY: -- the gaps in access to service as well, and how states are filling those gaps. I think particularly the certified peer specialists and recovery coaches. Is that something that's on your radar at all, because there is such a dearth of psychiatrists out there willing to take Medicaid.

MS. SCHOBER: They didn't come up in the roundtable. Peer support specialists did not come up in the roundtable specifically, though there was discussion about the need to expand the workforce generally. So

that's certainly something we can consider for future work.

MR. NELB: I think it fits with the idea, again, advanced practice professionals, to the extent there aren't physicians available, are there other folks that can help complement and provide access, and would include peer supports in that category.

CHAIR BELLA: Thanks, Dennis. Jenny, and then Heidi.

COMMISSIONER GERSTORFF: Just to follow up on something that John mentioned, you can ask the state about the percent of fee-for-service a managed care plan is paying by different types of providers, different types of services. You also can often find that information there, actuarial certification. So if you were to request all of those from CMS you might find that and all kinds of other wonderful information.

MR. NELB: Great. You'll show us where to look on those thick reports, but we appreciate it.

CHAIR BELLA: Great idea. Heidi.

COMMISSIONER ALLEN: Oh, sorry about that. I am interested in the FQHC, though from my perspective I'm a little more interested in specialty care because I do think

that access to primary care is better. And I would be interested to know just if any, beyond behavioral health, if any FQHCs are providing any specialty care. I assume maybe the really big ones in urban areas, but I don't know how widespread that is.

When I worked for a state, there was a lot of kind of charity care models around trying to get people from FQHCs into specialty care, but it was really a drop in the bucket.

I would also be interested in knowing -- John brought up provider consolidation, and I think that's really important. I think that there are a lot of health systems that do accept Medicaid in some specialty or in some clinics, but I'm concerned about segregation. And we've never seen segregation work in any kind of environment. I think FQHCs, which are designed to serve a certain population, bring a lot of value, but I'm not sure in a health care system that segregation ever looks good. I think that can be affiliated with poorer quality, more students, and less established faculty or providers.

So I would be interested to kind of see, as you're looking at that, to see if we do see a lot of

segregation and trying to understand what that means.

MR. NELB: We can definitely look into it. I mean, I think one thing that came up is, you know, we'll see how much we can get into the data, but sometimes people have access to the academic medical center but as you note there's a student clinic that will serve the Medicaid patients and then the faculty practice plan won't. And so it might be hard from our data. We see that you're getting care at a certain institution, but hard to distinguish.

But you raised some good points. You know, we have a lot on our plate, but as you know we're doing a larger set of work on hospitals, including hospital outpatient services, which is where some of that specialty care is provided, that maybe an FQHC doesn't have capacity for. So I think understand as we think about the role of DSH and other funding, to what extent is it supporting access to that type of specialty care that people maybe can't get in the FQHC, could be another thing to add on our long list, but again, an important list of priorities.

CHAIR BELLA: Sonja.

COMMISSIONER BJORK: Since we're on that directed payment topic, I've brought it up before how important it

is to maintain the requirement that hospitals contract with the managed care plans in order to have access to the directed payments. Otherwise our whole goal of ensuring access might fall by the wayside if they can just go around the plans that are serving people on Medicaid and still get directed payments but not be fully engaged in offering specialists and other services. So that is, again, my pitch for that.

MR. NELB: We provided that comment in the access rule. We will see if anyone listens. Hopefully they do.

CHAIR BELLA: All right. I have just a couple of things. I don't think they're plate-adding. First, I wanted just to say thank you for doing the roundtable. Kate and I were at another conversation, and it ended up it one of the people was at this roundtable. So it was fun to hear that, oh, actually somebody participated and we got some feedback. And any time that we can involve people that look at the world in different ways, or experience it in different ways, in guiding our work and informing our work, I think it's really important.

On that note, and maybe this is plate-additive, but at some point, I noticed none of the states were at the

roundtable. That was by design. But thinking about how to get the states' point of view incorporated as we think about this will be important.

And then, lastly, I am just really thankful for the work. There are so many myths out there about Medicaid payment and why people do or do not take payment. I think if you asked ten different people what the studies showed about the primary care bump you get very different answers about what they believe that the analysis showed and not.

I think what we're adding, what we're trying to add, with the best information we have, is just going to be really valuable. So I really appreciate that investment that we're making in this work. And clearly you can see there is a lot of interest in a lot of future work here.

I'm not even going to ask if you need anything else from us. We'll just say thank you, and Melissa, this is how it goes, so welcome to the jungle. Behavioral health is going to be a big one for us.

Thank you both. And we had near-unanimous participation from Commissioners, so thank you.

Please do not let that deplete your energy for Chris, as he comes up to talk to us about physician-

administered drugs.

[Pause.]

CHAIR BELLA: Welcome, Chris.

MEDICAID COVERAGE OF PHYSICIAN-ADMINISTERED DRUGS

* MR. PARK: All right. Thank you. And yeah, I'm sure this will be as exciting as that last discussion. I mean, it does involve physicians, so maybe it will.

All right. So today I'll be providing background information on Medicaid coverage of physician-administered drugs. We're focusing specifically on these drugs because many of the high-cost drugs are administered by a provider, and there are some unique features and policies related to these drugs that make them different from other outpatient drugs obtained from a pharmacy.

So staff contracted with Milliman to conduct an expert roundtable to better understand what strategy states are using to manage spending and utilization of these treatments. The roundtable was held last week, and so findings will be presented at the next Commission meeting. Today's presentation is really just to provide some context for the upcoming discussion in March.

So first, I'll go through the Medicaid Drug

Rebate Program. It's been a little while since we've done this, but it's just to provide some background about how the program governs Medicaid coverage, rebates, and payment policies. Then I'll discuss physician-administered drugs and how certain policies apply differently to these drugs versus drugs obtained through the pharmacy and additionally some of the challenges related to managing utilization and spending for these drugs. And then I'll present some new data that we did using the T-MSIS data on utilization and spending of physician-administered drugs, and finally, we'll wrap up with next steps.

The Medicaid Drug Rebate Program (MDRP) is a statutory provision that covers coverage of drugs in Medicaid. Drug manufacturers are required to provide a rebate to Medicaid in order for their products to be eligible for federal match. In exchange, states must generally cover all of the participating manufacturer's products. States do have some tools to limit such use -- to limit use such as prior authorization and preferred drug list, or PDLs, but cannot exclude coverage outright.

Products included in the MDRP are referred to as "covered outpatient drugs." Generally, these are drugs

that require a prescription, are approved by the Food and Drug Administration, and the manufacturer has that rebate agreement in place. Just to note, vaccines are not included in the MDRP.

So covered outpatient drugs are primarily those that are dispensed by a pharmacy but can include drugs administered by a physician.

The MDRP rebates are defined in statute and based on average manufacturer price (AMP), which is the average price paid by the manufacturer to wholesalers of drugs distributed to retail community pharmacies. There is a slightly different definition for these physician-administered drugs that includes other channels besides pharmacies.

There are different rebate formulas that apply to brand and generic drugs. For brand drugs, the rebate is the greater of 23.1 percent of average manufacturer price or the difference between average manufacturer price and best price, and then there's an additional inflationary rebate if the drug's price has risen faster than inflation over time. And then there's additionally another alternative rebate that could be calculated if the drug is

considered a line extension. So a line extension might be something like an extended release version produced.

For generic drugs, the rebate is 13 percent of AMP. There is no best price provision. The inflationary rebate was added to generic drugs starting in 2017, and then one thing to note is that prior to this year, the total rebate -- that is the sum of the basic and inflationary rebates -- cannot exceed 100 percent of AMP. But starting this year, the rebate amount can now exceed 100 percent of AMP.

States can negotiate supplemental rebates on top of the statutory rebates with drug manufacturers. Manufacturers generally pay these rebates to have fewer restrictions on their products and increase their market share, and similar to state supplemental rebates, managed care organizations can also negotiate their own rebates with manufacturers.

On the payment side, there are two components to the state's fee-for-service payment to pharmacies, the ingredient cost and dispensing fee. The ingredient cost covers the pharmacy's estimated cost of acquiring the drug. The 2016 Medicaid outpatient drug rule requires that states

pay based on the actual acquisition cost for drugs.

The dispensing fee is intended to cover the pharmacy's overhead and services to fill the prescription.

The beneficiary may also pay some amount of cost sharing, depending on the state. Under managed care, the MCOs typically use a similar payment structure of ingredient cost and dispensing fee. However, managed care plans don't have to pay on the basis of that actual acquisition cost but need to have payment rates sufficient to provide an adequate provider network.

And then many MCOs can also use the pharmacy benefit manager to negotiate payment terms with individual pharmacies in their network.

While 340B is not a Medicaid provision, I did want to highlight some interactions between 340B and Medicaid that can be challenging to navigate. The 340B program allows certain qualified entities, such as federally qualified health centers, to purchase drugs at a discounted price. The discounted price, also known as the "340B ceiling price," is calculated using the Medicaid rebate formula, and it's similar to getting the Medicaid rebate up front and should produce a similar net price that

Medicaid will receive after rebates.

Drugs purchased under the 340B program are not eligible for the federal Medicaid rebates, and states must exclude those drugs from their rebate invoice. This prevents the manufacturer from paying double rebates on those particular products.

Under fee-for-service, federal regulations require that 340B pharmacies are paid at acquisition cost. So that means that they would be paid at that ceiling price. This requirement does not apply to MCOs who may pay more than the 340B price.

So physician-administered drugs are drugs that are typically administered by a health care provider in a physician office or other clinical settings. These drugs are typically billed through the medical benefit instead of the pharmacy benefit, which leads to some differences in coverage in payment policies from other outpatient drugs dispensed from a pharmacy.

The physician-administered drugs may be considered a covered outpatient drug for the purposes of the MDRP and receive the federal rebate, but this is dependent on payment method.

Drugs are not included in the MDRP if they are provided in certain settings and billed as a part of a bundled service, such as an inpatient hospital DRG payment.

However, if there is direct payment for the drug separate from the other services provided, for example, a drug billed using a drug-specific procedure code, then it is considered a covered outpatient drug, and the state can claim the rebate. So this means that whether a physician-administered drug is considered an outpatient drug subject to the rebate can vary depending on how a state or MCO pays for the drug.

And just a quick note that the recent proposed rule in May 2023 for the Medicaid Drug Rebate Program, CMS did propose a change to the regulatory definition of a direct payment. And so the proposed change would allow a drug included in a bundled payment for a service to be considered a covered outpatient drug if the drug and its itemized costs are identified separately on the claim, and so we'll just have to see what gets finalized when the final rule gets published.

The structure for physician-administered drugs is similar to drugs dispensed from a pharmacy in that payers

typically pay an amount that covers the cost of acquiring the drug and a separate fee for related professional services in administering the drug. However, there are key differences in how these components are established in the medical benefit compared to the pharmacy benefit.

Payment for drugs not traditionally dispensed through retail pharmacies, such as physician-administered drugs, are not required to follow the regulations regarding actual acquisition cost. Because this actual acquisition cost requirement doesn't apply to physician-administered drugs, states have greater flexibility to determine payment rates.

Unlike pharmacies, most states pay for physician-administered drugs above acquisition cost and include a markup on the drug to cover other associated costs such as special storage or handling requirements.

Based on our analysis of Medicaid state plans and provider manuals, we found that many states pay for these drugs based on the Medicare Part B formula, which is average sales price plus 6 percent.

As you can see in the chart on the slide, almost half of the states, 23 states, paid at the Medicare formula

of ASP+6, while another 11 paid at or above average sales price but less than Medicare.

One thing that's not shown here is most states do utilize the lesser of methodology where they compare pricing under different formulas and benchmarks and pay the lower amount. For example, a state may pay the lesser of the ASP+6 percent or usual and customary charges. So this table just kind of focuses on that primary payment benchmark.

Additionally, states are not required to pay 340B providers at the 340B ceiling price. As such, some states have implemented policies that require those drugs to pay at the 340B price, while other states pay the same amount they would pay to non-340B providers.

One thing to note for physician-administered drugs is that dually eligible beneficiaries do come into play in that Medicaid is responsible for some costs for dually eligible beneficiaries. Dually eligible beneficiaries may qualify for assistance with Medicare premiums and, in some cases, Medicare cost sharing, but Medicaid does not pay for Part D drugs or any associated cost sharing for dually eligible beneficiaries. This means

that Medicaid does not typically pay cost sharing for drugs obtained from a pharmacy. However, for physician-administered drugs, those drugs under Medicaid would generally be covered under Parts A or B where they would pay the coinsurance. And so for Part B, beneficiaries generally face a 20 percent cost sharing.

And another thing to remember is if a state does pay any amount for a prescription drug, such as a Part B, such as a Part B cost sharing, then it is eligible for the full amount of the rebate authorized under the MDRP.

Due to some of these differences in policies between physician-administered drugs and other outpatient drugs, there are some challenges that states encounter in managing utilization and spending for physician-administered drugs under the medical benefit compared to drugs under the pharmacy benefit.

Payment amounts are generally higher under the medical benefit, because many states do include that markup and pay above acquisition cost.

Additionally, many physician-administered drugs are available in single-dose vials, and waste may occur when the entire amount of the vial is not administered.

Depending on how states have established the payment policy, states may be paying for a portion of the drug that is ultimately discarded.

Additionally, there are some system limitations in billing medical claims that can limit the use of typical utilization management tools such as prior authorization. Pharmacies have real-time, point-of-sale claims processing systems that allow for immediate feedback on prior authorization or other requirements that must be met before a drug is dispensed. Medical claims are generally submitted after the service is provided. So there may be cases where the provider has administered the drug already but did not fulfill the utilization management requirements.

Physician-administered drugs can be administered at various sites of care, such as the physician's office, hospital outpatient department, or home infusion. The cost, submitted charges, and payment for the drugs may vary by site of care. So this introduces another variable in terms of managing spending through the medical benefit.

Additionally, rebate collection can be more challenging. Physician-administered drugs are typically

billed using procedure codes. Whereas drug rebates are collected based on the National Drug Code, or NDC. Medical claim forms frequently don't have a proper field to collect NDCs, and so providers have to include that in a free form field.

Additionally, units may differ on how they're billed on the medical claim form, using the procedure code, versus how they would have been billed under the NDC, and so there may need to be a -- providers and states may need to convert the units from the medical claim into the NDC units used for rebate collection.

Finally, as mentioned before, whether or not a state can actually claim the rebate depends on the payment method, and so states may need to change their payment methodology for certain drugs to unbundle the payment from the other services in order to capture the rebate for high-cost therapies. Some states have done this for cell and gene therapies.

Finally, there may be some overlap between whether or not a drug can be covered under the medical or pharmacy benefit, and some of the physician-administered drugs can be shifted to the pharmacy benefit by using

specialty pharmacies to acquire the drug. This can eliminate the markup over acquisition cost and may make prior authorization easier because the claim system is a little bit easier to implement prior auth, but then it can also introduce logistical challenges in coordinating drug delivery with the administrating physician and beneficiary.

So there's been little information publicly available specific to Medicaid utilization and spending for physician-administered drugs. Prior research on Medicaid drugs have typically focused on drugs obtained from a pharmacy or just overall drug spending that has not isolated physician-administered drugs specifically.

We conducted an analysis using fiscal year 2021 data from T-MSIS. We identified the physician-administered drug and administration claims using procedure codes using lists from Medicare Part B as well as publicly available lists from five states.

For the analysis, we calculated unique users, number of claims, and Medicaid spending for physician-administered drugs and administration for non-dually eligible beneficiaries and dually eligible beneficiaries. For non-dually eligible beneficiaries, we excluded those

with limited benefits because they would not necessarily have coverage for drugs.

One thing to note is we were only able to capture drug claims that were separately identified in an outpatient claim. So we were not able to capture other than drug spending through the medical benefit that may have been included under a bundled payment such as a hospital DRG. As such, our analysis is likely an undercount of physician-administered drug utilization and spending.

The other thing to note is that the spending here represents gross spending. So that is the amount that was paid to the provider and does not include the rebates that states may have collected from the manufacturer.

In fiscal year 2021, Medicaid spending on physician-administered drugs totaled $10.4 billion. That was $8.4 billion for full-benefit, non-dually eligible beneficiaries and $1.9 billion for dually eligible beneficiaries.

In addition, spending for administration totaled $1.8 billion, and that was broken down to $1.6 billion for the full- benefit, non-dually eligible beneficiaries and

$0.2 billion for dually eligible beneficiaries.

Approximately 17.6 percent of full benefit, non-dually eligible beneficiaries used a physician-administered drug during the year, and that varied greatly by eligibility group. Only about 8 percent of children utilized a physician-administered drug, whereas about 30 percent of the beneficiaries eligible based on the disability used a physician-administered drug. And almost a quarter of those dually eligible beneficiaries used a physician-administered drug where their coinsurance was paid by Medicaid.

One thing to note is individuals eligible based on disability were only about 7.3 percent of enrollees but accounted for about 22 percent of claims and almost one-third of spending. Most of the spending is concentrated in that small group of beneficiaries.

Again, for dually eligible beneficiaries, the spending shown here is primarily for the Medicare Part B coinsurance, which would be up to 20 percent of the drug's cost, and because Medicaid can receive that full rebate amount, which is, for a brand drug, 23.1 percent of the average manufacturer price, the net spending for dually

eligible beneficiaries may ultimately be minimal because the rebate amount could offset most or all of the coinsurance paid.

And this graph just shows the spending per full-year equivalent beneficiary, and so you can see that for the full-benefit, non-dually eligible beneficiaries, this was about $130 per a full-year equivalent. And again, it varies greatly by eligibility group. Children were the lowest at about $30, and those eligible on the basis of a disability were about $550. And that was kind of reflective of the earlier statistics about how a lot of the spending is concentrated in that group.

So, as mentioned previously, we just conducted the roundtable last week, and we plan to present findings at the March meeting. This session today was primarily background information. So please feel free to ask any clarifying questions regarding the background information provided today, but also feel free to ask questions, provide comments on particular topics or challenges related to these drugs, and we'll see what we can address in the March session.

Thank you.

CHAIR BELLA: Thank you, Chris. You always do such a nice job with the refresher, which is necessary for all of us.

Questions or comments for Chris?

Heidi.

COMMISSIONER ALLEN: Do you have any sense of what percentage of these are cancer drugs?

MR. PARK: We didn't specifically look at that, but there have been some reports. Like, Magellan Rx puts out a Medicaid medical benefit trend report every year, and oncology drugs are the vast majority of physician-administered drug spending.

COMMISSIONER ALLEN: How did that change during the pandemic? Were there any of these drugs that were -- I know that there have been some -- that there were physician- administered drugs for which there were competing new formulations that could be taken at home. Do you know if during the pandemic that there was a shift? And if so, were they billed differently? I'm just curious about that.

MR. PARK: I don't know that specifically. I'll maybe take a look at those trend reports to see if they've

highlighted any particular trends from the pandemic, if they've identified any kind of shifts in sites of care. Certainly, there are decisions that need to be made by the states in terms of where. Pandemic or not, they do try to make policies regarding where they prefer to have certain drugs delivered, and so there may be some things driven by the pandemic that have shifted, or some states may prefer to use office space settings versus home infusion.

CHAIR BELLA: John?

Thanks, Heidi.

COMMISSIONER McCARTHY: I think this would be a great place if we could look at the work, Chris, you're doing with the work that Rob was doing on access, because I know for most states and having worked in this area and per your data that you've shown, the states do a pretty generic job of pricing these. It's like we follow Medicare, right? So is that the right amount?

But the reason I say can we look at what your work compared with Rob's is, theoretically, what we would see in this is they are all physicians, but generally, these are specialists who are providing these drugs. And then you would see at some level better access because

their payment is greater, because they're getting the office payment, just like your primary care doc, but then on top of that -- and they are doing additional service. I'm not saying it's a bad thing or anything, but on top of that, they're getting paid 6 percent on top of the drug. And obviously, then you've got this incentive to use more expensive drugs because the more expensive drug you use, the percentage you get paid is higher.

So we were dealing with this from a standpoint of what is the best way to price this? Is there a good way to price it? And then the second part was, how do you ensure that you are getting the best care possible? And this was an area we really were focusing on value-based purchasing. Was there a better value-based purchasing model?

So I guess my question is, can you work with Rob a little bit in his work on access, and if there's anything that we see, whether it's positive or negative when it comes to this very, very crucial area of health care? Because people need these services.

And lastly, I will say in the states that I've worked in around prior authorization, we didn't see too many physicians in Ohio and D.C. who would give the drugs.

They knew what needed to be prior authorized, and they generally wouldn't provide the drugs without having that prior authorization. So what we saw was the opposite side of it was delays in care while they were waiting at the prior authorization. So we had to work with our managed care plans on that. So really, to me, it's how can we tie this work that you're doing around payment to access on the other side too.

CHAIR BELLA: Thank you, John.

Other comments?

[No response.]

CHAIR BELLA: I think we're just all anxiously awaiting the results of the roundtable. Don't take it as lack of interest. And that will come back in March?

MR. PARK: Yep.

CHAIR BELLA: Okay. Let's just see if anybody else has comments or questions. I have a lot of interest in what's going to come out that you discussed around cell and gene therapy. I'm super curious about that. I assume that was part of the roundtable.

MR. PARK: Yeah, it certainly is part of the roundtable. I think the difficulty is some of the more

general challenges with high-cost drugs, regardless of whether it's, physician-administered or not, in terms of how do you pay for value and collect that information, like the outcomes data came up. Because there's this potential for markup, there are some things that states may want to consider.

I can say that one of the participants did seem to indicate that providers were willing to bill at acquisition costs for cell and gene therapies and not include that markup at this point in time. That may not be a specific factor for Medicaid, but in terms of bundling and whether that's advantageous or not in regards to whether they can collect a rebate did come up.

CHAIR BELLA: Very interesting.

Anybody? Last comment?

Dennis?

COMMISSIONER HEAPHY: Did you look at the different types of therapies that are provided, there's a difference between allergy shots and someone getting gene therapy.

MR. PARK: Yeah. I mean, it's possible using the procedure codes to identify some of those drugs. We didn't

look at it at that level. There is some information from that Magellan medical benefit report that I mentioned that does provide at least like the top classes of drugs that are being used. It's generally oncology drugs, the hemophilia factor, things like the immunosuppressant type of drugs that are being used on a physician-administered basis.

COMMISSIONER HEAPHY: Thanks.

CHAIR BELLA: All right. Well, we'll pick this back up in March. Thank you very much, Chris.

MR. PARK: Thank you.

CHAIR BELLA: All right. We're in the homestretch. Gabby is going to take us home on the Duals Data Book. Get excited, everyone.

[Pause.]

CHAIR BELLA: And Kirstin also. I've missed you twice now. I know. I have heard that this has been a hot item on social media, for those of you that don't think this is the most exciting thing. If you haven't looked at it, please do so, so we can keep those counts going up.

[Pause.]

HIGHLIGHTS FROM THE DUALS DATA BOOK

* MS. BALLWEG: Thank you and good afternoon, Commissioners. I'm here today to share highlights from the 2024 edition of the Duals Data Book, a joint publication between MACPAC and the Medicare Payment Advisory Commission, or MedPAC. The annual Data Book compiles information on people who are dually eligible for both Medicaid and Medicare.

This year's publication highlights new data from calendar year 2021. I will begin with an update of this edition of the Duals Data Book, followed by an overview of key statistics. Next, I will share select demographic characteristics of dually eligible beneficiaries compared with non-dual eligible beneficiaries, followed by Medicaid eligibility pathways and enrollment as well as service utilization and spending. Lastly, I will highlight trends in population composition, spending, and service use between calendar years 2018 and 2021.

As I review the comparisons between the dually eligible and non-dual eligible population, please note that the standard non-dual population comparison group is generally the non-dual Medicare beneficiary population, when possible. When comparing Medicaid-specific factors

such as eligibility pathways or long-term services and supports, that standard comparison group includes non-dual Medicaid beneficiaries with a disability and under age 65. We use these standard comparison groups because their populations are more similar to the dually eligible population, providing more control over any potential confounding variables. So throughout today's discussion I will try to note these comparison groups, and they're also available in the Duals Data Book.

Lastly, before diving into key statistics, we had an update to the 2024 edition of the Data Book. Many proposals to improve Medicare/Medicaid integration for dually eligible beneficiaries rely on managed care, making that overlap between Medicare managed care and Medicaid managed care enrollment an important measure of the potential for greater integration, because this is the segment of the population that might be best positioned to enroll in highly integrated models.

Additionally, through our analysis in the Duals Data Book we have seen consistent growth in both Medicare and Medicaid managed care enrollment. For these reasons, in the 2024 iteration of the Data Book we added a new

exhibit that shows the overlap between Medicare managed care and Medicaid managed care enrollment status for dually eligible beneficiaries, disaggregated by age, whether a beneficiary is under age 65 or ages 65 and older, and Medicaid eligibility, whether they are eligible for full benefits or partial benefits.

The new exhibit, which is Exhibit 13, stratifies total dually eligible beneficiaries across the following three categories: first, beneficiaries enrolled in both Medicare Advantage and comprehensive Medicaid managed care; second, beneficiaries enrolled in some combination of fee-for-service and managed care; and lastly, beneficiaries solely enrolled in fee-for-service Medicare and fee-for-service Medicaid.

Moving on to some of the key statistics, certain subgroups of individuals dually eligible for Medicare and Medicaid benefits accounted for a disproportionate share of Medicaid spending relative to enrollment. For example, in 2021, full-benefit dually eligible beneficiaries made up just 10 percent of enrollment but accounted for 27 percent of all Medicaid spending.

Regarding Medicaid managed care, 42 percent of

dually eligibles had at least one month of enrollment in a comprehensive Medicaid managed care plan compared with 73 percent of non-dual Medicaid beneficiaries eligible on the basis of disability and under age 65.

Among full-benefit individuals in fee-for-service, dually eligible beneficiaries were nearly four times more likely to use Medicaid-covered institutional long-term services and supports, compared to non-dual eligible Medicaid beneficiaries with a disability and under age 65.

Population demographics for the dually eligible population are fairly similar to last year. Overall, most dually eligibles were female and white, compared with all non-dual Medicare beneficiaries. Dually eligible beneficiaries are more likely to be female, Black and non-Hispanic, and Hispanic, whereas non-dual eligible Medicare beneficiaries are more likely to be male and white.

Among all Medicaid eligibility pathways, dually eligible beneficiaries were more likely to qualify for Medicaid through one of two pathways highlighted on this slide, either a poverty-related eligibility pathway, where 44 percent of dual-eligible beneficiaries qualified,

followed by receipt of supplemental security income, or SSI, at 36 percent of dually eligible beneficiaries. In contrast, non-dual eligible Medicaid beneficiaries with a disability, under 65 overwhelmingly qualified for Medicaid benefits based on receipt of SSI benefits, which you can see here is about 85 percent.

In the new exhibit showing the overlap between Medicare and Medicaid managed care enrollment, one-quarter of all dually eligible beneficiaries had at least one month in which they were simultaneously enrolled in Medicare managed care and/or another type, which could be a Medicare Advantage plan or another type of Medicare health plan, and a comprehensive Medicaid managed care plan. This exhibit also stratifies results by age, and beneficiaries under age 65 were more likely than those aged 65 and older to have no enrollment in either Medicare managed care or comprehensive Medicaid managed care.

In regard to service utilization and spending in fee-for-service, dually eligible beneficiaries were more likely to use Medicaid-covered institutional long-term services and supports and represented a greater share of total Medicaid spending on that service, compared with non-

dual eligible Medicaid beneficiaries.

Despite the higher utilization in overall spending on institutional LTSS among the dually eligible population, the spending per user is significantly lower for dually eligible beneficiaries at $62,000, compared to about $87,000 for non-duals.

Within the full-benefit dually eligible population, dually eligible beneficiaries were more likely to receive HCBS, or home and community-based services, through a waiver than a state plan. However, when compared with calendar year 2020, a greater share of both dually eligible and non-dual eligible Medicaid beneficiaries used HCBS-covered services under a state plan.

Finally, the trends in the dually eligible population composition spending and service use were fairly similar to those observed in 2020. The population grew by 2 percent annually, on average, from 2018 to 2021, to include 12.8 million individuals. Additionally, from 2018 to 2021, the total number of full-benefit dually eligible beneficiaries increased in 44 states and the District of Columbia.

Regarding trends in managed care utilization, the

share of dually eligible beneficiaries with at least one month of comprehensive Medicaid managed care enrollment increased by 7.5 percent from 2018 to 2021.

Spending per beneficiary also grew. Medicaid spending for dually eligible beneficiaries grew an average of 3.9 percent annually, and among non-dual beneficiaries the growth was even faster, at 8.5 percent annually. Specifically, per-user Medicaid spending for full-benefit dually eligible beneficiaries in fee-for-service increased for in-patient hospital services, institutional LTSS, and prescription drugs, even as the share of beneficiaries using these services declined.

This concludes the highlights from the 2024 edition of the Duals Data Book. I welcome any comments or questions at this time. Thank you.

CHAIR BELLA: Can we go back to Slide 8? I just want to make sure -- I heard you say something about duals being quite a bit less, that I'm puzzled on. Can you remember if like $32,000 was the number? It was on this slide.

MS. BALLWEG: I think -- oh, the differential between the per-user spending, which was $25,000 lower for

duals, that it was $62,000 compared with $87,000 for non-duals. Is that the question?

CHAIR BELLA: Yeah. So that is fee-for-service Medicare non-duals versus duals?

MS. BALLWEG: Yes. So that is going to be duals versus non-duals in Medicaid. I think we can also look at the exhibit as well.

COMMISSIONER MEDOWS: Something is not right.

CHAIR BELLA: Can we -- what exhibit is it? Well, let me say a couple of other things while you're looking for that. I just want to draw everyone's attention to Exhibit 3, which is stating that in 2021, spending is about $500 billion a year. So if anyone wonders why I get obsessed, it is first and foremost because it is terrible to be a dual and navigate these systems. But if we think we can kind of get a handle on publicly financed care and not pay attention to these 12 million, 13 million folks, it seems silly.

My second question, after we find this, I'm super excited about Exhibit 13, because we have trouble sometimes matching what sort of delivery system people are in. And I, what I would love to be thinking about, going back to

the earlier discussion, is how much -- I mean, this is all state information rolled up, and I know there are certain states where we have more challenges. There is some data we don't have. But if we think about how we would create a data book for Ohio, right, like Ohio-specific, can we see how we could work with ICRC and MMCO and others to try to give states, even in Exhibit 13, would be pretty cool. And I know there are challenges in that.

Yeah, if you want to direct us to an exhibit that would be helpful on this one.

MS. BALLWEG: Yeah. So thank you for that question. It was on Exhibit 16. So if you go to Exhibit 16, I believe it is page 50, and you look at the institutional LTSS, you can see in the exhibit it is comparing full-benefit fee-for-service dual-eligible beneficiaries with full-benefit fee-for-service non-dual Medicaid beneficiaries with a disability and under 65. And we were looking at spending per user, so you'll see that that's the $62,000, about, or $61,724, compared with $86,810 for the non-dual Medicaid population with a disability and under 65.

MS. BLOM: And this is not really a change in

pattern over prior years. We try to make these comparisons with Medicaid and Medicare non-duals so that we can better understand what's happening in the duals space, but this isn't a concern. We were just highlighting it for the group.

CHAIR BELLA: This isn't even compared to Medicare. This is Medicaid, Medicaid, right?

MS. BALLWEG: Yes, Medicaid and Medicaid.

CHAIR BELLA: Okay. Because some of those dual costs should be on the Medicare side then, which is going to make the Medicaid side look so much higher.

COMMISSIONER KILLINGSWORTH: And my guess is why you're seeing that, is a lot of those non-dual institutional costs are individuals with intellectual and developmental disabilities. For them institutional costs are substantially higher. So I think that's probably the big part of that differential.

CHAIR BELLA: Yeah.

MS. BALLWEG: Yeah, and for clarification, I pulled up last year's Data Book as well while we were talking and it's pretty similar. The $84,000 for the non-dual fee-for-service Medicaid beneficiaries compared with

$53,000 for fee-for-service dual-eligible beneficiaries.

CHAIR BELLA: Yeah, it makes sense. My brain needed a minute to catch up when what I heard, the sound bite, and I was thinking how is that possible. I understand that.

Over time it would be really great to understand -- I forget when we started doing this with MedPAC, but every few years to see have we noticed anything that changed? Have any of these relationships changed, or have we seen different patterns in utilization? You know, it's interesting to see. Obviously, there is bumpiness year to year. There was bumpiness with COVID, for sure. But part of the value of us starting to have this now is we actually have a frame of reference to go back and see, what do we see, and ideally someday we'll be able to say what do we see when, on Exhibit 13, we have higher numbers of people in the same types of products. So thank you for that.

MS. BLOM: Yeah, and if I can, Melanie, that's kind of the main thing that we see changing is the enrollment in managed care, and the more that happens the less we know about that group. So Exhibit 13 is an effort to kind of start moving in that direction. But otherwise

the numbers are generally pretty consistent.

CHAIR BELLA: The more that happens, the less we know because we don't have managed care data. Add that to the list.

All right. Thank you for answering my questions. Other questions or comments from Commissioners?

COMMISSIONER HILL: I have a question.

CHAIR BELLA: Tim.

COMMISSIONER HILL: And maybe it's an end-of-the-day, it's an existential question, I don't know. So when we look at the Data Book, from a Medicaid perspective, to Melanie's point it's always drawing our attention and verifying why we worry so much about duals, and think it's an important issue to worry about.

I haven't looked at it, but I'm wondering if like when MedPAC gets together and they look at the Data Book, are they as alarmed about their people and their program as we are about ours? And I hate to put it in "ours" and "theirs." It's not a fight, but it is a little bit of that. Reflecting on the SMAC conversation and the other conversations we've had about D-SNPs just feels like getting a fire under the Medicare people to worry about

this as much as we do. It feels like -- I'm preaching to the choir.

But I guess, how are they reacting to what they see? Do we have a sense of how they feel about what the data is showing them? And can next year --

CHAIR BELLA: We actually have a plan to reach out. We thought we'd let them get through their meeting.

COMMISSIONER HILL: Can we get MACPAC listed first next year?

CHAIR BELLA: Medicaid is never listed first, you know. We could try. But we actually have, kind of on our list, once we both got through our January meetings, to reach out and talk about a shared agenda beyond the Data Book. And so we can certainly ask. Five hundred billion dollars has got to get somebody's attention, right? Yeah.

Any other questions? Tim, that's a great point. John, you have a smirk on your face. Any comments?

COMMISSIONER McCARTHY: I'm just agreeing with you. It's $500 billion. Just per some of the conversations we were having earlier around just the impact on each state, how important this is. And whether it's the SMACs or MMP, or whatever is going on, there needs be a lot

of work in this area.

CHAIR BELLA: Five hundred billion dollars and generally not great experiences in care. Angelo?

COMMISSIONER GIARDINO: I just want to note, $500 billion is a half a trillion, so it sounds even bigger if you say that.

CHAIR BELLA: And over 10 years we're really talking.

Well, my recommendation is we take this page, with our earlier recommendation for a state strategy, we sign it, all of us, we send it to every state and Congress with a big bow on it, and we offer to be resources as they try to move forward on this area. Yes, Kate. We'll bring that back for a vote in March. Patti?

COMMISSIONER KILLINGSWORTH: I actually have one question. So when we look at that chart on Exhibit 3, and we look at the $181.5 billion, presumably -- is this claims-based data, right? So this doesn't sort of tease out the portion of the Medicare services that Medicaid is actually paying for. Is that fair?

MS. BLOM: It's meant to get at the portions that both programs are covering.

COMMISSIONER KILLINGSWORTH: But is that going to show up, for example, if I think about Part D, the clawback provisions, and what states pay for drugs, and if I think about the premiums and cost-sharing. Is all of that going to be reflected in that $181.5 billion?

MS. BLOM: We have Part D in here, but I should probably get back to you on that rather than giving you an incorrect answer.

COMMISSIONER KILLINGSWORTH: Yeah. I'd just like to really understand sort of net-net, if we even know that, what the percentage of total expenditures really sit with Medicaid, when you take everything into account. And maybe this is it. I just want to know that. Thank you.

CHAIR BELLA: Thanks, Patti. Any other questions?

[No response.]

CHAIR BELLA: Gabby, Kirstin, thank you so much. We are right on time.

CHAIR BELLA: We will open it up to public comment on any of our sessions today. If you'd like to make a comment please raise your hand, introduce yourself and the organization you represent, and we ask you to keep

your comments to three minutes or less. And people are also welcome to submit comments to comments@macpac.gov.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: We've worn everyone out, ourselves and the audience.

All right. Well, thank you to the folks behind me. Thank you to Kate. Thank you to the tech team and the Commissioners. We are adjourned for today. We will restart tomorrow at 9:30 a.m., talking about the Medicare Savings Program, and then we will have a panel on ARPA. So we will see you all in the morning. Thank you.

* [Whereupon at 4:31 p.m., the meeting was recessed, to reconvene at 9:30 a.m. on Friday, January 26, 2024.]

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PUBLIC SESSION

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, January 26, 2024
9:30 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
VERLON JOHNSON, MPA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
RHONDA M. MEDOWS, MD
JAMI SNYDER, MA
KATHY WENO, DDS, JD

KATHERINE MASSEY, MPA, Executive Director

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P R O C E E D I N G S

[9:30 a.m.]

CHAIR BELLA: Good morning. Welcome to Day 2 of the MACPAC meeting.

We are going to start out with votes, and we have Lesley and Amy with us.

VOTE ON RECOMMENDATIONS FOR THE MARCH REPORT TO CONGRESS

* CHAIR BELLA: So here's how this is going to work. We are going to talk about a couple of changes that have been made to the recommendations based on the discussion yesterday. We're going to give Commissioners the opportunity to make any broad comments. I'm going to read the Conflict of Interest Committee report, and then we're going to take a vote, and we're going to vote on each of the seven recommendations separately. And Kate is going to call the roll for each of your names.

Because this is more nuanced than some, if you would like to attach any statement to your vote about why you are voting yes or no and if there's anything that you want to be listed or memorialized in the record or in the chapter about your vote, this is the opportunity to do so

for each recommendation and your particular vote on each recommendation.

Does that make sense?

[No response.]

CHAIR BELLA: Okay. Can we pull up Recommendation 1, please?

First of all, a tremendous thank you to Amy and Lesley and Kate and Chris and everyone for being so responsive to the feedback that the Commission provided yesterday. So we had quite a bit of discussion on Recommendation 1, and just so that everyone understands, this recommendation has been revised, and they will read the revised recommendation. It's on the screen.

And what we were trying to get across here is that states will have an external medical review, that beneficiaries will have the choice of whether to elect the external medical review, but there may be some choices where it's appropriate to have automatic external review in cases where the state has noticed that there are inappropriate denials or lack of access to certain services or procedures, in which case proceeding to an automatic external medical review is thought to be of supreme

importance, particularly for access to care. But in all of these events, the addition of an external medical review should never delay a beneficiary's ability to access the state fair hearing.

There are a lot of moving pieces there to make that all work, but the intent of this is to provide more trust -- a system that beneficiaries can trust and access in ways that we feel will be better than what we've learned is the experience today.

So that is what the changes are intended to reflect, and I will just -- we will go through any other minor changes on each recommendation as they are read. This is an opportunity for any Commissioners to make any overarching comments before we go to each recommendation.

Any comments from Commissioners?

[No response.]

CHAIR BELLA: Okie doke.

This is a voting meeting, and as a result, our conflict of interest rules apply. Our policies are posted on the MACPAC website.

As required by our statutory authority, our Commissioners represent a wide range of backgrounds and

disciplines and bring diverse views, and we all bring reportable interests to the table.

Our conflict of interest policy is meant to ensure that certain kinds of financial and other interests and affiliations, should they rise to the level of potential conflict, will be disclosed during a voting meeting.

Under our policy, the MACPAC Chair appoints a Conflict of Interest Committee that represents a mix of us in advance of a voting meeting, and that committee reviews the reportable interests on file for each Commissioner and other information that the committee deems relevant.

On December 11th, the MACPAC Conflict of Interest Committee, chaired by the esteemed Bob Duncan, to my right, met by conference call and determined for the purposes of our votes today under the particularly, directly, predictably, and significantly standard that governs our deliberations, no Commissioner has an interest that portends a potential or actual conflict of interest related to the recommendations under consideration.

And just for the record, the conflict of interest committee members are Bob Duncan, Jennifer Gerstorff,

Angelo Giardino, Tim Hill, Verlon Johnson, Jami Snyder, and Kathy Weno. Thank you to Bob and the Conflict of Interest Committee.

We will now proceed to vote on each of the recommendations. So Amy and Lesley will start by reading each recommendation, and then Kate will call the roll -- or maybe you read them. I don't know who reads them. Someone reads them, and then we'll take the vote.

* MS. ZETTLE: Lesley is reading them.

* MS. BASEMAN: Yeah, thanks.

All right. Recommendation 2.1 reads: "To bring independence and improve trust in the appeals process, Congress should amend Section 1932(b) of the Social Security Act to require that states establish an independent external medical review process that can be accessed at the beneficiary's choice with certain exceptions for automatic review at the state's discretion. The external medical review should not delay a beneficiary's access to a state fair hearing."

EXECUTIVE DIRECTOR MASSEY: Great. So calling a vote on Recommendation 2.1. Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: No.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes. [Speaking off microphone.]

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: No.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes. But I would also like to include in the chapter, specifically,

consideration of how this particular recommendation interacts with Recommendation 2.6 and to consider whether we should first -- whether Congress should think about first implementing an independent audit and gathering data before moving forward with an external medical review.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: I'm voting no, but it's because I believe that states already have this ability to do this, and so looking at that, and also you have the legislative process to go through if there are issues around this subject, and lastly, tied to what Patti just said, we're going to recommend later on the audits. And so I'd like to see how those audits work and then tie incentives to those audits for states.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: I'm truly undecided, so I'm going to vote abstain.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: I'm going to vote yes, and I'm going to vote yes because I truly believe that, although there may be legislative or administrative things where people can actually complain or raise issues, the

average beneficiary does not have access or know how to use those tools. I believe an external review -- medical review that helps them not have a delay in their care and not have barriers put in front of care that actually is medically necessary, it may be of debate which some of the Medicaid plans needs to be reviewed for appropriateness. My answer is yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: So the tally is 13 yes, 3 no, 1 abstention.

Can we proceed to recommendation 2.2?

MS. BASEMAN: Recommendation 2.2 reads: "To improve the beneficiary experience with the appeals process, the Centers for Medicare and Medicaid Services should issue guidance to improve the clarity and content of denial notices and share information on approaches managed care organizations can leverage to fulfill their

requirements to provide beneficiary assistance in filing appeals. Additionally, CMS should clarify how Medicaid funding may be used to support external entities, such as ombudsperson services."

EXECUTIVE DIRECTOR MASSEY: Calling a vote on Recommendation 2.2.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. 17 in favor. Recommendation 2.3?

MS. BASEMAN: Recommendation 2.3 reads: "To ensure beneficiaries receive denial notices in a timely

manner, the Centers for Medicare and Medicaid Services should require managed care organizations to provide beneficiaries with the option of receiving an electronic denial notice in addition to the mailed notice."

EXECUTIVE DIRECTOR MASSEY: Calling a vote on Recommendation 2.3.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes. And I'd like to see the chapter include something about the ADA and the importance of providing materials and format to people to

read.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. 17 in favor.

Recommendation 2.4.

MS. ZETTLE: Recommendation 2.4 reads: "To improve beneficiary access to continuation of benefits, the Centers for Medicare and Medicaid Services, CMS, should extend the timeline for requesting continuation of benefits. Additionally, CMS should issue guidance offering tools, including model notice language, to improve beneficiary awareness of their rights to continue receiving services while an appeal is pending. Guidance should also clarify the federal limitations on managed care organizations seeking repayment for continued benefits after a denial is upheld and provide model notice language to explain to beneficiaries that repayment could be required if the state allows for recoupment under fee for service."

EXECUTIVE DIRECTOR MASSEY: Okay. Calling a vote on Recommendation 2.4.

Heidi Allen?

COMMISSIONER ALLEN: Yes. But I think it's very important in the chapter that we make clear that this has been -- that we are very concerned that the language does not serve as a deterrent for people using their right for

continuation of benefits by fearing that -- you know, we talked about it in the meeting yesterday, but that states should make some kind of effort to quantify the probability of something like that happening so it's not just this kind of big blanket threat.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes. And I think it's important to plain language in all these sections. I mean have it so every section talks about the importance of plain language for beneficiaries.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. 17 in favor. Recommendation 2.5.

MS. ZETTLE: Recommendation 2.5 reads: "To improve monitoring and oversight of denials and appeals,

the Centers for Medicare and Medicaid Services, CMS, should update regulations to require that states collect and report data on denials, beneficiary use of continuation of benefits, and appeal outcomes using standardized definitions for reporting. The rules should require that states use these data to improve the performance of the managed care program. Additionally, CMS should update the Managed Care Program Annual Report template to require these data fields. CMS should also issue guidance to states regarding implementation of this data reporting requirement and incorporation of these data into monitoring and continuous improvement activities."

EXECUTIVE DIRECTOR MASSEY: Okay. Voting on Recommendation 2.5.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes. And also the importance of bringing out the data by rating category and racial composition, rural versus urban, all the categories that we find -- that we know that are important.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: 17 in favor.

Recommendation 2.6.

MS. ZETTLE: Recommendation 2.6 reads: "To improve oversight of denials, Congress should require that states conduct routine clinical appropriateness audits of managed care denials and use these findings to ensure access to medically necessary care. As part of rulemaking to implement this requirement, the Centers for Medicare and Medicaid Services, CMS, should allow states the flexibility to determine who conducts clinical audits and should add clinical audits as an optional activity for external quality review. CMS should release guidance on the process, methodology, and criteria for assessing whether a denial is clinically appropriate. CMS should update the Managed Care Program Annual Report template to include the

results of the audit."

EXECUTIVE DIRECTOR MASSEY: Voting on Recommendation 2.6.

Heidi Allen?

COMMISSIONER ALLEN: Yes. But if you implement Patti's suggestion that some of the Commissioners felt like this should precede Recommendation 1, I would like it to be noted that that wasn't universally agreed upon. That's not what I would want in the chapter. So if you could just make sure that both sides are presented there.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes. And I want to echo

Heidi's comment about 2.1 versus 2.6.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes. And adding, I guess, the alternative view that this should take place first before Recommendation 1 is implemented.

Thank you.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes. And I'm echoing Dennis and Heidi in terms of this shouldn't have to come before 2.1.

Thank you.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes. And adding I do believe that this is responsive to the concerns about trust but also tries to get at the root cause of what the cause of the distrust of the system is, and so I do believe that

this is the first in the sequencing.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes. This should be occurring in parallel, simultaneously. There's no excuse for delay in care.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes. And just to clarify, Recommendation 1 has passed. So Recommendation 1 and Recommendation 6 have now both passed, and so any commentary will be in the chapter, but both recommendations have enough votes to proceed.

EXECUTIVE DIRECTOR MASSEY: The vote tally for Recommendation 2.6, 17 in favor.

And then finally, Recommendation 2.7.

MS. ZETTLE: Recommendation 2.7 reads: "To improve transparency, the Centers for Medicare and Medicaid Services, CMS, should publicly post all state managed care program annual reports to the CMS website in a standard

format that enables analysis. Reports should be posted in a timely manner following state submissions to CMS. Additionally, CMS should require that states include denials and appeals data on their quality rating system websites to ensure beneficiaries can access this information when selecting a plan."

EXECUTIVE DIRECTOR MASSEY: Voting on recommendation 2.7.

Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes. And I'd just like to say that public reporting is a really great thing for public programs.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows?

COMMISSIONER MEDOWS: Yes.

EXECUTIVE DIRECTOR MASSEY: Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. 17 in favor.

CHAIR BELLA: All right. Thank you all. Lesley and Amy, thank you very much for your work on this. We are excited to see it proceeding to the chapter with recommendations. Thank you, Kate and Commissioners.

We will now move into the panel on MSPs, and Kirstin will join us to tell you about all of those acronyms in this program.

Welcome, Kirstin.

MEDICARE SAVINGS PROGRAMS (MSPs): ENROLLMENT TRENDS

* MS. BLOM: Thank you. Good morning, everyone. I'm here today to talk about enrollment in the Medicare Savings Programs.

Our purpose here today is to examine MSP enrollment trends in today's changed policy landscape. MACPAC previously analyzed MSP participation under contract with the Urban Institute back in 2017. We found then relatively low participation rates of about 50 percent, and based on that analysis we recommended, in 2020, that the Congress require states to use the same income and asset methodologies as the Social Security Administration uses

for purposes of the Medicare Part D low-income subsidy program to streamline enrollment.

The MSP and LIS programs serve a similar population and provide similar benefits, so it makes sense to align their methodologies. And there is an automatic link in federal regulations with the LIS program. Anyone eligible for the MSPs does not need to apply for LIS. They are considered automatically eligible.

The reverse, though, is not true. Anyone eligible for LIS is not automatically eligible for MSPs.

Because of renewed interest in the MSPs after recent CMS rulemaking and because of changes in the landscape since we last analyzed MSP policy, such as the growth in Medicare Advantage enrollment, we decided to revisit our prior work on MSPs and take an up-to-date look at enrollment that could serve as an indicator for us of whether the Commission should pursue additional policy options aimed at increasing enrollment in these programs.

So last fall we again contracted with the Urban Institute to build on their prior work with us but this time to look at enrollment trends starting with calendar year 2010, which is more or less where our prior work left

off.

I'll start today with some background on the MSPs, mainly as a refresh, and as Melanie said, to kind of get all of the acronyms out of the way, and then briefly describe the recent CMS rulemaking. After that I'll walk through our analysis of the enrollment trends, covering the 12 years or so from 2010 to 2021, and then wrap up with conclusions from our analysis and a preview of our next steps.

So let's delve into some quick background on MSPs. As many of you know, there are four separate MSPs that have been enacted at different times and provide coverage to different types of duals. The first is the Qualified Medicaid Beneficiary program, or QMB. It was the first to be enacted and is the most expansive in terms of enrollment and benefits.

That is followed by the Specified Low-Income Medicare Beneficiary program, or SLMB, which was enacted after QMB, but provides similar benefits to people at slightly higher income levels.

The Qualifying Individual program, or QI, is unique among MSPs in that it is fully federally funded. It

is a capped federal allotment, and states receive 100 percent match up to the amount of that allotment.

Finally, the Qualified Disabled and Working Individual program, or QDWI, is the smallest of the MSPs both in terms of enrollment and in benefits offered. It was designed to provide assistance to a small subset of Americans who have lost premium-free Medicare Part A coverage.

The MSPs, as you can see on this table, provide varying levels of assistance and have different criteria. The QMB program covers people at or below 100 percent of the federal poverty level. SLMB sort of picks up where QMB leaves off but covers a more narrow income range, from 101 to 120 percent FPL.

One thing to note on this table is that the QMB and SLMB programs both have two sub-programs that serve either full-benefit duals or partial-benefit duals. You will remember that full-benefit duals are people eligible for full Medicaid benefits. Partial duals are only eligible for assistance with their Medicare premiums and cost-sharing through these MSP programs.

The sub-programs, as shown here, are referred to

as either QMB Plus or SLMB Plus for the full benefit groups, and QMB Only or SLMB Only for the partial benefit. The QMB Plus and SLMB Plus offer the most benefits, covering both Medicare premiums and coinsurance, deductibles and copayments.

And then the QI program, as I mentioned earlier, is fully federally funded, covers Medicare Part B premiums for people between 121 and 135 percent of the FPL. And as I said, finally, QDWI covers the Part A premiums.

States determine eligibility for the MSPs and they have the option to be more generous than the federal standards that are shown on this slide, both in terms of income and assets, and more than 15 states and D.C. have chosen to do so.

Let's turn now to the recent CMS rulemaking.

You are all familiar with the CMS proposed rule on eligibility and enrollment, which was published to the Federal Register in 2022, and which Martha and I spoke to you guys about at that time. That rule also included comprehensive changes related to the MSPs.

Subsequently to that proposed rule being published, CMS made the decision to finalize that rule in

two separate pieces. The first piece is focused on the MSPs and was published this past fall in September. This final rule addresses eligibility determination and enrollment specifically in the MSPs. CMS is using this final rule to codify existing agency guidance on accepting leads data from the Social Security Administration, which states can use to initiate an MSP application. Leads data is data from a beneficiary's LIS application which occurs through the SSA and which the SSA then shares with states.

In the final rule, CMS encourages states to align their MSP eligibility processes with SSA, including things like the methodologies around income and assets.

As I think many of you know, states have the flexibility, under Section 1902(r)(2) of the Social Security Act to achieve this alignment under current law, but many states have not done so. The purpose of aligning with SSA is to enable states to more easily use the leads data and streamline enrollment.

So in the final rule, starting on April 1, 2026, states that haven't aligned their financial eligibility for the MSPs with that of the SSA will be required to accept self-attestation from beneficiaries. States have until

that date, April 1, 2026, to come into compliance with most of the provisions in the final rule. One exception to note is the requirement that states automatically enroll Medicaid beneficiaries who have SSI into the MSPs. That requirement is going into effect on October 1 of this year. But CMS notes in the rule that 33 states and D.C. are already doing that.

To get a sense of state activity around the MSPs, in light of CMS rulemaking, we talked to a few states that are actively engaged in MSP policy, and we heard general support for the rulemaking as well as some interesting anecdotes.

For example, we heard that the structure of the MSPs could be more streamlined with particular attention being paid to the SLMB program, which a number of states have chosen to either eliminate or subsume into their QMB program. This has been done to simplify and reduce confusion for beneficiaries.

We also heard that the leads data from SSA could be more user friendly and that it requires a fair amount of work for states to use it. And then states did note their limited capacity to come into compliance with the final

rule while still working through the unwinding of the public health emergency, and my understanding is that CMS heard comments from states in the proposed rule review and changed the deadlines accordingly.

So with that slightly weedy foundation behind us let's move to the analysis of enrollment trends.

As I noted at the start, we contracted with the Urban Institute, our partner on the 2017 study of MSP participation rates, to this time analyze MSP enrollment trends using monthly enrollment data from the Medicare Beneficiary Summary file for calendar years 2010 to 2021. Our results are displayed across these five categories so that we can see the differences in enrollment trends across the QMB and SLMB sub-programs. And we have excluded QDWI because enrollment in that program is too small to report.

So we found that enrollment in the MSPs has steadily increased since 2010, and the majority of duals are now enrolled in an MSP. In 2021, of the 12.8 million duals in the country, 10 million were enrolled in a Medicare Savings Program.

Enrollment has steadily increased in all of the MSPs since 2010, at an average annual rate of growth of 3

percent. Most MSP enrollees, or 6.3 million people, or 63 percent, were enrolled in the QMB Plus program, which provides the most generous benefits. As we noted earlier, it is the most expansive, covering Medicare Part A premiums if needed, Part B premiums, in addition to cost sharing for anyone below 100 percent of the federal poverty level.

People eligible for QMB Plus are also eligible for full Medicaid benefits. This program has the highest enrollment, as you can see in this table, of any MSP in any year.

Growth rates are not depicted on this slide, but you can find them in Table 4 in your meeting memo, and I'll make a couple of notes about those. Partial dual enrollment in the QMB Only program had higher annual growth rates than the other MSPs, with several years experiencing growth of 5 percent or more. That program also had the highest average annual growth rate at 4.7 percent.

This might be an area for us to look into further down the road to kind of understand the differing growth patterns between MSPs that provide coverage to partial duals and those that cover full duals, and the reasons for that higher rate of growth among the partial benefit

population.

The SLMB Plus program had the lowest enrollment of any of the MSPs and experienced flatter growth, with some years experiencing less than 1 percent growth year over year. This dynamic could be related to some state actions to change the structure of the MSPs by eliminating the SLMB program or combining it with the QMB program. As I mentioned earlier, this is kind of something we would have to dig into a little bit more, but something that was of interest in this analysis.

And then just a quick look at enrollment levels in the QMB Plus program relative to all the other MSPs. As I have mentioned, QMB Plus is of interest because it offers the most benefits and enrolls the most people, by far, so we called it out separately on this graph, the dark blue line underneath the overall MSP growth.

So to summarize, we can identify a few key takeaways from this analysis. First, again, we saw really steady growth in MSP enrollment. Of all the MSPs, the QMB Plus program, with 63 percent of all enrollees, accounted for a larger share of enrollment than all the other MSPs combined. The SLMB Plus program has the lowest levels of

enrollment of any of the MSPs, and relatively flatter growth.

Over the 12-year period, enrollment growth was highest in 2020, likely related to the pandemic. And the QMB Only program, as I noted, which covers partial-benefit duals, had the highest growth year over year with several years experiencing rates of 5 percent or higher.

A number of factors can explain these growth rates, the steady growth over the decade that we looked at. The enactment of the ACA in 2010 gave states the option to expand their Medicaid programs to a new adult population, and since then most states have opted to do so. Given the number of adults who gained coverage under that expansion and the state demonstration of a propensity to provide coverage or expand coverage for beneficiaries, additional enrollment would have occurred among adults who turned 65 and became eligible for Medicare post-ACA expansion.

In addition, the people receiving benefits only through managed care has been increasing. As we saw yesterday in the Duals Data Book, we are up around 40 percent managed care-only in both programs, and that is an increase from around 20 percent or so back in 2013.

Also, the aging population is increasing the number of people enrolled in Medicare, which, in turn, will increase the number of people enrolled in the MSPs. And I should have noted, the growth in managed care is relevant, in particular, because plans have an incentive to make sure that beneficiaries are getting their premiums and cost sharing covered through the MSPs.

In addition, CMS and states have been engaged in pretty significant efforts to increase MSP enrollment, including ongoing guidance on state flexibility options available under current law to streamline enrollment, as well as state efforts to expand income levels and asset limits. Like I said, more than 15 states have expanded those, and as of January 2024, as of this month, 12 states don't have an asset limit, including 2 states with a large share of the nation's dually eligible population, which are California and New York. Combining those two states accounts for about 20 percent of the country's duals.

I'd also like to note the contributions of organizations like State Health Insurance Assistance Programs, or SHIPs, and Area Agencies on Aging, who have worked to connect eligible Medicare beneficiaries with the

MSPs. One state I talked with noted that SHIPs in their state bring eligible MSP enrollees to the state agency, identifying that they are eligible and then connecting them with coverage.

Okay. So let's move to conclusions and next steps.

To conclude, our analysis found steadily increasing enrollment across the 12-year period across all MSPs, with average annual growth of about 3 percent over the period, and that has led to a majority of duals being enrolled in the MSPs. These trends indicate that state and federal efforts over the past decade may have achieved their intended goals. And this analysis has led us to conclude that additional policy options are not warranted at this time.

Our next steps will be to consider areas for future work based on this analysis of enrollment trends, which could include, as I noted, working to better understand different growth patterns between the partial-benefit and full-benefit populations. We also plan to monitor state efforts to come into compliance with the final rule over the next couple of years, ahead of the

April 1, 2026, deadline. We will plan to describe this analysis in a chapter in our June report, and are happy to take any questions about that today.

I'll turn it back to Melanie. Thank you.

CHAIR BELLA: Thank you, Kirstin. This is not just a good-news story. This is a phenomenal-news story. I mean, I don't know how many of you keep track of the amount of Part B premiums, but it is about $175 a month. So we're talking about a couple thousand dollars a year for folks if they are able, just on Part B alone, to participate in this program. And it's remarkable to see the uptick in the enrollment. And I totally understand there might be no policy options at this time, but very much support keeping our eye on things as states roll out. Also keeping an eye on things about getting rid of the asset test that we see states doing, I think there might be future work here.

And since I have the mic, I will just say last thing. We haven't spent much time on partials. We dabble in partials. Most of the duals efforts are focused on full-benefit duals. This might be an opportunity, next year and beyond, for us to think about what does good care

mean for partial duals, and especially as we see more programs focused on full duals, like not forgetting that population. So I'll put a plug in for that.

And then I saw Heidi's hand first. Thank you, Kirstin. This is really excellent.

COMMISSIONER ALLEN: Thanks. This is really exciting. I guess I just have like worry that it could be just population shifts, demographic shifts, and eligibility shifts, and that actually the trend might not be. Because if the population shift is really big then maybe it's not, if you adjusted for that, maybe it's not as high as we would want it to be.

So is there any way to look at the trends adjusted by number of enrollees, so like percentage, not percentage increase per year but percentage of enrollees? Or is that what was there? Did I just misunderstand?

MS. BLOM: That's a good question. I mean, I think we've done what we can do with this current analysis, but we could consider down the road trying to dig in more deeply.

I think if you look at the final rule, CMS's estimates for how many people will be added based on the

changes they are making, which are pretty comprehensive, those numbers are fairly small. There is this population of people in LIS not in the MSPs, which they estimate to be around 1 million people. So that is an area that we could potentially look at.

But overall, in the rule, their numbers are sort of a million or lower in terms of who is going to be coming in as a result of, like I said, pretty comprehensive changes.

CHAIR BELLA: John.

COMMISSIONER McCARTHY: I just want to point out on Slide 5, when we're talking about why do Medicaid directors throw up their hands when it comes to duals policy. If you look at Slide 5, this is why, right here, because in most Medicaid programs you're trying to figure out, well, what do you mean it's a QMB Plus rule? It just becomes overwhelming on some of these things.

So I think sometimes the language we use is really important because this whole time, in all of our other discussions, we've been talking about full duals, and all of a sudden we start calling them QMB Plus. Which is it? So that's just one clarifying piece on that.

Second, I do want to say this program is incredible, especially in states -- you know, many people don't understand that for Medicaid eligibility the federal poverty level is the same across all 50 states. It is not adjusted for cost of living. And so in states with high cost of living, which I was here in D.C., we raised our QMB limit to 300 percent to help aged individuals be able to cover their drug costs because this was when there was donut hole and different pieces like that. So it really was beneficial to people in the District who were struggling to cover their drug costs. So it is a great tool for that.

Having said that, I think the one area of policy we can look at going forward is two pieces. One is when you're the Medicaid director it's great when you're looking at this. You know, you're seeing an increase in QMBs and SLMBs. But that portion of your budget just automatically grows every year, and you can't do anything about it. So if you're in a budget crunch and your governor or legislature is asking you to reduce costs in the program, you cannot do anything about in this area, and so thus you are forced to cut other areas at a greater rate to cover

these increased costs.

But the more important part of that is there is a very technical issue, and Melanie, you might have remembered it, that if there is a negative growth rate, if there is negative inflation, individuals enrolled in Medicare don't have their premiums reduced, they're flat, but states are on the hook for that. So instead of the states having that same kind of, you know, the QMB and SLMB premiums don't go up, they actually do go up to cover the costs of everybody else.

And so I think that is one of the areas we should look at, because it is an impediment of going forward for states making some of these changes in here, because again, one of the things Medicaid directors try to do is keep people at home, and this program helps do that. I mean, especially if you lift some of the asset limits, especially for people with high-cost drugs, this really does help a person stay at home and age at home.

CHAIR BELLA: Does that make sense to the other Commissioners that don't live and breathe this? I mean, it's another example where Medicare is setting a price and the state is taking the price.

John, you're right. I do think, Kirstin, that would be on the list of things. Because I would like to see the states, the states that have tried to collapse the SLMB and the QMB. It would be great. I turned to Kate and said, "We could try to consolidate this whole thing." That might be a little bit too much to take on for the June report. But keeping that on the list, looking at what John is talking about, and always opportunities to monitor SSA, Medicaid, and LIS, because despite all of the recent efforts I think there are still some gaps.

Tricia, and then Dennis.

COMMISSIONER BROOKS: So this sort of builds a little bit on what Heidi was saying, but Urban for other Medicaid populations have calculated participation rates, which would be looking at data suggesting who might be eligible and who's enrolled, what share of those are enrolled. And I think that's actually a better measure, which gets you at a growing population that might be becoming eligible, so looking at participation rates, and Urban is good at that stuff. They've figured out how to do it in Medicaid.

MS. BLOM: Yeah, I hear that, Tricia. We did do

that work with them years ago, and it was a heavy lift. So we have not gone back to that.

CHAIR BELLA: Thank you, Tricia.

Dennis?

COMMISSIONER HEAPHY: Yeah, thanks.

My mind went to where you were, Melanie, was quality of care and access. And my first thought was, what are the churn rates of folks in managed care or other -- what's the stability? What kind of access to services are they getting? Because we've done so much work on full duals. We need to do something similar for these folks.

MS. BLOM: That's on the list for sure.

CHAIR BELLA: Other comments or questions?

Patti, nothing? No? Taking a pass on this one? Okay.

Verlon?

COMMISSIONER JOHNSON: So I just have to say that I'm in Medicaid because of this program, and it is very exciting to me to see the numbers increase like this. I do echo a lot of what Heidi and Tricia said in terms of looking at the broader population around this and then also, of course, some of the things you also indicate as

well. But I just had to go on record saying that this is phenomenal.

When we think about the outreach and education efforts that we talk about in almost all our recommendations and actually seeing something like this happen, I think that's impressive, and so it's something we always want to keep in the back of our mind too as we think about things moving forward. So thanks for this.

MS. BLOM: Thanks, Verlon. I appreciate that.

CHAIR BELLA: And just like a shout-out to CMS, in particular, at the duals office and Tim Engelhardt. This has been a huge priority for them and so really nice to see when policy starts to align.

All right. Any other Commissioner comments?

[No response.]

CHAIR BELLA: Kirstin, do you have what you need?

We're going to open it up. I'll ask you to stay there just a second in case we get any technical questions from any public commenters. We have a little bit of time. So I'll go ahead and take public comment now on this session.

So if anyone in the audience would like to make a

comment, please use your hand icon, introduce yourself and the organization you represent, and we ask that you keep your comments to three minutes or less, please.

Looks like we have Denise. I think you can unmute and then introduce yourself, Denise.

PUBLIC COMMENT

* MS. FRANKLIN: Hi. My name is Denise Franklin. I am a training and employee development specialist with Claim Aid. We train patient resource advocates in hospitals in Indiana, Michigan, and Ohio.

The Medicare Savings Program, particularly enrollment related to SSI recipients, has been something that I have struggled with for years. I see a real disconnect between what the state says is happening as far as their auto-accrete and what's actually happening on the ground. Can you elaborate a little bit more about what the changes are going to be on October 1st?

MS. BLOM: The change, yeah. So 33 states and D.C. are already covering this group, but the change is to require that people that have -- Medicare beneficiaries with SSI be enrolled in the MSPs.

MS. FRANKLIN: Well, now, that's -- that, I

think, is where some of the problem is coming from is SSI recipients aren't enrolled in Medicare automatically. So you're trying to thread a needle in making sure that they have access to their Medicare without, boom, $500 Medicare Part A premium, $170 Part B premium, them being liable for that. So there's -- that may be where we're seeing a disconnect between what's happening on the ground and what policy says is supposed to happen.

CHAIR BELLA: Thank you, Denise.

Any other comments?

Oh, yes. Melissa.

MS. SIMPSON: Hi. Thank you so much for this work and presentation.

I work with the Administration for Community Living. My name is Melissa Simpson, and I work in an office that funds the SHIP and MSP and MIPPA grant work, which really focused on helping folks get access and understand these MSP programs.

So I just want to first thank you for continuing this work. It is really helpful when we talk to folks about these programs and the need for the programs to demonstrate some of the success or, you know, lack of that,

so really appreciate that.

I was really interested in hearing the considerations of combining the programs and thinking about it from a Medicaid director's perspective of, you know, sort of understanding all of these technical pieces. I just wanted to say that we might be able to look at some of the experience that happens this year in 2024 with extra help.

So as you likely know, we had two different levels of subsidy, a partial and a full, and extra help for LIS, and now in 2024, there's just one level. So I just wanted to mention that, and thank you again for your work.

CHAIR BELLA: Thank you very much for making the comment and for the work that you do in this area and beyond.

And I guess I would say, Melissa, as you see that unfold, please don't be shy about making sure we're seeing the same thing you're seeing. There's always an opportunity to reach out to the team here.

All right. I don't see any other comments. We have a panel, but the panelists will not be online for

about another 10 minutes. So we'll take a 10-minute break. We'll come back at 10:30 Eastern time and go into our panel on ARPA.

Kirstin, thank you.

* [Recess.]

CHAIR BELLA: Welcome. We're really excited for this panel, and I'll turn it over to you to get us started.

PANEL ON THE AMERICAN RESCUE PLAN ACT (ARPA): SUSTAINABILITY AND EVALUATION

* MS. HUSON: Okay. Thank you, and good morning, everyone.

So we are having this panel today to talk about the American Rescue Plan Act, and as you know, ARPA provided a temporary increase in the federal medical assistance percentage for state Medicaid programs to support the infrastructure for home- and community-based services. And it increased the FMAP by 10 percent for the one-year period of April 2021 through March of 2022, and states have until March 31st of 2025 to spend the increased FMAP that was earned during that one-year period.

ARPA funding is the largest federal investment in

HCBS that states have received in the past few decades, and it's estimated to have provided an additional almost $37 billion in both state and federal funds for HCBS activities.

And so you'll recall that about a year ago, we had a panel on states' early experiences with implementation, and so we're having another panel today as we look towards the end of the funding period. So we know about half of states have plans to wrap up their activities this year, and the majority of states have plans to wrap up by 2025.

And so we've invited three panelists for today's session. We are joined by Jen Bowdoin, who is the director of the Division of Community Systems Transformation within the Medicaid Benefits and Health Programs Group at CMS. We're also joined by Bonnie Silva, who is the director of the Office of Community Living at Colorado. And finally, we have Alissa Halperin, who is the principal consultant at Halperin Health Policy Solutions.

And so my first question today goes to Jen. So, Jen, given CMS's role in approving and reviewing states' ARPA spending plans, can you tell us what types of ARPA-

funded programs states are most frequently planning to sustain after their ARPA dollars are expended? And how have states prioritized which programs to maintain?

* DR. BOWDOIN: Thanks so much for the question. Hi, everyone. It's great to talk with you today.

So, as you all probably know, states have a lot of flexibility in terms of whether they sustain particular activities that they've included in their spending plans. We did ask states to provide information on how they would sustain their activities after the funds are fully expended. So even though it wasn't required that they sustain them, we do have some information on whether a state intends to sustain a particular activity.

So for a lot of activities like bonus payments for providers or temporary rate increases that have since ended, these are clearly time-limited activities that will not be sustained. But there are a substantial number of activities that states have either clearly committed to sustaining or have indicated that they're working to sustain the activities, such as through requesting funds through their state legislative processes.

So with the caveat that this is preliminary

information and it's subject to change as states fully implement their spending plans, what we see is that of all the activities that states have indicated that they'll sustain or that they're working to sustain, over a third are focused on the workforce. So these are things like rate increases, worker registries, developing standardized training programs. So those are some examples of the types of workforce activities that states have indicated that they're sustaining or that they're working to sustain.

I'll note, though, that workforce activities are -- they're also the most common types of activities in state spending plans, and so it really makes sense that they would make up a high proportion of ongoing activities. We actually see that activities focused on reducing or eliminating waiting lists are actually two times more likely than workforce activities to be activities that states are planning to sustain after the 9817 funds are fully expended.

Also just know -- and this is a little bit more anecdotal, but I would expect that certain types of activities like new or enhanced information systems, where -- the types of activities where there's a large upfront

investment that the state was able to pay for with 9817 funds and then relatively smaller ongoing costs, those would be activities that I would expect to be more likely to sustain -- be sustained by states than other activities where there are extensive ongoing costs.

But we'll continue to monitor this, and to the extent that we can provide more specifics as we update information on 9817, we'll certainly make an effort to do so.

MS. HUSON: Great. Thank you.

My next question is for Alissa. So can you please share a little bit of background on the ARPA HCBS TA Collective that you are a part of and how it has supported states in developing and implementing their spending plans? And in particular, can you share the Collective's work on program evaluation and sustainability?

* MS. HALPERIN: Absolutely. So the ARPA HCBS Technical Assistance Collective joined forces in 2021, the brainchild of Brian Burwell, and it is comprised of ADvancing States; NASDDDs; my organization, Halperin Health Policy Solutions; Anne Jacob's organization, Riverstone Health Advisors; and Brian Burwell.

And with the funding of six foundations, the John A. Hartford Foundation, The SCAN Foundation, the Milbank Memorial Fund, they funded us for three rounds of technical assistance to states, and we also had one round each funded by Arnold Ventures, the Peterson Center for Healthcare, and the Care and Respect with Equity for All, or CARE Fund. They each funded one of our rounds of technical assistance.

But the idea behind the collective was to provide free rapid-fire technical assistance to states in implementing their ARPA spending plans. They had to move very quickly in planning and submitting plans, and there was a lot to do in terms of actually lifting up their ideas into actionable activities.

So our first two rounds of technical assistance were primarily focused on providing project planning. So we would meet with the states. We assisted seven in our first round, and it was really rapid fire. I mean less than three months. And we met with them at least weekly, and we helped them develop an actual project plan for how to implement.

And every time we did, one of the questions we would always ask is, how will you decide what will work,

what works? When do you need to know what works in order to get approval or funds to continue this? And for many -- well, I'm going to say for almost all the states we worked with at that time, none of them had -- you know, they agreed that, yes, ooh, that's going to be important, but they hadn't thought of it yet.

And then in our second round of technical assistance, we assisted five states again with project planning. We also convened two affinity groups, one on the direct care workforce, one on enabling technology. And again, the groups met weekly, and the questions were always, well, how are we going to determine what's successful? How are we going to judge what had the greatest impact? When will we get that information if we're still trying to figure out what to do with our funds?

And then our Technical Assistance Collective recognized that both evaluation and sustainability were critical issues for states, and so for our third round of technical assistance, we provided not just direct substantive assistance this time, technical assistance, year long, free to -- I think it was six or seven states this round on actually the specifics of some of their

initiatives, but we also put together a paper on evaluation efforts by states that was based on a survey that we conducted of all states and then focus groups that we conducted with states that indicated that they were undertaking some evaluation efforts. And part of round three also included a sustainability summit of a small select group of HCBS thought leaders that took place in October to talk about sustainability.

Evaluation, I believe, is critical for decision-making that states make around what to sustain, whether to sustain, what worked, what didn't, who was helped, who wasn't. It's not just about, did this save money? It's also about, was this effective? Was this helpful? And can we take the lessons learned and apply them in some way, even if we don't continue the specific activity that we were doing?

Oh, wait. Also, in that third round, we were able to -- I was able to work directly with Bonnie's team in Colorado on their sustainability work, which was fabulous. So I can't wait to hear what Bonnie has to say.

MS. HUSON: Well, that was a perfect segue. Thank you.

So, Bonnie, let's turn to you. Can you describe your state's evaluation efforts and particularly how you chose which initiatives to evaluate and how your evaluations might support your long-term program sustainability?

* MS. SILVA: Thank you, and good morning, everyone. Thank you for the opportunity To come and speak about Colorado's work around ARPA. We really deeply appreciate it.

First, I'd like to piggyback on Alissa's comments related to the interconnection between sustainability and evaluation. Because of the one-time nature of these funds, we had to begin thinking about sustainability from day one when we developed our plans.

Our projects really fell into a number of categories. We had projects where one time -- that we knew would be one time in nature, whose outcomes would inform our future work. And we had 33 projects that qualified there.

And then we had projects who -- where the one-time nature, but depending on the outcome, could require additional resources to sustain. And we had 22 projects

that would fall in there.

And then we had projects that we knew we'd immediately require resources to sustain. Like, we weren't going to implement them unless we knew that we would have the buy-in from the governor's office, from the legislature to have ongoing funding, and we had just eight categories in there.

Looking at those three categories really set us up for how is it that we would have our sustainability projects, if you will.

The categorization really mattered because it determined, like, how we set up those projects, if we will, and the metrics associated with them.

For example, we would look at, say, national best practices related to compensation for direct care workers. You heard Jen talk about that being like a key activity across many states and activities related -- you know, we have a research and evaluation project related to what is the benefit package that would help keep those direct care workers in those positions, sort of mitigating the benefit cliff that we often hear people talk about.

We wanted to make sure that even though it was a

research project, that the sustainability process for that particular project would make sure that that research project didn't just sit on the shelf. We had to have action plans, for example, that made sure that we put that research project into action.

The outcome metric, for example, we have research developed related to how can we do value-based payment for long-term care and fee-for-service as a "for example." Right? Again, outcomes related to what are the next steps once we have the research and evaluation so that we can test and pilot it to see if this is something long term. Colorado happens to not be a managed care state, but we want to implement in the longer term. So that's a pilot as a "for example."

And then in terms of immediate resources, one of the things that we were able to do was raise the base wage requirement for direct care workers, again, really critical for us to stabilize and increase that workforce. But we didn't want to increase wages and then say, "Oh, gosh, ARPA is over. So we're going to take your wages back down." We knew that that would be a pretty catastrophic outcome.

So before we did that with the one-time funding,

we were really careful to ensure that we had an ongoing commitment from our legislature to sustain that funding so that those increases would maintain.

We knew that we had to have development of, I think, strong metrics. So the process, ideally, we had these outcome metrics, wherever possible, attached to all 63 of our projects. That would demonstrate what is considered successful and how do we move that forward.

In some cases, we were testing a new model of care or benefit. So, for example, we have a project that takes people experiencing homelessness, who are people with disabilities or people with significant mental health needs. And so we have rigorous evaluations around those pilot projects as a "for example" that help us decide, is this something we want to move forward with in the future?

Because we have so many projects with so many different goals, each project really had to be evaluated. I think as Alissa talked about, on its individual own project plan basis to make sure we had the right metrics for each one, but I will say that some sort of standardization has been really important for us to be able to manage all 63 of them in their totality. So all

projects were required to have metrics to report on the success of their activities. Every project has had to develop a sustainability plan that outlined what is the intended plan for the post-ARPA HCBS, including the need for ongoing resources, if required, and how it will on its own move that work forward.

We wanted to make sure that we had -- if we needed to include it in our budget request that we had that included into our ongoing work streams and that we didn't miss the opportunity to move it forward.

Through this strategic work, we have begun developing our own plan to continue this work, I think, ongoing. But we've also been able to really narrow and identify the projects that are already showing promising results and that we want to continue immediately. So through our last two legislative sessions, we've been able to get funding to sustain some of the projects that we've already put in our sort of ARPA plan as they exist today.

I think I talked about our base wage increases. We already have funding for that.

And then also, we have, as Jen had talked about, funding for our standardized training for direct care

workers. We have an IT platform that connects direct care workers with job seekers. We also received ongoing funding for that.

So we're not waiting for the end of ARPA, if you will, to sort of sustain the plan as it exists today.

MS. HUSON: Thank you for sharing that. That's very helpful.

So thinking about other states that might want to do evaluations, my next question is for Jen. So for states that are taking the full time through March 2025 to spend their ARPA funding, but maybe don't have an evaluation plan in place now, is there still time for them to build in that, into their state spending plan? And how is CMS working with states that might be interested in doing that?

DR. BOWDOIN: So the short answer is yes, of course. So the way we've designed the implementation of Section 9817 is really to give states flexibility and to be responsive to changes in states' activities and changes that they would like to make to their spending plans. And so states really have flexibility to make modifications to their spending plans at any time.

And we would really welcome, I think, seeing more

states make revisions to their spending plans to include evaluation activities.

The state would obviously need to clearly document that the evaluation activities are focused on the activities in the spending plan and evaluating their Section 9817 either more broadly or specific activities in their Section 9817 spending plan. But so long as they do that, they would very likely be approvable. Those changes to state spending plans would be approvable if states wanted to incorporate evaluation activities.

A state should, of course, be mindful of the deadline for fully expending the funds. There isn't a lot of time left, and so that does limit the amount of time that states would have to make those changes, and of course, in many states, it limits how much funds -- how much of the funding is really left. So that might drive a state's decision on whether or not to do that.

And I'll just note that the requirements under Section 9817 continue to apply until the funds are fully extended, and so states would have to keep that change -- that in mind if they wanted to make changes to their spending plan.

But we are, as always, available to provide technical assistance to states on any questions they have related to this, to making revisions in their spending plans, and we would certainly help to try to connect them to some other states that are implementing evaluation activities if they wanted to learn more about what other states are doing in this area.

MS. HUSON: Great. Thank you. That is good to know.

So I'm going to turn back to Bonnie to ask, what, if any, challenges have you encountered in your efforts to evaluate and sustain your ARPA initiatives? And in particular, has the time-limited nature of this funding posed any challenges for Colorado when conducting your evaluation?

MS. SILVA: Yeah, thank you so much. I have this frog in my throat, so I hope you guys can hear me.

Time has absolutely been our greatest challenge in implementing that ARPA HCBS initiatives, but being given the opportunity to solve, I think, what those of us in the field would agree are decades-long problems within the HCBS system is incredible.

But making thoughtful decisions about the right path to tackle these issues, developing a plan for those actions, and finally being able to implement them, evaluate them, is not a quick undertaking. We are incredibly grateful for the extension and the ability to have an additional year for implementation, and we are taking all the time that we can. But absolutely, the time restriction has been challenging.

Related to timing, but specific to the evaluations, is when you have a short timeline for initiatives, such as those that we have designed, particularly when the planning phase must be built into the timeline, building an evaluation adds significant complexity.

Most of our projects required at least a year to hire staff, develop a budget and project plan, and to execute contracts to get the work underway. That left us just two years to execute on the work, which has to also include the evaluation. That significantly limited the number of projects that we were able to incorporate the type of rigorous evaluation into the scope of that project that I think we all would like to see and be able to use to

inform our work as we move forward.

For that reason, our teams needed to be really creative so that we could rely on these other metrics to evaluate our success of these projects.

So this is not to say that the timeline made the evaluation of the work impossible. Like, we incorporated it, absolutely, but it did limit the extent and type of evaluation that was possible within that available timeline. Absolutely.

MS. HUSON: Thank you.

And now I want to turn to Alissa. With your work with multiple states, are there any other challenges that you have encountered working with other states or anything that you would point out?

MS. HALPERIN: So as I mentioned previously, we have a paper in evaluation that is due out imminently, although I think I've been saying that for a little while. I mean, we surveyed all the states. We received full answers from about 24, and then we used their answers as well as the focus groups that we conducted, and one of the questions was about challenges. And they absolutely, all the things they said, you know, the timeline, the need to

identify ideas, plan, implement, operate, and then think about their timelines for going to legislators or going back to CMS for permanent authority and what that looked like.

So the maintenance of effort requirements were definitely a challenge because a lot of the ideas that states chose were unique. They were things they hadn't done before because of the maintenance of effort requirements, and that, in many ways, from what we heard from states, they articulated that they didn't have baseline data because it wasn't anything that they had ever really -- sometimes it wasn't a population they'd worked with, or there were other unique factors that made it hard to evaluate -- planning for evaluation, not having staff capacity to evaluate, the things that Bonnie mentioned, not really having a good framework for evaluating innovation grants. A lot of states used some of their dollars to provide innovation grants, and since they were all unique, were creative, or things that hadn't been done before, they hadn't really thought through ahead of time the best ways to evaluate the impact of those grants.

And then I think the last one that we heard was

that with so many initiatives happening all at once it wasn't just a timing issue, it was also a how to identify which initiative has the impact. And this is specifically around direct care workforce, for example. If a state was doing multiple direct care workforce initiatives, they just threw it all out there with their ARPA dollars. You know, their efforts to evaluate were somewhat clouded by the inability to parse out which one was having the impact as they tried to judge what the impacts were.

MS. HUSON: Thank you for sharing those additional considerations.

So following up on that, my next question is for Jen. What factors impact initiative sustainability beyond the ARPA spending deadline, and what kind of policies or flexibilities are available to support sustainability? And how is CMS playing a role in supporting program sustainability for states?

DR. BOWDOIN: Yeah, so this is probably not going to surprise many people, and I'm sure there are other factors, particularly state-specific situations. But I think the biggest factor that likely impacts sustainability is ongoing funding. When we look across all the activities

in state spending plans, as you mentioned early on, they are investing nearly $37 billion in additional funding in their HCBS system, thanks to the American Rescue Plan. That is a substantial amount of funding.

And we know that many states are hopeful and many states have committed to be able to sustaining at least some of the activities in their spending plans. We've also heard from a lot of states that they simply don't have the money available in their state budgets to be able to sustain all of the activities that they would like to.

You know, so we have approved some activities in state spending plans like capital investments and affordable and accessible housing that just simply are not approvable under Medicaid authorities. But there are actually relatively few activities in state spending plans that can't be sustained under a Medicaid authority.

So put the funding issue aside, I think in a lot of instances, if a state is able to, there is a lot that they can actually continue under the Medicaid program, under regular Medicaid authorities. And in a lot of instances we've worked directly with states who identify ways to sustain activities that were maybe initially

approved under a disaster authority, and help them, work with them to move them under a regular Medicaid authority so that the state can make a particular change in a program, say a rate increase or an expansion of eligibility or new waiver services, to be able to make those changes permanent.

We would certainly welcome the opportunity to work with any states that have questions about how to sustain their activities in the spending plans under existing Medicaid authorities, so that door is always open to states.

Also note that we are trying to support and encourage state-to-state information sharing on this topic. We do have regular calls with all of the 9817 spending plan points of contact. We're really trying to leverage those calls to have the states really learn from each other, because we think that often the best people to hear from in this area, it is not people in the federal government. It is really people at the state level that are wrestling with the same challenges and issues. And to the extent that we can connect into the dual states kind of through other mechanisms we certainly have been trying to do that as

well.

MS. HUSON: Thank you for that. Jen, one quick follow-up question for you. CMS recently published two different overviews of state spending plans. So as we're looking forward, does CMS anticipate releasing any sort of final publication on the experience of ARPA HCBS-funded initiatives?

DR. BOWDOIN: So we are planning to update, hopefully later this year, the National Overview and the State Summary. So those were the two materials that were recently posted on Medicaid.gov. For the updated versions that we're hoping to release we're planning to use federal fiscal year 2024 quarter 1 data, which is the most complete information we have for all states at this time.

I'll just note, though, that those State Summaries and National Overviews, they are actually fairly resource intensive to produce. There is a ton of variability across states in their spending plans, both in terms of the types of activities that are included but also how they present the information in those spending plans too.

So we'll need to assess whether we can continue

to produce them on an ongoing basis, at least until the funds under 9817 are fully expended. But we are planning, minimally, to continue posting spending plans and narratives until the funds are fully expanded by all states so that the information is available to external groups that would like to review what particular states are doing under 9817.

MS. HUSON: Thank you. That is great to know.

Okay, so my last question is for all of our panelists. Knowing now what you do about the challenges that you've encountered, is there anything you would do differently in order to plan for the sustainability of programs? Are there challenges that you wish you had anticipated? And finally, what advice would you give to other states that are looking to conduct evaluations of their ARPA programs?

I don't know who wants to start, but please feel free to chime in.

DR. BOWDOIN: I can start, and I think this is a good question. Unfortunately, I wish I had some really good answers to it. I'm actually really looking forward to hearing from the other panelists, particularly if they have

thoughts on how CMS can help to increase the sustainability of states' activities in their spending plans, and especially if there are places where we are creating barriers to sustainability.

You know, what I'll note is that we knew from the outset that this would be a substantial infusion of funding in states' HCBS programs, and so from the start we were really worried about sustainability. We were worried, for instance, Bonnie mentioned cliffs. We were worried about payment or rate cliffs, where there was a huge drop-off in payment rates for HCBS when the 9817 funds ended, or where there was a benefit cliff where services or benefits were added for HCBS beneficiaries but then those services or benefits dropped off expeditiously after the funds were expended.

So in our conversations with states we really tried to encourage them to try to avoid these types of situations in designing their activities.

So we don't have statutory authority to require states to sustain their activities, but we did ask states to discuss sustainability in their spending plans and really to be thinking from the start about sustainability

and what would happen when the funds were no longer available.

And to the extent that we were able to, we tried to provide states with technical assistance on how to continue activities under Medicaid authorities or, for instance, to identify ways that states may be designing programs that might prevent them from receiving approval under a Medicaid authority and to provide suggestions about maybe how to address them. So rather than provide a rate increase through a grant payment to a provider, which might be hard to approve under a Medicaid authority, providing them suggestions about other ways to do that under existing Medicaid authorities.

And as I mentioned, we have also tried to encourage peer-to-peer learning through our regular calls.

But if there are other things that we could be doing or should be doing, we would really love to hear about it, and I think we would be happy to help connect states that want to learn from other states that are dealing in this area or help to support states that want to make revisions to their spending plans.

I would just encourage that if there are states

that want to make changes, to increase sustainability, or to revise their spending plans, they should really come talk to us as soon as possible because the deadline for fully expending the funds is approaching, much more quickly than I think many states would like, and we know that things like evaluation activities and things like that, or implementation of new activities or changes to activities, if they are well designed, they can take a substantial amount of time to implement.

MS. SILVA: I'm happy to jump in next, if that is all right, Alissa. You know, you asked us what we would do differently, but maybe I would start with what worked really well. And hats off to Jen and her team, they also didn't get any additional resources to manage this extraordinary effort nationwide, and they have been, I think, really great problem solvers at the federal government, helping states that wanted to tackle this in very different ways figure out how to do that in innovative ways.

I also think that because we're talking to MACPAC, right, what Congress demonstrated was coming out of the COVID-19 pandemic the reason that they dedicated this

once-in-a-lifetime tranche of funding to HCBS is that there was a demand to say how do we make sure that we really strengthen home- and community-based services for people with disabilities and older adults. How do we make sure that we have the right infrastructure, and innovation in Medicaid has to something that we are all striving for. And this is something that I think Congress uniquely has this ability to say, you know, we are going to direct that maybe a certain enhanced percentage of FMAP can go towards those innovative efforts.

And maybe in future years it isn't this huge tranche of funding, but maybe it's a one percent FMAP or a two percent FMAP. Maybe it's in partnership with the federal government, where we keep our eye on that innovation and look at new Medicaid authorities and make sure that we're not continuing to rely on what is and really keeping our eye on what could be. Because I think the real promise of ARPA funding is shame on us if we have the exact same problems that we have today at the end of the spending period. Like we should have new and innovative solutions to what has sort of plagued us. We're removing those regulatory confines that typically sort of

box us in. And by doing it through Congress we have this opportunity for this national strategy to these problems, working in concert with our federal partners.

So that wasn't exactly your question, but I would be remiss if I didn't say. But looking back on if I could change or do anything differently, honestly, we would've done less projects. Like being the state that had more projects than anybody else, like not exactly the badge that I wanted to wear, but also, I think, a testament to just our passion and dedication in Colorado and really being responsive to our stakeholder community and our desire to sort of be innovative and come up with those solutions. But 63, perhaps, was even a little much for us.

I am very, though, proud of our team and the work that we have done, so I would be remiss if I didn't say that. We knew that it would be challenging so we weren't Pollyanna-ish when we put those 63 projects out there, with an extremely difficult timeline, one-time restricted funds. But we didn't want to look back and think that we hadn't fully leveraged this once-in-a-lifetime opportunity to truly improve our HCBS system for the long term. So we were tired, and we agreed to be more tired collectively, as

a state. Like we just were all in it together.

A practical change that I would have made would have been to hire more administrative support staff to wrap around our program staff. I was very focused on like, oh, I need program staff to do the work. The truth of the matter is with this many projects there is a lot of administrative work in executing 63 projects, and the evaluation part of that, in particular.

We have amazing subject matter experts in Colorado, but we don't have a lot of people that have expertise in understanding the need for and designing evaluations. So I would've probably built in providing additional support around this early on, and in the program design phase specifically this would have been beneficial. We kind of backed into that, if you will, with some of the TA help that we received.

In terms of advice for other states, I would recommend just starting. It doesn't have to be rigorous, it doesn't have to be academic, you know, if you will. It just has to be informative. So ensuring that every initiative has at least one outcome metric can be a great place to start, and demonstrating progress through data is

really powerful, and making a case for sustaining important work, whether that's within your own Medicaid agency or working with your legislature or working with your federal partners.

MS. HALPERIN: So without taking too much time to echo thoughts I've heard by Bonnie and Jen so far; I think that one of the things that I can't miss out on the opportunity to say is that ARPA highlighted both the incredible ingenuity of states but also the incredible commitment to HCBS. And I think that we can talk about how states can sustain the efforts, but I do think we need to focus on how we, as a nation, as I think Bonnie was suggesting, can continue to sustain the commitment and dedication to expanding and easing access to HCBS, easing administrative burdens for states that ARPA created, you know, ARPA offered.

And I just think that we need to take the lessons learned about HCBS generally from the ARPA experience and use them to improve upon our HCBS system. So I just want to say that first.

And then I will say that in our forthcoming paper we did actually ask all states that participated in our

survey and focus groups to share with us recommendations for other states, and similar to what Bonnie said, although Bonnie was one of the states that participated in our paper survey, to be thoughtful about the scope, to focus your evaluation on those initiatives that you are actually possibly thinking about sustaining, to be really transparent in the process. It was important to some of the participants that they recommend to states that as they evaluate that they really center the participant experience. I mean, if an initiative didn't save money but people were better served, isn't that what this was all about? And I have probably a direct quote.

They encouraged using existing resources, if states have relationships with state universities, maybe using them for evaluation, to expedite procurements for evaluation as well as for the underlying initiatives, so that there is time to do evaluation. They recommend to other states to build on existing requirements for providers to build in facets that relate to gathering data that you need for evaluation purposes, so leveraging existing requirements that are placed on providers. They encouraged designing survey administration methods

carefully. And for innovation grants, establishing well-defined sets of uses for the grants, well-defined sets of desired outcomes, or a rubric that the grantee has to complete, in terms of what expected outcome they anticipate having.

And those are just a few of the suggestions that states offered to other states that will be in the paper.

MS. HUSON: Great.

Thank you all for your answers.

And with that, I would like to turn it back to the Commissioners for their questions.

CHAIR BELLA: Thank you very much. It's such a highlight to have panels and to hear from CMS and the states and folks helping the states. So we really appreciate the three of you taking time with us today.

Tamara, thank you for setting that up.

We'll open it up. We have our panelists until 11:30. So we'll open it up to some questions or comments from Commissioners.

Jami.

COMMISSIONER SNYDER: Great. Thanks for joining us today. Really appreciate your participation in our

meeting this month.

I have one question for Bonnie, and then I have another question for Alissa and Jen. But, Bonnie, wanted to start with you.

Kudos to you and to the Colorado team for being so proactive in thinking about sustainability and actually starting to talk with policymakers about some of the projects where you think you'll need ongoing funding. So I'm curious, though. Were the projects where you do need ongoing funding -- were there instances where to date you haven't been able to convince legislators to fund those projects or you don't anticipate that they'll provide the funding? And if so, what are you doing to identify other resources to sustain the projects? Are you thinking about dismantling them?

MS. SILVA: Thank you, Jami. I think that's a great question.

So for the eight projects that we identified early on that we knew would require ongoing funding, we're really fortunate in Colorado that we have secured that funding to make sure that it's ongoing.

Disability policy tends to be bipartisan policy,

and so working with our legislature, we have been really fortunate to have true champions on both sides of the aisle to make sure that this work is appropriately funded and supported and taking the time to explain to them why the initiatives that we needed ongoing funding were really instrumental to creating good supports in our state. We got 100 percent yeses so far.

And so we do have a few initiatives that are working their way through our legislature this year, but so far, it is looking like we are going to get those ongoing fundings.

I would also say I am really thoughtful about when I ask for money, and so being able to, going back to the evaluation piece, say this is the data, this is why, you know, here are the things that we're doing to save money, here's the federal government's participation, here's how we're living within our cost envelope. And I think that lends towards credibility, and it makes it easier to get the yes.

COMMISSIONER SNYDER: That's great to hear. Thank you.

And then a question for Jen and Alissa and

perhaps Bonnie. I think there is some concern -- and there's been a lot of sort of dialogue about it recently -- around states that chose to direct a lot of their funding to one-time provider payments, and I know states were very, very clear with providers, as they did that, to use that funding, knowing that it wouldn't be available on an ongoing basis for things like bonuses and stipends.

But I think there is concern that, in fact, providers in many cases use them for salary increases for direct care workers, even knowing that the funding wasn't going to be available.

And I guess I just -- I think you all are much more in tune with how things are playing out or how things are likely to play out. So I'm just kind of curious to know from your perspective. Do you think there is reason to be concerned, and are there states that are already talking with policymakers, state legislators about the need for funding to maintain those funding levels that providers have gotten used to, I guess, over the course of the last couple of years?

DR. BOWDOIN: Alissa, do you want to go first?

MS. HALPERIN: Sure.

I will say that the question is not whether states have started talking to policymakers. In my observation, it's that they've started talking to policymakers, but they don't have everything that they need in order to convince them. I think it certainly a concern.

But I don't actually think -- I mean, there are several states that I worked with and that we worked with as a Collective that had not anticipated at the start of ARPA, when they designed their HCBS spending plan, how much trouble they would have getting the necessary authorizations from their legislature. That was absolutely an experience in some of the states that we worked with that, you know, making the case, even though they'd already gotten something that CMS was okay with, they still hit some roadblocks in their legislature.

So I don't think it's necessarily that they -- I mean, I think states are pushing, and they're working and doing their best, but if they don't have what it takes in their back pocket in terms of data and evidence -- and some of them just haven't operated their initiatives long enough to even start to have the data or evidence -- it's a hard case to make for some states. So that would be my

observation.

Jen?

DR. BOWDOIN: Yeah. So I don't know that I have all that much more to add.

I think if there are concerns that the funds haven't been used for their intended purpose or have, they been approved by CMS, we've heard some instances of that, but I'm not -- I would say it's not a consistent drumbeat. It's not something that we've heard all that much about, and where it has come up, we've tried to work with the states to identify. But the states had a lot of discretion under 9817 in terms of how they implemented particular activities.

And so, in a lot of cases, as long as it was -- you know, an activity is consistent with what's in the spending plan and what's been approved under a Medicaid authority, if that's applicable, there isn't necessarily a federal concern, we would -- but we do try to work with the states to flag where issues have been raised about whether funds have been used the way they were intended and to work to resolve those issues.

But I would say that those are, at least from my

perspective, a little bit more kind of one-off issues as opposed to things that we're hearing consistently having had having happened.

Of course, that doesn't mean -- you know, not everybody comes to CMS when they have concerns about things. They may be going directly to states or to others, and so there may be other things that we just have not heard yet, haven't gotten to us at this point.

I think that for the most part, the states that want to sustain activities have started talking to policymakers. In many cases, they started talking to them really at the outset of 9817 or very early on in that process. We largely defer to states to figure out kind of those processes and things, although obviously if a state wants to do something under a Medicaid authority, they need to make sure that they have the appropriate state approvals in place as well.

COMMISSIONER SNYDER: Yeah. And just to follow up, you both made really good points, and I'm remembering now, because I was in Arizona still, when we were getting approval on our spending plan and going through that process with the state legislature and having to really

make the case around some of the provider payment initiatives around -- that they are one time or were one time in nature.

I'm curious, Alissa. Are there states -- I know you said that states are still gathering the data, but are there states that do have data on hand to really demonstrate that, in particular, those provider payments have been impactful from a direct care worker recruitment and retention standpoint?

MS. HALPERIN: I'm not sure that I can speak to that with current data because we conducted our survey and our focus groups as of last spring. But as of last spring -- I mean, we set out to actually write a paper on what states were finding in their evaluations, and instead, we found that states were still deciding whether and what to evaluate and how to do it and, you know, that it was a lot, a lot left to be done.

So I can't answer that as to current data. Most states did not have virtually any data. I think there was one state that had some data that they had been collecting, and that was only in their other DD side as of last May.

MS. SILVA: Jami, if I may. We with our -- with

our rate increases, we did require it to go to direct care worker salaries, like through a base wage increase, and then we required reporting on it. So we are able to demonstrate that through the use of this one-time funding that, again, we only did when we knew that the legislature would sustain it, because we're not going to increase your salary only to decrease it, because that would be catastrophic, that we have moved the starting salary for these workers from an average of $12.41 an hour to now nearly $18 an hour during this time period.

So I think that is pretty substantial and helps us to at least try to keep pace with other low-wage industries in our state. Colorado happens to have a really high cost of living.

We also used ARPA funding to develop two surveys that are Colorado-specific aimed at helping us better understand not just the national data for direct care workforce turnover, but specifically the Colorado. Like, are all of these initiatives having an impact? To your point, I think it will be a few years before we really have good data to tell us did it work or not.

COMMISSIONER SNYDER: Thanks so much.

CHAIR BELLA: Thank you.

Patti and then Dennis.

COMMISSIONER KILLINGSWORTH: First of all, thank you for the panel, and thank each of you, not just for your time today, but really for how much you've put into this over the last several years.

I feel like this is a conversation that we have over and over again as it relates to home- and community-based services, not just specific to the ARPA funding, but really with regard to just being able to demonstrate the value of home- and community-based services. And it's not hard to demonstrate the value to the people that we serve, but to be able to demonstrate the value from a budgetary perspective that these are things that are worth investing in because of the impact that they have on the system sort of broadly.

So I wonder if either specifically related to the ARPA funding or perhaps not specifically related to the ARPA funding, maybe just related to Medicaid home- and community-based services more broadly, if there's some value in thinking about an overall evaluation with minimally key outputs that could be measured across states

and maybe even getting to some outcomes.

So we know, for example, that a number of additional people have been enrolled into these services as a result of these funds. We know that a certain dollar value of additional benefits have been provided to people. We know that there have been substantial investments in workforce payments. We know that salaries have increased as we've talked about.

Maybe we could even get to, with some of the national workforce surveys that are happening, the impact on vacancies and turnover. Certainly, we could look at the impact on rebalancing both as it relates to expenditures and as it relates to enrollment into HCBS versus institutional care, really being able to serve people where they want to be served.

I think a part of what we really need to be able to think about is not just sustainability state by state, which really does matter -- it matters a lot -- but sustainability as a country in terms of really the intent of this funding, which was to improve the overall service delivery system in a sustainable way. And I think that is going to take the data that states often don't have in

their hands to go make the case that they need to make to their state legislatures around why they should invest in this.

So if we could gather that data -- maybe MACPAC could be involved in that -- on a more broad scale and then be able to hand that over to states as something that they could take to their state legislatures to help them make the case, that in fact, these are worthwhile investments, they are having a positive impact on people, but they're also saving money by serving people in more cost-effective home- and community-based settings, I think that would be a huge contribution that we might be able to make to this work.

And again, thank you all so much for all that you've done and all you are doing.

CHAIR BELLA: Thank you, Patti.

Dennis?

COMMISSIONER HEAPHY: Thank you, and thanks for all the -- everything you're doing.

I have two questions. The first one is, I guess, for Jennifer and Alissa. How are you tracking best practices for including the disability community, HCBS

users, in the development of the ARPA plans and evaluation of the ARPA plans and also determining sustainability in which programs will stay and will go? Are you doing that, and how? So not talking about providers but talking about HCBS utilizers specifically.

DR. BOWDOIN: Alissa, do you want to go first?

MS. HALPERIN: I am not involved in tracking that, but I can tell you that all the states we spoke to highly valued and highly recommended to have really robust, ongoing stakeholder engagement across all populations served, to both always be thinking about innovative new things that could be done, as well as always gathering feedback and input into what is being done, what's working, what's not, as well as design -- you know, the activities related to designing the evaluation. So that was certainly front of mind for all the states that we worked with, and it was certainly front of mind when we worked with states and made recommendations for their project plans. We kept saying, "When will you incorporate stakeholder feedback? What will that look like? How much time do you need for that?"

It definitely is something that I think states

have considered, but I am not -- I have not been involved in tracking that.

COMMISSIONER HEAPHY: Thank you.

DR. BOWDOIN: We did ask all of the states in their spending plans to talk about how they're engaging with their communities, with their stakeholders, including people who receive HCBS, to talk about that in their spending plans. It's something that we asked them to keep updated. And just like all of their spending plans, we aren't necessarily compiling that information in a way that presents itself for best practices sharing, because there's so much variability across states in terms of how they're implementing their spending plans, but we could certainly -- to the extent that the resources available, we could try to look for best practices and at least make that information available to other states that are implementing 9817.

And I think we are always interested in finding ways that states can effectively engage with interstate spending, with individuals receiving services, with their family members, with their providers, with the direct care workers that are providing the care for individuals. And

so I think to the extent that we're able to learn from 9817, I think we're certainly interested in doing that and making sure that states are aware of the information, but we don't necessarily have a formal activity underway in that area.

COMMISSIONER HEAPHY: Thank you.

I think in the future, if there's any opportunities to do that, it would be really helpful to see what the best practices are, because I think that affects not only development but the implementation of projects.

And then my second question is you talked about the cliff, and are you tracking the cliffs? Do you anticipate they are coming down the line and the harm that may come from them? Will you be tracking that once the ARPA dollars are finished in 2025?

DR. BOWDOIN: We are not sort of formally tracking where those cliffs exist, and part of the reason is it's just it's very, very complicated to do that, because in some states, they may have had multiple temporary rate increases and temporary bonus payments. And then maybe they're making changes on an ongoing basis to rates that impact some providers, don't impact others, and

so sort of navigating that on an individual state basis, even just looking at it for one individual state, it's sometimes very, very complicated.

For instance, when we get a request for a state to make a change to a rate and they're still subject to the maintenance of effort requirements under 9817, we do look to make sure that the rates are at least at the same level as they were as of April 1, 2021, to make sure we're not approving something that would be an MOE, a maintenance of effort, a violation. And even sometimes just looking at that on an individual state level requires intensive resources to figure out with the state to make sure that it is -- you know, that it's not an MOE violation before we approve it, because we certainly want to avoid those situations, I'm sure, as much as states do. And so we are not formally looking at those cliffs.

I think to the extent that we have information in spending plans and people are interested in seeing what states are doing in this area and whether there are cliffs, we can try to make that information as transparent as possible. And we would certainly work with any state that is interested in and try to mitigate any potential cliff

that may be coming or the impact of them.

COMMISSIONER HEAPHY: Thank you. I think it's something to follow up on.

CHAIR BELLA: Okay. Well, as soon as we're done with the panelists, which is right about now, we'll have a chance to talk among the Commission.

So I want to be respectful of their time. We asked them for an hour, and they gave us an hour. You have a lot of work that you need to get back to. So thank you to the three of you for joining us. You've given us a lot to think about, and I know this is a subject that we'll continue to return to. So I would extend the offer to please don't be shy about reaching out as you see opportunities or best practices or things that you think you want to make sure on our radar screen. Thank you again very much on behalf of my Commissioners. Enjoy the rest of your day. Thank you.

DR. BOWDOIN: Thank you so much for the opportunity.

MS. HALPERIN: Thank you.

MS. SILVA: Thank you.

CHAIR BELLA: Tamara, thank you.

So we have the remainder of the time for Commissioner discussion. Patti has already shared some interests that she has. Dennis had just flagged this might be a good thing for us to look at. So this is an opportunity just for further reflections and kind of thoughts on what we may want to keep an eye on or what we think we want to make sure we learn from in case we find ourselves in a similar situation down the road and as we think about how to bolster the HCBS infrastructure, building on what ARPA has funded so far.

Jami, you look poised. You're ready.

COMMISSIONER SNYDER: Yeah. I'm just curious from my fellow Commissioners, this idea of cliff and, in particular, around provider payments that have been made. I'm just curious to hear from you whether you really think it's an issue.

I mean, clearly in Colorado, they establish it from the outset as a rate increase and ask those dollars to be funneled down to direct care workers. It was really impressive that they were that proactive.

I've been hearing -- and maybe it's just the subset of states that I've been hearing from -- that, in

fact, there's a real concern, states that have made kind of these one-time payments to providers and ask that providers really focus any money that goes down to the direct care worker on, like, bonuses and stipends and that sort of thing, because they don't know if the money is going to be there post March of 2025.

But it may be that I'm just hearing from a subset of states that have concerns, so just curious to know Commissioners' perspectives on that issue.

COMMISSIONER KILLINGSWORTH: So the last data that I saw, at least, indicated that there were a number of states, in fact, that contemplate funding that has been paid to workers ending, wasn't completely clear, but it seemed as if that was funding that was not just presented to them as bonuses or incentive payments, such that it could actually constitute a wage reduction.

I think there were states that secured that recurring funding on the front end. Tennessee was one of those. We had approval before we ever began implementing that the funds would continue on anything -- well, on provider rate increases that were targeted to the frontline workforce and also on enrolling new people into programs

and really reducing waiting lists.

I think other states were able to secure that funding sort of after the process or somewhere along the way, but there were a substantial number. It was approaching 20-ish, if I remember correctly, who had concerns about sustainability of workforce payments.

I don't know where that sits today. I mean, that was prior to probably the last legislative session that that data was published.

VICE CHAIR DUNCAN: I was going to add, I echo Patti's comments. What I've heard there is concern when this funding and what happens.

CHAIR BELLA: Tamara, I'm not sure where you might be able to tap into that information, but it would be helpful as you hear.

Jami?

COMMISSIONER SNYDER: Yeah. I do think it would be helpful to have a better picture, a current picture of where states stand, because I think it could be pretty problematic in the coming year if we don't at least try to get our hands around states that are facing that issue.

CHAIR BELLA: I think it probably fits as we do

the HCBS work and we're looking at access and capacity and all those things. It would be naturally something we would look at as a red flag if we feel that those cliffs and that there's not continued ability to sustain those increases.

COMMISSIONER KILLINGSWORTH: And this is an area where I think our associations might be able to help us. I think NAMD, ADvancing States, NASDDDS, they've all worked very closely with their member organizations to track in various ways what's actually happening. And so it might be a good starting place to just speak with them about what's the most current data that they have available on this issue.

COMMISSIONER HEAPHY: I also wonder about the folks who are taken off waiting lists and whether states will actually be able to sustain those folks over the long term, that increase in folks living in the community that are relying on services. Is that going to be sustainable for over the long haul if they weren't anticipating that extra cost?

CHAIR BELLA: Heidi?

COMMISSIONER ALLEN: This really isn't totally my area of expertise. So, in some ways, I'm kind of naive

about it, but I thought the problem that we were trying to address is that institutional care was dangerous in the middle of a pandemic and that people were dying in nursing homes and long-term care settings, and we wanted to support people as much as possible to stay home and be able to be safe in their home and age in their home.

It was such a large amount of money, and I really feel for the states trying to execute that kind of money in a short-term way that would ever be sustainable, because it was so much money.

So I think that there's some lessons to be learned about not forgetting that -- and if a new -- we have a new pandemic, which I assume that we will at some point, the institutional care will still be dangerous, and that if we just put resources in and then pull them out, that we can't really expect that to change these systemic preferences that we have built into our system for paying for long-term -- you know, institutional care over home-based care.

So I feel like I don't know if that's a commentary of a -- who's going to make that commentary. Hopefully, lots of people will make it, but I guess my

question is it seemed from what they were saying that the evaluation was contained into this funding cycle. And that seems problematic when you think of how long that they had to hire people. As it was said, it took a year to get contracts in place. Then there was just a year to implement, and then you have this year of evaluation. Like, how will we ever really know if it worked if the people charged with evaluating it aren't funded to evaluate it beyond the life of the money?

So is this an opportunity to say to somebody, we might need to allocate more money to have a longer-term, more robust, more -- you know, yes, you can't -- I don't -- I can't imagine how they could have had very rigorous designs in the middle of it. But it is possible to create rigorous designs retrospectively to try to see what happened, and I'm like, but who is funding that? Who is thinking about that? It isn't clear to me. So maybe if somebody here knows, I would be interested.

COMMISSIONER KILLINGSWORTH: So you're right. They are systemic preferences. They are also systemic challenges. So the things that states were facing in the middle of the pandemic related to home- and community-based

services were simply exacerbations of longstanding issues. Right? We've been talking about workforce issues for decades now. We've been talking about waiting lists for home- and community-based services for decades now. We've been talking about the institutional bias in the Medicaid regulations for decades now.

And I never want to look a gift horse in the mouth. Right? It was wonderful to have the funding to be able to do some things about those longstanding challenges, funding that we had longed to have, had tried to get, were not able to secure, all of those things, and all of a sudden, we had it. And then you had to spend it really fast and try to make sure that you spent it in a way that was effective and wasn't going to leave your state in a worse position once the funding went away.

One of the things that Bonnie mentioned was more of a permanent strategy around HCBS sustainability, because these problems are going to persist. The preferences are going to persist, and we need to create a system that is better equipped to manage the challenges and support the preferences of the people who need these services, a population that is increasing, by the way, as we all age

and maybe eventually are among those individuals.

And so the notion of a permanent FMAP increase for home- and community-based services tied to a longer-term, more comprehensive state-specific HCBS improvement plan that addresses the key barriers, expands access and capacity, makes a ton of sense to me, because it really -- I mean, that is sustainable improvement. Right? That is focusing where we need to focus on ways that will impact the system for decades to come, and I believe the data is there if we can pull it together to support that, yes, it is an upfront investment, but it's an upfront investment that has long-term payoffs that will more than cover the cost of the long-term -- of the short-term investment.

We observed in Tennessee that when we spent money to support people in home- and community-based services, it saved money on the institutional side. Even when the rates per day went up on the institutional side, it still saved money to be able to support people in home- and community-based services, and I think if there were a concerted effort to really look at the value of home- and community-based services, yes, the value to the people, but also the value to the system, that we would see that these are

investments that we should be making. And we should be making them on a continuing basis, not just throw in a bunch of money at a big problem when we have to do something quickly but being really thoughtful about the approach.

CHAIR BELLA: So let me just try to frame this a little bit and then John and then Dennis.

There are several venues to tackle this. Right? We talked yesterday about the relationship between payment and access. There is that path that the Commission is going to go down. We have an HCBS path, and it's coming -- HCBS is coming back in March. We've been talking about HCBS payment. We have a compendium coming out that's going to look at the rate certifications. There is the HCBS path.

There is also, though, not to lose sight of -- part of what we're trying to do here is to say there will be another issue where Congress infuses money into states, and so what can we learn about that infusion of dollars to make sure that it actually -- that something benefits from that infusion of dollars that is sustainable beyond the one-time infusion. So I don't want to lose sight. Yes,

institutional bias. Yes. But also, let's also be thinking about what -- how -- and what is our position in gleaning some of those learnings, so we can continue to work on to the best that we can.

So I just would encourage you to think about that it could cross many of those buckets, but let's not lose sight of keeping an eye on how -- if we have thoughts to Congress on how to provide infusions of dollars for whatever, bring back counter-cyclical FMAP maybe -- kidding. There's this -- don't lose sight of that, please.

Patti and then John and then Dennis.

COMMISSIONER KILLINGSWORTH: So one of the things that really helped us in Tennessee was that when that funding became available, we already had a strategic plan. We had worked on that strategic plan for a couple of years. We knew what the priorities were of our stakeholders. We weren't sort of scratching our heads trying to figure out what are we going to do with this money. We knew what the priorities were, and what we really had to figure out was how do we use the money. How do we make it sustainable for the longer term? That was our -- but we could go to the legislature -- to the governor's office, to the legislature

with a plan that was well thought out that had the support of stakeholders. We were kind of ready to roll, and it allowed us to develop a plan quickly, submit it quickly, get quick approval, get the approval of the legislature to spend the funds, and to have recurring dollars for the things that needed to be recurring so that it did have sustainable impact in our state.

And that's a part of the kind of getting ready is -- we talk about this with respect to duals. Every state needs a plan on how they're going to advance integration. Every state needs a plan on how they're going to -- how they're going to address and support the HCBS systems and really prepare for the populations that are to come and address the challenges in their own states. So I think that is a part of preparing for short-term infusions of funding.

I guess what I really want to say to Congress -- it’s far more impactful than short-term infusions of funding. -- is a longer-term pathway to really support the things that we say we value. If we say we value supporting people in the community where they want to receive services, if we say we value supporting their independence,

then let's spend the money in a way that really aligns with that and incentivize states to spend money on home- and community-based services by providing a higher FMAP for them than we do for institutional services, do some things that really incentivize states but build into it an expectation of there is a well-thought-out plan, there is accountability, there is a measurement process for outcomes, so that when the dollars are spent, we can point back to and say, "And this is the impact that it had."

CHAIR BELLA: Thank you, Patti.

John?

COMMISSIONER McCARTHY: I just want to say I have to go back to the crisis that people were in at the time when the short-term funding was put into place, and that for providers at the time, they were already losing employees because the employees were getting higher pay in other jobs, and they were already going to the maximums of their -- what they could pay due to the amount of money in rates.

So a number of states looked at this as like let's do this as bonuses. Now, how that sometimes was then -- you know, how the provider talked about it to their

staff is something different. But I know a number of states who said this is going to be a one-time bonus. You're doing it for retention payments, and they enforce that. And there was that in there, and it was trying to get through this crisis that was going on.

And then those states also got rate increases in their budgets in the upcoming years, and this did relieve a lot of pressure on states' budgets to be able to just get through this very crucial point, because I agree with Heidi. And we saw institutions have huge negative impacts.

Let's not forget, we also saw those impacts in HCBS workers going into people's homes. This was complicated, and how did you deal with it? And if you did -- it was very complicated.

I think the one thing that would -- I would like us to be talking about to Congress is if you're going to do one-time infusion of money, that's great, but you really do have to plan for a little bit of longer time, more than just one year. It's going to take a little -- just because I know states struggled with, hey, they could get the money, but they still had to go back to their legislators to get appropriation authority. And not everyone meets,

you know, all the time, like Congress does here, so just understanding that little piece of the puzzle and how does that fit in there.

I think the other thing to be careful of -- and it's like how do you look at some of these things -- is also there's not enough money for every state, and it's just some states. Well, then it's the same states you get to this every time.

Patti and I were talking about this earlier. Tennessee is like way out in front on some of these things compared to some other states, and so, yes, she had the ability to have a strategic plan to do some of these things. Some other states just don't have that infrastructure. So it's how do we help those states also.

The last thing I want to say is, when it comes to evaluations, I totally agree. This is the problem we always run into. I just want to raise the question to think about is, in projects like these, when you give it to the state and tell the state to do the evaluation of their own programs and they're trying to procure all these things at the same time, is that the best way to do it? I know I rarely say this. Sometimes I do, though. Would it be

better to have CMS get that money and CMS do the evaluations? And they would have money over a longer period.

I know Tim will say CMS doesn't have enough staff to do these things, and there's issues, but again, it's just how to look at some of these things possibly a little bit different to make those things work. So we do learn from them and then learn what works, what doesn't work, and then try to move those things forward, because I think sometimes we think stuff is going to work, and we find out it doesn't.

CHAIR BELLA: Thank you, John.

Dennis.

COMMISSIONER HEAPHY: Yeah, thank you.

I'd love to see either a roundtable or a panel of folks, either from -- well, just several, like Disability and Aging Coalition, the Community Living Policy Center, and leaders from a couple of states to get a sense of what their experience was with development of ARPA and then also the impending cliff. So I think maybe one or two over the next couple of years would be really helpful.

CHAIR BELLA: Thank you, Dennis.

Heidi.

COMMISSIONER ALLEN: Well, on the evaluation front, I just cannot resist saying that this is just another example of how important it is for state Medicaid offices to have academic partnerships that are in place with data use agreements, with the ability to do contracting, because academic researchers would love to study this. And they would be so incentivized by their own incentives to make sure that it's as rigorous as possible.

And I'm not even advocating for universities like mine, which are private, but every state has a public university. And it would build up the health services research in that university if these relationships were strong and robust and the data use agreements were in place, and they could access the data. And they could access what -- I think from an academic perspective, the hardest part about something like this is you can't study it because you don't understand the intricacies of what happened, because you're not an insider.

And if these relationships are robust -- and it's not just for studying big infusions of dollars. It's for all of the Section 1115 waivers that happen. Every time we

have these really innovative things happening in Medicaid that everybody could learn from, other payers could learn from, that policymakers in general could learn from, we have a difficult time having a robust evaluation.

And so I don't know if this is something that MACPAC would ever be interested in talking about or thinking about, but evaluation is key to this process of innovation, and Medicaid is a laboratory. And the better we are prepared to produce research that is credible, that is peer reviewed -- I'm sorry, but that does help a lot -- designs that are robust, like, the better we can say to states, this is good information that you could use to take to your policymakers to decide if you want to adopt some of these innovations.

So rant over. Soapbox down. Thank you.

CHAIR BELLA: Thank you, Heidi.

Any last comments from Commissioners?

[No response.]

CHAIR BELLA: All right. Tamara, do you have any questions for us? Then we're going to go to public comment.

MS. HUSON: No. Just thank you for the

discussion.

CHAIR BELLA: All right. We will open it up to public comment. A reminder to introduce yourself, your organization, and please keep your comments to three minutes or less.

Looks like we have two, Ellen and Camille.

Ellen, if you can unmute yourself, you can begin talking, please.

PUBLIC COMMENT

* MS. BRESLIN: I don't have any questions. I did not raise my hand. Thanks.

CHAIR BELLA: Okay. Wonderful.

Camille?

MS. DOBSON: Thank you, Melanie and the Commissioners, for an opportunity for public comment.

Advancing States was the lead awardee for the ARPA HCBS TA Collective that Alissa was part of, and two thoughts. One, thank you, Patti, for shouting us out about our access to state information and learnings.

We are in the process of fielding a survey to our states about the experience of their ARPA implementation, not specific to their individual, because that would be --

I agree with Jen. It is a massive, massive undertaking. Just our analysis of the spending plans took just hundreds of staff hours. But more about the process. What initiatives did they need to stop? Why did they need to stop? What lessons would they offer for another round? All to the service along with the evaluation paper that hopefully we'll release on Monday to inform policymakers if another opportunity comes and Congress more directly recognizes the crisis in home- and community-based services, that some of those challenges that the states faced -- and frankly, CMS faced -- we have some learnings and some recommendations for a different approach for the work.

So I did want to let this -- we'll have that report out by the end of March. It's the final deliverable from our foundation grants on ARPA work, and we'll take under advisement the interest in finding out the impacts of provider rate increases, particularly, and see where we could go collectively with our partners at NASDDDS and NAMD to try and start that work.

CHAIR BELLA: Thank you, Camille. We will look forward to seeing those products.

All right. We don't have any other hands.

Any last comments from Commissioners?

[No response.]

CHAIR BELLA: No? All right.

COMMISSIONER HEAPHY: I'd just say, like, how important it is to get the voices of folks directly impacted by the services, and that seems to be lost in some of the conversation. And so we really need those voices in this as we're going forward.

CHAIR BELLA: That's a good note to end on. Thank you, Dennis.

January is a wrap. We will be back March 7th and 8th.

Thank you to Kate and the team, and safe travels, everyone. Thank you very much. We're adjourned.

* [Whereupon, at 11:55 a.m., the meeting was adjourned.]

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