PUBLIC SESSION

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10:30 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[10:30 a.m.]

CHAIR BELLA: Good morning. Welcome to the MACPAC March meeting. We are going to kick it off talking about transparency in Medicaid financing. I'm going to turn it over to Bob, and we'll get rolling.

VICE CHAIR DUNCAN: Thank you, Madam Chairwoman.

Fellow Commissioners, excited to have Rob back today to talk about, again, as Melanie said, transparency in financing.

Before we get started, I just want to say thanks to Rob for the diligent work that he has done, as this has led down many paths and a lot of research, and I think you've gotten us to a great place. So he's going to present recommendations. It is up to us to weigh in on the wording and the policies that he'll be bringing back in April.

So, Rob, thank you, sir.

PROPOSED RECOMMENDATION FOR IMPROVING THE TRANSPARENCY OF MEDICAID FINANCING

* MR. NELB: Thanks so much.

I'll start with everyone's favorite topic of

Medicaid financing. I'll begin by reviewing some background that we've discussed before about different types of permissible Medicaid financing methods and review some of our prior findings about gaps in existing transparency requirements that we've discussed in previous meetings. Then I'll review proposed text for a consolidated, comprehensive Medicaid financing transparency recommendation, as well as some of the rationale, design considerations, and implications that we can include in a chapter. Finally, I'll also discuss a proposed recommendation for applying similar requirements to CHIP.

So first, some background. As you know, the Medicaid program is jointly financed by states and the federal government, and states are permitted to finance the non-federal share of Medicaid spending through a variety of sources, including state general funds, health care-related taxes from providers, and intergovernmental transfers and certified public expenditures from local governments, which often includes public hospitals.

When providers pay taxes or contribute IGTs or CPEs to finance Medicaid payments, it represents a cost to the provider that effectively reduces the net payments that

providers receive, and so as the Commission has been doing its work on payment policy, we've highlighted the importance of really understanding the net payments that providers receive to assess payment policies. In the past, we've made some recommendations about the need to collect some of this data to inform analyses of net payments for hospitals and nursing facilities.

Congress has yet to implement those recommendations, and so we've been doing some work over the past year to better understand the barriers to collecting this data and to think about what would be the best way to do it if Congress did move forward.

In addition to reviewing the policy history, we conducted a number of interviews with state and federal officials, national experts, and provider associations. Based on that work, we identified some opportunities to build on the Commission's prior recommendations by providing more specificity about the best way to collect financing data and how to use that to inform a comprehensive analysis of Medicaid payments to providers and thinking about doing it for all types of Medicaid services, not just hospitals and nursing facilities.

The primary goal of this work is to inform analyses of net payments to providers, but in the course of our work, we learned that it would also be valuable to collect additional state-level information to provide some more context about how states are financing their Medicaid programs.

In our review, we found several different gaps in existing transparency requirements, which is kind of the problem we're trying to solve through these recommendations.

First, with financing methods, CMS currently asks standard funding questions when states make changes to their payment methods, but these responses aren't publicly available, and they're not collected in a comprehensive way.

In addition, CMS collects some information on tax parameters when they're initially approved, but this also isn't publicly available and isn't updated.

Second. in regard to state financing amounts, states are statutorily required to provide information on provider taxes, and they do so through CMS Form 6411 in the Medicaid Budget Expenditure System. However, these data

are just used for informational purposes, and in our review, we found that they're often incomplete. In addition, of course, you're not getting information about other types of financing, such as IGTs or CPEs.

Third, there's no existing requirements related to provider-level financing information. CMS does permit states to account for some of the costs of provider taxes when setting upward limits for fee-for-service supplemental payments, but they don't allow states to account for the costs of IGTs or CPEs, and the data isn't consistently collected.

CMS does have the authority to go in and sort of ask for more detailed financing information, but currently it's just done in the case of an identified problem or oversight issue and isn't used to help monitor and improve the program.

So our recommendations are really intended to address some of these different barriers, and in your memo, there's a table sort of detailing how the recommendations sort of fit into these specific challenges. It was a little too complicated to put on a slide, but we can put it in the memo to kind of help people see the larger picture.

The table also includes information about some of our prior payment recommendations, which are, of course, needed to complete the picture. So we're talking about financing today, but the Commission has also made a number of recommendations about improving payment transparency as well. So in the chapter, we can reiterate those recommendations and highlight -- you know, our ultimate goal is to fully understand how much providers are being paid.

Okay. So tying it all together, here's our proposed Medicaid recommendation. It's a bit long, but I'll read it so we can all follow along. It says, "In order to improve the transparency and enable analyses of net Medicaid payments, Congress should amend Section 1903(d)(6) of the Social Security Act to require states to submit an annual comprehensive report on their Medicaid financing methods and the amounts of nonfederal share of Medicaid spending derived from specific providers. The report should include a description of the methods used to finance the nonfederal share of Medicaid payments, including the parameters of any health care-related taxes; a state-level summary of the amounts of Medicaid spending

derived from each source of nonfederal share, including state general funds, health care-related taxes, intergovernmental transfers, and certified public expenditures; and a provider-level database of the costs of financing the nonfederal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the nonfederal share. This report should be made publicly available in a format that enables analysis."

So the primary rationale for collecting these data, as we've discussed, is to inform analyses of net payments to providers and to account for all the costs that they incur in financing Medicaid payments. This recommendation is intended to help fill in some of these gaps we've identified with current policy.

We're proposing a statutory change to the section of the statute that currently requires states to report tax data and broadening that section of the statute to include reporting for all types of Medicaid payments to providers.

Also, based on feedback from the January meeting, we decided to propose one consolidated recommendation to emphasize the importance of collecting all this information

together.

As we discussed at a previous meeting, in the course of our review, we considered what would be the best way to collect this data, and ultimately, we concluded it would be best to collect it from states rather than providers because states already collect a lot of this financing data in the aggregate.

However, to reduce administrative burden on states, we found it would be better to just collect information at the provider level rather than tracking it to specific categories of service, such as inpatient or outpatient hospital services.

In the course of our review, we also learned about efforts in Texas to collect some of this data, and so I think it's a good example of how this could be used. I'll discuss more some of the specific design considerations we've learned from Texas.

Finally, last but not least, public reporting has been a key part of the recommendation because it would help enable analyses by all stakeholders, not just MACPAC or CMS.

In the report chapter, the Commission will have

an opportunity to outline potential design considerations for CMS to consider as it implements the proposed statutory change.

One area the Commission may want to highlight is some of the specific financing method information that CMS should collect. For example, in addition to the standard funding questions that CMS already asks, it might be more useful to gather some information on tax parameters and any administrative fees that are collected by states or MCOs. We welcome your feedback if there's particular areas you want to highlight in the chapter.

In addition to ensure data quality, the Commission may want to comment on the importance of establishing more process controls to ensure the accuracy of the data submitted and avoid some of problems that we've seen with the 6411 form.

Finally, the Commission has the opportunity to comment on how to make the provider-level data most useful for analyses of net payments, and here we can draw on some of what we've learned from our analyses of the Texas data; first, the importance of being able to link the provider-level data to other provider-level information in Medicare

cost reports and other databases; and second, importance of really clarifying the dates. Sometimes the date when the financing is contributed is different from the date when the actual payment is made to the provider, and that's important for sort of reconciling the information we have.

The Texas report does identify the extent to which the financing is tied to specific supplemental payment programs, and I think that information is useful to the extent that it's available. However, of course, we know from our review that some states, the provider contributions go into a general fund, and it's maybe a little harder to track exactly where that money is being used.

Finally, we know the importance of collecting administrative fees. So the Texas data collects information on the administrative fees retained by local governments in the state. However, as we noted previously, sometimes these payment programs also have some other administrative fees that are collected by MCOs and others, and so that's something to keep in mind.

We talked previously about 6 percent of the state's directed payment is sort of retained by the MCOs.

Collecting that information is probably more something that would be done through efforts to improve transparency of directed payments, which the Commission has previously recommended. But we can think about how all these different pieces, again, tie together to get that comprehensive view of how much providers are being paid.

Looking at implications, all our recommendations try to think about the implications on federal government, states, providers, and enrollees. In terms of the federal government, t there will be some increased administrative burden. However, we don't anticipate increases in federal spending that would be scored by CBO.

In the long term, CMS may have opportunities to reduce some of the administrative burden if it aligns some of its existing systems and requirements with the new proposed recommendation.

At the state level, there may also be some increased administrative burden, which could increase state administrative spending. However, states may be able to offset some of these increased costs through some of the administrative fees that they collect. For example, with the new Texas report, it's being financed. The

administration of that report is being collected from fees from the providers that are paying these taxes.

Obviously, providers would maybe prefer if more of the funding went back to them, but I think there's been openness to if it's clear kind of how the administrative fee is being used, there's maybe less concern about that piece of it.

In terms of providers' health plans, we don't anticipate a direct effect under a recommendation. Again, we're proposing collecting data from the states rather than the providers. However, there may be some administrative burden if states don't already collect the financing data.

Finally, for enrollees, we don't anticipate a direct effect since this is primarily a transparency recommendation.

Since we're the Medicaid and CHIP Payment and Access Commission, we don't want to forget CHIP, the Children's Health Insurance Program. We've also proposed a second recommendation, which would apply the Medicaid financing recommendations to CHIP, it reads as follows: "In order to provide complete and consistent information on the financing of Medicaid and CHIP, Congress should amend

Section 2107(e) of the Social Security Act to apply the Medicaid financing transparency requirements of 1903(d)(6) of the Social Security Act to DSH."

The rationale, of course, is similar in Medicaid. We haven't talked as much about CHIP, but basically in CHIP, states are permitted to finance the nonfederal share using similar methods that are used in Medicaid. But we actually have very little information about it. In general, I think there's less use of provider financing in CHIP, but it's just an area where the current requirements for reporting of taxes and things don't apply to CHIP.

This recommendation would affect separate CHIP programs. As you know, CHIP states have an option to implement it through Medicaid, in which case the Medicaid requirements apply, or they can do it through a separate program.

As of July of last year, 39 states operated a separate CHIP or a combination between Medicaid expansion and CHIP, and so from a legal standpoint, these states are sort of subject to some of the Medicaid requirements that are cross-referenced in this section of the statute that I've listed.

There is like a regulatory cross-reference that could potentially apply, but I think it's sort of cleaner if we're changing the Medicaid statute to also change the CHIP statute at the same time. Then some of the state effects are kind of similar in Medicaid and CHIP.

So that concludes our presentation for today. We, of course, welcome your feedback on the recommendations and the rationale, and based on that feedback, we'll come back at the April meeting to review our draft chapter and vote on recommendations. Thanks for your time.

VICE CHAIR DUNCAN: Thank you, Rob.

All right. Fellow Commissioners, any comments? Tim.

CHAIR BELLA: Can you put the recommendation slide back up, please? Thank you.

COMMISSIONER HILL: First, thank you. This is great work. I'm wondering, can you get a little further away? I can't quite see you. One very micro question and then a more general approach question.

In the last sort of little bullet there on the provider-level database, the cost of financing, what you mean, I think, by cost of financing is the provider

contributions, whether it's an IGT or a tax. So it feels a little like a term of art to me. I'm not used to using it, but I want to be sure that that's what you're referring to. It's a provider-level database of what the providers have contributed, whether it's a CPE, an IGT, a tax.

MR. NELB: That's right. Yeah. I know in our prior work, we've used the term "provider contributions." During our interviews, some stakeholders sort of preferred using the term "cost" instead, since there are times when a provider contributes the tax or IGT but doesn't actually get paid back in return. So the term "contribution" might imply that you're necessarily getting paid back. But at a more fundamental level, they're all sort of costs to the providers, and when we think about net payment, that's that cost that we're trying to sort of subtract out.

COMMISSIONER HILL: That's helpful and clear for me.

The second question is much more macro and is driven by the desire to not have yet another financial reporting mechanism that is untethered to expenditures, if you think about the 6411 or other things. So the notion of an annual report to me -- and it is the way the

recommendation is drafted -- it's not clear to what years or to how it's -- it just feels a little too aggregate, and I'm wondering if you had given any thought to states are claiming on a quarterly basis, the notion of reporting similar information along with the claim so that it's tied to a quarterly claim instead of expenditures that you can then track to in the 64 versus an annual report.

MR. NELB: Absolutely, yeah. So I think that fits in when we think about process controls and way to make sure that this report isn't just a separate one, but it's sort of part of the overall claiming structure.

One idea, for example, the 64 you submit every quarter, you know, drawing down federal funds, and part of that, you indicate the nonfederal share as well as the total amount. I think it's done each quarter, but there could be an opportunity perhaps at the end of the fiscal year to sort of look back on the entire year. This is the total amount of nonfederal share that was sort of claimed throughout the fiscal year and basically requires states to sort of indicate what extent it came from, all these different sources.

COMMISSIONER HILL: Right.

MR. NELB: And putting a process control to make sure that it like adds up to the total would be good.

This is actually similar to -- there's this new non-DSH supplemental payment report that CMS has been doing, and they've also added a sort of similar process control where they're making sure that the provider-level information you submit has to add up to the total amount that the state is claiming.

COMMISSIONER HILL: Right.

MR. NELB: And that has helped improve the quality of that data. So, yeah, I think there are opportunities to integrate that here, at least on the numbers side to make sure that it adds up.

We thought annual would be less administratively burdensome than quarterly, and since that's typically more how states keep track of their financing as well, it would be more useful.

COMMISSIONER HILL: And maybe this is just for -- as we noodle on the language, just having done this in the past, it would be nice if we're writing a statute anyway to make it clear that we're looking for some reconciliation on this annual report to the quarter -- the past prior four

quarters or whatever, just to make it a little easier for CMS.

And then the last -- and maybe you kind of got to this, but just a pressure test. So CMS does some questioning. They do -- they ask the five funding questions, presumably. They could be a little more rigorous, like what's the balance between asking Congress to change the statute versus recommending to CMS they ought to just do more in terms of what they're collecting and how they're interacting with states?

MR. NELB: Yeah. So I think we did hear from stakeholders that sort of a statutory change would be preferable, in part, because there seems to be some tension between states and CMS about what the current rules are for some of these types of payments. For example, the funding questions that were put in place 15 years ago, they asked questions about -- for example, public providers about whether they're getting paid more than their costs. And that was -- you know, which is permissible, but is sort of a relic of an old question that was a CMS-proposed rule that got rescinded and all these things. So there's sort of a lot of like baggage, I guess, with some of these old

questions. So it is a chance to articulate, and I think if there is clarity in statute, that would help.

It's important to note, though, the intent of this is really just for transparency and is not oversight. These are all permissible sources of financing, and we're just trying to collect information about what's being done. So the intent isn't to use the report to disallow financing sources or whatever, just to collect that information. And it may inform future policy in the future where there are some gray zones about areas that need to be clarified. But this report would be just sort of getting that information and all the interviews. Financing is always like a third-rail topic in Medicaid, but it was actually surprising that everyone agreed that more clarity would be helpful. And so that's sort where we -- the sweet spot where we're trying to land.

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

I appreciate you going back to some of the conversation earlier we've had in this topic that gets to that trust between the states and CMS and the clarification of what this is and what this isn't.

With that, Sonja?

COMMISSIONER BJORK: Thanks, Rob. These recommendations are very practical after all the discussions we've had over all the months, and I think they're reasonable and also achievable. So it's a triple header.

I wanted to reinforce what you just said about not using the information to disallow legitimate financing options that states have. I think that's an important part of the report and in the recommendations.

Also, I think it is good to shine the light on the potential administrative costs for providers, and I know that you said that it probably won't impact the plans. But sometimes when the states are collecting info, they get it from the plans who get it from the providers. So there may indeed be administrative costs, and I just want to make sure it's allowable that there can be some financing available through the process to cover any administrative costs.

Then finally, on the report itself, some states, they're paying the directed payments two years after the date of service, and so I was wondering if you could talk a

little bit about -- is the intention of the report to reflect the period when the services were provided or the period -- the fiscal year when the payments went out, and is one more valuable than the other, or do you want both in the report, or how will it be used? Thanks.

MR. NELB: Sure. To start with the last part, yeah, the Commission has recommended more transparency about the directed payment amounts and things.

I think what the reality is, yes, that a lot of these payments are sort of paid retrospectively or in different years and things, and that's just a reality of the program. The goal is to sort of just capture what's happening.

But one of the nice things about the Texas report is again distinguishing this is the date that maybe that the tax amount was paid or the financing was provided, and this is the date that it's sort of claimed and paid for.

When we think about tying this back to the 64, that is sort of how it also kind of keeps track of those sort of two dates. There's a date of service, and then there's a date where you drew down the federal funds. So we're not going to fix all Medicaid claiming issues with

this report, but if we can at least clarify the importance of getting both pieces of data, it can help researchers and others sort of piece it together to understand what were the net payments for a particular period of time.

I think that hopefully answers your question. In terms of other administrative fees, I think it probably would be allowable costs for an MCO or others to count it.

VICE CHAIR DUNCAN: Thank you, Rob.

We have Jami, John, then Heidi, and then Patti.

COMMISSIONER SNYDER: Thank you, Rob, for this important work. I know it's been a labor of love but clearly challenging. But you've done a fantastic job. I'm fully supportive, not only of the recommendation, but the need for a statutory change. I think that's really important.

You brought up a number of, I think, important design considerations, one of which Sonja just alluded to, the importance of really getting our hands around the administrative fees. I think that's incredibly critical to this discussion.

Also, I think establishing controls, having CMS establish controls to ensure the accuracy of data submitted

is another important piece.

Then the other design consideration that you mentioned that I just wanted to highlight was understanding whether the financing ultimately is allocated to the specific supplemental payment program or to programs more generally. I think that's important as well.

I do think it's important to kind of think about whether we want to incorporate some of those design considerations that we feel particularly strongly about in the actual recommendation, understanding that the recommendation is already pretty detailed and lengthy.

MR. NELB: Yeah. So open to suggestions on, obviously, how to tweak the specific recommendation on the third sub-bullet. The third last part about costs that are not used to finance payments to the provider contributing the nonfederal share was a vague attempt to sort of get at those payments that are used to sort of finance the program more generally rather than a specific program. But we can think through -- if you have better wording, we know -- it's also why we have -- the rationale section can be a lot longer and can explain some of the nuances there.

I think it is, probably, with those supplemental

payments, hard to exactly match it up provider to provider, but if you can at least, you know -- getting a sense of the -- you know, if this is hospitals are putting funding in, is it going back to hospitals at least as a class, or is it going to some other part of the program?

COMMISSIONER SNYDER: To your point, it may be advisable to include it in the rationale. Thank you.

VICE CHAIR DUNCAN: Thank you, Jami.

John, Heidi, Patti, and Verlon.

COMMISSIONER McCARTHY: I'm really struggling with this one, and Kate maybe can help out a new Commissioner on this one of how detailed we need to get in some of our recommendations, because I have the same concerns that have been raised, a little different, though. Like last meeting, I was all agreeing with Tim on everything. This one, I don't agree with him on. Annual is more than enough for this report. I can't see it being more than annual.

But little things are really important on this one as we gather this data to be able to really use it and do comparisons and things like that. So when we say annual report, there's this issue of, well, what does annual mean?

Is that a calendar year or a state fiscal year? And half the states report one way and half the other. Can we really compare the data? I know there's generally ways you could, but it makes it harder to do.

Back to what was brought up previously about payment, data payment, versus when the annual period was for these things is really important. So I'm thinking of it almost more like a cost report where, yes, the year that we were looking at to do these payments and the calculations were done in calendar year '20, but we don't get the payment to '22. But that payment in '22 was for the data in '20. And so if you want to do comparisons of later on around like how much was a hospital paid, you almost can't use that '22 number in '22. You really need to use it in '20, and what do you compare it to?

So my question really is, how detailed do we need to get in these recommendations to hit those things, or is this level good enough, and then that's dealt with later? That's my question.

EXECUTIVE DIRECTOR MASSEY: Sure. So let me take the first stab, and then I'll punt to Rob.

When it comes to the recommendations, what we're

really trying to do is convey policy intent, and then as Rob just mentioned in the rationale, we can include a whole host of considerations such as the ones that you're talking about, John, which are operational, kind of pros and cons, things to think about as not only Congress, but then also the implementing agency might think about in terms of how they would kind of take this structure and then make it real.

But, Rob, what would you add to that answer?

MR. NELB: Yeah. I think the design considerations part is the right spot here. I think in the actual text that maybe noting annual is helpful in the sense of trying to signal that balance we're striking between reducing administrative burden, like you don't have to do it every month or something, but also, we want it kind of on a regular basis. And annual is how the new non-DSH supplemental payment reporting and other stuff is based. So I think we have a sort of a rationale for doing that.

But yeah, the specifics would likely get sorted out in a regulation or something. We can highlight these differences, and we certainly are familiar with that. But

to make sure that we don't lose the forest for the trees, I think coming back to sort of our bigger principle is we want to be able to calculate net pay -- we want to know how much a provider is paid, right? And to do that, you have to do a bunch of different steps, but it helps if our recommendation isn't too long so that people don't miss that main point, that we want to basically know how much providers are paid on that.

VICE CHAIR DUNCAN: Thank you, Rob.

Heidi.

COMMISSIONER ALLEN: So I think this is like one of the most substantive contributions that MACPAC is going to make this year, and I'm really excited for it. I think it really would be a big step forward for transparency and for understanding so many issues that we care about.

I had really -- I support the recommendation. I have really minor kind of questions just to make sure I fully understand.

One is -- and I think you alluded to this during the earlier conversation about provider contribution. Somebody brought up an equity issue last year that I didn't see -- or last month that I didn't see reflected in the

rationale, but it was something about some providers paying in and then not getting -- or some providers not being able to --

CHAIR BELLA: HCBS providers not -- yes.

COMMISSIONER ALLEN: Yeah. I think that putting something like that in the rationale too, that it would be helpful, because I remember being struck by it as being like a really good reason why we would want to have this data.

Maybe, Patti, you were the one who brought it up. I can't remember. But I just remember thinking like, oh, I don't -- I remember that being compelling.

The second thing is under design consideration slide that you have, if it could be used to Medicare cost reports, what -- I'm trying to understand like why that would be helpful.

MR. NELB: Yeah. So at least in our work on hospitals and nursing facilities, we found that Medicare cost reports are helpful and that they provide a consistent measure of facility costs. States conduct their own cost reports or something, but when you're trying to get a national picture of the program, using some of those

standard Medicare definitions is helpful. Obviously, not all providers are Medicare providers, and there's certain classes that don't do cost reports, but it's been helpful just, again, to sort of link what's available and connect with other research.

COMMISSIONER ALLEN: So basically, that's an economies of scale function so that we don't have to collect the same data. We can link to data that's already collected. I think just spelling that out, that there's information that it's already collected, that if we can make that link, it would allow for a richer analysis. And if we didn't make that link, we would need to get the information ourselves. So yeah, great. Thank you for that.

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

Patti.

COMMISSIONER KILLINGSWORTH: Heidi, thank you for setting the stage for me.

So yeah, I have raised this issue before, and I want to just sort of re-raise it, if you will. Particularly in light of the fact that these health care-

related taxes favor institutional providers, I think that transparency in net payments to these providers and whether or not they meet the statutory goals is really, really important, especially when we think about it in relation to more integrated home- and community-based services.

If the net effect of such health care-related taxes is really to make those Medicaid institutional services more accessible to people than home- and community-based services, which do not really have access to these kinds of taxes, then I hope that that's a matter that as a Commission that we would want to take up. So great note, and I appreciate you raising that again.

I will say just recognizing that there will be some additional burden for states, I think that on balance, the need for transparency really wins out here, and that you've done a great job, Rob, of sort of getting us to a place where I feel like we're recommending the most efficient way to get to what we need.

I do have a little bit of concern, and I'm glad that Sonja raised it. I'm glad that John talked about it. I appreciate Kate's comments. But at the end of the day, what we're trying to do is really understand what providers

are paid, and this whole issue of how payments work and the timing and the reporting, I fear could result in a place where we get all of this information and we still can't link it together in a way that tells us what the providers were paid.

So I want us to be really thoughtful about that, whether it's in the rationale or in the recommendations themselves, that the end goal is, how much did the provider get? And if that requires being able to link information across different years, the mechanisms need to be there for us to be able to do that, or we got a lot more information, and it's still not useful.

MR. NELB: Yes. We want to have the report that ends the need for more reports someday.

[Laughter.]

VICE CHAIR DUNCAN: Thank you, Patti, Rob.

Verlon.

COMMISSIONER JOHNSON: I think that was a drop-the-mic statement there that Patti made, because my whole thing was about transparency as well. I usually don't agree with John, but I think a lot of what he said really stood out for me as well.

But one of the big things that really stands out for me on the recommendations and the implications is around administrative burden, and so I know that we put some ideas in place of how we can ease that from a state perspective, a little bit from a federal perspective. But I'm just curious. Maybe in your conversations, were there some ideas around how we can -- how the Feds can address it at all?

MR. NELB: Yeah. So I think standardizing definitions and clarifying these reports will sort of help. Texas had to kind of create a new report from scratch, but maybe other states can use that same model, and you don't have to sort of reinvent the wheel, I think will help.

Again, the states who are already kind of -- you know, they report to their state legislators about financing or other things. There's already data collected, but it's just sort of putting it in that standard format that I think is helpful.

Talked about ways to sort of integrate with information that's already in the Medicaid budget and expenditure system. So rather than just creating a new standalone report, let's integrate -- you're already

reporting nonfederal share. You're just not reporting the type of nonfederal share. So there may be opportunities to sort of fit that in there.

CMS has been improving its reporting system. So rather -- in the past, someone had to -- you had to pay someone to type in the spreadsheets into this form, and now you can upload an Excel file. Anyway, as those sorts of systems improve, it will make it easier to provide this, more level of data that's going to be more useful.

So I think, yes, standardization and then just better use of technology, I think, will help make this a bit easier for everyone.

COMMISSIONER JOHNSON: That's great. And I just want to say again, like everyone else said, great work that you've done here. This is very important for all of us, and you have turned all of us into lovers of financial data. So we appreciate that.

MR. NELB: Everyone's favorite topic.

COMMISSIONER JOHNSON: Yes.

VICE CHAIR DUNCAN: So we had two drop-the-mics, Patti, then Heidi saying this is the most important thing this year for us.

So, Rob, I think that's a testament to the work that you've done. Do you feel like you've gotten the feedback that you need as you prepare to come back in April?

MR. NELB: Yes. It sounds like a good plan.

VICE CHAIR DUNCAN: Anything else from the Commissioners?

[No response.]

VICE CHAIR DUNCAN: With that, thank you again, Rob, for the work. Look forward to April.

It's yours, Madam Chairwoman.

CHAIR BELLA: Thank you. Thank you, Rob.

We'll transition into our session on HCBS administrative requirements and welcome Tamara and Asmaa.

Just to remind the Commission, we're looking at three options that is the culmination of prior work, and we'll be looking for Commissioner feedback on those options and other areas of interest, either now or down the road. Thank you.

MEDICAID HOME- AND COMMUNITY-BASED SERVICES (HCBS): ADDRESSING ADMINISTRATIVE REQUIREMENTS

* MS. HUSON: Hi, Commissioners. As you'll

remember, Asmaa and I first presented on the topic of addressing administrative requirements for Medicaid home- and community-based services delivered through Section 1915 programs in November, and so we're here today to share with you the findings from some additional interviews we've conducted since then and to walk through three policy options for your consideration.

So this slide should look familiar to you. There are four domains in our HCBS access framework, and today's presentation focuses on the fourth component of administrative complexity. In order to set up today's conversation, I'm just going to give a quick refresher on the Section 1915 HCBS authorities.

There are four Section 1915 authorities that states can use to deliver HCBS, including Sections 1915(c), (i), (j), and (k), and there are additional authorities that states may use, such as Section 1115 demonstrations or Section 1905(a)(24) state plan personal care services, but our work focuses specifically on Section 1915.

I'm going to start with Section 1915(c), and this is a waiver authority that allows states to offer a broad array of HCBS to individuals who meet an institutional

level of care, which is the typical standard for Medicaid coverage of HCBS. And it is the most widely used authority, with over 250 waivers operated by 47 states. These waivers allow for a number of design flexibilities, which I'll describe shortly.

The remaining three authorities are all state plan options. Section 1915(i) allows states to offer HCBS to people who need less than an institutional level of care, and 14 states use Section 1915(i).

Section 1915(j) gives states authority to cover self-directed personal assistance services, providing beneficiaries with the ability to hire and direct their own attendants. Beneficiaries may also manage their own individual budget for services, and states use this authority in conjunction with other HCBS authorities. And financial eligibility criteria for 1915(j) is linked to the corresponding HCBS authority under which self-direction is permitted.

Then finally, we have Section 1915(k), which provides states with a 6-percentage point increase in their FMAP for HCBS attendant services covered under the state plan, and this authority is also known as Community First

Choice, or CFC. And nine states have a CFC program.

States consider a number of factors when selecting which HCBS authorities they will operate. One such consideration is the design flexibilities allowed under each authority and the ability to waive various Medicaid requirements found in Section 1902. First, states can waive statewide-ness in Sections 1915(c) and (j), which allows states to target authorities to certain areas of the state where there is need or where certain types of providers are available.

Using Sections 1915(c), (i), and (j), states can also waive comparability of services, which permits them to make HCBS available only to certain groups of people who are at risk of institutionalization.

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

Finally, states may consider other flexibilities when developing their HCBS systems. For example, Section

1915(c) waivers allow states to limit the number of people who can enroll in the waiver, as well as set limits on the amount that can be spent on each enrollee, and these flexibilities help states better predict and manage costs.

I want to touch briefly on the Access NPRM. CMS released a Notice of Proposed Rulemaking on ensuring access to Medicaid services last May, and we expect the Access NPRM to be finalized soon. And if finalized, it could have implications for the administrative requirements that we analyzed as part of this project.

So for starters, it would result in changes to reporting requirements for all Section 1915 HCBS authorities. For example, the NPRM proposed to improve beneficiary protections and align requirements across fee-for-service and managed care delivery systems by requiring states to establish a grievance system for fee-for-service beneficiaries for grievances that are not subject to a fair hearing requirement.

The proposed rule also looks to require the use of a nationally standardized HCBS quality measure set, and CMS is proposing to update metrics every other year, and that would include an opportunity for public comment and

input on the measures.

The Access NPRM also makes updates to incident management systems by proposing to establish a minimum definition of critical incident and state performance and reporting requirements for investigating and resolving critical incidents.

Then to improve public transparency, the NPRM proposes to mandate that states make available a website that includes information on HCBS program quality and performance. And finally, the Access NPRM established beneficiary advisory groups.

In November, we presented the findings from our contracted work with Mathematica. Mathematica reviewed the requirements for each Section 1915 authority and grouped them into the five categories that are on this slide. They developed a background paper for us comparing these five categories, and this included a review of federal statute, regulations, sub-regulatory guidance, and other CMS resources. They then conducted 17 interviews with state and federal officials as well as policy experts. And since that November meeting, Asmaa and I have conducted additional interviews with CMS and other policy experts to

dive deeper into three specific areas and to understand the implications of potential policy changes.

With that, I will turn it over to Asmaa to walk you through these areas and the policy options.

* MS. ALBAROUDI: Thanks, Tamara. Good morning, Commissioners.

I'd like to spend the remainder of our time discussing technical guidance, renewals, and cost neutrality. For each area, I will review state requirements followed by our findings. Then I'll wrap up with some policy options for Commissioner consideration.

Requirements related to annual reporting, quality improvement, and evidence-based review vary across the four Section 1915 authorities. For Section 1915(c) waivers, states submit data annually via CMS-372 reports. Reporting requirements for this authority are the most prescriptive, and a technical guide is available for states to support use of the authority.

Sections 1915(i) and (j) reporting elements are defined in regulation, but we found that one factor that complicates reporting is the absence of a technical guide.

Section 1915(k) annual reporting requirements are

also included in regulation, but its accompanying technical guide is lacking in detail.

All 1915 HCBS authorities have quality improvement requirements, though the way in which states must demonstrate compliance with these requirements varies.

States looking to renew their Section 1915(c) and (i) authorities must submit evidence demonstrating compliance with federal requirements via evidentiary reports. CMS will then complete a findings report, and items identified by CMS are addressed by the state before a renewal is approved. States must submit the results of their evidence-based review process to CMS approximately two years prior to waiver or state plan option expiration.

Interviewees shared that the absence of a Section 1915(i) technical guide causes uncertainty about the authority's reporting requirements. Policy experts discussed the benefits of technical guidance in terms of creating consistency and transparency by reducing ambiguity and uncertainty in administering authorities. Federal officials shared that a technical guide could be valuable for states. However, they suggested that CMS technical assistance and the 1915(i) SPA preprint are adequate to

support implementation of Section 1915(i).

On the other hand, interviewees shared that CMS TA is lacking or difficult to access. For example, states may receive inconsistent answers, and the scope of assistance is variable.

We also heard other general feedback on CMS TA, such as the extent to which it was efficient, readily available, and comprehensive varied.

Interviewees also raised several considerations related to developing a technical guide. On one end, CMS officials suggested it's a low priority due to limited resources and the number of states using 1915(i) authority. Federal officials also indicated that the access rule may have possible implications for administrative requirements, but they did not indicate that the changes would lead to development of a 1915(i) technical guide.

Several interviewees noted that developing a guide for Section 1915(i) could possibly put pressure on CMS to develop technical guides for other non-HCBS SPAs. However, Section 1915(k) SPA has an accompanying technical guide, so developing a technical guide would be in line with another HCBS state plan option.

Finally, several policy experts indicated the value of written guidance in maintaining institutional knowledge given staff turnover at the federal and state level.

Differences by HCBS authority exist in application length, completing time, approval periods, and renewal requirements. Section 1915(c) and select 1915(i) HCBS authorities are the only two subject to renewals. 1915(c) waivers have an initial approval period of three years or five years if the waiver serves individuals dually eligible for Medicaid and Medicare, after which they must be renewed every five years.

1915(i) has a one-time approval, after which the program can continue indefinitely, unless the state chooses to exercise the flexibility to restrict eligibility for services to specific populations, in which case there is a five-year renewal schedule.

For both waivers and state plan options, states can submit changes to CMS via the amendment process.

Federal officials, states, and policy experts shared that renewals are resource intensive. Some indicated that this process depletes resources that could

otherwise be spent on quality improvement or spending time to better meet the needs of beneficiaries in a person-centered way. For states, this can involve months of back-and-forth with CMS, which can be burdensome and can create uncertainty about approval timeline.

A few interviewees also noted that the questions they received from CMS during the request for additional information process can be time-consuming and duplicative, both within and across waiver programs. One state received over 800 questions from CMS, many of which were duplicated in other waivers. We also heard some burden associated with preparing the evidentiary reports during renewals.

All interviewees expressed that renewals are critical for oversight and evaluation of program performance. They also shared that renewals provide an opportunity for public input on the entire waiver.

We heard mixed feedback on changes to renewal requirements. For federal officials, renewals support a comprehensive review of an HCBS program. Policy experts and state officials expressed support for changes to the renewal requirement but differed on whether a change should be an increase to the renewal time period, several

suggested a time frame no longer than 10 years, or elimination of the renewal requirement.

Section 1915(c) waivers are the only HCBS authority which must comply with cost neutrality requirements, meaning that the average per-person cost for waiver services should not be greater than the average cost of the institutional services that the waiver services are an alternative to.

States use their annual CMS-372 report submission to demonstrate that they are in compliance with cost neutrality requirements.

We heard general consensus on states' ability to successfully meet cost neutrality prerequisites for their Section 1915(c) waivers. Some interviewees pointed to the generally higher cost of institutional care as compared to waiver services.

While we heard that states do not encounter challenges meeting the requirements, some interviewees shared challenges demonstrating cost neutrality for certain populations. We heard varied feedback on eliminating cost neutrality. Federal officials shared that cost neutrality data can be useful in demonstrating that HCBS results in

lower federal and state spending relative to institutional care, and some interviewees suggested that eliminating the cost neutrality test could lead to an increase in HCBS spending.

On the other hand, several policy experts and a state official expressed support for eliminating cost neutrality for waivers.

Interviewees shared that the cost neutrality requirement was likely enacted due to concerns about a woodwork effect, where a large number of individuals would enroll in the program as soon as services were made available. We also heard that the requirement was an attempt to manage spending, given the lack of data on HCBS costs relative to institutional care. Several interviewees indicated those concerns are no longer relevant.

Two experts pointed to a tension between cost neutrality and Olmstead. For example, we heard that in one state, a new waiver had to be put in place for a beneficiary with high HCBS costs because the waivers available in the state at the time would have exceeded the cost neutrality limit if the beneficiary had enrolled in one of them.

MACPAC staff analyzed CMS-372 cost data for Section 1915(c) waivers that were active over three years, so 2019 through 2021, to determine how often waivers meet the cost neutrality requirement. After cleaning the data, we were left with 169 Section 1915(c) waivers in 37 states and D.C. for our analysis.

Over the three-year time frame, of the 169 waivers we reviewed, one waiver in one of the three years did not meet the cost neutrality requirement, and at least 60 percent of waivers across the three years had waiver expenditures that were less than 50 percent of institutional spending. This demonstrates that states are generally meeting the cost neutrality requirement for their Section 1915(c) waivers and often had waiver spending that was significantly less than institutional spending.

On the following slides, I'll be presenting three policy options for Commissioner consideration.

At a high level and informed by our findings, one challenge interviewees shared is that the lack of a technical guide for 1915(i) creates ambiguity around authority requirements. The policy option is to develop an authority-specific technical guide.

Next, we heard that the renewal process for both Section 1915(c) waivers and 1915(i) state plan amendments is resource intensive. A policy option here would be to extend the renewal period.

Finally, given that states are generally able to meet cost neutrality requirements, this raises questions about the usefulness of the cost neutrality test relative to its administrative burden. A potential policy option is to remove the cost neutrality test.

Policy Option 1 states the Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare and Medicaid Services to develop an authority-specific technical guide for Section 1915(i). Interviewees shared that not having a technical guide creates uncertainty about requirements, that the availability of timely and consistent TA from CMS varies, and that written guidance provides a definitive interpretation of authority requirements and maintains institutional knowledge to account for staff turnover.

Federal officials noted that a Section 1915(i) preprint is available to support states. However, other 1915 HCBS authorities such as 1915(k) SPA and 1915(c)

waivers both have a preprint or application as well as an accompanying technical guide.

Next, we often hear about the complexities associated with managing several HCBS authorities. Developing a technical guide would provide more consistent and clear guidance on operationalizing Section 1915(i). Under this policy option, CMS would likely need to invest time and resources to develop an authority-specific technical guide, which would result in some administrative burden. However, this initial investment could mean less demand for TA in the long term.

The next policy option is related to renewals. It states Congress should amend Section 1915(c)(3) and Section 1915(i)(7)(C) of Title 19 of the Social Security Act to increase the renewal period beyond five years.

To address the resource-intensive process of renewals, this option would allow for more time between renewals and would reduce the administrative burden for both state and federal officials. This could in turn free up additional staff time for program improvements. We did not specify a time frame for the new renewal period because CMS is best positioned to identify an appropriate time

period. However, interviewees shared that the renewal period should not extend beyond 10 years. This aligns with select Section 1115 demonstrations that were renewed for 10 years under the previous administration, CBO standard practice to provide 10-year budget projections, and one policy expert shared that this would likely be the highest time frame which Congress would consider.

Concerns around potential loss of oversight could be mitigated by other available tools, including CMS-372 reports for Section 1915(c) waivers and proposed changes in the Access NPRM that are intended to improve monitoring of state compliance with statutory and regulatory requirements as well as improve the health and welfare of beneficiaries.

Potential declines in opportunities for public engagement due to an extended renewal period can be addressed through current requirements that public comments be available at initial program approval, renewals, and when a substantive change is made via an amendment.

Separately, the Access NPRM also includes proposed changes that support public input and transparency, including a public comment period when HCBS quality metrics are updated, changes to MCACs, and

establishment of a state website that would include publicly available information on program performance.

Finally, states can make amendments to their programs outside of a renewal, and nearly all states do.

The final policy option is Congress should amend Section 1915(c)(2)(D) of Title 19 of the Social Security Act to remove the cost neutrality requirement. Under this policy option, only the cost neutrality test would be removed, but states would continue collecting data on waiver cost and utilization. There was general agreement that states can meet the cost neutrality requirement, and our analysis of CMS-372 cost data supported this.

Several states and policy experts found no practical utility in the requirement. Some interviewees expressed concerns related to possible increases in HCBS spending if the requirement was eliminated. However, any potential increases in spending would be mitigated by states' ongoing need to operate within their budget parameters, and states can use cost containment tools available through waivers to manage spending and enrollment.

Elimination of this requirement would result in

decreased administrative burden for states and CMS, given that information on institutional spending would no longer be required for submission and review.

We welcome Commissioner feedback on the three policy options presented. We will return in April with a draft chapter on our work analyzing HCBS administrative requirements and will include recommendation language for any of the options the Commission would like to advance. Thank you for your time.

CHAIR BELLA: Thank you very much.

I'm sure Commissioners would like to say everything at once, but I'm going to ask that we take each policy option one by one. This will make it easier to go through each of them. So if you could pull up the Policy Option 1 more detail right after this.

We are entertaining comments right now on Policy Option 1 only. I saw John's hand first. No, I did not? Yes, I did? John, then Patti, then Jami.

COMMISSIONER McCARTHY: I guess I have more of a question on this one, on (i), than a comment on it.

CHAIR BELLA: Questions are allowed on Policy Option 1.

COMMISSIONER McCARTHY: What I couldn't get out of what we were asking for this one is, did any state not do a 1915(i) because they didn't know what to do?

So the context of my question is, having been Medicaid director twice, yes, there's a lot of things you don't know, but you just go ahead and do it, and then people get services and things are good. Did you hear from those comments, "Oh, we wanted to do this, but we didn't because we didn't understand it," or is it just that people are doing them, and then there's some ambiguity about certain things?

MS. ALBAROUDI: Yeah, so it's the latter. So states are able to implement 1915(i), but there is some level of ambiguity.

COMMISSIONER McCARTHY: So then I guess from that standpoint, I don't know if I would support this recommendation from a standpoint of we're doing them, you know, is this good, but there's -- and the reason I'm saying that is because I have a big comment on No. 2. So I'll hold it for that.

CHAIR BELLA: Thank you.

Patti, then Jami.

COMMISSIONER KILLINGSWORTH: So I want to make just an overarching comment, not about the policy options specifically, but just I really -- I appreciate that administrative complexity is really recognized as a key domain of Medicaid access, because what we're saying is that complicated and burdensome administrative processes can have this unintended negative impact on states and even on health plans and providers' ability to ensure access to Medicaid benefits for people in their programs. So that's a powerful statement, that it's not just about how busy people are. It's really about the net impact that that has on the people that we are here to make sure have access to these benefits.

And I think that that's nowhere more true than it is with regard to home- and community-based services. We have this really complicated structure of sometimes concurrent authorities that you need to access a set of benefits that we know from everything that we've just heard is more cost effective than institutional care, is overwhelmingly more preferred by Medicaid beneficiaries, and allow states to be compliant with other federal laws, not the least of which is the Americans with Disabilities

Act. So these recommendations really, really matter.

And you've heard me say this before, but it really is a bit like eating an elephant, right? Because Medicaid is very good at administrative burden and not very good at simplifying administrative burden. So we are still following many of the processes that were put in place back in the '80s when some of these authorities were created.

And appreciating the fact that the access rule at least has some promise of alignment across authorities, I do want to note that the alignment is mostly in favor of the most burdensome process. So what we're really doing is taking the things that we require in 1915(c) and making it apply to all of them, as opposed to really going back to the drawing board and thinking about, are the things that we created when we started these very new programs that we were worried might be really expensive still necessary all these decades later, or have we learned enough to really go back and streamline some of the processes? So that's kind of my overarching comment.

Now I'll comment on Policy Option 1.

CHAIR BELLA: But I'm going to -- I just want to make an overarching comment in response to that. This is a

multiyear body of work, right? So this is an opportunity for us to bite the elephant or whatever that is, little pieces of things -- I actually don't like that.

[Laughter.]

CHAIR BELLA: Like bite-sized chunks of work to get to a larger end. So what we have before us are three potential things we could do. They're not exhaustive. We're not stopping here. So it really is just to think about, is there a benefit to doing these in addition to the work that the Commission will continue to do next year and in future years?

So I would ask you to keep that in mind. This is not we're either going to do these and then we're moving on. These are three options of a multitude of things that we should and could do in this area and will continue to address as those opportunities come before us.

COMMISSIONER KILLINGSWORTH: Thank you for that context. That's very helpful.

I will say that I also want to be cognizant, though, that our recommendations may create their own degree of administrative burden, right? So I want to be sure that if we're going to propose three recommendations,

that they are three recommendations that we feel like will really yield significant value relative to the burden that they will create. And that's an area where I have concern with the first recommendation.

So I believe it was 47 states who have 1915(c) waivers relative to 14 states who operate 1915(i) authorities. The most recent data I could find was fiscal year 2020, which shows that in 1915(c) waivers, 1.9 million beneficiaries were served as opposed to 165,000 in 1915(i). So if you just think about sort of relative value, there's a whole lot of value in 250 waivers across 47 states serving probably now more than 2 million beneficiaries that I think we -- I think our recommendations may be better vested in ways to streamline 165-page application and that process relative to let's develop a technical guide for 1915(i). Not saying that it wouldn't be beneficial, but relative to burden, I think there are probably recommendations that we can make that would be more impactful than this one.

CHAIR BELLA: Thank you, Patti.

Jami?

COMMISSIONER SNYDER: So as the former

administrator of two Medicaid programs, my first comment related to this policy option is be careful what you ask for.

But one thing I'm really curious about, you noted in your presentation that there's a lack of technical specifications or a technical guide for 1915(i) and 1915(j) waivers, and I noticed that the policy option speaks to 1915(i), but not (j). Is there a reason for that?

MS. ALBAROUDI: Yeah. So we asked during our follow-on work about both 1915(i) and (j), and I would say 95 percent of the comments were directed to 1915(i) because 1915(j) is often used concurrently with other authorities. And over time, most of the 1915 authorities allow for self-direction.

COMMISSIONER SNYDER: That makes sense. Thank you.

CHAIR BELLA: Other comments on -- Carolyn.

COMMISSIONER INGRAM: Yeah, I just have to, I think, go on record and agree with my colleagues down this side of the table that creating some other administrative guide is just going to create more administrative burden. I'm not sure it solves the problems that we're trying to

tackle, so I don't think I could be supportive of that recommendation. Thanks.

CHAIR BELLA: This is not one where -- I don't get the sense that anyone is going to like beat the table for this kind of guidance, but I do want to remind us, this came from states.

I appreciate that we all have state experience, but it did -- we didn't kind of pull this one out of the air. So this is direct, current state folks who have asked for this. Doesn't mean that all the comments that you made aren't applicable about burden and sometimes being careful what you ask for.

Dennis, comment on this one?

COMMISSIONER HEAPHY: Yeah. I think this is something, as you said, states are asking for, and it does move us in the direction of having a more universal set of requirements that states can provide information on. So I think looking at it incrementally, as you were saying before, Melanie, that this is an incremental step and a positive incremental step. And it's going to provide technical assistance that can help states and help us all moving forward, maybe align, more align the different

sections in a more comprehensive reporting manner, if that makes sense.

CHAIR BELLA: Thank you, Dennis.

We'll go around to all of them and then come back, because I know there are some interrelated thoughts from Commissioners.

Oh, sorry, Verlon. And Sonja. I didn't see your hand. Sorry.

COMMISSIONER JOHNSON: Yeah. So just a quick question. I mean, I noticed, obviously, that it has a preprint guide. So the preprint guide, it's just not -- it's challenging, I guess, for states. I'm just trying to get a sense of the resources that are there. What's the bigger issue?

MS. ALBAROUDI: Yeah. So our understanding was that the preprint was not adequate enough to support use -- or like support their use of the 1915 --

COMMISSIONER JOHNSON: And the other ones actually have the technical guide associated with it.

MS. ALBAROUDI: Yeah, so --

COMMISSIONER JOHNSON: So that one is more helpful.

MS. ALBAROUDI: That's correct. Yeah, 1915(k) SPA and 1915(c) does have a technical guide.

COMMISSIONER JOHNSON: All right. Thank you.

MS. ALBAROUDI: Of course.

CHAIR BELLA: Sonja?

COMMISSIONER BJORK: Thanks. I just want to put another pitch in for if we're going to do all these interviews and gather up the information, then we should be responsive to what we gathered in the interviews, and it sounds like the states need some help. And this technical guide could be the help that they're asking for, especially with the clarification on the preprint guide. I thought maybe that would be the -- maybe that was good enough. But it turns out that's not adequate.

So I just -- I'm in favor of listening to the interviewees and trying to help meet their needs.

CHAIR BELLA: Thank you, Sonja.

All right, moving on to Policy Option 2. I'm going to guess this side of the room would like to start us off. Patti?

COMMISSIONER KILLINGSWORTH: I'm happy to.

So, first of all, I agree with Policy Option 2.

I do believe that we know enough about these waivers now to really have a renewal period that extends beyond five years.

My primary comment would be that we append that recommendation to minimally direct the Secretary of HHS to work with states to identify opportunities to streamline that renewal process.

Today it amounts primarily to starting all over again with a whole new waiver application as opposed to continuing on with what you've already demonstrated has been working effectively to provide access to these services in your state. So I'm all for the public input process. I think that's incredibly valuable, but I do think there are, again, significant opportunities to reduce the administrative burden of the application process, the renewal process, the reporting process, all of that, based on what we have learned in these waivers over decades of experience. And we've never really gone back to the table to do that. So I would like to see this be expanded to include some of those elements as well.

CHAIR BELLA: So just to be clear, I think that would have to be a new recommendation, because this is a

recommendation to Congress. That, I think, would be a recommendation to CMS to do the administrative simplification.

COMMISSIONER KILLINGSWORTH: Unless Congress were to direct them to.

CHAIR BELLA: Rhonda and then John.

COMMISSIONER MEDOWS: I'd like to second her motion, please. I'd also have a question for clarity.

This is all about renewal, right? So the ongoing interim reports that are already required would still continue on, even if the renewal period was extended. The updates would still continue. I think that makes the case for extending the period longer, because we're already getting the updates.

CHAIR BELLA: Thank you, Rhonda.

John?

COMMISSIONER McCARTHY: So in theory, I support this. However, what I would like to see is -- why are we doing these still as waivers? And so I would have liked it better to have a recommendation that this just gets converted into a state plan amendment type of a process and not having to renew at all, because in state plan services,

we have none of these requirements whatsoever.

And the state plan option, right, that you have opposite of this is institutional care, nursing homes. So we don't do any of these things for nursing homes. We have no tests for nursing homes. And so to me, our push really should be to eliminate the need for this waiver, change it into a state plan option, and maybe have some of the requirements on the reporting. But you get it approved, and that's it, and then you move down the path from that. So that's what I would like to see.

I'll stop there.

CHAIR BELLA: So we did a body of work last year? When was core benefit? Last year, where we did -- so the goal of all of this -- and we're just trying to figure out the right point of entry -- is to eliminate barriers to allowing people to remain home or in the community to get services, and that may not always mean that we can kind of tackle institutional bias in certain ways. But we can try to get it in other ways around simplifying the ability of states to have opportunities and beneficiaries to avail themselves of those opportunities.

The core benefit work, though, was redirected to

focus on what are the administrative barriers that we believe. We did not get a lot of people saying that they thought the core benefit would solve the problem, stacked up next to sort of some of the challenges it might create, according to folks who participated with us in those discussions.

So we redirected the work this year to say, what's keeping people away? Well, some of it is like the burden of doing the waivers, the burden of getting on the waivers, all of those things, which is what we're trying to attack right here. So I hear you. It's not to say that the Commission can't bring back exactly what you're talking about, but in the interim, is there interest -- would you have interest in at least taking a step here while it takes -- even if the Commission brought that back, it would take a while, I'm guessing, for Congress to move in that direction with some of the budgetary realities.

And so I guess I would ask that we think about -- again, these are not either/or things. We can move ahead with some of these things in the interim, while the Commission then says, we're still interested in coming back to ultimately making this a state plan option.

COMMISSIONER McCARTHY: I guess I'm not saying that it's necessarily a state plan option, per se, because you brought up budget issues. So I wouldn't say that we'd make it somehow a budget issue. You could still have some of the limitations in there, like in a waiver of limiting the numbers of slots and things like that. But it's just what you said. It's the waiver application process. You'd be getting rid of that and making that part a state plan process.

So I hear what you're saying. That was before my time. So I just have to get on record to saying, you know, I disagree with what happened there. I would rather see us move in this direction.

And it's back to what I said for the first one is it's hard for me to say, yes, just focus on this, because this other thing will come. Well, I don't know if the other thing will come. So it's where do you put your efforts?

That's why, back to the first one, I was saying, do I really want to put efforts into making that technical guidance or putting the efforts into making this change? I would rather see a change on fundamentally redoing the

waiver process. So that's kind of where I'm at.

CHAIR BELLA: So just so I understand, if there's state plan today with kind of no limits, there's waivers today with limits, you want sort of a hybrid of that, which is --

COMMISSIONER McCARTHY: Right.

CHAIR BELLA: -- make it more state plan-like, but still give states the tools to have limits.

COMMISSIONER McCARTHY: Right.

CHAIR BELLA: Okay. So that's different than state plan.

COMMISSIONER McCARTHY: Yeah.

CHAIR BELLA: Okay.

Jami.

COMMISSIONER SNYDER: I appreciate the context in which this policy recommendation sort of lives, super sensitive to the challenges associated with modifying the core benefit package. I'm wholly supportive of the policy option that you've presented. I don't think it should preclude us from revisiting this issue in the context of a core benefit matter.

CHAIR BELLA: Thank you, Jami.

Heidi, did you have a question?

COMMISSIONER ALLEN: It was just a follow-up question to try to understand the distinction between a state plan amendment, a core benefit, and the waiver. So the waiver -- if we went to a state plan amendment, then is that a de facto core benefit?

CHAIR BELLA: What he says -- I just don't want people -- we're talking about an ability to sort of ask for these services in a state plan way versus a waiver way but still retain the features of being able to have some controls over the way that the waiver is administered, the number of people served, those things.

Verlon,

COMMISSIONER JOHNSON: I really like this Policy Option 2 for a lot of the reasons that I think many people have already spoken about, though reducing the administrative burden is really important, but also that whole idea about the potential for innovation that Patti mentioned. I mean, 10 years gives a little bit more time to really figure out how can we do this even better and do it right, and so I really appreciate that.

I guess the question that I have is that we have

up here that we want to increase the renewal period beyond five years, and I guess the question for me is, why can't we just determine what that should be in this setting? Could we say 10 years? I know we've talked about that or -- you know, as opposed to just leaving it out there a little bit more. Thanks.

MS. ALBAROUDI: Yeah. So we don't feel like we collected enough evidence to support a specific time frame, which is why we deferred to CMS. CMS did renew Select 1115 demonstrations to 10 years. So, you know, we did pose that question to them, but they didn't comment. So we feel like it would be best to leave that to CMS to decide what an appropriate time frame would be.

CHAIR BELLA: John?

COMMISSIONER McCARTHY: I guess to that point, like why -- and I understand we didn't find the evidence, but I think we've had enough evidence to know that these waivers work, and waivers haven't been disallowed. And so why would we even say 10 years? Why don't we say once you get it approved, it's good forever until you change it? I mean, that would be kind of back to that state plan idea. So it just would be eternal until you want to have a

change.

CHAIR BELLA: Yeah. My comment was going to be also I don't like giving recommendations that are -- there are times when we've had to do recommendations that are open-ended. But in this case, recommending to Congress and hoping they go talk to CMS to get a number doesn't feel as sort of definitive as we could be. And so I do think there is a reason to suggest 10. We could also entertain John's suggestion. But then I think, John, we would have to do some more work on the conditions under which you would have -- you know, that would trigger a renewal.

Patti.

COMMISSIONER KILLINGSWORTH: It would almost be changing a renewal period to a review period. Practically speaking, based on current reporting requirements, they're reviewed every year. But if you wanted to do a more in-depth programmatic review at certain cycles, you know, short of it becoming a whole sort of resubmit the entire waiver all over again process, I think that could be another option.

EXECUTIVE DIRECTOR MASSEY: So can I --

CHAIR BELLA: Kate.

EXECUTIVE DIRECTOR MASSEY: Asmaa and Tamara, can you speak a little bit? Because when you were doing your work, there were reasons actually to have a renewal period check-in. That was to ensure that there was compliance and adherence to newly implemented or newly finalized HCBS policies. There were public input requirements that were important for generating consensus among the stakeholder community. Can you just talk a little bit about what the research revealed in justifying the importance of renewals?

MS. ALBAROUDI: Yes, of course. So I'll say that like all interviewees -- so we're talking about federal officials, state officials, and policy experts -- all indicated that renewals are important for oversight, so to confirm that states are meeting statutory and regulatory compliance and also to allow for public comments for the entire waiver, which beneficiaries might not have the ability to do so outside of the renewal period to look at the entire waiver. So it seems like across the board, there was agreement that renewals are critical, which is why we said extend it beyond five years but not eliminate it.

CHAIR BELLA: Dennis and then Patti, and then

we're going to go to Option 3.

COMMISSIONER HEAPHY: I agree in terms of the concern about the time frame, but with me, having those renewals is critically important to ensuring that there's appropriate access to HCBS services across states and we're actually moving towards a system of equity. So the renewal piece is a federal protection. It is a protection for folks in different states.

CHAIR BELLA: Thank you, Dennis.

Patti?

COMMISSIONER KILLINGSWORTH: Here's what I don't understand. Why do I need that protection for home- and community-based services, but I don't need it for institutional services, and I don't need it for any other service in the Medicaid state plan?

We are positioning home- and community-based services in a way that limits their access in a way that we don't do with any other Medicaid benefit and especially with institutional services, and I think that's a problem. I think we are far enough along in this process to recognize the value of home- and community-based services for the people who are enrolled in the Medicaid program and

to eliminate things that are making it more difficult for them to be able to access those benefits.

CHAIR BELLA: That is a perfect tee-up to Policy Option 3, which is intended to address the fact that something that exists for these waivers doesn't exist on the institutional side. Who would like to start comments there?

Patti.

COMMISSIONER KILLINGSWORTH: I'll start. I'm going to try to figure out how I'm going to make it -- how I'm going to turn that around, Melanie, so that it doesn't sound like I'm reversing my position.

It does exist, in a way, right? In reality, all of the different kinds of waiver options in the Medicaid program come with some sort of cost requirement, whether it is cost neutrality, cost effectiveness for 1915(b) or -- I'm trying to think of what it's called in the 1115 world. So there's always some sort of a comparison to make sure that we are efficiently using federal and state dollars well, and I think that is an expectation. It is one of the things that -- it's one of our fundamental principles is around efficiency in the way that we deliver services.

Cost neutrality is so fundamental a concept as it relates to home- and community-based services in terms of it offers a more cost-effective way to meet people's needs, which, oh, by the way, they prefer.

My own experience over more than 20 years, closer to 25 years in state government, would say that if you reduce or eliminate the cost neutrality requirement, HCBS costs will absolutely go up. It is that fundamental to the way that these programs are operated.

Practically speaking, though, the fact that states are complying with something that is a federal requirement doesn't mean that the federal requirement should go away. It means that the requirement to prove that you're complying with the federal requirement should either go away or at least be minimized commensurate with the risk that you're not complying with it. We know by looking at all of these different reports that very rarely does a state struggle to meet cost neutrality. Don't do away with the requirement, but come up with a better way than making every state every year demonstrate that they're in compliance with something that almost everyone always is.

There are probably ways that CMS could, through reporting, identify that a state's costs have escalated commensurate to institutional costs in that state, which would warrant a review of cost neutrality. We could be much more precise about how we're assessing compliance than making every state do it every year with every waiver, but I would not and could not support eliminating what I think is a really fundamental principle that is good public policy because it ensures that we are managing, investing federal and state dollars well.

CHAIR BELLA: Thank you, Patti.

John?

COMMISSIONER McCARTHY: I agree with Patti, and I also have to say that I can't support this recommendation.

I think having done rate setting both as a consultant and as a state, there would just be too many things that right now that this limits that you would run into off loading costs into rates, and you would run into some issues around that.

And I know you tried to cut me off, but I'm going back to it. If we're going to, on No. 2, say, oh, we can't do some of these things, well, then let's put these same

requirements on nursing homes and others. And so you have to renew nursing homes every five years or something like that if that's the direction we're going.

CHAIR BELLA: Thank you.

Jami?

COMMISSIONER SNYDER: One of the things that I think is important to kind of note -- and you noted it in your presentation -- that CMS actually stated that cost neutrality data can be useful in demonstrating that HCBS services come at a lower cost than institutional care.

I would say from a practical perspective, I found cost neutrality tests to be really, really helpful to me as a Medicaid director when I would speak with policymakers in my state. So it's just something to keep in mind that that can be a lever that you can employ or an argument that you can make to policymakers in trying to garner their support for important programs like this.

MS. ALBAROUDI: Can I just provide a response to that? I actually appreciate that comment, and we tried to be responsive to CMS by saying that this would just eliminate the cost neutrality test and would still require states to submit cost and utilization data. So I

appreciate that in CMS' comments as well.

CHAIR BELLA: Caroline.

COMMISSIONER INGRAM: You can tell you have a lot of people sitting here who have had to fill all these things out and argue over and over again with the federal government about them, because we have very strong feelings about them.

But I have to agree with my colleagues. I don't think we can eliminate the whole piece, but almost the comments you just made there at the end makes me think that there's a way we can figure out to talk about how can we streamline these requirements to make the cost neutrality piece easier since all states are meeting it but still keep the requirement in place. And so I think that's what we're trying to get at here with our feedback for you.

CHAIR BELLA: Okay. I'm scratching my head a little bit about -- because we are at a little bit -- we are very consistent in that we want to make it possible for people to have access to home- and community-based services. We're not completely consistent, it doesn't feel to me, about we do or do not want to renew something, we do or do not want to keep a standard in place. I mean it

feels like we're a little bit like we want to keep cost neutrality, but we want unlimited sort of time on the waiver.

So I want to ask if these recommendations are not hitting the mark with the Commission, we don't have to move forward with them. We can continue to try to find the right place to do what we think needs to be done to make an impact here. It doesn't feel to me that we are as consistent as we could be if we're really trying to address institutional bias and increase access to home- and community-based services. And perhaps that's because we don't have exactly what you want to see up here.

But these are all intended to do those things, and so I think that on this one, Patti, I appreciate we do have cost neutrality on 1115s, but like what John just said, we don't have it on state plan services, which are the institutionally biased services that you're most worried about. So that's where it feels like we sort of haven't really figured out exactly how we want to move forward in the best way on that.

COMMISSIONER KILLINGSWORTH: I think that there is a way, particularly with respect to the second two

recommendations.

I think most people voiced support for Recommendation No. 2, although many of us wanted to go further than that, right? So whether that is an incremental step with additional recommendations down the road and considering maybe even how we re-look at approval processes for the things that we do under 1915(c) waivers kind of in totality, I think there was widespread support for that.

I think the concern with No. 3, we've identified a fundamental issue. I think there is disagreement about -- so what is the right way to address the fundamental issue? Is it to eliminate the requirement, or is it to eliminate the burden associated with proving that you've met the requirement every year? And so I think it's just a subtle nuance of let's not take away the requirement, which I think states do find valuable. Let's take away a requirement to prove it every year and instead come up with a more efficient way to address that issue.

CHAIR BELLA: Again, I want to reiterate that it is inclusive of states who indicated to us that eliminating this requirement would be of interest to them. So we did

hear that. It doesn't mean that there's not good reason to keep it, but there at least were states who were part of this discussion who were in favor of eliminating it.

COMMISSIONER KILLINGSWORTH: I think it would be fascinating to hear from a lot of states on how they feel about this topic. I hope that some are listening and provide public comment or otherwise share their thoughts on this.

I suspect, certainly don't know, that there will be more states that are concerned about eliminating cost neutrality than not.

CHAIR BELLA: Any additional --

COMMISSIONER HEAPHY: Melanie, I just have this question about --

CHAIR BELLA: Dennis, yep.

COMMISSIONER HEAPHY: -- the idea of using institutionalization as the basis of determining cost neutrality at all, particularly since there's a bias for institutionalization. So we talk about cost neutral. We really don't know what neutrality is in a world where we're talking about HCBS services being the preferred or equivalent to institutionalization. Does that make sense?

Why are we using that as a bar to begin with?

CHAIR BELLA: Yes.

COMMISSIONER HEAPHY: So I'd like to get those --

CHAIR BELLA: It's a complicated --

COMMISSIONER HEAPHY: Right.

CHAIR BELLA: -- system that's kind of layered on top of itself year after year.

COMMISSIONER HEAPHY: And that goes back to Olmstead and all that, but if we think about it, why are we using that as a bar, the standard to determine the value of having folks in the community rather than institutionalized? And does it take into the social benefit of people living in the community, whether it's because they're employed or they're able to stay with their families, all those sorts of things? So how do we measure those benefits to society? We're only looking at the comparison to the nursing home costs. It just seems like a very archaic or -- yeah -- way of doing this.

CHAIR BELLA: Thank you. And again, the Commission is not precluded from taking this whole thing up, continuing to -- I don't know what word I want to use. There's so many words we're not using right now.

Adrienne, you were going to talk and then Rhonda.

COMMISSIONER McFADDEN: Yeah. So just to Dennis's comment there, I do think there's probably some value away from these policy options of re-evaluating what truly is the gold standard, and I think that's really the basis of the conversation around the cost neutrality conversation. And so it sounds to me like institutions have been sort of anecdotally seen as not necessarily the gold standard anymore, but having the research to be able to say we need to be using a different standard for cost neutrality, I think would be valuable and maybe an arm of something that we can take up as a Commission.

My comments are really as a non-sort of lucky person who's had to deal with these renewals and applications. I think there's sort of -- given the context you provided us earlier with not eating the elephant but maybe a crawl, walk, run sort of framework. I do feel like there may be some value to thinking about figuring out the periodicity of how we prove the cost neutrality of the home- and community-based services and maybe thinking about renewals as truly renewals instead of re-applications and, therefore, maybe having the proof point be in the ramp-up

period of the initial sort of application and then at each point of renewal versus having to do it every year. And so that was just sort of my suggestion of thinking about that to sort of simplify as a crawl, walk, run process for the renewal process.

CHAIR BELLA: Thank you, Adrienne.

Rhonda.

COMMISSIONER MEDOWS: So I think I'm going to be repeating some of what has already been said, but can we -- and I know you've already done the work to talk with states, but can we go back and simply ask is it the policy or the process? And if it's the process, is it a matter of having a best practice to actually tie it to our jobs in Medicaid which is care and cost management? I mean, does that sound like a reasonable -- I used to hate that -- the cost neutrality, I used to hate it because we built up this whole big process around it, and initially, each time I would start with a new state Medicaid program, we had to tie it to actually what we did every day and not just check a box on a report or renewal. Do you get what I'm saying? It's got to be part of your daily operations.

EXECUTIVE DIRECTOR MASSEY: Asmaa, you dug into

the nature of the state concern. Can you shed light on Rhonda's question?

MS. ALBAROUDI: Sorry. I missed that.

EXECUTIVE DIRECTOR MASSEY: Can you shed light on Rhonda's question? Because through the interviews, you actually pressed on the state concerns that were raised regarding cost neutrality and the related administrative burden.

MS. ALBAROUDI: Yes. So they indicated that the process of cost neutrality was burdensome, both because of Appendix J, so having to do all those projections as part of the renewal process and also reporting yearly through CMS 372 reports. And some indicated support for eliminating the cost neutrality requirement, and others noted that there was no, as I mentioned, practical utility to the requirement. And it came down to burden.

CHAIR BELLA: All right. Let's go back to No. 1. So we had at least four people who were not in support of No. 1. We had two people who spoke in support of No. 1. The rest of you did not speak, which is fine. We don't ask you to speak if you're not feeling it.

But let's take a show of hands. Who is in

support of No. 1 coming back?

[Show of hands.]

CHAIR BELLA: Are the other hands not in support? Who's not in support of number one coming back?

[Show of hands.]

CHAIR BELLA: Okay. There's a lot of hands that haven't been raised in either case. Who is indifferent?

[No response.]

CHAIR BELLA: All right. I think No. 1 comes back, and if there's feedback that you want to make any tweaks to No. 1, we'll bring it back. It may or may not make it out of here in April, but there is enough interest for it to come back.

No. 2, there was -- so I'm going to say in my mind, there's kind of three ways we can handle No. 2. Leave it as is, which is open-ended and not specified, stick 10 years on there, or have it be -- what is it? Infinity? Happening in infinitum or whatever.

So I'm going to put out as a straw-person that we put it in there for 10 years, and we can have some discussion around whether there's an opportunity to further streamline and whether perhaps maybe there should be time

spent by the Commission on further refining it down the road so that it only has to happen with certain triggers, but to move forward the recommendation that we put 10 years in there. How do people feel about that coming back to you for continued discussion in April? That's okay? Dennis, is that okay?

Okay. Policy Option 3, we are not going to get this figured out today. There has been a lot of feedback that they have been writing furiously. I think we understand the intent that there's an opportunity to eliminate it. There's also an opportunity to functionally make it less burdensome. We need to go back and, I think, think about how to get at the intent, make sure we're not doing anything that signals, that we're not trying to be completely committed to the efficiency and economy and sort of economics of the program. But I don't think we're in a position to take all of this feedback and process it right now to come back to you.

So the team will do that, and we'll bring Policy Recommendation 3 back in April, reflecting the best job that we can do with the variety of perspectives that have been offered, including Adrienne's at the end kind of

crawl, walk, run. I guess you walk and step is the same thing.

Okay. Any other comments? Kate, is that acceptable to you? Okay.

COMMISSIONER HEAPHY: Actually, is there a way to look at this, maybe it's not for today or even April, but looking at this from an equity perspective as well, the impact of cost neutrality or which populations are most likely to benefit from, most likely to benefit from HCBS services versus those who are not? I don't know. Somehow, we need to insert equity into the conversations.

CHAIR BELLA: Yeah, I agree with you, Dennis, and I think that it is an underlying piece of all of it. The work does go into some specifics around different populations served by different waivers, but we can make sure that the amount of data that we have about that is included in the chapter. And if there are areas where we need to continue to push to get more granular level of information about the population served by the various waivers and the impact of our changes on -- if it's disproportionately on one population or another, for good or bad, that if we need to highlight that that's more data

that needs to be collected or found through ways we can make sure that we're doing that.

So that's how we're going to handle these three policy options, and then the Commissioners, we all should continue to decide where we want to go next in addressing issues around expanding access to home- and community-based services, addressing any institutional bias, again, because this is just this work cycle's set of recommendations, and there's a lot that can be tackled here.

I'm not even going to ask if the two of you need anything else. I don't think the answer is yes. Are you good?

MS. ALBAROUDI: Yes, I think we are. Thank you.

CHAIR BELLA: This has been a really good conversation among the Commissioners. Thank you.

We're going to open it up to public comment now. We'll take comment on either -- we've only had two sessions so far. Either of our two sessions. If you'd like to make a comment, please use your hand. Please introduce yourself and the organization you represent, and we ask that you limit your comments to three minutes. And we'll open that up now.

Welcome Camille. You should be able to talk.

PUBLIC COMMENT

* MS. DOBSON: Good morning. Can you hear me?

CHAIR BELLA: Yes. Hi.

MS. DOBSON: Hi. Good morning. Thanks for the opportunity to comment. Great presentation from Tamara and Asmaa on this topic. I appreciated the diversity of opinions about the recommendations today, and I would just leave you with one thought.

We have -- I'm sorry. Camille Dobson, Advancing States Deputy Executive Director. We represent the aging and disability directors who deliver HCBS for most of the states to older adults and people with physical disabilities.

We have started the conversation with our colleagues at CMS about approaches to stop treating HCBS like it is so different from any other Medicaid service, except for the places where it is extremely different than other Medicaid services. And so we're generally supportive of any recommendation to John's point that streamlines the administrative processes, for example, demonstrating that eligibility determinations are done correctly, proving that

payments are made accurately, proving that there's appropriate oversight among sister state agencies. All of those requirements are part of core Medicaid functions and don't need to be separated out specifically for HCBS.

But where there is difference, for example, around level of care determinations and how people are determined to need those services, where service planning is a core part, where health and welfare and safety issues are paramount for people getting HCBS, which are very different in those three areas than the rest of the Medicaid program, appropriate safeguards, reporting, and data are absolutely necessary.

So we would encourage the Commission as you continue the work to look at places where we can normalize HCBS as a core part of the Medicaid program and really start focusing on those things that make HCBS so different from the rest of the Medicaid program.

Thank you.

CHAIR BELLA: Thank you, Camille. Appreciate you taking time to make comments.

Anyone else like to make a public comment?

[No response.]

CHAIR BELLA: Well, I appreciate the framework that Camille -- I mean, thinking about it that way, places where we can normalize and the places where it needs to be different would be a good way for us to think about the next area of this complicated web that we want to take up.

All right. I don't see any more folks who want to make a comment.

We are going to take a break so Commissioners can eat lunch and come back raring to go for the next session, and after lunch we will be talking about duals.

So, Tamara and Asmaa, thank you again very much for this work. It's obviously going to be an ongoing area of commitment for the Commission.

Commissioners, thank you, and we will reconvene at one o'clock Eastern Time. Thank you very much.

* [Whereupon, at 12:15 p.m., the meeting was recessed, to reconvene at 1:00 p.m. this same day.]

AFTERNOON SESSION

[1:00 p.m.]

CHAIR BELLA: Good afternoon. Welcome back to the afternoon session of MACPAC. We are going to kick off with a continuation of the work around duals, in particular, around dual eligible special needs plans and the SMACs, the state Medicaid agency contracts.

Drew, welcome, and we'll let you take it away. Thank you.

OPTIMIZING STATE MEDICAID AGENCY CONTRACTS (SMACS): POLICY OPTIONS

* MR. GERBER: Thank you.

Good afternoon, Commissioners. Today I'll be presenting some policy options that staff developed following our presentation in January that aim to support states in optimizing their state Medicaid agency contracts or SMACs.

As a refresher, I'll begin with some background on Medicare Advantage dual eligible special needs plans, or D-SNPs, SMACs, and the Commission's prior work in this area. Then I'll walk through several tools we identified

from our interviews with key stakeholders to support states at any step of their integration journey in overseeing their SMACs. Finally, I'll present the Commission with two policy options to consider with the goal of returning in April with final recommendation language for a vote.

So to begin, D-SNPs are a type of Medicare Advantage special needs plan designed to provide targeted care to dually eligible beneficiaries. These plans have varying levels of Medicaid-Medicare integration, ranging from plans that meet federal minimum requirements to coordinate Medicaid benefits, all the way to plans that cover nearly all Medicaid and Medicare benefits through the D-SNP or an affiliated Medicaid managed care organization.

D-SNPs differ from other MA plans and even from other special needs plans because they're required to contract with state Medicaid agencies through the SMAC. There are federal minimum requirements established by law, but states can exceed these requirements to require greater integration or to better tailor D-SNP coverage to serve their dually eligible populations.

Over the course of this project, we have tried to examine how states can optimize their SMACs. As a

reminder, we've conducted a literature review that described the federal requirements that states must meet in designing their SMACs as well as the extent of a state's contracting authority under 42 CFR 422.107.

We reviewed all SMACs for 2023 to understand how states are currently using or not using their SMAC authority to tailor requirements related to, for example, issues of care coordination or data reporting.

As we presented in January, we conducted interviews with five states that go beyond minimum requirements, the Centers for Medicare and Medicaid Services, and representatives for two D-SNPs that operate across our case study states. Through those interviews, stakeholders consistently highlighted barriers to optimizing and overseeing their SMACs that mirror the larger challenges that prior MACPAC research has identified states face in integrating care as a whole: state capacity, both in terms of workforce and expertise, and the need to connect integration goals for dually eligible beneficiaries to larger state goals.

Over the last four years, during which the Commission has studied the issue of integrated care models

for dually eligible beneficiaries, MACPAC has made several recommendations, which we want to reiterate here as they remain relevant to the challenges states face with their SMACs. In June 2022, the Commission recommended, paraphrased, that Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop an integration strategy and to provide federal funding to support states in developing these strategies.

Back in 2020, the Commission similarly recommended that Congress provide federal funds to enhance state capacity to develop expertise in Medicare, and to implement integrated care models.

While Congress has yet to enact these recommendations, interest remains on the Hill, and these recommendations informed several bills in the last Congress. And as of last week, or this week, actually, a bill was introduced that brings back some of these recommendations.

So now we have two policy options to present to the Commission today, which we believe will support states in optimizing and overseeing their SMACs and that will

continue the Commission's push for greater integration for dually eligible beneficiaries.

When developing policy options to support states with their SMACs, we want to recognize that states may include a variety of requirements in their SMACs that address differing populations, state goals, and priorities.

However, through our interviews, stakeholders did identify data on care coordination and Medicare Advantage encounters as key for monitoring D-SNP compliance and assessing quality. States may include care coordination requirements in their SMAC that modify the D-SNP's model of care, which describes the plans' design for care coordination, and state Medicaid agencies may use care coordination data to oversee these requirements in a number of ways. For example, Minnesota uses completion rates of health risk assessments, which the state requires to be completed in either 30 or 60 days, depending on the program, as a performance target for its quality withholds.

Alternatively, a state could require detailed care transition plans for enrollees or require D-SNPs to collaborate with certain Medicaid or community-based organizations, among a variety of other potential options

for states to pursue.

As Medicare is the primary payer for many health care services for dually eligible individuals, Medicare Advantage encounters describe health care utilization for this population that the state Medicaid agencies cannot fully understand without access to this data.

While states do not currently receive Medicare Advantage encounter data unless they require the plan to submit them, these data can be leveraged to compare service use among D-SNP enrollees with those not enrolled in a D-SNP, identify disparities within the dually eligible population, or inform quality improvement goals among other potential analyses.

In addition to the utility of both these data elements in conducting effective oversight, we also found that requirements for plans to submit data on care coordination and Medicare Advantage encounters are applicable to any D-SNP, even those with minimal levels of integration.

So to lay out Policy Option 1: "State Medicaid agencies should use their contracting authority at 42 CFR 422.107 to require that Medicare Advantage dual eligible

special needs plans operating in their state regularly submit data on care coordination and Medicare Advantage encounters to the state for purposes of monitoring, oversight, and assurance that plans are coordinating care according to state requirements.

"If Congress chooses to require that all states develop a strategy to integrate Medicaid and Medicare coverage for their dually eligible beneficiaries, states that include D-SNPs in their integration approach should describe how they will incorporate care coordination and utilization data and how these elements can advance state goals."

We found there are several pieces of our research that support such a recommendation. Care coordination is central to integrating Medicaid and Medicare services, and it serves as a key feature of the D-SNP model. In our interviews, both CMS and state officials identified care coordination data as a useful measure of D-SNP performance and an overall indicator of health of the integrated program.

As states begin to take their first steps towards requiring greater integration from their D-SNPs, states

should use their SMACs to require that D-SNPs submit care coordination data so that states may ensure that dually eligible beneficiaries in these products are receiving the levels of coordination the state expects.

While few states currently collect and use MA encounter data to oversee D-SNPs, state officials said that these data are key to understanding the health of dually eligible individuals and for informing quality improvement efforts.

Importantly, these data elements are applicable to more integrated plans as well as minimally integrated, coordination-only D-SNPs, which means that states at any level of integration can begin requiring these data as a first step.

If states choose to require that D-SNPs submit data on care coordination and MA encounters, we would expect there to be an increased administrative burden on states to collect and oversee these data elements. This may include even a substantial upfront burden to receive MA encounter data, which could require information technology system upgrades.

We do foresee the potential for some additional

burden on health plans to report these data in a format that the state requires. The plans already submit Medicare Advantage encounter data regularly to CMS, and many of these requirements that a state chooses to include would naturally have associated burden. If states collect these data and use them to oversee plan performance, beneficiaries could benefit from potential improvements in care coordination and quality.

For Policy Option 2, we wanted to be responsive to the barriers that states face, addressing the broader issue of integrating care as well as the specifics of SMACs, especially as more states are beginning to leverage this tool.

The option reads: "The Centers for Medicare and Medicaid Services should issue guidance that supports states in the development of a strategy to integrate care that is tailored to each state's health coverage landscape. The guidance should also emphasize how states that contract with Medicare Advantage dual eligible special needs plans can use their state Medicaid agency contracts to advance state policy goals."

So, as I'm sure you're aware, this policy option

echoes the Commission's previous recommendation, and it looks to ensure that states have the information they need to develop an integration strategy. We believe that by outlining the tools available to states, CMS guidance may prompt the development of these strategies.

As we heard in our interviews, there still is a lack of awareness of state contracting authority, its limitations, and the overall value of leveraging the SMAC, and these barriers continue to hinder states in leveraging these contracts.

Federal guidance, similar to a 2018 state Medicaid director letter the agency issued that described integrated care models at the time, could provide states with greater clarity.

We would expect this option to create minimal additional burden for CMS, while states may engage with the guidance and choose to better leverage their SMACs through additional requirements that meet state goals.

I look forward to hearing the Commission's discussion of these options today, and we plan to return in April with a draft report chapter and recommendation language that reflects the conversation. Thank you.

CHAIR BELLA: Thank you, Drew.

I'll just do a little context setting, and then we'll open it up for questions and comments.

I want to reiterate, especially for the new folks, we've been kind of pounding the drum about state capacity and the need for state resources for years. This as everything we do, sort of reinforces that there's a need for that, recognizing that you can only do things with SMACs or other levers if you actually have the capacity and the expertise on the Medicare side to do that.

So we've made recommendations to Congress. We've tried twice. We did it in 2020, recommending resources. We did it in 2022, recommending a state strategy and resources.

As Drew mentioned, there have been a few bills, which is exciting, and another one was introduced yesterday by Senator Casey that would support states, very similar to ones last year with Senators Casey and Scott and Cassidy.

This time, we're going to try to make a recommendation to states and also make a recommendation to CMS, but it doesn't diminish the importance of Congress, hopefully, acting on our recommendations as well. I think

there's an opportunity. We do know that states struggle with some of the SMACs, but we're also signaling that care coordination and encounter data are really important elements that we can be building to for the states.

Then with regard to CMS, as Drew mentioned, in 2018 CMS did guidance to help states understand opportunities, various opportunities. There's new folks in states, and so it seems like it might be a good idea to get that back out there so that, again, we're trying to tackle this to all three levels for whom the Commission can make recommendations and suggestions.

So that's just a little bit of context for folks to understand where we've been and how we see this or how we might see this. With that, I will open it up for comments and questions.

Heidi.

COMMISSIONER ALLEN: I just have a question that reflects my limited understanding of this topic. What does care coordination data look like? Is it encounter data for the person? Is it activities between the plans or the D-SNPs?

MR. GERBER: It can encompass a variety of

things. There could be process measures, such as Minnesota uses, which would be completion rates of the health risk assessments within the required amount of time. It could be the actual substance of the care transition plans for enrollees.

States could require and receive the data from plans that's the actual information in the health risk assessment. They can ask for that to be stratified by an indicator that's relevant to the state, whether that's race and ethnicity or something else.

There's a variety of areas in care coordination that states can explore, but it's really focusing oversight activities around that data and making sure that they are receiving data that's meaningful to achieving state goals was sort of the focus for us.

CHAIR BELLA: Thank you.

Jami?

COMMISSIONER SNYDER: There we go. Just one quick question about the second policy option, which begins with the CMS should issue guidance that supports states in the development of a strategy to integrate care that is tailored to each state's health coverage landscape.

I guess the question I have is whether that's practical for CMS to develop kind of tailored plans, and is there a way to state the policy option a little bit more broadly to say something like that is reflective of the full range of delivery system frameworks supported by states or something along those lines where you know that they're presenting kind of a range of options in terms of that guidance, but it's not specifically tailored to the state? And that's only because I question sort of whether that's feasible, given CMS's bandwidth.

MR. GERBER: Right. I think your phrasing gets to the intent that we had for this option, so we can definitely workshop the language.

COMMISSIONER SNYDER: Okay. Perfect.

CHAIR BELLA: I think the goal is so the guidance to the state can tailor it as part of its strategy, not that CMS is going to tailor, but I agree. What you just said might make that a little bit clearer and crisper.

COMMISSIONER SNYDER: Yeah, that makes sense.

CHAIR BELLA: Okay. Patti?

COMMISSIONER KILLINGSWORTH: So, first of all, I'm glad to sort of see us taking this issue on multiple

fronts. I ultimately do believe that seeing the recommendations to Congress implemented will have the most significant impact, especially if that includes support to states to really build out their capacity as it relates to dual eligibles and Medicare.

I support both of these recommendations. I think that they're very good.

I do worry a little bit about -- and maybe this is just sort of in the detail we can explain this. In that guidance, just helping, really, states who aren't really engaged in this work, yet understand how to link it to their state policy goals, we sort of identified that as a barrier. But I think there are an awful lot of Medicaid directors who still say, why should I care about duals, amongst all the other things that I have to care about? And so some of that policy rationale and linkage might be just really helpful.

Drew, really good work. Thank you.

CHAIR BELLA: Dennis?

COMMISSIONER HEAPHY: I support both policy recommendations, I wonder if there are any best practices in encounter data that could also be put into the document

that states are doing; for instance, even getting the assessments done on time. It says the assessments were done on time, but it's the same thing, but the quality of the assessments. And so what are the practices? What are the other things that we've done to ensure that states are getting the data they really need that's accurate and appropriate?

I guess one other thought is it seems that the plans decide how -- the form of the data that states get, and how can we make it so the states define the format of the data that they're given by the plans and the consistent language, consistent use of terminology, so it's easy for the plans -- for the state to provide appropriate oversight? Because I don't envy state Medicaid leaders when they're looking at five different MA plans, and the five different MA plans use different language and different code for determining them. And how do we create some uniformity across the D-SNPs to make it easier for the states to provide oversight?

CHAIR BELLA: Thank you, Dennis.

Drew, did you have any comments on that? We have gleaned a few best practices. A couple of them are called

out, but there may be more that you've come across.

MR. GERBER: Right. I think we'll be able to highlight a few of those.

And I think, to Dennis' point, it does differ from the states we spoke with, which have significant experience dealing with these D-SNPs to -- as we want this to be applicable to all states that have D-SNPs. Those that maybe lack stronger or deep relationships with their D-SNPs, as of right now, may have more trouble negotiating sort of those pitfalls relating to getting data in the way they want.

Ultimately, all of these things are achievable through requirement language in the SMAC, but again, that's where sort of the expertise and state capacity would come in.

CHAIR BELLA: Did you have another comment, Dennis?

[No response.]

CHAIR BELLA: Okay. Tim?

COMMISSIONER HILL: So just on Policy Option 1, sort of, obviously, the notion here, right, of using the data makes a ton of sense. What I'm struggling with is, do

states not have the authority now to require MA plans to submit this data? And what is telling Congress -- it just feels administratively burdensome, in a way, to say states already have this authority and they're not using it.

CHAIR BELLA: Yeah. This is actually directed to the states, just sort of an additional encouragement to the states --

COMMISSIONER HILL: Okay.

CHAIR BELLA: -- to use the authority they have to actually go after these things, because they do have the authority, but they're not using it. And so we're calling attention to that.

COMMISSIONER HILL: So it's just a calling. Okay.

CHAIR BELLA: Yeah. Does that make sense?

[No response.]

CHAIR BELLA: Okay. We're giving Congress a pass this year, since they haven't taken our other two years. We'll try it with the CMS and the state.

Carolyn?

COMMISSIONER INGRAM: My comments are on Policy Option 2, and I think it's great that we're going to try to

get these things coordinated and worked out and give some guidance out on how to do that.

But as we all know, Medicaid and their health plans there in the states operate on certain procurement timelines differently than what Medicare does. So I'm wondering if there's something we can add in the explanation.

Certainly, the comments that Jami had will help clarify, but that there needs to be some work done to work back with the states in terms of how their procurements are working to align up with the timing around certifying D-SNPs or HIDEs or FIDE plans, because I think we've seen more than once states who get frustrated. They're on a certain procurement cycle. They'd like to do integrated care, but it's going to take so long to get those D-SNPs up in their state or FIDEs, that they just don't -- they give up. They give up. They're very frustrated with that, so if there's something we could do to add something in the discussion about making sure to work with states to figure out how to do that alignment.

My second comment is on stars, and it goes really with the first comment as well. Stars measurement has a

lot of effects on the abilities of health plans to bring up D-SNPs or MA-PD products across the country and how they're looked at and measured.

CMS has the flexibility to look at just stars in one state and how that affects that state. Whether the health plan is delivering good quality care there and they don't have the stars, that inhibits them from moving forward or growing, or if they do have the stars in that state but maybe not in another state. And what I would say is we need to put something in that talks about CMS needing to look at the requirements around stars and making sure it applies specifically to that state.

We've got different populations in each state. Native American populations need different services and take a different amount of time to serve and have different effects than maybe other populations in New York. And the way that CMS is right now applying the stars and looking across states, they're not applying it individually by each state. So I think that is something we need to speak about, even if it doesn't have anything to do -- we don't normally comment on Medicare pieces, but it does affect how a health plan and how a state can do integrated care and

something that does affect the Medicaid duals population. So I think it's something we should comment on. Thank you.

CHAIR BELLA: I'll just say on the first piece -- and it does actually kind of tie to the stars piece -- that we heard pretty loud and clear when we had the panel. When was that? November? October? -- of Michael and Tim and Michelle.

MR. GERBER: December.

CHAIR BELLA: When was that?

MR. GERBER: December.

CHAIR BELLA: December. Wow. December.

And it was brought up about the challenges where the programs collide and particularly procurement and enrollment, and I think that the team has been exploring, is there something we could do in this area around kind of giving CMS more of an ability to make those things work better together? So I think, Carolyn, that might be an area that comes back to the Commission next year.

And to the extent that kind of there are Medicare things, whether it's stars or whatever it is, that impact Medicaid procurements, I think that would all come to light sort of in that discussion.

Other comments? Jenny.

COMMISSIONER GERSTORFF: So, Drew, you mentioned the potential cost burden for states to begin collecting Medicare Advantage encounter data. I wanted to just kind of highlight that. I think it could be significant, especially in situations where states would have relationships with plans that they're not already contracted with for Medicaid.

So with each state, they have their different 837 companion guides and requirements for submitting encounters to their system that are going to be different than what the plans are submitting to Medicare already, and so that can be a burden not only for the states but for the health plans as well that hasn't been measured.

Then I think it could be important, since plans are already submitting the encounter data to CMS, suggesting some sort of quality or completeness metrics that CMS could give to states as states are kind of onboarding the data to facilitate early identification of concerns from a technical perspective.

MR. GERBER: Thank you.

CHAIR BELLA: Thank you, Jenny.

Other comments?

COMMISSIONER HEAPHY: The star rating system was mentioned, and is the star rating system that's used for Medicare appropriate to the duals population? We also need to make recommendations for it, especially the under-65 population, the high level of services that are not measured in the star ratings, the star rating system right now. That would be helpful to include as well.

CHAIR BELLA: Yes. I think we can look at all the places where stars bump up against Medicaid. We'll be a little more constrained in making actual recommendations around stars since they're not in our title, but we can certainly explore it and talk about it.

COMMISSIONER HEAPHY: On the Medicaid side --

CHAIR BELLA: Yep.

COMMISSIONER HEAPHY: -- to augment the Medicare star rating system.

CHAIR BELLA: Yes, yes. And ideally, we would have an integrated rating system, which we could talk about.

Okay. Other comments or questions?

[No response.]

CHAIR BELLA: Drew, do you have what you need from us? Thank you for this.

MR. GERBER: Yeah, I think so.

CHAIR BELLA: Okay. This is great. So it will come back next month for a vote for the June report. Is that right?

MR. GERBER: Correct.

CHAIR BELLA: All right. Well, thank you very much.

We will move into our next session, which is on payment policies to support the HCBS workforce. Rob and Gabby. And this one is going to be run by Bob.

VICE CHAIR DUNCAN: All right. Rob, Gabby, are you ready to walk us through?

FINDINGS FROM INTERVIEWS ABOUT MEDICAID PAYMENT POLICIES TO SUPPORT THE HOME- AND COMMUNITY-BASED SERVICES WORKFORCE

* MR. NELB: Sounds good.

VICE CHAIR DUNCAN: All right. Thank you.

MR. NELB: More fun. So talking this afternoon about some findings from some interviews we did about Medicaid payment policies to support the HCBS workforce.

Those of you following along at home, this is sort of a follow-up from our discussion at the November meeting last year.

We'll begin with just some general background about the workforce and the frameworks that we've been using to address the work, and then I will talk about some of our findings. I'll review some of the promising practices we heard about regarding HCBS rate setting, and I'll turn it over to Gabby to talk about some of the challenges we heard with funding rates at levels recommended by those rate studies and other nonfinancial factors that are also at play here.

Today we'll really be looking for your feedback on next steps for this work. I know there's a lot of interest and a lot of different areas we can go. I think the challenge is going to be to think about how -- based on what we've learned so far, what do you think the most promising areas for the Commission to really focus in on as we continue to work in this area.

MS. BALLWEG: Great. Thank you, Rob.

And as we discussed this morning, we'll start out with a review of the HCBS access framework, which consists

of these four domains as shown here.

This work on the HCBS workforce is primarily focused on the provider availability and accessibility domain, which captures the potential access to providers and services, regardless of whether these services are used. So, as a reminder, the Commission outlined this framework as well in its June 2023 report.

Within the access framework, the providers that we focused on in our research were HCBS workers. When discussing the HCBS workforce, we're referring to a variety of professionals that assist individuals with their long-term care needs. As listed here, they could be direct care workers who assist with activities of daily living, direct support professionals who assist individuals with intellectual or developmental disabilities, or ID/DD, and independent providers employed through self-direction.

In 2022, there were approximately 3.5 million HCBS workers. Of these 3.5 million, 2.8 million are home care workers, and about 40 percent of those workers are employed through self-direction. In addition, there were about 700,000 residential care aides who supported individuals in group homes, assisted living, and other

residential care settings.

In general, the HCBS sector is facing many workforce challenges as the demand for HCBS is outpacing the growth in the HCBS workforce. The COVID-19 pandemic has exacerbated workforce challenges, and in a recent survey of state officials, all states reported shortages in at least one HCBS setting.

MR. NELB: Great.

To guide our work on how Medicaid payment policy can help address these access goals, we've been using our provider payment framework, which you know aims to look at the statutory goals of Medicaid payment and how they relate to each other.

During our interviews, we heard that most states are focusing on adjusting their payment rates, so that's the first part of this framework, the idea of economy and what the underlying payment amount is. So we'll primarily talk about that today. However, as Gabby will discuss, it's important to consider other factors, such as whether the payment methods encourage agencies to pay enough of the rate paid to the direct care workers and then also to consider other nonfinancial factors that may affect access

and quality goals.

* MS. BALLWEG: Turning back to our November 2023 presentation to the Commission, we contacted with Milliman to review state payment policies and interview national experts. Milliman completed a compendium of fee-for-service payment policies described in Section 1915(c) authorities. As a reminder, we found that many states have not regularly updated their HCBS payment rates and that there's a limited use of value-based payment methods.

Since then, we've conducted a second round of interviews with state officials and other state stakeholders, as mentioned on this slide, in Kentucky, Minnesota, New York, North Carolina, and Oregon. These five states use a range of waivers and state plan options to authorize services, including Sections 1915(c), (i), (j), and (k), Section 1905(a), and Section 1115 authorities.

The state also represents a variety of different delivery systems. So, for example, within Kentucky, Minnesota, and Oregon, they're delivering services exclusively via fee-for-service, and New York as well as North Carolina use a mix of managed care and fee-for-

service delivery systems.

Additionally, all five case studies have recently conducted HCBS rate studies.

MR. NELB: Great.

So, let's dive into some of the key themes in the study, starting with payment. As I mentioned, rate setting is the primary tool that a lot of these states were using to help address some of their workforce challenges, and one of the first steps to figure out payment rates was to conduct rate studies.

To get the most out of these rate studies, the stakeholders we interviewed highlighted the importance of conducting what we're calling a "data-driven rate study" that's sort of based on current needs and kind of contrasting that with what we're calling a "budget-based rate study" where the state gives them a fixed pot of money and it's just sort of dividing that among different types of providers or services.

So, for example, in Kentucky, one of the states we interviewed, they first tried doing sort of a budget-based rate study in 2019, but it wasn't really well-received by stakeholders because it was just sort of

shifting the funding around without adding any new money into the system. However, in 2023, the state did a new kind of more evidence-based rate study that could better account for inflation and other wage pressures and to figure out what the rate should be, ideally.

We found with stakeholders that were doing this, sometimes the state doesn't have the funding to maybe fund the rate at a higher rate that might be recommended by a data-driven rate study, but they still found that process to be valuable because it set at least a benchmark for what the current funding needs are that could be a starting point for negotiations among stakeholders.

During our interviews, we also heard more about the time and resources that are needed to conduct these rate studies. Typically, states need to collect some more detailed cost, wage, and other service information, often from providers, which, if they're not used to reporting, it requires some additional training and technical assistance.

In addition to the quantitative information collected, stakeholders also valued the important -- the ability to provide feedback during the process, and some of that qualitative feedback is important, but that also takes

time and resources to convene stakeholders and solicit their input.

Many of the states in our studies funded their recent rate studies using some of that enhanced funding provided by ARPA.

Even in some of these states that had conducted rate studies, another sort of challenge that we came across was about aligning payment rate assumptions across HCBS services and different subpopulations. Maybe a state did a rate study but only for one specific subpopulation, and this created potential access challenges where, if the rates are higher in one waiver compared to another, workers may just sort of shift to the higher-paying service, which doesn't really address the statewide access challenges.

Talking with different stakeholders about this, we heard there may be some justifiable reasons why the rates differ in different waivers to account for different beneficiary care needs. So, for example, maybe some habilitative service to someone with intellectual disabilities is more intensive than just regular assistance with activities of daily living for an older adult. There may be, based on this different service definition, some

reasons for having different rates.

However, in the course of our review, we also identified a number of other cases where the rates differed more for various administrative reasons, so the fact that we were talking earlier today about all the different authorities, and if the timing isn't exactly lined up, one waiver gets updated before another -- also talked about variation in the data available to assess rates. Some types of providers might submit more regular cost reports than others, and so then they get their rates updated more frequently.

Also, in many of the states, I think it's important context to keep in mind that there often isn't one single group representing all beneficiaries of HCBS or all HCBS providers, and so kind of differences in the political power of each group kind of may result as they're sort of lobbying the state legislature for funding may also result in some of these differences that we see; for example, some groups getting a minimum wage for their provider type but not applying to others.

To add to the complexity, because it's a lot of complexity in HCBS, we looked more into the two pieces in

particular, self-direction and managed care. So, with self-direction, this is the option that beneficiaries have to sort of hire their own caregivers. In general, stakeholders value this, and it's a potential tool to really help address workforce challenges when you can employ family members as a paid caregiver.

However, diving under the hood, there were a lot of questions that state officials weren't able to answer about exactly how the wages in self-direction compare to wages paid to workers employed through an agency, and this kind of comes back to the fact that most states use what's called a budget-based model to deliver benefits where they give a beneficiary a fixed budget, and they can sort of figure out the payment rate that they pay.

If we wanted to do future work to really get at the wages paid in self-direction, there may be some opportunity to look at what are called "fiscal intermediaries." Typically, there's an entity that helps a beneficiary sort of distribute funding out of their budget, and so they may have some data about wages that the states that we spoke to didn't have, so more potential work in that area.

Second, in terms of managed care, MCOs generally do have flexibility to pay rates that differ from fee-for-service. However, when we spoke to different health plans in the states we studied, we found that they actually often were just paying the same rate as fee-for-service. Some of this, in some states, it's sort of encouraged. The states will develop a benchmark rate for the plans based on the fee-for-service rate as sort of a starting point for negotiation. In North Carolina, one of the states we studied, they actually require MCOs to pay at least the fee-for-service rate.

All right. Last but not least, in terms of rate setting, we also talked about some of the challenges updating rates. These rate studies are very valuable, but they take a lot of time to do it, and sometimes you finish the rate study, and then you realize that with inflation or something else, the rate is no longer current. In recent years with the rapid inflation, it has been a particular challenge.

So, we heard about two strategies states are using to address this. The first is the idea of indexing, so tying the rate to specific trending factors, such as

consumer price index, which is the measure of inflation, and that helps update the rates over time.

In our review, we learned about a unique practice in Minnesota where they're actually adding what's called a "competitive workforce factor" to help account for not just using wages of what the current wages for direct care workers is but also kind of factoring in the wages for other industries that employ workers of similar skills, so like retail or fast food, for example.

Second, another strategy we learned about is rebasing, right, which is where you're updating the rates based on more recent data sources, typically from the providers. Minnesota, again, was unique in this area. They have what they call their "disability waiver rate system," that rather than do a comprehensive rate study every year, they kind of update the various factors that go into that rate model. They make it publicly available on their website, and it was generally well received by stakeholders for understanding kind of all the different factors that go into their rates.

Another approach to rebasing is sort of cost-based payment methods, and cost-based methods can help keep

up with costs like inflation. But we also heard some potential unintended consequences that may happen as well. In New York, for example, just began using more budget-based rebasing, some of the providers noted that because it's so much focused on the individual provider costs, if they end up reducing costs to improve efficiency, they're sort of penalized by having their rate be reduced. So it's an unintended consequence we might want to keep in mind.

Now I'll turn it over to Gabby.

MS. BALLWEG: In addition to some of these challenges updating rates, we also found that there were some challenges funding HCBS rates.

The ability for states to pay providers based on rates developed through rate studies as well as update these rates based on current economic conditions is limited by state budget constraints. The stakeholders we interviewed know that the variability of the state legislative process often creates uncertainty for providers about the available HCBS funding and related payment rate increases.

They also noted that the state legislators are faced with very difficult tradeoffs when determining

funding for HCBS compared to funding for other priorities such as health care or even in other non-health priorities such as education.

The temporary 10-percentage-point increase in the Federal Medical Assistance Percentage, or FMAP, for HCBS expenditures under the American Rescue Plan Act, or ARPA, has increased Medicaid funding of HCBS without requiring additional state funding. However, to maintain these payment rate increases, states need to identify additional state funding to pay for the new rate at the regular FMAP.

National and state interviewees for this project indicated that while short-term funding from ARPA has helped to stabilize the workforce, these gains may be lost if funding is not sustained in the long term.

Because of growing inflationary pressures, some stakeholders also expressed concern that simply sustaining ARPA rate increases may not be enough to address current HCBS workforce challenges. In these circumstances where there were gaps between the rates and the current costs, stakeholders noted, as Rob has already said, that the rate studies are a valuable tool to support a common understanding of a benchmark rate.

Increases in HCBS funding and payment rates do not always translate into equivalent wage increases for HCBS workers. Many states in our study used wage pass-through policies as a strategy to require providers to pay a direct share of the provider rate increases to workers. Other states determined minimum wage requirements for the HCBS workforce, as Rob also touched on.

Assessing whether wage pass-through policies are achieving their intended goals is challenging. Several interviewees indicated that provider attestation alone is not sufficient to ensure compliance and that there needs to be some additional back-end monitoring. Although some states in our study were able to leverage existing provider cost data reporting to track compliance, most HCBS agencies do not submit regular cost reports. So many states had to collect additional data to assess compliance. This additional reporting can be burdensome for providers, especially some smaller providers which have limited administrative capabilities.

There may also be some unintended results of wage pass-through policies, such as the potential to create challenges for providers to fund the non-wage components of

the rate or that wage pass-throughs may result in wage compression between HCBS workers and their supervisors, which may increase supervisor turnover.

In addition to the financial strategies, we also heard a little bit about non-financial strategies. Some states are using a range of these non-financial strategies to attract and retain workers, and some of the strategies identified in our review include training and credentialing programs, public campaigns, and expanding employment of family caregivers.

However, there's limited research into the effectiveness of a lot of these non-financial strategies implemented to date. In some cases, the initiatives were just not mature enough to determine their effectiveness, and in other cases, funding evaluations of these initiatives was just not a priority for the state and other stakeholders at this time.

As such, the understanding of the impact of some of these nonfinancial investments is a bit challenging, and it may take years to realize.

Additionally, in some cases, states have developed payment approaches that complement nonfinancial

strategies. So, for example, in New York, they provide one-time bonuses for HCBS workers who seek certification across three different certification levels.

In terms of next steps, we would really appreciate any Commissioner feedback on how these findings should inform MACPAC's future work in this area. We also welcome any feedback or reactions on our study findings.

Among the potential areas for additional policy analysis identified in this presentation, we're interested in which ones we should prioritize moving forward, strengthening HCBS rate studies, rate alignment, and processes for updating rates, further exploring the use of self-direction in HCBS, and further evaluation of nonfinancial approaches if and when data are available. We are also interested in areas for continued monitoring, such as ARPA spending, wage pass-through policies, and overall HCBS spending data.

Thank you for your time today, and we look forward to hearing your discussion and feedback.

VICE CHAIR DUNCAN: Thank you very much. Appreciate the information and understanding the various complexities and inconsistencies across the country when it

comes to home- and community-based services and how the funding flows through.

With what's been presented, Commissioners, feedback? Direction?

Yes, Jami.

COMMISSIONER SNYDER: Thank you again for this important work.

A couple of comments. I really appreciate your attention to self-direction and looking more closely at families, family members as paid caregivers. I think during the pandemic initially and then as the ARPA funds rolled out, you saw sort of an extension of some of that work, in particular, to parents of minor children. Many states, understanding the tremendous workforce challenges, decided to extend paid care to parents of minor children. So I think that's just one facet of the equation that we should definitely include in our study of this area.

Also -- and I've said this before in prior meetings -- I think we all share real concern around increases that have been offered to providers with the ARPA funding and the sustainability. You mentioned it, of course, but I think ongoing monitoring in that area is

really critical.

Then the nonfinancial strategies, that's a real area of interest for me personally, and again, with the extension of the ARPA funding, I think states have done a lot of work in that area. So it will be interesting to see how those nonfinancial strategies really complement reimbursement increases, and I hope that we continue and that federal and state officials continue to look at those as a way to address the workforce challenges that we're facing.

VICE CHAIR DUNCAN: Thank you, Jami.

Heidi?

COMMISSIONER ALLEN: This is a really interesting report. I enjoyed learning more about it, and I guess I try to think of what our role is at MACPAC and who our audience is and what kind of control we have. This is obviously a huge, huge issue and will continue to be a huge issue because there's a lot of competition for people in that dollar range, and being a caregiver is really difficult work.

Because we are a federal commission and we report to Congress, it seems to me some of these issues might be

addressed through national policy, like immigration, and thinking of caregivers as a skilled workforce and thinking about pathways for people to come to this country to be a paid caregiver, which I know that like Japan, which has a really aging population, that they've had to really turn to that. And I think that there have been some other countries that have thought of that as an approach.

I like the idea of us thinking about what are the creative ways that states are trying to stay on top of what the dollar amount is needed. I like that Minnesota's approach was really transparent, and I could see why people felt invested in it, even though they weren't able to keep up with the market demand rates that they hoped for.

The last thing I would say is if you look at other companies that are trying to vie for a similar workforce, they really have gotten creative around education, and I know that -- I'm not talking about training people to enter into the caregiving workforce or even training people to be promoted or advanced in that workforce. But thinking of it as what -- like Starbucks has an agreement with Arizona State University where you get 100 percent tuition paid if you're a Starbucks

employee, thinking of bringing people in who may not stay in the health care workforce forever but really care about education and the opportunity to get a bachelor's degree. It seems like some of those, particularly because states do have some levers that they can engage with state universities to have really creative partnerships. And I just wonder if anybody is considering that at all.

MR. NELB: Yeah, those are all great points. We could take them back.

The view to sort of figure out exactly the Commission's role, I guess I can share, though, sort of where we've landed in the past, right? I mean, we could certainly acknowledge some issues of integration or just the workforce in general, but we've sort of treated that as sort of outside of, you know, Title 19 and have focused more on what we can do within the Title 19 statute.

If you remember from our work on nursing facilities, I mean, we did make recommendations there related to rate setting and rate studies kind of thing, and it feels like that area may be a spot to start. So we've sort of, of course, avoided as a Commission sort of saying a state needs to pay a particular rate but have focused on

sort of what are the -- what's the information you need to determine whether rates are appropriate, and then also whether states have that authority to pay what's needed.

So it didn't really come up in the review, but we could think about things like tuition reimbursement. It's unclear how that -- I'm not sure many of the rates today are sort of more cost-based and sort of focusing on someone's cost right there. But if some of those additional benefits are useful for encouraging retention, it may be sort of worth considering how should those sort of indirect benefits be calculated when you're setting rates and things. And so that type of stuff we could still consider, but in the context of, you know, the Medicaid rate.

VICE CHAIR DUNCAN: Thank you, Rob.

Patti?

COMMISSIONER KILLINGSWORTH: Thank you both for bringing up what I think is probably the greatest challenge that's facing states right now with regard to home- and community-based services. It's just it's super important, and honestly, there are no easy solutions. So I appreciate the opportunity to think about sort of where we want this

work to go in order to identify potential policy recommendations.

Kind of starting with the absence of really good workhorse data, it's really hard to make decisions without information upon which to base those decisions, and so it does seem that there is a pretty immediate need for much broader capture of much more detailed workforce data that could inform good public policy.

We saw in the NPRM that addressed kind of -- or that sought to address this issue with the 80-20 rule, I think, sort of, you know, an attempt to create a policy, but without a really solid foundation upon which to base that policy. And so I think that's kind of step one.

I do think using that data then to try to help figure out what is a reasonable percentage of a Medicaid payment that should be passed on to a frontline worker, what does that process actually look like, how do we make sure that that payment to the frontline worker is adequate, I think it's a good thing for us to think about.

One of the benefits of the ARPA funding, temporary though it was, is that it enabled what I would sort of term "rapid-cycle pilots," right? We push a bunch

of money into the system in lots of different ways. What did we learn from that? So lots of states did lots of different things to try to address this issue. Almost everybody did something. What worked? And I think going back and really trying to drill into those different strategies and kind of the outcomes of that, almost no one had time to really evaluate the impact.

Especially for states that were able to sustain or that will be able to sustain post-ARPA, what has been really the impact of the way in which they chose to try to address this issue with an influx of cash?

The third thing I would say -- and this is just getting very real and practical -- is that you cannot, we cannot, states cannot throw enough money at this problem to fix it. It is fundamentally an issue of demographics where we have a population that is aging, people with disabilities that are living longer. All of those are great things. The demand for LTSS, in particular, in home- and community-based settings, is increasing at the same time that the trajectory of people who would be in an age for that workforce is pretty darn flat, right?

So we will -- if sort of trends continue -- and I

have no reason to believe that they won't as it relates to how many babies people are having -- we just won't have enough people to deliver all of the supports that individuals are going to need, no matter how much money we want to spend to buy those people. And so we have to be able to begin to look at alternative ways to support people.

The other thing that happened during the public health emergency and the infusion of ARPA funding was rapid-cycle pilots with respect to leveraging alternative ways of supporting people. We didn't have the people to send into individuals' homes, and sometimes they didn't want them coming if we did have them. So we had to find alternative approaches via remote supports, via technology, via all sorts of alternative ways. And my gosh, some of those worked. So it's another area for us to really look at from an efficiency perspective. Is doing the work in person always the most efficient way to deliver the support that an individual needs? And by the way, is it also the most empowering to them to have someone come and do for when they would rather be able to do for themselves with some technology that might enable their own independence?

So I think that's another piece that if we're really worried about access in the long term, we have to focus on, because we'll never really fix the workforce issue. But I do think there are meaningful things that we should do to help address it.

VICE CHAIR DUNCAN: Thank you, Patti.

Carolyn?

COMMISSIONER INGRAM: I think I agree probably with my colleagues in some of what you're hearing. I'll just add a little bit more, but it sounds like what we're gathering around is that it's not just the payment rate that is important. But it's the alternatives to what we're doing to increase the rates but also figure out the pipeline and what we're going to do about the future in terms of being able to make sure we've got enough services for people to access care, whether it's alternative ways to encourage people, places for folks to go where they can receive care during the day, maybe alternative methods. So I think my feedback to you would be mostly around your question on looking into alternative methods for reimbursement and payment here.

The next piece I will add is that I think there

are quite a few states -- Heidi brought up some examples, and I know there are health plans doing things to encourage the workforce. We have initiatives, for example, in Tribal communities working to incentivize folks to move into this field or paying scholarships and that type of thing.

I would ask also if there may be some folks looking at tax credits on the back end.

And then the other big piece of feedback we hear is making sure that the payment isn't going to do something to kick them off of other services they might be getting if they end up getting too much. So is there a way to do that through tax credits? Is there a way to do that by reimbursing for education or some of those other pieces? So that's where I'd like to see some of our work go.

VICE CHAIR DUNCAN: Thank you, Carolyn.

Dennis?

COMMISSIONER HEAPHY: Yeah, thanks, everyone, for the comments.

I'm living this every day, and posting ads online, where before you might have had 10 folks actually applying, now there's nobody. Or go online and the state actually has a website to look for folks, and they've never

had a COVID vaccine. And so these are the sorts of issues that we're facing day-to-day. So it is moving towards a crisis.

I think it will be really helpful to understand more how the cash and counseling works in different states because there are folks who live in rural areas or live in areas where they can't find personal care attendants, and if people actually have control over their budget and can pay a PCA or care attendant $30 an hour to come in for an hour and a half because they can't find someone to come out there for 45 minutes, to give them the control over their budget would be really helpful, because it is very tough.

I think to Heidi's point, there are times in my life where I find it much easier to find folks when we had an influx of immigrants. Immigrants are very much interested in doing work that will help them get on the way and start a new business or go into different endeavors.

I think one of the -- for me, just my personal real opinion is one of the mistakes we've made is to define the home- and community-based workforce as health care folks as opposed to social service folks. And so we narrowly define certification. People get certification in

home care or in whatever sort of medical -- move up the medical ladder as opposed to recognizing that this is really about social services and supporting people to go to whatever field they want to go to, as opposed to just narrowly defining it.

I would say like years ago, college students that would apply for this job, a variety of different majors, but now it's just medically oriented students, physical therapy students or pre-med students. So how do we open this up again and say this is about employing the folks to engage with people in the community, to support them, social service, social workers, whatever field they want to go to? So I think it's reframing the messaging and the marketing is really important.

I do think it's important to look at the consumer-directed one, because that's something that I believe very strongly in, and that it does help. But again, going back to cash and counseling, I really do think it would be helpful to figure out are there ways to allow people to manage their budgets so that they may -- even if they're not able to get all the services they need met, they're able to get some of those needs met to keep them

out of nursing homes and keep them out of the emergency departments. I think that should really be our goal during this crisis, which is only going to increase over time, as Patti was saying.

VICE CHAIR DUNCAN: Thank you, Dennis.

Anyone else? John.

COMMISSIONER McCARTHY: To me, on your question of what do we need to monitor, it's getting at what Patti was saying. At some level, we don't have the data to look at these things, and I know at a retreat, we talk about what's a policy question versus a research question. But on this one, I think because we start talking about things like wage pass-through policies, we just don't have the data to talk about some of those things, whether it's good, bad, or indifferent.

So I think a part of it is if you could, in my opinion, think about looking at the data we have from states on HCBS rates, if you took those and normalized those, taking out the differences in costs versus across the country, and then regressing that against quality metrics.

We talked earlier on the waivers, and so in all

the waivers, we have a whole bunch of data that comes from the waivers around incident reporting or how big are wait lists or things like that. So trying to figure out, is there some way to correlate anything, is there any type of correlation whatsoever between payment rates and quality outputs, so that we would have some of that information to be able to talk about some of these different pieces.

The reason I bring that up is there's an area agency in aging in Cincinnati that I worked with before, and I just talked to them a month or two ago. They were having an issue of getting people to serve individuals to the point where people were being -- the wait list actually started growing for the passport waiver in Ohio because they couldn't find people to serve people. And they started -- and they kept on raising how much they would pay. So they were at $15 an hour, $16. They were up to like $27 an hour, and they weren't getting additional people.

But what they did create was an app that's kind of like an Uber-ish-type app for people, and they got a whole bunch of people who would worked for $15 an hour at that time, and it was because they could have a schedule

that worked best for them. And so it was like, how does that work?

Now, for the person being served, may not be the best, because you may have different people serving you all the time. But they had a larger -- they were able to access a larger pool of individuals willing to do the work.

To me, it's one of those exploratory areas of could we look at the data that we have and from that make any decisions around anything that we see that's a positive or negative around those things.

MR. NELB: Well, maybe just to jump on this and maybe to follow up on Carolyn's comments, I guess what I'm hearing is sort of talking about innovations, right, and service delivery and how to capture that here.

And I guess you've talked about it. We have this sort of nonfinancial factors sort of this big slide, but it sounds -- I mean, like perhaps this is sort of different than just like putting more marketing on a website or giving someone a different title without paying them any more or something, because in the -- I guess when we've asked about those innovations, sort of some of the issues that came up, as I mentioned, with New York, you know, were

sort of interesting challenges, right, where you -- if you just look at the cost or something, sometimes you do these -- your Uber-like app or, you know, better use of tech, remote monitoring or something, it lowers the cost per person. And so then it's -- but the way we sort of set up our rates don't always account for that in thinking about the innovation and so maybe an area to explore.

I will say, you know, we put in our -- you know, with T-MSIS and stuff, we can look at overall spending data, but it's very difficult to look at payment rates in the same way that -- you know, with nursing homes and with hospitals, we're doing these sort of larger rate studies, you know, what can we say about how rates vary across states? But it's very difficult in HCBS because there's so many different services.

And, you know, just our compendium, we tried to, you know, pick the three most common categories, but even within that, there were like hundreds of different flavors and variations. And so it's hard to say how one rate compares to another because the service is slightly different or the acuity.

But there may be ways to look at -- and we are

doing work on HCBS spending to look at, you know, more -- getting away from the individual service and looking more at the person, and that may be a way to better understand, you know -- you still need to sort of maybe adjust that person-level data for acuity, and that's going to be a challenge because we don't have kind of common measures of acuity or whatever. But yeah, presumably, you know, someone with similar care needs, if they're getting the care they need in a more efficient way, and, you know, looking at the quality outcomes, you know, maybe thinking about how to reward and support those sorts of deliveries.

So it's -- I guess it would -- in our, like, payment framework type of thing, it would sort of fit more under that really, efficiency bucket perhaps rather than being, like, this nonfinancial factor or something that's sort of outside of the payment policy. We can sort of iterate on the right levels, but I just wanted to maybe flag that distinction or see if that was maybe helpful to clarify or make sure I'm getting it right about when you talk about -- it seems like what you're really interested in are these sort of innovations in care delivery, which could help in the future, if we're not going to have enough

workers, how to -- the workers we do have, how their work can go further, basically, in serving more people. So just a thought to think.

VICE CHAIR DUNCAN: Thank you, Rob.

Jami.

COMMISSIONER SNYDER: Absolutely. I think you're right on the mark.

I do think it's about innovation on the member end of the equation as well as the DCW end of the equation, and I think this is one of those instances where it would be just invaluable to do more work in the arena of sort of interviewing individuals that are recipients of HCBS services and really talking about, outside of just face-to-face care, innovations that make sense and that are empowering and have an efficiency sort of factor to them.

And then on the DCW end, I think this is -- the example that John gave is really fascinating about this sort of Uber-like matching service to talk to direct care workers about what's most important. I mean, pay is one component, but we all know that flexibility, especially when it comes to work like this, can be equally important. So I think sort of additional work in terms of really

engaging with members and DCWs, I think would be valuable.

VICE CHAIR DUNCAN: Thank you, Jami.

Any other Commissioners? Go ahead.

CHAIR BELLA: I'm thinking about what Dennis was saying. I mean, I think it's important that we bring it back to the member or the individual always, because I would imagine that in an ideal world, as John mentioned, we wouldn't have different people every day coming into the home. We want it to be comfortable and dignified and all those things. So balancing the innovation with making sure we have some continuity and sort of trust, I think, for the people that are using the services should be foremost.

COMMISSIONER HEAPHY: Yeah. I can tell you that there are situations where in a building or a neighborhood, people will borrow each other's PCAs, their care attendants, and say, "Is So-and-So there today? Can they stop by for five minutes?" to help that person out across the street or down the block or even in the same building.

And so I think what you're saying, John, in that way makes sense, because it's continuity. The people sort of know each other. One of the challenges of something like that is with electronic visit verification, if the

person is supposed to be working with John for the day or for six hours, then John is going to help Mary or the person is going to help Mary for 10 minutes. Do they clock in and clock out and they go back to help the person who's supposed to be with them that day? That time, does that make sense?

It's like you have to make sure that systems enable flexibility in how the direct care workers function in the lives of people with disabilities and elders, and I can't imagine what it would be like for an older person, a different person coming in every day. It would be a nightmare waiting to happen.

Although I do think, John, to your point, there are times when people will be grateful for anybody to show up in their house.

VICE CHAIR DUNCAN: Thank you, Dennis.

Anyone else?

[No response.]

VICE CHAIR DUNCAN: Rob? Gabby? There were a lot of comments made, a lot of thoughts, but as I listened to it, it really came down to member-focused and innovation. I think Patti's words about this is not going

to get better and how we think of innovation in the workforce and innovation technology to deliver those services --

COMMISSIONER HEAPHY: I think it's also looking at the workforce, again, women of color, and how do we make sure that when we're looking at this, we're addressing some of the social determinants of health. And someone, I think, mentioned a lot of these folks don't have Medicaid, and doing this work and being able to maintain the Medicaid would be huge or get Medicaid would be huge, a huge incentive for both going into this workforce. And so these are sorts of things that I think we really need to look at with the workforce, with the burdens involving it, and how can that burden be reduced.

VICE CHAIR DUNCAN: Thank you, Dennis.

So do you feel like you've got the information you need to go back and take this funnel and prioritize next steps?

MR. NELB: Yeah, I think this is all helpful, and yeah, we'll take back and sort of think through it. We'll have to think through how to -- you know, again, like from the interviews, sort of the rate study-type thing came

across as most important, but it doesn't seem like that's maybe the highest priority for Commissioners. So we'll just sort of think about how to square that together.

Potentially, like those rate studies could get the data that could be used for those future studies of, you know, what's next, you know, to sort of -- right now there's such little data, right? We don't even know how much we're paying. It's hard to figure out, you know, what's most efficient.

But yeah, we'll take these back and think of how to prioritize and fit into a long-term work plan to keep chipping away at this issue.

VICE CHAIR DUNCAN: Thank you very much. Appreciate it.

Madam Chairwoman?

CHAIR BELLA: Thank you.

We're going to turn it over to public comment now for the last couple sessions we had on duals and the state Medicaid agency contracts and then the session we just had on workforce and payment policy. So we'll open it up to the public. If you would like to make a comment, please use the hand icon, introduce yourself, the organization you

represent, and we ask that you keep your comments to three minutes, please.

Welcome, Camille.

PUBLIC COMMENT

* MS. DOBSON: Hi. Good afternoon. I'm sure you're tired of hearing from me. Camille Dawson from Advancing States. Again, we represent the Aging and Disability Agencies that deliver HCBS for older adults and people with physical disabilities.

I had two thoughts I would share around the SMACs. I would offer that while getting the Medicare data, encounter data seems easy, it is an incredibly complicated process for many states. And those that don't do managed care or don't have their HCBS programs in managed care, that is a very daunting undertaking for them. Notwithstanding the support that's coming from the ICRC and the State Data Assistance Center, it's a very hard thing. And just having the states use the admit, discharge, and transfer data that's required for D-SNPs to transmit is a big lift for states, so again, state capacity and ability to use the data that's coming for care coordination.

The second part I would add -- and just for Rob

and Gabby and the rest of the team as they do more work -- 17 states have direct service worker advisory boards. We're supporting two in two states, in Missouri and Indiana, but we have found that they are an incredibly valuable source of feedback and input around what's actually -- informing the policy around what actually is going to make a difference to attract and/or keep individuals in their workforce.

The benefits list that somebody mentioned, I think, is real, and the concern about being paid too much, that it would drop workers out of SNAP and Medicaid is a real issue and I think a systemic sort of national policy conversation that we should be having.

But again, commend the work. The rate conversation is so complex. Value-based payment and what value looks like in HCBS is really complex as well. Look forward to seeing the work that the Commission does in this area. It can only help. Thank you.

CHAIR BELLA: Thank you, Camille.

Anyone else would like to make comments?

[No response.]

CHAIR BELLA: All right. I do not see anyone

else. There will be another opportunity at the end of the day. Thank you very much.

We will take a break until 2:30, and we'll come back and talk about a roundtable that we had on physician-administered drugs. So we'll see you back here in about 15 minutes. Thank you.

* [Recess.]

CHAIR BELLA: Welcome back. Thank you, Chris. You are going to lead us through an expert roundtable we had on physician-administered drugs. So take it away.

THEMES FROM EXPERT ROUNDTABLE ON PHYSICIAN-ADMINISTERED DRUGS (PAD)

* MR. PARK: Thank you.

So today I'll be presenting on the themes and findings from a recent expert roundtable on physician-administered drugs that was held in January. We focused on physician-administered drugs because many high-cost drugs are administered by a health care provider, and there are some unique features and policies related to these drugs that make them different from other outpatient drugs.

The purpose of the roundtable was to better understand what strategies states are employing to manage

spending on physician-administered drugs and determine if federal policy changes are necessary to help states develop different models for coverage, payment, or rebates that address these challenges.

First, I'll provide background on the Medicaid Drug Rebate Program and how certain policies differ between physician-administered drugs and those dispensed from a pharmacy. This information was presented in greater detail in January, but I just wanted to have a brief refresher to provide the context for the roundtable themes. Next, I'll summarize the key themes of the roundtable and some potential strategies identified by the participants.

The Medicaid Drug Rebate Program, or MDRP, is a statutory provision that governs coverage of drugs in Medicaid. Drug manufacturers are required to provide a rebate to Medicaid in order for their products to be recognized for federal match. In exchange, states must generally cover all of the participating manufacturers' products, but they may limit use through tools such as prior authorization or preferred drug lists.

Products included in the MDRP are known as covered outpatient drugs. Generally, these are drugs that

require a prescription, are approved by the Food and Drug Administration, and a manufacturer has a rebate agreement. Vaccines are not included in the MDRP.

Covered outpatient drugs are primarily those dispensed from a pharmacy but can include drugs administered by a physician or other health care provider.

The MDRP rebates are defined in statute and based on average manufacturer price. For brand drugs, the rebate is 23.1 percent of average manufacturer price or average manufacturer price minus best price. There is an inflationary rebate. So if the drug's price increases faster than inflation, there's an additional rebate that's paid.

For generic drugs, the rebate is at 13 percent of average manufacturer price. There is no best price provision, and the generic drugs also have that inflationary rebate.

The majority of states also negotiate supplemental rebates with manufacturers in addition to the federal rebates. Manufacturers pay these rebates to have fewer restrictions on their products and increase their market share. Similar to the state supplemental rebates,

managed care organizations can also negotiate their own rebates with manufacturers.

While 340B is not a Medicaid provision, there are some interactions between 340B and Medicaid. The 340B program allows certain qualifying 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 drug rebate formulas, and it's like getting the Medicaid rebate up front.

Although the 340B program does sit outside of Medicaid, it interacts with Medicaid rebate and payment policy. Drugs purchased under the 340B program are not eligible for the federal Medicaid rebates, and states must exclude the 340B drugs from the rebate invoice. This prevents the manufacturer from paying double rebates.

Medicaid also pays 340B providers for drugs that may have been purchased through the program and dispensed to Medicaid beneficiaries.

Physician-administered drugs, or PADs, are drugs that are typically administered by a health care provider in a physician's office or other clinical setting and

generally covered through the medical benefit instead of the pharmacy benefit. PADs may be considered a covered outpatient drugs for the rebate program and can receive the federal rebate, but this is dependent on the payment method.

Drugs are not included in the rebate program if they are provided in certain settings and billed as part of a bundled service, such as an inpatient 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 can be considered a covered outpatient drug and is eligible for the rebate.

And just a quick note that the proposed rule in May 2023 would have a slight definitional change about direct payment, and so it would require that a drug is itemized and identified separately as a claim to be eligible for the program.

This slide highlights differences in how states pay for drugs obtained from a pharmacy versus those administered by a physician. For pharmacies, these claims run through the pharmacy benefit and are billed based on

the NDC code. There are two components to the payment, state fee-for-service payment. There is the ingredient cost, which covers the pharmacy's estimated cost of acquiring a drug, and then there's the dispensing fee, which is intended to cover the pharmacy's overhead and services provided to fill the prescription.

The 2016 Medicaid outpatient drug rule required the states pay the actual acquisition cost for the ingredient cost component of payment. For 340B providers, that means it is the 340B ceiling price.

Physician-administered drugs generally run through the medical benefit and are paid based on the billing code, such as a procedure code or a DRG. The structure of payment is similar to drugs dispensed from a pharmacy in that there is a payment for the amount to cover the cost of acquiring a drug, and then there's a separate fee for related professional services in administering the drug.

The requirement to pay at average acquisition cost does not apply to the physician-administered drugs, and there are no specific fee-for-service payment regulations for these drugs.

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

Many states pay for physician-administered drug acquisition costs based on the Medicare Part B formula, which is at average sales price plus 6 percent.

Additionally, states are not required to pay 340B providers at the 340B ceiling price, and as such, some states have implemented policies to pay at the ceiling price, while others often pay similar to how they would pay non-340B providers and include that markup.

Just quickly on dually eligibles, you know, for drugs obtained from a pharmacy, most of these are covered under Medicare Part D. Medicaid does not pay for any Part D drugs or any associated cost-sharing, but for physician-administered drugs, those would typically be covered under Medicare Part A or B. Medicaid does pay premiums and cost-sharing, and so for Part B, that is 20 percent. And a quick note that Medicaid can claim the rebate, statutory rebate, if they do pay for cost-sharing for duals.

So we contracted with Milliman to convene a

roundtable to discuss the challenges associated with physician-administered drugs and the strategies to address them. The panel included federal and state officials, drug payment experts, Medicaid MCOs, drug manufacturers, beneficiary advocates, and providers. The key themes are listed on this slide, but we'll walk through them in greater detail.

The panel spent a lot of time discussing Medicaid payment policies for the physician-administered drugs and the tension between the potential excess in spending created by the markup and the need for those payments to subsidize costs for professional services that may not be fully covered by Medicaid through the administration fees.

While most states include a markup on the physician-administered drug payment, this is not the case for every state. A participant described one state that requires the provider to include the NDC on the claim, and then they use that NDC to run it through the pharmacy claims processing system. So under this process, many of the physician-administered drugs are actually paid under the pharmacy benefit at acquisition cost without the markup.

While acknowledging the potential for excess spending due to the markup, particularly on very high-cost drugs such as cell and gene therapies, several stakeholders noted the importance for providers to be profitable or at least, you know, cover costs. Providers expressed the need for payments to cover the upfront risk posed for purchasing expensive drugs but acknowledged that the typical 6 percent margin on drugs that cost hundreds of thousands of dollars or even a million likely goes beyond a provider's risk.

A provider representative was open to divorcing the markup from the drug for sufficient reimbursement for administration and overhead costs. You know, they wanted states to consider the payment for administration to be appropriately structured to account for differences in service intensity and associated costs.

State representatives did express concern about their budget for any additional provider administration expenses without sufficient offsets elsewhere, such as on the drug payment.

A drug manufacturer representative did note the importance of providers being paid adequately to ensure access to their products. As such, he thought

manufacturers maybe should consider providing additional rebates to states, so long as those rebates were passed along in the form of higher payments to providers. That way, providers would be paid more for their services, but the state would not necessarily increase in net spending.

Some participants noted paying 340B providers at the ceiling price could represent a savings opportunity for states. However, other participants noted the importance of that spread, the difference between the payment and the 340B price, in allowing them to, you know, fulfill their safety net mission and provide services to low-income populations.

Participants also noted that there could be ways to reduce the 340B spending while still providing some funding to support to safety net. So, in one state, 340B providers were reimbursed at the 340B ceiling price plus 6 percent, but that markup was limited to $600. In this case, the spread was still provided, but it had been reduced because 6 percent on the 340B ceiling price is less than 6 percent on the typical acquisition cost, and the markup was limited to $600.

Other approaches to 340B payment were also

discussed. For example, payment could be tied to the amount of charity care provided and tiered in such a way to further incentivize entities to ensure that the 340B revenue is used to serve the uninsured and develop community programs.

While some participants noted that bundle payments may be beneficial and that sometimes they cover the cost of additional services that may not be separately billable, the general consensus was that there were challenges with providers receiving adequate drug payment for drugs included in a bundled payment, particularly for cell and gene therapies.

There can be delays in updating the bundled payment rate to reflect the cost of new drugs and therapies. One manufacturer representative noted that DRGs in Medicaid were not updated frequently enough compared to Medicare, and this makes it difficult to quickly account for the cost of new therapies, such as the cell and gene therapies, and align the DRG payment with the cost of those drugs.

A participant mentioned that many comments on the May 2023 drug rule seemed to indicate that providers

thought separate payment outside of the bundle was more likely to be paid at acquisition cost.

Additionally, the state is not eligible for the statutory rebate if the drug is included in a bundle payment under current policy, so that could ultimately increase a state's cost as well.

Several stakeholders noted challenges in managing physician-administered drugs under the medical benefit in terms of prior authorization or other utilization management tools. The processes were not as robust under the medical benefit as they have under the pharmacy benefit.

Additionally, there could be further confusion because states employ separate vendors and systems to manage prior authorization under the pharmacy and medical benefits frequently.

Some participants noted that it would be beneficial for states to better integrate the clinical teams under the medical and pharmacy benefits. Referring back to the one state that had run the physician-administered drugs through the pharmacy benefit, that process allowed the state to run the claims through a

common process and make consistent clinical decisions across all of the drugs.

And another key component was that it moved utilization management up in the process to ensure that it happened before the administration of the drug.

Although some states have been trying to work toward that type of integration, it was noted that it takes significant time and resources. The integration requires significant changes to states' Medicaid management information systems, and there also needs to be time included to train both state staff and providers.

The dichotomy between the medical benefit and pharmacy benefit can also lead to confusion for managed care plans in states with a pharmacy carve-out. There's not necessarily a clear definition of physician-administered drugs, and some of those drugs could be covered under either the medical benefit or the pharmacy benefit. So depending on those situations, it could either be the plan's responsibility or the state's responsibility. So in a state with a recent carve-out, there was a lot of confusion as to what remained the MCO's responsibility versus what transitioned over to the state.

Providers and beneficiary advocate stakeholders expressed concerns with the prior authorization turnaround time and how that can affect patient access. The process can be more of an issue for physician-administered drugs, which may be more specialized and complex and require additional information from the provider to get approved.

Beneficiary advocates discussed how it can be difficult for patients and providers to know exactly what information is required for prior authorization.

Another concern was that complex therapies, such as oncology or cell and gene therapies, are the classes with the highest spend but often have clinical criteria that need to be met on an individualized, case-by-case basis, and so that can be administratively burdensome and expensive. And some state programs may not have the state capacity to quickly develop and update clinical guidelines for appropriate utilization or patient selection.

Most participants acknowledge that providers should have an active role in managing spending for these drugs. However, this can be challenging because providers do not know the net cost of the drug after rebates because specific rebate amounts are confidential, and so this lack

of information can be a barrier to driving utilization to lower net cost products.

One participant noted that while states are unable to share the net cost with providers, they could consider assigning drugs a ranking, such as like one to four dollar signs, to indicate the relative net cost of products and give providers insight into the cost of the drugs they're prescribing.

Roundtable participants also discussed options to structure drugs into net cost tiers and use provider payment to incentivize providers to administer lower net cost drugs. So, for example, lower net cost drugs could have a higher markup. Participants also considered creating a shared savings program with providers so that providers could receive a bonus for using the most cost-effective products.

Beneficiary and provider representatives were concerned about making cost a primary factor for complex conditions where treatment may be more personalized. They strongly advocated for a standardized and robust medical exceptions process, especially for those personalized treatments.

Participants briefly discussed value-based arrangements and outcome-based contracts and how these can be difficult to develop and administer. Drug manufacturers' representatives mentioned that it's generally easier to enter these contracts with state Medicaid programs rather than individual health plans. It's easier for the states to enter into these agreements for the entire population, whether the drug is carved in or out of managed care, because the states ultimately bear the risk. And then the state supplemental rebate agreement doesn't trigger any best price concerns.

While these arrangements are promising, there are significant administrative burdens to setting up these contracts, and some of these barriers that were noted included the administrative burden and lack of resources to support outcomes tracking and reporting, kind of uncertainty as to who should bear the responsibility for monitoring and tracking outcomes between the state, the health plans, drug manufacturers, and providers, and just generally the lack of negotiating power under the MDRP, states generally have to cover these drugs. So manufacturers do not necessarily have to enter into any of

these types of agreements.

Cell and gene therapies were of particular interest throughout the discussion. The extremely high cost of these drugs and the limited access at a small number of qualified treatment centers, or QTCs, made all of these existing issues of PADs more challenging.

States may not have a qualified center in the state for administering a particular cell and gene therapy, so they would need to have agreements in place with out-of-state providers as well as considering coverage of additional services such as transportation.

Stakeholders noted that the provider administering the cell and gene therapy may be different than the provider performing follow-up care. So this can create additional challenges for determining appropriate provider payment, especially if the cell and gene therapy was included in a bundled payment.

Participants discussed how payment differences across sites of care don't necessarily reflect the financial risk, the high cost these drugs may carry, and it limits the ability to use the different types of providers.

Participants thought the current administration

fee in the outpatient setting, such as a physician office -- you know, maybe that's like $100 -- would not sufficiently cover the costs and risks of providing a multimillion-dollar cell and gene therapy. And there's also significant financial risk and lack of capital for smaller providers to purchase these treatments. So that can limit access and ability to shift costs to lower-cost sites of care.

Stakeholders also noted that bundled payments that include cell and gene therapies frequently were insufficient to cover the cost of the drug, and so without clarity as to how these treatments may be paid for within a state, that could disincentivize providers from pursuing the qualified treatment status. And that can limit access to beneficiaries.

Just wanted to recap the potential strategies that were highlighted in the themes in the roundtable discussion. Participants thought that the payment between the two components of physician-administered drugs could be realigned, similarly to how drugs are billed under the pharmacy benefit. The markup of the drug could be reduced or eliminated, and the administration fee could be

increased to better account for providers' operational costs. And so this could improve transparency by untangling providers' costs for the drug separate from the costs of the services provided.

States could also explore implementing tiered payment to providers based on drug characteristics, including but not limited to the drug's cost and complexity of administration. For example, the drug markup could be relatively higher on drugs that are lower net costs to the Medicaid program.

One participant thought the recommendations made by MedPAC on a tiered Part B payment approach could be looked at as a potential model. One person thought that that type of tiered approach may be more palatable in Medicaid.

Additionally, states could share more information with providers regarding the cost of products, such as a ranking system, or implement payment incentives, such as shared savings, to further encourage the use of lower net cost products.

Similarly, states could consider different payment structures for 340B providers that pay closer to

the 340B ceiling price and limit the amount of markup to address provider concerns about the need for the drug spread to support uncompensated care and community benefits. States could make higher payments to covered entities that provide a greater amount of charity care, and that could better tie the 340B revenue to services provided to low-income populations.

It could also be beneficial for states and providers to consider extremely high-cost drugs, like cell and gene therapies, and removing them from bundled payments and paying them separately, at acquisition cost. States would get the rebate while providers would be more confident that the payment will cover the cost of the therapy, and that could increase patient access.

Finally, to improve utilization management, states could develop a unified process for prior authorization and other tools across the pharmacy and medical benefits. This could allow for more comprehensive and standardized clinical criteria and for greater expediency and efficiency in the review, regardless of how the drug is delivered.

So for next steps, staff can draft an issue brief

highlighting the variety of challenges of physician-administered drugs and the potential payment and utilization management strategies identified during the roundtable. Just to note that the strategies that were identified by the participants are all activities that states could pursue under current authority.

So given this information, we'd appreciate your feedback on the findings in the roundtable and if there's additional work you'd like to pursue in the area.

CHAIR BELLA: Thank you, Chris. It's always a lot to digest, but we are comforted to know that you know all of this as well as you do.

Commissioners, the default is an issue brief on this with all the things that were mentioned, and I think what would be helpful is to understand if there are other things you'd like to drill in more or if we think the issue brief is our biggest contribution at this point, and then we'll continue to keep an eye on this and the CMMI demonstrations around outcomes, so kind of opening it up for feedback from folks with the default of the issue brief for certain.

Comments? Carolyn.

COMMISSIONER INGRAM: Everybody's overwhelmed by all of the data this is producing, so I'll jump in.

The one area I did want to hear a little bit more about, Chris, was just the value-based purchasing. I know you said there was some -- I'm trying to find it in the report, but that there was some discrepancy amongst there isn't any consistency among states about what they're really trying to do around value-based purchasing. And I know that's something that states are really interested in and probably even folks, congressional staff. So was the anything else you were able to glean there from the interviews about states starting to look at some value-based purchasing with just certain specific drugs or anything else that we could try to bring to the table from your work?

MR. PARK: Yes. Certainly, it's not exclusive to physician-administered drugs, but states have been developing supplemental rebate agreements with some manufacturers that are value-based or outcomes-based arrangements.

I think what we've heard from a few states is that this has been a very difficult process. Oklahoma is

one of the first to do it a few years ago, and I think some of their comments reflecting back on the process, it took several months or even years to kind of come up with the arrangement. Not necessarily all. They might be talking to like 20 manufacturers, but at some point, they only ended up with like four. So it was kind of difficult to go through the process, identify what the particular metrics are in terms of outcomes. How do you track those outcomes? Because they're not all claims-based. So if it requires lab testing results or other assessments, for spinal and muscular atrophy, there might be other types of functional assessments that are required. How do you track that, keep track of that, particularly over maybe a long period of time for the cell and gene therapies, like three years, four years, five years, if they're switching health plans, moving to a different state, not on Medicaid anymore? So those are all kind of like these administrative challenges.

Then certainly, we've heard from manufacturers that negotiating these individual agreements with states can also be challenging. So that's where like the CMMI model might be attractive to manufacturers is that they can negotiate a standard agreement that all states could kind

of walk into with like kind of clear definitions of what the outcomes are. So that's something we'll definitely be keeping track of.

CHAIR BELLA: Carolyn, anything else? Okay. Thank you.

Jami?

COMMISSIONER SNYDER: And you hit on it. I was going to ask about the CMMI model. Clearly, I think that holds promise from a negotiation standpoint but also holds promise in terms of CMMI's willingness to do some of the back-end analytics work. Have you heard any more about states' interest in the model? I know there was some concern around the timing because it's a couple years out, and some of these cell and gene therapies are coming to market clearly now.

MR. PARK: Yes. CMMI has put out basically the -- I think it was just announced today, they released the application for manufacturers to apply, and it's only for sickle cell disease right now. So they're starting with that one. They anticipate that the actual agreement would go into effect in 2025. So I think the first step is for manufacturers to apply, and then once they apply, they'll

go through the process of negotiating the agreement with CMS.

States, I think, need to apply or express interest at least in the next few months, and then -- but they won't know the exact parameters until probably later in the year, once they're hammered out. And at that point, they can kind of like decide to go through with it or not.

Some of the interesting aspects of that model, you know, because it's demonstration authority, they're trying to do some additional things like providing fertility preservation services. So part of the agreement that manufacturers are supposed to agree to are to cover those types of services, because the process can result in infertility. So that's something that I think manufacturers are not allowed to do currently under anti-kickback statute for federal programs, and so that's something that may be particularly interesting for the manufacturers to sign on to because it could increase access to their products.

States, I think, will be subject to kind of like uniform like prior authorization management requirements, and I think CMS will ask them to provide additional

services, maybe like behavioral health and other things. There are kind of things on both sides that I think might be attractive.

CHAIR BELLA: Can you say a little more about the incentive for the manufacturers to apply to do this? I understand it's sort of like one standardized approach, but that's only for the states that choose to participate, right?

MR. PARK: Yeah. I mean, it's a standardized approach. I think to the extent they are interested in providing the fertility preservation-type services, that's something they wouldn't be able to do outside of the demonstration arrangement. So that could also be a way to kind of incentivize greater access because beneficiaries may be more comfortable doing that if they don't have to pay for those services themselves.

Again, the standardization I think may be attractive in that, and the fact that CMS is supposed to help track the outcomes is another thing that might be attractive to them, because states may be reluctant, may not have the administrative capacity to actually do the outcomes tracking themselves. To the extent that CMS is

providing that assistance, that may be more attractive than manufacturers to know that. That's not necessarily a barrier for a state to create their own arrangement.

CHAIR BELLA: Thank you.

Other comments or questions from Commissioners?

[No response.]

CHAIR BELLA: Well, it sounds like the issue brief is a great path right now, but I think we do want to keep an eye on things, particularly as some of the CMMI models roll out. Sickle cell is obviously hugely important to Medicaid, as are some of the other cell and gene therapies that are going to be coming. So I would say we'll do the issue brief, keep an eye out for new things that might bring you back on this topic, but thank you very much for the work and for putting the roundtable together.

All right. Bob, it's all you.

VICE CHAIR DUNCAN: Thank you, Melanie. This is a session I'm extremely excited about and appreciated the work that Linn and Ava have put into this. They come to us today talking to us about children with special health care needs and their transition into adulthood and reaching the services that they need, and so I look forward to hearing

from this distinguished group on what they have found and where we go from here.

So with that, Linn, I'll turn it over to you.

TRANSITIONS OF COVERAGE AND CARE FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

* MS. WILLIAMS: Thank you and good afternoon, Commissioners. Today Linn and I will be introducing our work on children and youth with special health care needs, transitions of coverage and care.

I will start by giving background on children and youth with special health care needs and how they are served in Medicaid. I will then move on to explain transitions of coverage and care, and finally, I will begin our conversation on our findings from our federal and state policy scan by presenting the federal requirements. Then I will turn things over to Linn to discuss the federal, the state policy scan findings and literature review findings before they discuss the next steps for this work.

The children with special health care needs population includes a wide range of health conditions, and the most commonly used definition is by the Maternal and Child Health Bureau. This definition is intentionally

broad and is inclusive of children who are at an increased risk of physical, mental, behavioral, developmental conditions and require health and health-related services that go beyond what is generally required.

However, state Medicaid agencies may establish their own definitions of children and youth with special health care needs and may define them more narrowly to focus on subpopulations that are specific to disability eligibility pathways.

Almost one in five children have special health care needs, and one in three have multiple conditions. Almost half of children and youth with special health care needs are covered by Medicaid or a combination of Medicaid and private insurance. The majority of these individuals are covered by Medicaid on the basis of income under a supplemental security income pathway or state optional disability pathway including Katie Beckett. The Katie Beckett pathway -- the Katie Beckett eligibility pathway gives states the flexibility to serve children with disabilities whose families' income would ordinarily be too high to qualify for Medicaid and allows these children to be served in their homes.

Historically, the majority of children and youth with special health care needs covered by Medicaid were covered under the fee-for-service model of care, but it's becoming more common for this population to be enrolled in Medicaid managed care, and in some states these individuals can receive services through a specialty Medicaid managed care plan that is designed specifically for children and youth with special health care needs.

Finally, Title V agencies also provide services to Medicaid-covered children and youth with special health care needs. State Title V agencies receive Title V block grants from HRSA's Maternal and Child Health Bureau, and states are required to use at least 30 percent of the block grant funds to provide and improve services for children and youth with special health care needs.

Additionally, state Medicaid and Title V agencies are required to have an inter-agency agreement that outlines coordination efforts for children and youth with special health care needs.

As children and youth with special health care needs reach the age limit of child eligibility pathways and transition to adulthood, they need to transition to adult

insurance coverage and adult care. When this population ages out of child Medicaid eligibility pathways and child-specific waivers, they need to transition to adult Medicaid eligibility pathways or waivers if they are eligible. Some will transition to private insurance, and some may -- others may lose coverage. Additionally, some may experience gaps in coverage when transitioning.

Most youth age out of child Medicaid eligibility pathways between the ages of 18 and 22, but some child-specific waivers may have more restrictive age ranges. When these individuals transition to adult eligibility pathways or waiver, they may experience a change in benefits they receive. For example, youth over the age 21 will no longer be eligible for services under the early and periodic screening, diagnostic, and treatment benefit. Additionally, the benefits provided under a child-specific waiver may differ from benefits provided under adult waiver.

Similarly, as these youth reach adulthood, they need to transition from pediatric to adult health care and providers through a process referred to as a health care transition. A health care transition is a multi-step

process that often begins several years prior to the child aging out of pediatric care and is meant to prepare the child and their caretakers for the adult health care system. This process involves the child, their family and caretakers, as well as both pediatric and adult providers.

There are several health care transition approaches developed by advocacy groups and professional organizations. However, there is no standard approach and little agreement among researchers on which approach to use. For this section, we will present the findings from the federal and state policy scan.

The goal of the federal and state policy scan was to identify federal and state coverage and care transition policies and to understand how Medicaid agencies, managed care organization contracts, and Title V agencies define and identify children and youth with special health care needs and support this population through their pediatric to adult transitions of coverage and care.

We accomplished this by using an intentionally broad definition of children and youth with special health care needs to be inclusive of all state Medicaid waiver and Medicaid managed care definitions as well as Title V

documentation. Our federal scan included a review of federal statutes and regulations related to transitions of coverage and care processes for Medicaid and Title V.

Our state policy scan examined a subset of state Medicaid program and demonstration waivers, including 1915(c), Katie Beckett, and 1115 demonstration waivers.

We also examined MCO contracts, including contracts specialized on children and youth with special health care needs, as well as all 50 states and the District of Columbia's Title V IAAs.

The federal policy scan did not identify a federal Medicaid definition of children and youth with special health care needs or federal Medicaid requirements for transitions for coverage and care policies for this population. The Centers for Medicare and Medicaid Services has provided states with some guidance related to transitions. For example, CMS issued guidance on ensuring that eligible children maintain Medicaid and CHIP coverage during the unwinding of the COVID-19 public health emergency, and this guidance included steps for identifying children and youth with special health care needs based on disability eligibility pathways, receipt of specialized

high-risk care, and claims and encounter data.

Additionally, existing federal managed care regulations require states to identify, assess, produce a treatment plan, and provide direct access to specialists for individuals with special health care needs. However, there are no requirements specific to children and youth with special health care needs, care transitions.

Finally, Title V does not have any requirements for transitions of coverage and care for children and youth with special health care needs.

* MX. JENNINGS: Thanks, Ava.

So, I'll continue with presenting our state findings.

For the definitions and identification processes for children and youth with special health care needs, there's variability across state Medicaid programs and MCO contracts. For state Medicaid programs, they can define children and youth with special health care needs based on specific eligibility pathways, waiver authorities, and state plan options, and may tailor certain programs for specific subpopulations. So the definitions of children and youth with special health care needs served in a state

or across states may vary.

For MCOs, there's no requirement for managed care plans to use a specific definition or to identify children and youth with special health care needs in need of a transition from pediatric to adult care. So the definition and process for this identification also varies.

The majority of these identification and notification processes are initiated by state Medicaid agencies and other state agencies such as partner agencies serving adults with special health care needs or state-assigned case managers.

State child Medicaid waivers vary substantially in the time frames between when states identify an individual approaching transition age and when they actually age out of child coverage. And so the time frame specified in the reviewed waivers range from eight years to 60 days prior to the child being ineligible for the child waiver program.

Five MCO contracts, of which two are specialty MCO contracts, included provisions requiring transitions of coverage assistance, and this assistance included assigning a care coordinator or case manager to facilitate

coordination with the health insurance exchange, state Medicaid program, or other private coverage options.

The findings from the scan of state waivers and MCO contracts did not identify any requirements for monitoring or oversight of the coverage transition process.

As Ava said, there are no federal Medicaid requirements for the transition of care process, and although there are professional organizations that have developed recommendations for the transition process, there aren't nationally recognized standards. Given this, our scan identified wide variation in state Medicaid and MCO transition of care policies.

So, for example, some waivers include language related to the development of a transition plan, which may include a continuity of care plan identifying adult health care providers and establishing a timeline for transition. In addition, some states require activities that complement and support the transition plan, such as assigning a service coordinator who is responsible for taking steps to ensure continuity of care.

A few MCO contracts include provisions that address transition processes, some of which align with

these professional organization recommendations, including the American Academy of Pediatrics.

Additionally, a few MCO contracts specify the role of a transition and benefits coordinator and the development of a transition plan for the beneficiary, and one MCO contract permits the beneficiary to receive care from both a pediatrician and an adult provider at the same time, which can help facilitate this transition.

Regarding the monitoring and oversight, findings from the state waiver scan did not identify requirements for monitoring and oversight of transitions from child to adult care. A few MCO contracts did include some requirements related to monitoring transitions. For example, one state Medicaid agency requires the MCO contract to designate a transition specialist to the coordination team, and their role is to monitor the effectiveness of the transition plan.

Regarding the roles and responsibilities of the state Medicaid and Title V agencies, in the review of IAAs, we found few that specify Title V and Medicaid agency responsibilities related to the health care transition. There were a few examples, one where the main Title V and

Medicaid agencies agreed to create messaging focused on continuity of care for transitioning populations, which included children and youth with special health care needs transitioning from pediatric to adult care.

And now moving on to our findings from the literature review, research indicates that in recent years, more than 90 percent of children with chronic medical conditions and special health care needs age to adulthood, and over 750,000 transition to adult health care each year.

Research also indicates that transition outcomes, such as quality of life, increased adult visit attendance, and treatment adherence for this population are improved when they receive structured health care transitions. However, studies indicate that children and youth with special health care needs and their families often receive little to no assistance during this process.

There are also many factors that contribute to the barriers that children and youth with special health care needs and their providers experience. For children and youth with special health care needs and their caregivers, there are barriers due to receiving inadequate transition preparation, lack of care coordination and

support during the transition, limited provider availability for individuals with pediatric onset conditions, and the distance required to travel to their providers.

For pediatric and adult providers, there are barriers due to limited coordination and communication between providers during the transition and difficulties with billing for transition services.

So the findings from this first phase of work indicate that there is variation in state coverage and care transition policies, and that children and youth with special health care needs experience barriers to transitioning to adult coverage and care.

The next phase of work will focus on understanding how state care transition policies work in practice, the roles and responsibilities of state Medicaid programs, MCOs, and Title V agencies, the responsibilities in supporting beneficiaries' transitions, and Medicaid-specific barriers to transitioning to adult care. And with our contractor for this phase of work, we will conduct stakeholder interviews and beneficiary focus groups, and based on preliminary interviews with experts and findings

from the state policy scan, the findings indicated that for the next phase of work, narrowing the population scope to children with more complex conditions and service needs would be helpful for establishing a more consistent definition across states and for assessing comparability of transition policies across states.

So for this work, we'll narrow our population focus to children and youth with special health care needs who are covered by Medicaid under SSI-related eligibility pathways and those eligible under Katie Beckett.

Additionally, this work will focus specifically on transitions of care, and future work will focus on transitions of coverage.

During the next reporting cycle, we'll return to present findings from the interviews and focus groups and publish findings from both phases of work in a chapter. At this meeting, we'd appreciate feedback on the direction of this work and specifically on the findings presented today and considerations for the upcoming work.

VICE CHAIR DUNCAN: Thank you, Linn, and thank you, Ava. Appreciate the insights to what you found to date.

Now I open it up to questions and comments from Commissioners.

Angelo.

COMMISSIONER GIARDINO: First, let me say thank you so much for bringing this issue forward. There's so much I want to say, but I'll limit my comments to some of the policy issues.

You've mentioned that there's no standard, and that's certainly true, although -- and you mentioned this earlier -- the Got Transition, which was called the National Center for Health Care Transition, does have that six-level model. So, I think that's the closest to a standard.

And as you think about stakeholders, the one that I think has a ton of information that could be really helpful to us is it's called the Policy Lab at the Children's Hospital of Philadelphia, and they talk about the cliff. And the cliff is when someone on Medicaid who has a special health care need turns 21, then they fall off the cliff benefit-wise. And it's really around the benefits. The transition happens because time marches on, and it either happens, as you said, in a planned way or not

planned way. What is clear from the health care literature is that when a transition happens in an unplanned way, it's disastrous for the health care issues that the person is confronting.

And then the only other thing I would just ask you to think about is in my clinical work, there's a real difference between health care transition for individuals with intellectual disabilities and those that have more of like a chronic illness. The opportunities for them in that transition are much different.

The adult system is much more capable of taking care of someone who has diabetes and becomes an adult than someone who has a level of intellectual disability. The adult system just might not be set up for that, so if you could help us understand that.

Then what my provider friends tell me is, again, if you follow the Got Transition, some of the things that happen are not traditional services. For example, an ideal transition happens when the pediatrician can talk to the internal medicine or family medicine person. But that bill -- you know, I don't even think there's a code for that.

And then six months after the child who's now an

adult and is seeing the adult provider, it would be ideal if six months into that, the adult physician could have a consultation with the pediatric physician and just confirm that everything is being taken care of. But again, there's no code for that. So, all that's done in a voluntary way, and that just starts to get in the way. So, from a policy perspective, I think Got Transition has a whole set of suggested infrastructures that we could do that would allow us to have this ideal transition.

So, I'll stop, but I'm just thrilled that you're looking at this. And this could have an enormous impact on these folks, because, again, from the policy lab, this cliff is disastrous. The person has a health care problem, and then it just goes into this Neverland for 7, 8, 10, 12 months until the transition really kind of takes place. And a lot can happen if you have a health care problem in a year or two. So, thank you.

VICE CHAIR DUNCAN: Thank you, Angelo.

Tricia?

COMMISSIONER BROOKS: Yes. Thank you for this work. Even though I know quite a bit about eligibility, I don't fully understand where we do or don't map to some

kind of ongoing coverage for kids who are aging out of Medicaid pathways, and I think that's worth having more information on, because one of the recommendations can be to establish additional eligibility pathways to ensure that that cliff doesn't happen. So that's one area I'd be interested in.

The second area is -- I think this is really a body of work that is ripe for some panels, and I think about them broadly from people, you know, with Medicaid experience or Title V. I think about the Catalyst Center at Boston University, providers who work in this environment. It's just you can do a lot of reading, and we can hear the presentations, but as you well know, we love panels, and we love hearing from people directly. And I do think that having some panels in the future would be helpful. Thank you.

VICE CHAIR DUNCAN: Thank you, Tricia.

John.

COMMISSIONER McCARTHY: I guess this is one of those areas where, in my opinion, we do need some more work. So, I think Angelo and Tricia brought up two areas that just confused me after they talked about it. What

Tricia was talking about, is this an eligibility issue or is it not an eligibility issue? So that's number one. In what states is it an eligibility issue? What's not? So that's getting a better understanding of that.

Same thing on the cliff side. I understand that better. The cliff side is a little bit -- I can understand it better. But if you could find within the work of what are those cliffs, I think that's one of the things that I never understood until you started digging into it, where you started seeing some of these things, just so we'd have some of like real-world examples of here's where these cliffs are, when it comes to what benefits you get, and why is it there? I mean, I know for a fact, some of it's just waiting lists for waivers. That could be it. But it's like having those real-world examples.

The last one is on access. You mentioned this a little bit. But where I've seen it, the biggest issue -- and Angelo hit on this too -- is on the transitions. You've been seeing a pediatrician all your life. There's often just not a lot of doctors who specialize in services or specialize in serving individuals with these needs. So, they stay with their pediatrician.

I know with me, the Children's Ohio is lucky enough to have a lot of Children's Hospitals, way more than other states. Those are huge advantages when it came to serving individuals, because many of them will just continue to be served later on into their lives, the people that do it. But that's not the case in many places.

So, if you get hit on some of that too, like when you say there's a barrier, you know, give us examples of where those are. And it probably could come out from some of the panels.

And last, I want to go back to what Angelo said. I had not heard about the transition. What's it called, Angelo?

COMMISSIONER GIARDINO: Got Transition.

COMMISSIONER McCARTHY: Got Transition.

So, looking at some of those things. You know, I am not a big fan of fee-for-service. And Angelo is right. There's not a code for that. I have a hard time even saying this, but it's like, yes, those are the things we probably have to look at. How do we pay for these services? Maybe it's a code; maybe not. But if you look at that and they have already looked at these things, what

can we as a Commission look at to be able to make recommendations on of saying, hey, this is -- we need to pay -- those services need to happen, and we know that payment makes some of those services happen? So, if we could look at some of those -- and somebody who's already done most.

It's not like that -- I don't want to say like you have no work to do, but there's -- they've already looked at a lot of these things. We don't have to make it up from scratch.

VICE CHAIR DUNCAN: All right. Carolyn, then Patti.

COMMISSIONER INGRAM: I think, to John's point, not just is eligibility important, but language is important. And in the writing, we keep talking about different types of waivers, TEFRA or T-E-F-R-A waiver, Katie Beckett authorities. I think we need to clarify what types of waivers and programs we're talking about. In some states, they don't even use the term "Katie Beckett," and I don't think that's a federally -- I don't think that's a federal authority under the term.

So when I was looking at the writing and

everything you presented here, I'm thinking of the different home- and community-based waivers that could be used for providing care to these members -- 1115 waivers, home- and community-based 1915(C) waivers, those types of things, frankly even, you know, managed care waivers. So I wonder if we need to define that a little bit better maybe.

And then I know there are some states that still refer to Katie Beckett waivers, but there's a lot of states that don't use that term, and it's not a federal authority. So I would say we be more clear in our writing about what we're actually referring to, maybe not use terms that are -- throughout. Maybe say some states refer to them as that but not use it throughout. Thanks.

VICE CHAIR DUNCAN: Thank you, Carolyn.

Patti.

COMMISSIONER KILLINGSWORTH: So I keep up. This topic is pretty near and dear to my heart.

First, on the definition, I agree with Carolyn that maybe some refinements could be helpful. I think what we're talking about primarily is kids who meet SSI eligibility requirements, notwithstanding the financial requirements of sort of setting those aside. We're really

talking about, do they meet the disability requirements, potentially adding in children who would meet an institutional level of care in a state, which could be different from the SSI eligibility requirements. So I think there's a way to get there.

I do worry about sort of linking it to particular types of waivers or even Katie Beckett. Coming from a state where we had had waiver programs in place for literally decades, that enrolled children under Katie Beckett eligibility standards but sitting in legislative hearings and explaining over and over again that yes, we did have a Katie Beckett waiver, because we were using the Katie Beckett eligibility mechanism, we just didn't call it that and still ending up with a brand-new program called Katie Beckett, because I couldn't convince them that we did that thing that they were trying to create. So I do think we just have to be crystal-clear about that.

I do think it's important that we look at transitions of coverage because eligibility is real, and for that population of kids who may qualify based on family income and then they turn 19, just making sure that those transitions are seamless for them and then also transitions

of benefits, sort of what happens when you go from EPSDT to an adult benefit and then transitions of care as it relates to providers.

So there's sort of three buckets of all of that, and I think following into that, kind of at the end of that, there's a real capacity issue, as has been talked about, in the adult system to meet the needs of some of these individuals as they become adults.

I do think sometimes that hits the medical world more frequently. It hits people who are in the IDD community, who may also, by the way, have very complex medical challenges, but physicians who are not sort of trained or comfortable with the broader challenges that go along with the intellectual disability, and so there's just real significant access issues for the IDD community. And a part of what we really have to address is how to build the capacity of the system to really serve those individuals well as adults.

As we think about groups that we could talk with that might lend expertise there, certainly NASDDDs, the National Association of State DD Directors, I think could talk about their experiences in serving this population

through transition, and then, of course, the Institute for Exceptional Care, I think is another.

And then the other thing I'll mention sort of -- and I think this is a separate body of work that we're already involved in, but there's overlap here, and that is kids in foster care. Talk about falling off a cliff. They really fall off of a cliff, and so there are some things kind of in place, at least from an eligibility perspective for them, but there's just a whole lot of opportunity there to really think about their transitions as well.

VICE CHAIR DUNCAN: Thank you, Patti.

Angelo, then Heidi.

COMMISSIONER GIARDINO: Just two other things to mention. This is an issue that I'm really passionate about, so sorry.

The health care transition work is really seen as a process, clinically. So the best practice is to start it at age 12 and to start talking to the child and family and essentially giving them assignments and having follow-up visits.

As we look at what infrastructure we need, we need to think about -- and again, John, not a code, but

there is a service that needs to be delivered in the health care setting, starting around 12, getting the person ready for 18 or 19. We have to make sure that that kind of work would be covered, and that's where the health care transition specialist comes in. But they have to be part of the team, so if you could just see what the clients or the patients say about that.

And then if I could just implore you to also, if you have panels, folks that deal with autism and autism spectrum disorders have some very unique issues around health care transition, and if we could make sure that we pay attention to that group, that would be really helpful. Thank you.

VICE CHAIR DUNCAN: Thank you, Angelo.

Heidi.

COMMISSIONER ALLEN: As I was reading this, I was just so struck about the stress that it must cause parent caregivers who are supporting a kid with really significant health care needs at home, as the kid is getting older, getting ready to age out of education services, so more time at home, less support in helping the kid's intellectual growth and development. Then to face these

massive transitions, also at a time where parents are maybe caring for their own parents, it's just like it seems like such an incredibly stressful time on the whole family.

I noticed that there were no beneficiaries or caregivers listed as stakeholders that the consultant group is planning on talking to, at least it wasn't in the materials.

MX. JENNINGS: So we will also be conducting focus groups with beneficiaries, and we'll have --

COMMISSIONER ALLEN: Oh, great.

MX. JENNINGS: -- both sessions that are focused on those -- or focus group sessions focused on individuals who haven't transitioned and those who have recently transitioned to kind of cover that full process.

COMMISSIONER ALLEN: Oh, amazing. Oh, that's so wonderful. I'm sorry, I missed that.

MX. JENNINGS: No, that's all right.

COMMISSIONER ALLEN: Thank you. I really do want to hear from families on how they're navigating this and especially because it seems from the materials like the evidence is that they kind of fall off. So this might be an area where we could really learn a lot. Thank you.

VICE CHAIR DUNCAN: Thanks, Heidi.

Carolyn, then Sonja.

COMMISSIONER INGRAM: One more thing that occurred to me after I was listening to Angelo and to Patty, we talked about children who are in state custody and that pathway. A lot of mental health services are provided to children with special health care needs, both in state custody and those that are not, and I wanted to make sure that whatever work we're doing, we pull in those aspects, especially kids who are now growing up after the effects of COVID and what that has done to mental health stability, especially kids also dealing with results of things around gun violence and things that are affecting our youth populations.

The other area that I've seen special -- that we need to pay special attention to, especially Native American populations who are going through some of these transitions in terms of what access they have to services and where they're able to get care, because it does tend to affect those populations a little bit differently just because of the -- sometimes the custody issues related back to Tribal law and where they're able to access care and how

we actually get services and access to care out to folks who are still living in Tribal communities and don't have those services. So I just wanted to add that to your list, not that you don't have enough to do, but --

VICE CHAIR DUNCAN: Thanks, Carolyn.

Sonja, then Dennis.

COMMISSIONER BJORK: Thank you. I'm hoping that some of the stakeholders that we work with can speak to the special challenges of rural families and individuals.

In California, there's a couple agencies that specifically work with those families. One is called Rowell Family Empowerment, and then another is Disability Action Center. They really work hard with the families to set up services where there might not be an abundance of services and navigate that transition from childhood to adulthood. Thanks.

VICE CHAIR DUNCAN: Thanks, Sonja.

Dennis.

COMMISSIONER HEAPHY: Thanks. I think another group to talk with would be the Federation for Children, the National Federation for Children, but I'd love to hear from the folks in the schools that work with folks fully

with medically complex needs. They work with these youth from the time they're 12, whatever on, they're providing physical therapy, occupational therapy, doing all these services? They're also going disappear when the person turns 22, and unless they have a really strong IEP, individualized education plan, once a person transitions out of school, there may be nothing there waiting for them. So it's not just about the medical providers willing to take these folks. It's also just the services themselves and how robust those services are. It can be dependent on what kind of services they're getting in the schools, things like that.

So I would just love to hear from schools. I know they're not part of Medicaid, but they work with folks who are on Medicaid and will need Medicaid when they leave.

VICE CHAIR DUNCAN: Thank you, Dennis.

Anyone else?

[No response.]

VICE CHAIR DUNCAN: If not, I'll weigh in. As I said, this is extremely important to me. How do you ask about hearing from a parent?

I'm a parent who had to navigate this, having two

children with special health care needs. One fell off the cliff, and one we've tried to navigate. But the trauma that she endured in navigating because -- John, you highlighted and Patti yourself -- about the capacity or the access to care, and having some of these diseases, I think we've got to look past the age and think of them as a pediatric disease. And so as they transition, that ability to have that expert that can deal with them and has known their lifespan, whether it's having somebody starting at 12 with that care coordination.

But, Sonja, to your point, growing up in rural West Tennessee and then moving to Wisconsin, the variation that you highlighted in the report of the state is very, very different in having that access. And so creating some consistency, particularly as these kids and adults transition or go across state lines -- because if you're looking for some of the subspecialty care that these now adults need, they may not find it in their community or in their state. So how do they access that part?

But I think this work is extremely important. I hope to have others not avoid the frustration and the trauma that my kids, now adults, experienced in the

process. And I think we have a lot of work ahead of us that we can do and bring some standardization and consistency to the process.

So I think this work is amazing, so thank you.

Yes, Heidi.

COMMISSIONER ALLEN: I just wanted to ask a question because I don't know that I fully understand. If when a kid with very significant health care needs who's eligible through like an SSI pathway or Katie Beckett pathway, when they become an adult, do they then get detached from the parent's income? And then is it their income that determines? So if they don't have any income, then do they still stay on Medicaid, and they're just in a different program?

MX. JENNINGS: This is something that we can kind of -- we'll continue to look into as we cover really the transitions of coverage piece. But my understanding, it becomes their income, but they could end up in a lot of different pathways, kind of dependent, or there isn't always kind of like a direct into a specific pathway on the adult coverage.

And I think it's waiver dependent. Like in our

waiver review, we found there was one state that had like an automatic process, but for the most part, it's kind of manually moving them between eligibility pathways.

COMMISSIONER ALLEN: A follow-up question, then. Do the parents then have to give up guardianship legally in order for the child to be considered independent, or are they able to continue to be a legal guardian?

MX. JENNINGS: I'll have to follow up on that, but that's a great question.

CHAIR BELLA: Patti.

COMMISSIONER KILLINGSWORTH: So if I can weigh in just a little bit here, I mean, the value of the way that Katie Beckett is structured because it's based on SSI eligibility criteria, you're literally talking about a group of children, slash, becoming adults who qualify for SSI, but for their parents' income. So once they become an adult, they typically can move from Katie Beckett, whatever Katie Beckett mechanism they're under, into sort of true SSI eligibility, but that's a process, and it's a complicated process. And so helping navigate what is a really critical coverage transition I think can be very, very important.

In terms of guardianship, you can still be -- as a parent, we could have a whole other discussion about this, because I do think the advice is typically be the guardian. And we need to think about how we preserve people's legal rights to be independent where they can be.

But beyond that, sort of technically speaking, you can still be an adult, if you will, from an eligibility perspective and have a legal representative or guardian who advocates on your behalf.

COMMISSIONER HEAPHY: As you're moving forward and collecting the data, that we look at racial and ethnic composition and who's getting which services and who's not.

VICE CHAIR DUNCAN: Thank you, Dennis.

Linn and Ava, I'd also recommend if we do a panel, talking with someone from the Children's Hospital Association. As I mentioned, our pediatric hospitals deal with this on a regular basis. Some areas, as Angelo pointed out, Children's Hospital of Philadelphia have some policy work and things going well, but in other areas, it is a struggle. And so I think you could get some insight there.

Anyone else?

[No response.]

VICE CHAIR DUNCAN: Linn, Ava, did we give you some definitions? I know the question was asked about narrowing the population down. I think you heard from Carolyn and Patti, the Katie Beckett piece kind of confusion, but sticking with the SSI qualification type.

MX. JENNINGS: Yeah, it was very helpful, and thank you for all of your considerations as we kind of continue to move into our second phase of this work. So thank you very much.

VICE CHAIR DUNCAN: Thank you. We look forward to it, and as you can tell, not only I'm passionate about it, but there's several around this table passionate, so truly appreciate it. Thank you very much.

Madam Chairwoman?

CHAIR BELLA: Great session to end the day on and obviously quite a bit that we can do here. So I echo Bob's thanks.

We will turn it open to public comment now, and I'll say the same boring spiel. If you'd like to make a comment, please raise your hand. Introduce yourself and the organization you represent, and we ask that you keep

your comments to three minutes or less, please. We'll open that up now.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Okay. It does not appear that we have any commenters this afternoon. Any last thoughts, questions, reflections from Commissioners?

[No response.]

CHAIR BELLA: Are you all worn out? We've had an active set of discussions today. Thank you very much.

Kate, any comments?

[No response.]

CHAIR BELLA: All right. So we will reconvene tomorrow morning at ten o'clock, and we will start with the Medicare Savings Program. So thank you very much. We are adjourned for today.

* [Whereupon, at 3:43 p.m., the meeting was recessed, to reconvene on Friday, March 8, 2024, at 10:00 a.m.]

PUBLIC SESSION

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

Friday, March 7, 2024
10:00 a.m.

COMMISSIONERS PRESENT:

MELANIE BELLA, MBA, Chair
ROBERT DUNCAN, MBA, Vice Chair
HEIDI L. ALLEN, PHD, MSW
SONJA L. BJORK, JD
TRICIA BROOKS, MBA
JENNIFER L. GERSTORFF, FSA, MAAA
ANGELO P. GIARDINO, MD, PHD, MPH
DENNIS HEAPHY, MPH, MED, MDIV
TIMOTHY HILL, MPA
CAROLYN INGRAM, MBA
VERLON JOHNSON, MPA
PATTI KILLINGSWORTH
JOHN B. McCARTHY, MPA
ADRIENNE McFADDEN, MD, JD
RHONDA M. MEDOWS, MD
JAMI SNYDER, MA
KATHY WENO, DDS, JD

KATHERINE MASSEY, MPA, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[10:00 a.m.]

CHAIR BELLA: Good morning. Welcome to Day 2 of our March meeting. We are going to start off with a chapter on MSPs, the Medicare Savings Program, and Kirstin is going to update us on that work and let us know of a few additions.

Welcome, Kirstin.

MEDICARE SAVINGS PROGRAMS (MSPs): ENROLLMENT TRENDS

* MS. BLOM: Thanks, Melanie.

Good morning, everyone. I'm here to review our draft chapter on enrollment in the Medicare Savings Programs, which is going to be included in our June 2024 report to Congress.

So, in this presentation, I'm going to walk through the sections of the chapter laid out on this slide, starting with a little bit of background on the four MSPs and then moving to a review of our prior work, estimating participation rates, which is relevant for where we're heading in this chapter. Next, I'll discuss federal and state efforts over the years to increase enrollment in the

MSPs, which will lead into our new analysis of enrollment trends. We're providing an up-to-date look at MSP enrollment from calendar years 2010 to 2021. Then we'll wrap up by walking through our next steps for the chapter itself.

I'm going to go through this background pretty quickly because you're all familiar with this information at this point.

There are four types of MSPs, as you'll remember. These are mandatory Medicaid eligibility pathways. The original MSP, the qualified Medicare beneficiary group, is the most expansive in terms of enrollment and benefits and was the first to be enacted. We're going to be focusing on that particular MSP group throughout this chapter.

Eligibility criteria and benefits vary across each of the MSP groups, as you can see on this slide. This slide also shows some of the complexity around the structure of these different groups. To some extent, each MSP kind of builds on the last one by covering people with incomes at slightly higher shares of the federal poverty level.

The first two groups listed here, the QMB and

SLMB groups both have two subgroups for people who are determined to be either full benefit, which is the "plus" groups, or partial benefit duals, which are the "only" groups.

This slide also shows the federal standards for income levels and asset limits, but states have flexibility under Section 1902(r)(2) to choose more generous levels. States choosing to do that might need to submit a state plan amendment to CMS for approval.

For context in the chapter, we're including a broader discussion of our prior work estimating participation rates. The 2017 study that we did under contract with the Urban Institute has been frequently cited in discussions of the MSPs, including by CMS most recently in the eligibility and enrollment rule, in part, because our study estimates participation in each of the MSPs rather than a combined rate across them, as some other studies have done, and also because it's the most recent, one of the most recent studies of its kind.

So to explain the prior analysis, I'm going to go through the methodology in the chapter, which involved linking administrative data from MSIS for 2010 with survey

data from the 2008 panel of the Survey of Income and Program Participation, or SIPP. That's how we got at both MSP enrollment with MSIS and the eligible but not enrolled populations using the survey data.

As a reminder, we found relatively low participation rates of about -- of just over 50 percent in the QMB program and just over 30 percent in the SLMB program, and it's important to note that these results are best interpreted as representing the latter parts of calendar years 2009 and 2010. So although the study was published in 2017, the findings are from an earlier time period.

In addition to analyzing participation rates, we also collected information on the characteristics of the MSP eligible but not enrolled populations, trying to understand that group a little bit better. We found that they were more likely to be age 65 or older, white, non-Hispanic, to report excellent or very good health, and were less likely to have limitations in activities of daily living. Also, about 45 percent of adults in the QMB group were also enrolled in other public programs such as SNAP.

Because our study found relatively low rates of

participation in the MSPs, it ultimately led the Commission to make a recommendation in our June 2020 report that CMS amend -- that Congress amend Section 1902(r)(2) to require that states more closely align their eligibility processes with those of the Social Security Administration for purposes -- that the Social Security Administration uses for purposes of the Medicare Part D Low-Income Subsidy program, or LIS.

Over the years, as we've discussed, the federal government and states have been working on increasing enrollment in the MSPs. There's an eligibility linkage between the MSPs and the LIS program, whereby anyone eligible for the MSPs is automatically eligible for LIS. LIS is a similar program, as you guys know, that provides a similar benefit, which is coverage of the Part D premium for low-income Medicare beneficiaries. For that reason, a primary focus of increasing enrollment in the MSPs has been on aligning state eligibility processes with those of the SSA for the LIS program.

CMS has been pretty focused on efforts to do this across these two programs, releasing guidance over the years in the form of state Medicaid director letters and

other types of guidance, but made its most kind of comprehensive efforts to date in their recent rulemaking.

In September of 2023, CMS finalized the first part of the eligibility and enrollment rule, which was released actually in the prior year. The first part of it addresses the Medicare Savings Program. That rulemaking codifies existing CMS guidance and encourages states to make changes to better align their MSP eligibility processes with the Social Security Administration. This includes things like requiring states to accept self-attestation from beneficiaries in areas where states choose not to align. The rule is very comprehensive, and so states have until April 1, 2026, to come into compliance with most of the provisions.

States have also been working to increase enrollment in these programs, including by expanding eligibility through higher income thresholds or asset thresholds or by eliminating assets altogether. As of 2024, 12 states have eliminated the asset test.

In addition, states have been working to streamline their programs. That's both through aligning eligibility processes with those of LIS to make enrollment

easier across the two programs. And a couple of states -- the District of Columbia and New York -- have innovated by doing things like combining the QMB and SLMB programs to reduce confusion for beneficiaries.

But our chapter's main focus is going to be on our new analysis of MSP enrollment trends which, as I said, covers calendar years 2010 to 2021, and which we walked through in some detail at the January meeting. One thing that is new this time around is a comparison of enrollment patterns among QMB enrollees by selected demographic characteristics.

So I just wanted to start with a little bit of the rationale about this analysis or behind our analysis. So we're focusing on enrollment trends, which is definitely different from our prior work estimating participation rates. Our participation study, as I mentioned, is frequently cited, but those findings are a bit dated. And because of the challenges we faced in collecting the data to do that work, we are not able to easily update that.

In order to contribute to the conversation that's been renewed by the CMS final rule, we decided, instead, to look at readily available monthly enrollment data going

back to calendar year 2010, which is sort of, more or less, where we left off in the participation study.

This required just the use of administrative data, and we were able to establish enrollment trends for each of the MSPs and then able to compare patterns across them. We also are adding in this piece about demographic characteristics, which is new over what you saw last time.

A couple of quick caveats. So our analysis of enrollment trends is not trying to draw broader comparisons to trends in the overall dual population, but we are going through our external review process right now where we have stakeholders, experts look at our chapter draft and provide us feedback. And we are hearing from them that some comparisons, in particular, to Medicare enrollment trends would be useful, as helpful context for understanding what we're seeing in the MSP enrollment group.

So just to reassure, we take that external review very seriously, and we are incorporating, planning to add in a table or two on Medicare enrollment as a way of kind of benchmarking what we're seeing on the MSP side.

Just in terms of methodology, we're using the MBSF data, looking at all MSPs except for QDWI where

enrollment is too small to report.

So I shared this enrollment table and the ones on the next couple of slides last time, so I'm going to breeze through these, but just at a high level as a reminder, they are depicting enrollment across all the MSPs, which is that top line, and then the individual breakouts below that.

Enrollment has grown pretty steadily over the years that we looked at, with about 10 million duals enrolled by the end of this window in 2021, and that's out of a total of about 12.8 million duals in that year.

Average annual growth, which you can see on this slide, is about 3 percent. Of course, that varies by individual MSP.

And this is not in your meeting materials, but as I just mentioned, we're going to add in a little bit of information about Medicare enrollment for comparison purposes. So average annual enrollment growth among all Medicare beneficiaries for a similar period of time, 2013 to 2022, was 2.6 percent relative to the 3 percent on this slide. But if we look only at Medicare beneficiaries who are age 65 or older, the rates are much more comparable, 3.2 percent among the older Medicare population compared to

the 3 percent on this slide.

So this table is just about the share of enrollment. The QMB plus eligibility group is kind of the main takeaway here, far and away the most utilized MSP with more than 60 percent of all enrollees in that group.

And this slide is just showing annual rates of growth across each of the MSPs.

Finally, this visual depiction of the levels of enrollment, which you saw on slide 16, there's a similar upward trend between the line for all MSPs, which is the top line, and the blue line below it, which is the QMB Plus program that has the most enrollees.

Okay. So now we're turning to the data on selected demographics for QMB Plus beneficiaries. As I said, we're focusing on this group because they have the majority -- it has the majority of the enrollees and is the most expansive of the four MSPs.

On this slide and the next couple, you'll see that we're breaking out this population by sex, age, and urban or rural residence, and you can see from the top line, the green line, that most enrollees are female, they represent about 60 percent of enrollment in 2021.

Analyzing QMB Plus enrollment by age, most enrollees are age 65 or older, illustrated by the top line or the dark blue line -- sorry. The lower line actually is not super visible, is it? The lower line is people under age 65. So the older group represents about 63 percent of the enrollment in 2021, with growth rates of about 3.4 percent, and that's, compared to the younger group, which is experiencing relatively flat growth, at about 1 percent.

I think the most interesting aspect of this slide, though -- and it's a little bit difficult to see because it's most prominent in that lighter line, but hopefully, it's a little bit more readable in your materials. The lighter line represents the younger group under age 65, and you can see that there's a zigzag pattern that kind of continues over the entire study period. It is there in both age groups but is more prominent in the younger group.

This line suggests that enrollees are losing coverage and regaining it on a regular basis, which could potentially be explained by a loss of coverage at a Medicaid redetermination.

Under current law, states are required, as you

guys know, to redetermine eligibility at least every 12 months for people such as duals whose eligibility is determined on a basis other than modified adjusted gross income, referred to as the non-MAGI population.

I do want to note that the second part of the eligibility and enrollment rule, which we're expecting to be finalized in the next few months, would limit renewals for non-MAGI groups to just once per 12 months, aligning the non-MAGI with the MAGI population.

There is evidence out there that duals lose coverage at redeterminations. One study that ASPE did found that almost 30 percent of new full-benefit duals lose Medicaid coverage for at least one month in the 12 months after they first become dually eligible. And then of the people losing coverage, nearly 30 percent had short breaks in coverage of like one to three months, which probably indicates an administrative reason for that break, such as a lack of familiarity with the renewal procedures.

While we can't determine precisely the reasons for this zigzag pattern -- that would require additional research -- these patterns probably indicate that younger duals could benefit from state adoption of automatic

renewal policies, such as use of pre-populated forms.

Finally, we looked at QMB Plus enrollees by urban and rural residence. You can clearly see that the vast majority of QMB Plus enrollees reside in urban areas. That's the dark blue line. Again, apologies on the coloring here.

Enrollees in urban areas represent about 85 percent of people, or about 5.4 million duals, in 2021. And then in the bottom line, which is a very flat line, that's about a million people, and as you can see, the growth rates are very different here. The urban population is growing at around 3 percent, compared to about 1 percent for rural enrollees.

So, to recap, this slide highlights a few takeaways from the earlier work, which we've already discussed, such as that the QMB-only group had the highest growth rates year over year, and you'll find all of this in your draft chapter. So I'm going to move to the demographics piece.

Based on our analysis, as we just walked through, most enrollees in the QMB Plus program are female, age 65 or older, and residents of urban areas. Perhaps the most

interesting piece is the age-based comparison where we saw that pattern that indicates a loss of coverage, a short loss of coverage among, in particular, the younger dually eligible population.

Okay. Turning to conclusions and next steps, our work shows that enrollment has increased over the study period across all of the MSPs in a fairly steady manner, average annual growth of about 3 percent over that time period, and has led to, over that time, the majority of duals ending up in an MSP. This data indicates that state and federal efforts have made a lot of progress since we last looked at this.

Okay. In terms of next steps, we are looking for feedback on the chapter in today's discussion. Happy to take comments today. We also are happy to take comments in written comments, you know, track changes. We're happy to send out a document for you guys to send back to us looking for any information that you think is missing or any comments on tone.

Following publication of this chapter in June, we're planning to continue monitoring state efforts to come into compliance with the final rule ahead of the April 1,

2026, deadline, including staying in touch with staff at the Medicare-Medicaid Coordination Office, hearing about state progress meeting these new guidelines, as well as continuing to explore further work in this area.

With that, I'll turn it back to Melanie. Thank you.

CHAIR BELLA: Thank you.

Can we go back to slide 21? Can we just talk about this one, one more time, what we do and what we can and cannot tell from this?

MS. BLOM: Yes. We can see these in the data at the end of the calendar year, and there's a clear drop in enrollment and then a clear increase at the start of the following calendar year. So while we don't -- we haven't done the work to figure out exactly what's going on here, I think it's safe to say that it does indicate some drop-offs that are then coming back.

Now, among the lower -- among the younger population, the line is relatively flat. So it's a little hard to know if that's just the same people coming off and coming back on or if it's resulting in like some people leaving and then not coming back and keeping that line so

flat.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: So are renewals aligned at the end of the year? I mean, generally, they're sort of spaced out.

MS. BLOM: Right. I'm not -- I don't know the answer to that. That's a good question. It is a little strange to me that you're seeing this clear bump at the end of the calendar year and then a clear uptick.

COMMISSIONER BROOKS: Interesting. Okay, great.

CHAIR BELLA: I don't know. I know we talked to ASPE. We can flag this with MMCO and with ASPE and with -- I know there's some researchers at Penn working on this. Maybe others can help us.

It does feel like if there are some procedural things that we can highlight for states, that feels like it would be an important contribution.

MS. BLOM: Right.

CHAIR BELLA: John and then Verlon and then Patti.

COMMISSIONER McCARTHY: I have two different questions in two different areas. So I'll ask the first

one, and then go to the second one.

So my first one is around this. Are we going to do any focus groups going forward? Because we're talking about enrollment in the program. One of the things that I have always thought about is, how do you market programs? And so a lot of other Medicaid programs don't call their programs "Medicaid." They've got interesting names for them and things like that.

This program, we always just call it QMB. It is the worst name, and people get confused. If we could do any focus groups with people who are either on the program or could qualify to find out if they know about it, do they not know about it, would that be a future work we could do to figure out access?

MS. BLOM: I mean, we can think about that for sure. I mean, focus groups are challenging to do, but we could definitely consider that and see who we could reach out to.

COMMISSIONER McCARTHY: And then the second question I had is kind of the why on this one, which I always have, which is -- so this is great that we've got more people enrolled, but then for our future work, our

next steps, can we look at does increased enrollment lead to better health outcomes? Is there any way we could look at states that have a higher percentage of their population enrolled? Do they get better health outcomes? And I know that's not like future work like next month, but like future work in the future to tie some of those things together.

MS. BLOM: Yeah, we can take that back. Especially, like a more targeted look at maybe like a handful of states would be more manageable for sure.

CHAIR BELLA: I also do think this is where we can tap the outside research community that's looking at some of these issues and ask them to try to put some of our interest in their heads too to look at some of this, because I do think there's been some work around lapses and sort of -- I feel like, John, it's been more of the when there's a lapse, what sort of increased utilization do you see as opposed to when you have something, what sort of positive health outcome do you see? And so it's a good question.

Anything else, John?

[No response.]

CHAIR BELLA: Verlon and then Patti.

COMMISSIONER JOHNSON: Yeah, just a question around the urban versus the rural. I mean, that was very striking to me as well and just curious around -- I mean, I think you mentioned about it could be more of a procedural admin issue there, but are there other indications that may show the difference? I know we talked a lot about -- before about the strides we've made because of all the outreach efforts around these programs. I'm not sure if that was perhaps leading to that or not.

MS. BLOM: Yeah, that's a good question. I don't know the answer to that. I think most people are located in urban areas, and I think that kind of is what we're seeing here. But digging in a little bit on what's going on in the rural population, that would be something we could think about for the future.

COMMISSIONER JOHNSON: All right. Thank you.

MS. BLOM: Thanks, Verlon.

CHAIR BELLA: Patti.

COMMISSIONER KILLINGSWORTH: Great work on this, and I think it's really important.

I still long for what's really hard to get, which

is getting back to those participation rates and really understanding sort of who we are leaving behind.

On this particular -- actually, if we go back to the other one, which is really more focused on age. Trying to figure out the story the data tells, context is so important. It's really hard to look at this and kind of understand the why.

I know from my own perspective in long-term services and supports, we always saw a dip in enrollment at the end of the year, and it was not related to people rolling off the program. We just stopped getting applications. In December, a lot of our LTSS applications really dropped down in that particular month, and it was year after year after year. And so it was just a natural trend that we came to expect in our data.

I don't know if it was driven by holidays or what it was, but it was every year. It may well be related to redetermination. I struggle a little bit with the notion of why is it in December if it's redetermination, because that's a year-long process. So I'd be interested to look at sort of enrollment trends more broadly and see if we see any parallel things and really just trying to understand

that a bit more.

MS. BLOM: Yeah. Unfortunately, I don't have more detail at this point, but we could definitely think about doing that down the road.

COMMISSIONER KILLINGSWORTH: Okay. Thank you.

CHAIR BELLA: Dennis, then Adrienne, then Jenny.

COMMISSIONER HEAPHY: I can't help but wonder why folks aren't automatically enrolled in these programs once they become eligible, and they can opt out if they don't want it, because if we're really serious about -- especially in rural areas or ethnic minority populations, we have disparities here.

Getting a letter saying, "Here, you are now enrolled in this program. If you don't want this program, please contact us and we'll take you off the rolls," but it should be an automatic. I don't understand why all this money and effort is being put into advertising and trying to build up the numbers, when we could just make it a given that people can opt out.

CHAIR BELLA: Thank you, Dennis.

Tricia, did you have something to say to that?

COMMISSIONER BROOKS: Well, I mean, there is

precedence for passive enrollment in other aspects of Medicaid. So I think it's an interesting point that Dennis raises.

CHAIR BELLA: Dennis, anything else?

COMMISSIONER HEAPHY: No. I think looking deeper into the under-65 population would be helpful.

CHAIR BELLA: Yep, I agree.

Adrienne.

COMMISSIONER McFADDEN: Can you go to the rural/urban slide one more time?

Like Verlon, I had questions around this one. It makes sense to me with population densities, why there would be such a wide gap. I think I'm curious as to if the data show, if there is a wide gap or disparity between those who are eligible and actually enroll in QMBs between rural and urban. I think that would be a really interesting graphic to understand and see as well.

MS. BLOM: The people who are eligible but not in the program? Yeah, yeah. Yeah, we weren't able to do -- that population is tough to capture, and we used the survey data last time to do that. But yes, that would be -- I appreciate that question.

CHAIR BELLA: Thank you.

Jenny.

COMMISSIONER GERSTORFF: Kirstin, can you flip back to the age? So I think I see kind of an inverse relationship in these two lines, and I'm wondering if you know what the methodology was for grouping the age buckets, because if it's assigned once per year, then you might have a drop in the under-65 and an increase in the over-65 each year as those kind of migrate.

MS. BLOM: That's a good question. I don't know.

I think the breakout was just meant to capture kind of like the older versus disabled groups, but that would be a question I have to -- the Urban Institute did this work for us, and I'd have to go back to them. But yeah, thank you, we'll check that.

CHAIR BELLA: We are so happy that you look at that, that way, Jenny. That could explain it all.

Carolyn.

COMMISSIONER INGRAM: I have a small, very small thing. For those of us who are older, maybe, you can't actually see the blue lines who are under-65 or enrolled. I could kind of see that there, but I know online you can't

see it. So I'd just asked that we use different colors or something darker for people who are also colorblind, I guess, or have those issues. Thank you.

MS. BLOM: Yeah. Apologies again on the colors. I know that they're --

COMMISSIONER INGRAM: That's okay. I didn't see what Jenny was seeing because I was like staring, trying the different like -- squinting things, but I understood what she meant. Thank you.

CHAIR BELLA: Any other comments?

[No response.]

CHAIR BELLA: Kirstin, you didn't think you'd have this much interest. Clearly, like this is -- well, I mean, really. I mean, I think she thought it would just be a regular update, but there's a lot. I feel like there's a handful of things we've identified that would be nice to include in the chapter as things that the Commission is interested in knowing, and some of those we could try to find out ourselves, but others, I would like to try to plant a seed with external folks who are looking at this issue too. So if we could reflect those things in the chapter, I think that would be really helpful.

MS. BLOM: Great.

CHAIR BELLA: But thank you for this work. It's really -- I mean, this is a really great example of a program that really matters for people who are enrolled in it and one that, as John said, doesn't get the most attention, isn't the sexiest program in Medicaid, but so important. So we really appreciate the work that you're doing here.

MS. BLOM: Great. Thank you, guys.

CHAIR BELLA: Thank you.

All right. We are preparing for our panel and the last session of the day, and we have a couple minutes before the panelists have been asked to join. So we'll get that set up, and the panel will begin at 1030. I would ask you all to stay here, but just we'll transition into that right now.

[Pause.]

CHAIR BELLA: All right. We have very prompt panelists, which we not only appreciate you being here, but especially being ready to start with us.

So, Tamara, welcome. We'll turn it over to you to lead us through this part of the panel, and then we'll

have an opportunity for the Commissioners to ask questions.

PANEL DISCUSSION ON AUTHORITIES AND STATE MEDICAID APPROACHES FOR COVERING HEALTH-RELATED SOCIAL NEEDS (HRSN)

* MS. HUSON: Okay, great. Thanks so much. Good morning, everyone.

We are going to have a panel today on the Medicaid authorities and state approaches to covering health-related social needs, and so we are joined virtually by four panelists. We are joined by Libby Hinton, who's the Associate Director for the Program on Medicaid and the Uninsured at KFF. We also are joined by Hemi Tewarson, the Executive Director of the National Academy for State Health Policy, or NASHP. And then we have two state folks on with us. We have Amir Bassiri, who's the Medicaid Director in New York, and also Dave Baden, who is the Deputy Director for Programs and Policy in Oregon.

So we're going to jump right into questions. My first question this morning is for Libby. She's going to provide us some background for the panel, which will be really great. So, Libby, can you please provide an overview of the Medicaid authorities that are available to

states to address the health-related social needs of their enrollees, and can you describe some of the ways that states are using these authorities?

* MS. HINTON: Thanks so much, Tamara, for the introduction and invitation to join the panel today.

This is a big question to tackle in just a few minutes, but I'll try to stay high level. So historically, states have had limited flexibility to address enrollees' social determinants of health outside of home- and community-based services programs. Authorities and options states have include using state plan authority to add optional benefits, like peer supports and targeted case management, leveraging managed care plan contracts and other managed care flexibility, using Section 1115 demonstration authority, and implementing integrated care models that emphasize person-centered care.

Today I'm going to primarily focus on managed care options and 1115 authority, as that's where most recent state activity has been and where CMS has expanded state flexibility and issued new guidance.

So let's start with managed care. Nationally, seven in ten Medicaid beneficiaries are enrolled in

comprehensive managed care organizations, or MCOs. Many states leverage MCO contract requirements to promote strategies to address enrollees' social determinants of health. KFF's 2023 Medicaid budget survey asked about select contract requirements and found more than half of states that contract with MCOs require plans to screen enrollees for social needs, to provide referrals to social services, and to partner with community-based organizations.

In addition to contract requirements, federal managed care rules allow for some flexibility for plans to pay for non-medical services. States may allow MCOs the option to offer services or settings that substitute for standard Medicaid benefits. These are referred to as "in-lieu-of services."

In early 2023, CMS released guidance expanding flexibility for states to use in-lieu-of services to address enrollees' health-related social needs, like housing instability and nutrition insecurity. The guidance followed the approval of California's request to use in-lieu-of services to cover a range of community supports.

I want to highlight just a few key points about

in-lieu-of services. First, federal rules require in-lieu-of services to be voluntary for plans to offer and for enrollees to receive. Costs of these services are built into managed care plan rates, providing a way for states to finance services on an ongoing basis. But CMS has established financial guardrails and other requirements, including monitoring and evaluation requirements.

Although California has approval to provide a range of housing, nutrition, and other supports using in-lieu-of services, KFF's 2023 Medicaid budget survey found few other states permit MCOs to cover social determinants-related services as in-lieu-of services.

Next, I want to shift gears to talk about 1115 authority. In late 2022, CMS announced expanded flexibility under Section 1115 demonstration authority to address enrollee health-related social needs, also referred to as HRSN. I want to highlight three key points about this new opportunity.

First, CMS released a detailed framework describing allowable HRSN services and certain duration limits. To date, the Biden administration has approved eight 1115 waivers under the new framework. We're going to

hear more from two states with approval on the panel today.

Second, these waivers authorize a range of evidence-based housing and nutrition services for specific high-need populations. CMS has approved coverage of rent or temporary housing and utilities up to six months, meal support up to three meals per day up to six months. Coverage of these services represents a departure from prohibitions on the payment of room and board in Medicaid. CMS has also approved infrastructure spending to support the implementation and delivery of these services.

The third key point is that CMS guidance outlines a host of requirements, including enrolling protections, fiscal guardrails, and monitoring and evaluation requirements. For example, spending on HRSN services and infrastructure cannot exceed 3 percent of total annual state Medicaid spending.

In exchange for expanded flexibility to address and release social needs, CMS is requiring states to meet minimum provider payment rate requirements for certain core Medicaid services.

Finally, CMS stresses new health-related social needs services should complement and not supplant other

federal, state, and local social service programs.

I'm going to stop there. I know I covered a lot of ground quickly but hopefully provided some background and grounding about managed care flexibility and 1115 authority to set up the rest of our panel discussion.

MS. HUSON: Yes. Thanks, Libby. That's very helpful.

So now I'm going to turn to Hemi. NASHP has been engaged in work with states examining opportunities to leverage managed care plan partners, specifically to address housing supports for beneficiaries. Can you describe for us at a high level the key ways that states are doing this?

* MS. TEWARSON: Yes. And thank you so much for having me here. It's wonderful to be on this panel and to be with Commissioners. I see familiar faces.

So, yes, NASHP has really invested, I'd say, over the past six years in really focusing on housing, and we do all our work -- as you know, we're a nonpartisan, nonprofit organization -- really responding to the requests of states. And the housing shortages and challenges for people to stay housed have only been growing. So I think

it's really reflective in our work that we've been doing over the past number of years.

I'll just note, over the past six years, we've worked with almost 20 states to really identify how they can move forward on their policies in health and housing. So that's just a testament of how focused states are in this area in the realm of health-related social needs.

A couple of things I just want to mention before I talk specifically about the managed care plan. So I hope you'll just bear with me for a moment.

So when we talk about housing and work with states on housing and health here at NASHP, we really talk about it as a three-legged stool. There's really three elements. There's the capital expenses for the housing itself. There's rental assistance to make the housing affordable and accessible to individuals, and then there's the other support services that help people find and stay in community-based housing. So today we're really focusing on that third piece, which is what Medicaid can cover with pre-tenancy and tenancy supports, along with -- you know, Libby was explaining in these new 1115 waivers -- the six-month rental assistance piece, which is new, as well as

infrastructure support to really help bring along housing providers and Medicaid together.

So I think it's a really interesting time for states to think about how they implement this and make this successful. Health and housing are two different worlds. They speak different languages. They are funded differently. The federal government goes directly and funds local organizations for housing, where Medicaid, obviously, you all know this federal-state partnership that really the state administers. So we're really talking about different ways the programs are structured, different resources, and really different -- just people and parties and parts of the system that really need to come together to make this successful.

So we have done a lot of work in this space. If you're interested, it's all on our website, but we just most recently published a paper on how states are leveraging managed care plans. We all know the big footprint that Medicaid managed care plans have across the country, and so we really think it's an important lever for states as they think about how to make their health and housing solutions and strategies work.

So there's a couple of things we found when we did this work, and we work closely with our state leaders across our projects. So all of our work comes directly from them. We don't take credit. We're just really sharing what they've been working on with us.

I know Amir and Dave will talk about their respective states here today, and we have Jami as a Commissioner who we also worked with in Arizona on these initiatives. So I think she can probably chime in during the discussion.

So a couple of things we found, like how are states really incentivizing and requiring changes with their MCOs to really create successful partnerships across housing providers? And there are a couple of things.

Some states are requiring MCOs to participate in community planning efforts, and that's really to figure out how do you identify what's out there in the community with respect to resources and assets. And, Dave, I hope you're going to talk about what you've been doing in Oregon on that.

Some states are requiring or incentivizing MCOs to invest a portion of their revenues into communities

being served or specific programs. We think this is really a great lever that states can pull, and as states and MCOs identify housing as their top community priority, they are directing their MCOs to make those investments, in some cases, directly into housing resources. We can talk a little bit more in detail about some of those examples later.

Many states are requiring MCOs to develop regular agreements or regular touch points with housing providers or other housing partners, and this gets to how do we really build those partnerships and make sure that's happening effectively.

Some of the more prescriptive contracts may require MCOs to form partnerships with specific entities or even require an MCO to employ someone whose position is dedicated to collaborating with housing partners, so really making that real. Again, we can talk about some of those examples in the discussion.

Many states are also leveraging their Medicaid managed care contracts to ensure that MCOs screen their enrollees for housing instability and document housing needs, which includes like referring individuals and

coordinating care, and it's really interesting when you look at some of these examples. Some states are leveraging their SDOH screening and referral requirements in different ways. Some, like North Carolina, are requiring plans to use a specific system. So, okay, you have to go this path with this system. Some are requiring certain questions so they're more uniform across the plans, and then some states are just saying, "Here's the tool that we approve. Please use this, plans, to make sure that we're going to get the right information to understand who needs housing."

States under this umbrella are also strengthening care coordination requirements in their MCO contracts for individuals who are experiencing housing instability. That's Nevada.

And then there are some states that are requiring MCOs to coordinate with existing housing programs. There's been a longstanding housing initiative, health and housing initiative plans. You have to work with that program in order to really be successful.

Then I'm going to follow up just two more points, and then I'll turn back to you, Tamara.

I wanted to just talk a minute about data and how

states are leveraging their MCO contracts to ensure there's better data sharing. Data sharing is a key challenge in all of this.

Again, I talked about sort of the two systems on that Medicaid side versus the housing side and how do we really think about exchanging data effectively.

Some states are requiring MCOs to collaborate with key holders of housing-related data, and in the discussion part, I can talk a little bit more about an example of how states are doing that.

And then in other states, Medicaid agencies are leveraging their MCO contracts to require MCOs to use specific methods to identify target populations that would most benefit from services like case management or targeted housing interventions and also determine if enrollees meet the criteria for certain initiatives.

And then finally, payment. I mean, payment, we know drives many different things, and so states are using that payment lever differently to really incentivize MCOs to provide housing-related services. Libby talked a little bit about different ways to think about that with the new authorities, but one is you factor the cost of providing

some of these housing services into capitation rates directly. You're asking plans to do more and so you actually build that into the capitation rates.

Some states are thinking about covering this -- or covering this as a value-added service, which is a different way to approach that outside the capitation rates, and then there are some states, Oregon and California specifically, that are having plans to think about covering this as in-lieu-of services. Of course, that's voluntary on the plan's part, but those states -- and Dave can talk about this in more detail -- they're also making incentive payments for MCOs to invest in infrastructure and partnerships.

So I think we can, Tamara, maybe talk in more detail about some of these examples, but I'll stop there for now. Thank you.

MS. HUSON: Yes, absolutely. Thank you.

So now I do want to turn to our state partners. So, Amir, I'm going to start with you. In January, CMS approved an amendment to New York Section 1115 demonstration. Can you please share with us at a high level what's included in that Section 1115, particularly

what health-related social needs it targets and how?

* MR. BASSIRI: Yes. Hi. Good morning. Thank you for the opportunity to be here.

I will try and give a high-level overview of our recently approved amendment. It is a broad and wide range of initiatives. So I'll spend more time on the health-related social need component, which is the primary focus and sort of policy goal as it relates to our amendment and half of the funding tied to our awarded waiver size.

But the primary focus of our waiver amendment has been to integrate health-related social needs into the managed care benefit and payment delivery system, and similar to what Hemi just went over, we are very focused in incorporating and including health plans as part of that solution, given the managed care benefit design and our goal for this to be a permanent fixture in how we do business in the New York managed care programs.

What we are proposing to do is to create what we're calling "social care networks," which are networks of community-based organizations as well as other primary care and health system providers, with lead entities that are contracting -- or value-based and contracting entities of

managed care organizations on behalf of those community-based organizations to coordinate the referral, screening, and delivery of the health-related social needs approved under our waiver.

Those include a range of different initiatives, a suite of housing or transitional housing supportive services, nutritional services, case management -- or health-related social needs case management, transportation, and other care coordination.

We have split up the state into nine regions, and we are having one social care network per region, with the caveat that New York City may have more than one.

We did a request for application that's on the street to select these entities, and this really builds on our prior waiver, the DSRIP waiver, with some lessons learned in that structure, ensuring that these coordinating entities can contract with health plans. We are starting off with health plans, paying them sort of a reconciled PMPM, so there's no risk for either the plan or the network. But ultimately, by the end of the amendment and demonstration, we hope -- and our goal is -- to have it incorporated into the managed care capitation.

Unfortunately, for us, we have less time with our amendment than some of the other recently approved demonstrations, but we have really built this on an evolution of the Medicaid delivery system since this. So there is some examples of this work happening on a smaller scale that we really hope to build out statewide.

And data, to Hemi's point, is a huge, huge focus of our demonstration, and we are leveraging our statewide health information exchange as sort of the backbone for the networks and plans and other providers to all have access to screening and referral information when appropriate, so that we can evaluate how referrals were made, whether services were delivered, and really evaluate the effectiveness, at least from a cost and quality standpoint, with the integration of these new services.

It's a massive undertaking, as I'm sure you'll hear from other states. We do have other elements of our waiver that I'll briefly touch on. There is a workforce component that does correspond with the integration of health-related social needs but very focused on some of the mental health and community health worker peer support navigator positions and helping people get trained into

those roles. And then we have a large population health and health equity improvement that has hospital global budgeting and primary care investment that aligns closely with some of the new innovation models from the Centers of Medicare and Medicaid Innovation.

I know that's a lot. So I'm happy to pause for a second, Tamara.

MS. HUSON: Great. Thank you.

So, Dave, similar question for you. Can you please share with us a high-level overview of what's included in Oregon's Section 1115 demonstration that targets health-related social needs?

* MR. BADEN: Yeah, thanks, Tamara, and thanks, Commissioners, for having this panel today. Excited to be here today.

I think Amir hit it really well of this is really exciting and also pretty intimidating to roll out a whole bunch of different kinds of benefits through our managed care plans and smaller fee-for-service sort of footprint here.

Yeah. I wanted to hit maybe two things before jumping into the health-related social needs pieces. One

related to our other pieces that were in our waiver, our 1115 demonstration waiver, and then a separate 1332 waiver that is in front of CMS right now.

In addition to all of these HRSN benefits, Oregon received the okay to do continuous eligibility for kids up to age six and two years of continuous eligibility for anyone above that. In some ways, that was a lot easier to implement. It's just some system changes, but I think just for us -- and will be a really strong focus of our evaluation plan -- is to see what difference that makes to not have as much churn, especially for kids, and to be able to have consistency for childhood immunizations, all the well-child visits and things to get kids ready to be in school.

I really do think for, you know, the nearly half of Oregon's kids that are on the Oregon Health Plan, on Medicaid, what impact that has on longer-term health and health variables in the state.

But, as we are going through redeterminations of everyone, Oregon really, I think, leaned forward and did a couple of things. We did a temporary expansion of Medicaid up to 200 percent of poverty, of the poverty level, and are

in the process of now replacing that with a basic health plan. We'll be the third state to have a basic health plan in Oregon and, you know, really will create, hopefully, a pretty seamless interchange between up to sort of the ACA level, all the way up to 200 percent of the poverty line. So also really excited that -- assuming CMS says yes, I'm going to be cautiously optimistic on that point, that we should be able to start this summer on that piece.

So, yeah, thanks, Hemi and Amir, on some of the background on HRSN.

I'll go specifically on what Oregon asked for, and we're about 18 months into our work in the -- after the approval of the waiver in here.

We focused on three big areas around the impact of climate and climate emergencies and the impact of climate change on a subset of our members, nutrition, and housing. And as of last week, we have our first HRSN benefit that has gone live. As of early March, we have a benefit for climate-related services for a subset of members.

Again, these -- as in our waiver approvals, it's not every Medicaid member. There has to be certain

eligibility criteria and sort of social needs factors met that will qualify for these benefits.

Oregon, not unlike many other states, has had some of its hottest years in history over the last five years, lots of impact of wildfire and smoke and poor air quality-associated health effects, so really digging into trying to be more proactive using Medicaid. Again, based on a subset of Medicaid members who meet certain criteria, they will qualify as a benefit to receive air conditioners, heaters, or other needs, depending on sort of what their individual situations allow.

Our focus really is, really trying to focus on areas and spots in the state that are most at need, really trying to dig in through work through community-based organizations to reduce health inequities and really tried to assure that the benefit is broad and meets needs throughout the state.

Second -- and Hemi and has been great to work with, as we sort of build a new housing benefit in Oregon on this HRSN journey as well. As stated up front, we've got some really exciting benefits on the housing front, again, for a subset of eligible Medicaid members that will

then qualify for this new benefit to have rental assistance or temporary housing for up to six months, utility assistance, home modification, pre-tenancy and tenancy support services, so really a broad swath of housing services that have been primarily run through housing agencies, community action agencies, local counties. And for us, it is all about braiding and interweaving our Medicaid managed care partners with this housing entity and not to overly medicalize a housing benefit.

I will just say up front that housing partners out there are really -- I'll just say are pretty scared of Medicaid. The requirements, all of the paperwork, if you say ICD-10 codes, I think they run away screaming. So we really are trying to approach this in a way that allows them to do their work, invoice to our local managed care entities here, and allow them to continue the work, as also support their staff and able to do that work. So that benefit goes live later this year. We're shooting for November for that benefit to go live.

Last but certainly not least is around nutrition support, so medically tailored meals for six months, fruit and vegetable prescriptions and other meals or pantry

stocking there as well. We're shooting for that to go live next January.

Really, all of this is building off of, I think, a lot of things that Oregon has been doing through flexible services and other ways that now shift this more into a benefit. I'm just fascinated as we get into evaluation of how that's going to work, and when you make something like housing a benefit with appeal rights and someone saying that "Wait. I think I do qualify here, and how do we do that?" We could dig into a little bit of how we're trying to assure that understanding that there's not enough housing stock for everyone in the state. And that's true in so many other places, how we're starting this in order to try to keep people housed and really focused on prevention rather than focusing on trying to house people who are currently houseless, because of concerns of just creating big wait lists, which we don't have the authority for.

So, Tamara, happy to turn it back to you. Look forward to the rest of the discussion.

MS. HUSON: Great. Thank you so much.

So I have a couple of follow-up questions for our

state partners. Amir and Dave, this question is for both of you. What did your state consider when designing its program? What factors were at play in deciding which interventions to cover for addressing health-related social needs? And we'd also be interested to know if there was anything that you wanted to include in your demonstrations that did not get approved by CMS.

So, Amir, can I turn to you first for this, please?

MR. BASSIRI: Yes, absolutely. And it's a great question.

I think we had the luxury of -- we had, similar to Dave, a long negotiation process with CMS and had the luxury of seeing some of the growing or implementation pains of the earlier states with respect to implementing the new HRSN services, similar to what Dave mentioned on housing stock and just the fact that we're all doing this with incomplete data and we're sort of projecting market demand and supply, which is not an easy thing to do.

So we wanted to -- in our conversations with CMS, we had originally proposed to have flexible funding under the HRSN framework, with the idea that let us design as we

go, let us collect some data, standardized data, and get an assessment and then have health plan downstream partners, CBOs, come to us with value-based payment proposals or ideas around quality incentives to implement those benefits, all under their approved framework. We really did prioritize housing supports, nutritional services, and case management.

We were able to get some additional flexibilities under the framework for transportation, cooking supplies, pantry stocking, which were all very good things that we were seeking.

We could not get support for things like childcare. That was something we had wanted. It was a non-starter with CMS.

But ultimately, the challenge we had was we really wanted to have flexibility in the design of some of these benefits, letting the market come to us with solutions, and CMS was not interested in that sort of broad focus. They wanted very much an alignment with other payment authorities to ensure that we were doing this through directed payments and existing managed care authorities, which is far more prescriptive than we were

hoping to be at the onset.

Tamara, we also wanted and had in our amendment criminal justice or in-reach services for those being discharged from incarceration. That was pended simply because they approved California's demonstration in the midst of our negotiations, and we became aware of that new opportunity and the additional flexibility. So we pended that conversation but intend to pursue that at a later date.

One other thing I failed to mention that Dave reminded me of, we did want to incorporate something during our negotiations, given the unwind and the focus on children, which was copying what Oregon led the way with, with continuous coverage for kids. We were not able to get that in our current or recently approved amendment, but we have an amendment that we submitted -- or are about to submit to incorporate that coverage expansion as well.

MR. BADEN: Yeah, great. I'll jump in here.

I think, as Amir said, a long sort of back-and-forth negotiation process with CMS. I mean, I guess I just would emphasize sort of the learning nature of all of this work and learning from other states, learning of CMS, of

them having to negotiate into other Cabinet-level agencies for things that are a little bit of outside what historically had been things that CMS had focused on, so a different relationship with housing and urban development and other places that just led to a more robust, I think, type of negotiation than may have happened on 1115 waivers in the past.

Yeah. I mean, I think one of our key points of focus was really about weaving these HRSN benefits into the community-based fabric that is here, and I think just generally, in some ways, the fact that we are really having to work on these HRSN benefits is a little bit of the failure of the country and of the state to not invest in social services, period. So glad that Medicaid is in this space, but frankly, it's probably in this space because resourcing for housing and nutrition, transportation, and other supports has not been there fundamentally as part of this.

But there are programs and services that are out there. I think bringing Medicaid into the housing space, there is excitement for the opportunity, excitement for weaving things together, but it really is for us trying to

approach it as about supplementing and support integration rather than replacing, rather than saying you got to do it this certain way and still meet CMS and Medicaid requirements. So it's definitely going to be a balancing act in here, but I think that's the exciting piece that's ahead of us.

We do have, as part of our waiver, a pretty robust capacity-building grant program that will help in data connections, training, other ways for local community-based providers of these HRSN services to be ready to deliver this benefit. We just have announced -- and there's some local competitions in each of our managed care entities, what's called "CCOs," community care organizations, here in Oregon that deliver the benefits.

We did ask for other things that, of course, we didn't get. I think if you sort of take a step back and say, "Gee, Oregon, why six months of rent? Why didn't you get a year rent?" If I had to answer that question a thousand times from housing providers, I would say I would have loved to have had a year's worth of rent because a lot of people don't sign six-month leases.

I will admit that is going to be a challenge in

how we implement this, period. It's all about integration and assuring that there's not -- at the end of that six-month period, that someone just falls off into losing that benefit.

We also, on the climate benefit, really were trying to look at how, during a climate emergency, we could add more folks to be able to do this. We couldn't get there, at least initially. It's just the systems and the timing that it would take from a declared climate emergency to actually people getting an air conditioner, that climate emergency likely would be over. And that's not early enough. So we're still trying to work through those things. I think it's focused on delivering services to our members and I think have a flexible community-based model in our managed care entities that I think make us pretty well-placed to do that. We'll see how it goes. It's a growth mindset for sure.

MS. HUSON: Great. Thank you for that.

So my next set of questions is around the implementation of these waivers. So, Dave, maybe we can pick up with you, since you already started talking about this a little bit. As you mentioned, your demonstration

was approved in October 2022. Can you tell us a little bit more about how implementation is going, what's working well, and what, if any, obstacles are you running into?

MR. BADEN: Yeah, great question. So, yeah, I think it is both hard in, I think, just sort of the overall environment that we're operating in, along with a whole lot of other programs and work to figure out how to both talk about these waiver benefits but also talk about them in a way that does not create sort of expectations, sort of greater expectations than we may be able to deliver on day one. So let me give a couple of examples.

Oregon, like many other states, is really trying to invest in services for its houseless and homeless population, more housing stock, and a lot of growth in our state-funded housing infrastructure, unlike ever before. It's the governor's number one priority here to push for this, and the waiver is part of that. But there's a lot of other things going on at the same time. So how to both enter that space in a way of how this complements is important.

Ultimately, we decided on the housing benefit to focus on prevention, to focus the benefit on those that are

at risk for homelessness and not focus the benefit to start with on those that are currently houseless as one of the potential eligible areas that we could focus on.

That was really done in partnership with our housing entities, the governor's office, and others, again, to complement a whole lot of other things that are going on in that piece.

But I think that in all of the implementation plans, I think the piece that I just want to emphasize of how housing providers and housing partners work with their clientele and how Medicaid as a benefit works with its clientele -- you go into a housing provider. The expectation and wait lists, and you have enough money to serve people, and when you run out of money, that's it. That's not how Medicaid works. So how those integrate together is fundamentally changing this conversation.

I'm hopeful in a good way, but it really is fundamentally changing that conversation. And anytime you change fundamentals of one system or another, they're really hard conversations.

So I'm excited we have a really robust implementation plan, an evaluation plan, and appreciated

CMS to provide us a significant amount of resources to evaluate how this will work, because ultimately, I think that's -- coming out of this is how these HRSN benefits, in our case, as an actual Medicaid core benefit for a subset of population, how did it work? And were there benefits? Even if those benefits meant that there were more medical services offered to start with, if that happens, that would be a success. It may not be cost savings to start with, but over time, someone who is more stably housed can go visit a dentist, can go actually get their prescriptions filled rather than worrying about where they're going to sleep that next night. So I think we've got an interesting thing ahead of us.

MS. HUSON: Great. Thanks so much.

So, Amir, I'm going to turn to you. How is your state approaching the implementation period? As you develop your implementation protocol, are there health-related social needs specific considerations that you plan to address? And how does this rollout differ from traditional health care service transformation, if it does?

MR. BASSIRI: Yeah, it's a great question. I mean, I really like what Dave shared, and I echo most of

those things.

I'll just talk a little bit about some of the considerations we have, and some of this, we recognized as we were going through the negotiations that it was going to take a lot longer than we had expected. We started to make investments through the state plan and in our budget process to really lay what I like to call a down payment on some of the permanency around our premise that these HRSN services will lead to better outcomes and in a cost-effective way.

We invested in supportive housing stock and then supportive services. Our Medicaid program does and has experience with supportive housing, with state-only Medicaid dollars. But like all other states, the stock was a challenge, and it's an ongoing challenge. So we made some investments in that area.

We expanded to incorporate community health workers in our state plan benefit, expanding doulas and other care coordination services, to really lay some groundwork and demonstrate to the industry our commitment to this post-waiver.

We have designed -- we spent a lot of time

designing the payment flow, the information flow, the data elements and collection so that it was a fixture of our existing infrastructure and our statewide HIE.

So that was very time-consuming but very important, because knowing that we have less time, we want to be able to measure and evaluate something. In order to do that, we had to make tough design choices that weighed flexibility for the industry versus the importance of standardization in the context of evaluation. So everyone is mad at me in New York about requiring the screening tool and prescribing which screening tool and how questions are asked to identify whether individuals in New York Medicaid are eligible and how they're referred and screened, but that is a critically important aspect of this for us. The data is critical.

We do want to be able to say whether it is true or not, that it is true and reliable, because we had a data infrastructure that was consistent and interoperable between different parts of the state and different networks. So that has been a primary focus of ours.

We spent an incredible amount of time in that aspect, because we are somewhat approaching this that our

goal is to incorporate this into capitated payment, meaning these networks are going to need to be able to submit social care claims to our health plan. Whether they're paid claims or pseudo claims is not really the point, but it's really all fundamentally around what happens after the waiver. So we really spent a lot of time in that area.

Tamara, I hope that answered the question.

MS. HUSON: That does. Thank you.

CHAIR BELLA: Tamara, I think we'll take one more question of yours to the panel, and then -- we're getting such rich information, but I can see the Commissioners are agitating to ask a few questions.

MS. HUSON: Oh, sure.

CHAIR BELLA: We only have 18 minutes left for four very busy people, so maybe one last one, and then we'll turn it over to Commissioners, please.

MS. HUSON: Sure. So why don't we do one kind of summarizing question, then.

CHAIR BELLA: Sorry. I just meant question for one. I think you might have had one for Hemi, and then we'll move -- we can let them summarize at the end.

MS. HUSON: Sure.

CHAIR BELLA: Otherwise, I'm afraid we might run out of time.

MS. HUSON: Sure. Okay.

So, Hemi, last question for you, then. We've heard a lot about housing already and about how to effectively coordinate health and housing services. Can you just tell us a little bit more about how this is being done and maybe focus on one key issue that states are running into?

MS. TEWARSON: Sure. And I just had to say ditto to everything Dave said, because really one of the fundamental issues is the partnership and understanding that Medicaid and the health system coming in to create a benefit for housing, when there has been this whole other system that has grown up around providing housing supports for people across states.

So it's really, I think, like critically important to understand that and understand that it's really important to build trust and complement existing initiatives and really build off of that to be successful. So I'm just going to say that.

The other thing I'll say too is the housing

shortage across the country and how to think about that in the context of the Medicaid work is also really important.

We're following governors, and the governor of Oregon is not alone in terms of prioritizing housing as just an initiative on sort of the economic development side of things, which is sort of a different world than Medicaid.

And we're seeing that in National Governors Association. This was a session. Governors were very focused on this. The legislators are as well. There's a lot of legislation across the country about just pure housing stock, and then how does those initiatives fit into what you're trying to do when you're building new benefit?

I'll just maybe point to one example because we always at NASHP like to share lessons learned from states that have come before, and it's really interesting to learn about what worked and what didn't and where to go next.

Louisiana is a state that we have really worked with closely over the years. They have had a longstanding permanent supportive housing program. They're not one of the new 1115 social determinant of health waivers, but they have a program that's jointly administered by the Louisiana

Department of Health and the Louisiana state-level housing Authority. And I think what's been really interesting about their program is they have really truly braided and blended various funding streams together to figure out how to provide rental assistance and wraparound services. If you look at that, it's like Medicaid dollars, it's Ryan White, Veterans' Affairs, community development block grant funds. And that's what you really have to start looking at, particularly for sustainability.

Dave talked about, you know, the six-month rental assistance, and then it goes away. So what comes afterwards for these populations, and how does the Medicaid benefit fit into the existing housing structure and programs that have already existed? So I just want to do a call-out for Louisiana.

They've just -- in terms of their outcomes, they've had a number of positive outcomes. So from 2010 to 2016, they saw 94 percent program retention, a 68 percent reduction in homelessness, a 24 percent reduction in average monthly Medicaid costs per person served in the PSH household. That was from 2012. So I think it's important to look at these programs that have gone before.

I'll also maybe just shout out to Arizona, and Jami is here. So I won't go on because she'll be able to probably provide some more detail. But in terms of managed care contracts and what to put in those contracts, they have some really interesting provisions to look at that they've had in place that requires housing specialists or community liaisons to have within MCO employment, to think about the data coordination and requiring plans to participate in data-sharing protocols with the data-sharing systems for homelessness.

So I guess I will just end there to say there's, I think, a lot that's new and that we're building with all of these recent 1115 demonstration approvals, but there's also some work that's come before with respect to health and housing and thinking about how you learn from those experiences, particularly in building the relationships and the data exchange, and then how you move forward with sustainability. So maybe I'll end there so that Commissioners can ask some questions.

CHAIR BELLA: Wonderful. Thank you.

Commissioners, this is going to be speed round. So please be succinct and directed with your questions so

we can get as many in as possible. This is fantastic. Thank you.

Carolyn and then Jami.

COMMISSIONER INGRAM: All right. Thank you so much for joining us. It's really exciting work, and I really appreciate all of the efforts you all are putting in. I love hearing about the housing and nutrition, but I want to ask you about gun violence and prevention of gun violence.

I know there are some states that have put together waivers to cover services around prevention of gun violence. Wondering if any of our panelists have any details on that or information they could share briefly with the group around maybe what they're covering, how they're doing that, are they doing it through schools or other means, and then how they're measuring ROI. Thank you.

And I said that really fast because Melanie told me I had to speak fast. So if I have to repeat any of it, I'm happy to do that.

CHAIR BELLA: Either of the states have anything? And then maybe Hemi or Libby, if you have anything from

other states?

MR. BASSIRI: Yeah, I can jump in. This is Amir from New York, and I'll be quick.

We do have a hospital-based violence intervention state plan amendment before CMS, and we are proposing to provide those services through community health workers that need to be employed by certain provider types, like hospitals or FQHCs, primary care providers. But we are proposing that benefit to be part of our community health worker scope of services.

MS. HINTON: And I can just add that North Carolina, I know they're pending renewal requests, their Healthy Opportunities Pilots. They're looking to expand the services that are available, and I know -- I don't have the details at my fingertips, but I know they do have a request, I think, for firearm safety and gun violence prevention.

CHAIR BELLA: Wonderful. Thank you.

Jami?

COMMISSIONER SNYDER: Fantastic panel. Thank you for joining us today.

I wanted to start by saying, Hemi, you were

invaluable to the state of Arizona, in particular, around the data sharing piece, which is so, so challenging. I just really appreciate your technical assistance.

My question is actually for Amir and Dave. It's really clear to me that you all have been really cognizant of the challenges facing community-based organizations in participating in a Medicaid program, billing for services, contracting with managed care organizations, and really sort of setting up these kind of new and innovative benefits as part of your core benefit package. Just curious to know what steps you've taken.

I know, Amir, you talked a little bit about your social care networks to really support CBOs in participating in the Medicaid program and specifically whether that sort of intermediary organization -- and I there's something like that in Oregon as well -- is carrying out functions like network aggregation, claims payment, and understanding better kind of how you structure those intermediary bodies.

MR. BASSIRI: I can jump in. Great question, Jami, and totally agree.

I mean, we definitely -- we have a very strong

social service network in New York, specifically in New York City. We did spend a lot of time talking with our local health departments, our social service agencies, others to understand sort of where their capabilities lie, how they've encountered Medicaid patients, the things that they focused on.

So our focus in designing was letting CBOs focus on core competency, not trying to suggest that CBOs need to contract with health plans to take risk. So we designed it and felt that the intermediary layer that you referred to -- - in our case, the social care network -- was an essential role and something that we wanted to be permanent and really built off our prior DSRIP waiver in many respects with the focus that they had to have contracting, fiscal contracting capability. They had to have the health IT and data exchange overlay. They had to be able to evaluate network adequacy, all the things that an independent physician association or an MSO does on behalf of the clinical services but for the social services and integrate those with value-based contractors and other primary care organizations.

But we had a very strong focus to make sure CBOs

just continue to do what they do best with the necessary supports in a fee-for-service payment system with those networks so that they get reimbursement for services delivered to Medicaid patients.

MR. BADEN: Yeah. And I think the only thing I would add from the Oregon piece, I think the uniqueness a little bit of our managed care model with having really only one sort of national health plan that has a footprint in the state and sort of 13 locally sort of run and managed, generally, community-based managed care providers that have already a historical relationship in their community with lots of social service and other network providers is that, you know, the core of this benefit, as Amir said, is it's sort of a non-risk start to this work, that they have a lot of these relationships already and are just providing money to grow, make them more robust and assure that this Medicaid benefit, like all of the other Medicaid benefits, basically, are run through our coordinated care organizations and so trying to build up, assure that there's connections.

We've got a lot of state connections with these community-based organizations but ultimately want those

local connections to thrive the most from there. So we do have a little bit of sort of a third-party intermediary for our fee-for-service side, but generally, it will be through our coordinated care organizations to sort of integrate with other benefits as kind of our operating principle.

CHAIR BELLA: Thank you.

Heidi?

COMMISSIONER ALLEN: Hi. Thank you so much for this presentation. It was really wonderful.

As a social worker, I really am pleased to see this kind of really important investment in the things that actually keep people healthy.

I have one question for Dave and then a question for both Dave and Amir. The question for Dave is, when John Kitzhaber first put forward the coordinated care organizations, this was the whole premise of his argument. Like, why would you pay for an emergency department visit for heat stroke when you could buy an air conditioner? And I'm curious as to if this -- you know, the CCOs ever lived up to that ideal and being able to pay for these kind of things, because I think that was what they were supposed to be able to do. And if not, how do these new benefits

change, improve? Why is this -- do you expect this to be more successful in making those things happen?

I'll let you respond, and then I'll ask my follow-up question, if that's okay.

MR. BADEN: Yeah. Thanks, Heidi. Boy, that's a great, fun question for us that we've talked and thought a lot about here.

Yeah. I mean, in some ways, sort of the setup of these coordinated care organizations and the model that Dr. Kitzhaber really wanted to create -- in some ways, I would say this is a little bit of a natural growth in next steps. I think that in some ways, sort of the idea of providing an air conditioner or some sort of device, that has happened on a local level.

But I think that the amount of flexible health-related services dollars that really have been spent historically, if I take a step back and look at them as a percentage of our overall capitation, it's really small. And it's really small because of how sort of core rates are developed and sort of just how expensive it is to sort of just pay for medical care that eats up 90 percent-ish-plus of sort of that capitation rate.

So I think this idea that there was enough flexible dollars that could be consistent year over year, I don't think has panned out the same way.

Now, building this into a benefit to where, again, there are resources that are being core provided and that CCOs, should people meet those criteria, have to provide these services, I think will -- again, I think just sort of extends and says, while it's great that we have flexibility to do these sorts of upstream things, if we really want to make a difference -- and this is what I think the evaluation question is -- these should or could be core benefits of Medicaid. And that if you need a knee surgery, you get knee surgery. If you need nutrition support or housing, Medicaid can help provide that. So that is, I think, sort of the fundamental growth.

In some ways, I think we're positioned pretty well to do that because of sort of the locally based community model here. But yeah, I mean, our health outcomes over the last 10 years, I would not say are any -- are much better than other states who don't have this model. So I think that is a little bit of our evaluation ahead of us.

COMMISSIONER ALLEN: Gotcha. Thank you so much. I really appreciate that.

And then for my question for both you and Amir, particularly as you try to keep people in stable housing, thinking about the intersection with mental health and substance use disorders, sometimes it's not financial, the reason that people lose housing. What kind of resources are going to be made available for social workers or peer support specialists in order to -- and, you know, how will you ensure that your -- whoever, whatever the entity is, is nimble enough to respond to a crisis to help keep people in their homes when it's not necessarily about being able to pay for rent, but maybe that the person is experiencing some instability?

MR. BADEN: Yeah, I mean, I'll jump in first on this one.

Yeah. I think for us, I think there's sort of two pieces. There are some specific sort of grant funds to sort of maybe prime the pump a bit for being ready for sort of the core benefit.

The core benefit itself has some outreach and engagement and other focus that will be actually part of

the overall benefit itself. So I'm hopeful that in the contracting that CCOs do with local providers, that it is not just a widget-counting exercise, that it's not here is six-month rent, here is six-month rent here. It is about some broader support so that the social workers, the care coordinators, the outreach workers have the ability to do exactly that, in some cases that have been already doing that, but Medicaid can again round out some of those things.

Yeah. So I will stay in a hopeful place that that's where we get to, and I know it is going to be a challenge. It is going to be a challenge.

MR. BASSIRI: Yeah, I'll just briefly add to it. Heidi, love the question. I'm also a social worker. So this is core to my passion.

Similar to Dave, we do have a range of community supports and I would say intensive outpatient behavioral health services that have been implemented or are being supported through our state plan. The challenge is that I think for us in New York, we do have some friction between behavioral health and managed care, and that has led to more fee-for-service-related investments when it comes to

behavioral health.

In thinking about our waiver, which is a managed care waiver, and how we integrate with those services, it is difficult and challenging to think how that's going to work perfectly.

I do think that the networks we've designed will be nimble enough to coordinate across the delivery system. They have experience. They're not new market or delivery system providers. They're only doing -- that we're forcing them to work together and bring some sophistication and leverage-existing infrastructure, but totally agree with you that it's not always related to health why someone loses housing. And we've made and are hoping that some of the investments in respite care and other intensive outpatient care for behavioral health will help support those transitions to more stable and permanent housing if they are available.

CHAIR BELLA: Last question, Adrienne, so we can honor their time.

COMMISSIONER McFADDEN: Yes, of course.

Thank you so much for this wonderful panel.

I am an unapologetic upstreamist. So, Dave, when

you talked about sort of the focus on preventing sort of housing insecurity or homelessness, that really spoke to me.

I also want to take that approach and lens to nutrition. So, Amir and Dave, can you just speak a little bit about how you're able to use your waivers to consider nutrition as a prevention tool beyond just sort of the medically tailored meals approach?

MR. BASSIRI: Do you want to go first?

MR. BADEN: Yep, happy to jump in on this piece.

I mean, I think this is, I think, another sort of spot to where through flexible benefits and other things that there have been sort of VeggieRx and sort of some of the prevention things that have been happening where specifically asked for and in sort of an overall care coordination of Medicaid members in that particular coordinated care organization.

So many to most of our CCOs have contracts and have sort of smaller-based programs in sort of prevention and upstream areas. What this will provide for, again, a subset of Medicaid members who meet certain conditions, right, is a look and an ability to be more focused

upstream, to be the upstreamist model here, to do exactly that. It is about sort of prevention, and it's not just someone who comes out of a hospital with diabetes that will be focused on, although that will be part of this too.

It is asking our CCOs to do sort of a broader look and see who sort of fits or could fit, do some proactive outreach, instead of having people come to them. We are sort of pushing and asking for that and paying for those things to be different and, again, emphasizing the benefit nature of this and that there are appeal rights, so people will be able to sort of advocate for themselves differently than in sort of when it was just flexible services. If it's just flexible services, a managed care entity can be like, "Hey, I would love to do this. I can't. I can't afford it. There's not enough money." Now they won't be able to say that.

To Hemi's point, that is very fundamentally different in how we've been approaching this work before.

MR. BASSIRI: I'll just add for New York, we have experience with the medically tailored meals, primarily for our -- and managed care with our managed long-term care plans. So, with respect to what is authorized for

nutrition supports and our waiver, it is much broader than that under the guise of what Dave shared and that all of these new HRSN services are being targeted to some of our higher need and more vulnerable members.

But we're expanding, certainly, to populations that have access to those services, and we are including more preventative nutritional services like counseling and education, cooking supplies for members, pots, pans, pantry stocking, groceries for up to weeks at a time for six months, authorized for six months.

We have taken the prevention lens, and we have made some investments in our state plan as well to have dietitians and other nutritional counselors as eligible Medicaid providers. So it is under the lens of prevention focused on our higher-need population.

CHAIR BELLA: Thank you very much. There's probably at least 25 more questions we have for you, so we may have to hit you up again. I like to end, if we have time, with asking what you need from us. We realize you have limited time, though. So we don't want to take it up any longer. Thank you very much. We would invite you to always be letting us know where the Commission can help

further your efforts and when you're running into barriers, all four of you, in the various work.

And a special thanks to Dave. I'm sure you work around the clock, but being camera ready at 7:30 is much appreciated.

MR. BADEN: My daughter made it to school on time.

CHAIR BELLA: Excellent.

Thank you all for this amazing work and for joining us today. We really appreciate it.

MR. BADEN: Thank you.

MS. HINTON: Thank you.

MS. HINTON: Bye-bye.

CHAIR BELLA: Tamara, thank you for that. We really could have gone on forever. I know you had some questions around implementation, or we've got some implementation, but around evaluation in the future. So I think there probably is a great interest on the Commissioners to understand the evaluation, particularly when Dave -- Dave sort of put a pretty important breadcrumb out there in response to Heidi's question about what have you been finding. And understanding, I think that those

states take evaluation pretty seriously, and if we can understand a little bit more about what they're doing, I think that would be helpful.

Jami?

COMMISSIONER SNYDER: I do think that's a really important question, in particular, because it's clear that the states are structuring their health-related social needs benefits differently, and that was really clear in the discussion today. So I think that evaluation component is going to be really critical in terms of determining the efficacy of different models that states have employed.

CHAIR BELLA: Rhonda?

COMMISSIONER MEDOWS: Just one question, maybe, Tamara, for the future. Are there -- to ask the panelists, if there are any restrictions that would prevent somebody from receiving these services; more specifically, substance users. Are they prohibited from you getting the housing benefit? That used to be a thing.

CHAIR BELLA: Thank you, Rhonda.

Other comments from Commissioners?

Verlon.

COMMISSIONER JOHNSON: Yeah, I just want to echo,

this was an outstanding panel. I mean, we've been talking about this issue for years, and it's been really good to see that states like New York and Oregon have actually been thinking about this and doing some things with their previous waivers and opportunities.

I love the emphasis on prevention, but I'm also still concerned about emergency situations as well and just wondering what states are doing around that. I'd love to learn more about that too, if we could, at some point. Thanks.

CHAIR BELLA: Thanks, Verlon.

Bob?

VICE CHAIR DUNCAN: Well, Verlon stole most of what I was going to say, so thank you. You're brilliant, Verlon.

I, too, enjoyed this. It was exciting to see where states are headed and what they're trying to do.

But back to your point, Melanie, I think it's going to be important for us to follow how they evaluate and the outcomes of these programs and the learnings from them, what's working, what's not, and what needs to be tweaked.

But this was exciting to hear that we've gotten to this point of incorporating this into the Medicaid program.

CHAIR BELLA: Well, we do, as a Commission, have a history of paying attention to the presence or absence of evaluations of waivers. So this feels like a prime spot for us.

Tricia?

COMMISSIONER BROOKS: I just want to echo this on evaluation, particularly in terms of multiyear coverage for children.

Just removing the barrier of having to renew every year isn't necessarily going to improve health outcomes. It improves, potentially, continuity of care. But, indeed, we need to be doing more to educate parents about prevention, to work on improving those EPSDT screening rates and referrals. So evaluation is going to be a really key part of that as well as whatever state's approach is to the implementation.

CHAIR BELLA: Thank you, Tricia.

Carolyn and then Heidi and then John.

COMMISSIONER INGRAM: I think a lot of my

colleagues have said this, but really just looking at the ROI, I mean, we know that when we get people housed, we see reduced emergency room costs. So that's pretty easy to track and follow.

Nutrition is a little bit harder because it's over a period of time, and so anything we can do to try to gather what states are doing to figure out that ROI, because my fear is that if we don't prove that and we don't show that ROI, these kinds of good programs that we're doing a lot of work to set up will go away. So as much as we can gather what states are doing and starting to look at what is being done to track the ROI, I think that's going to be important.

CHAIR BELLA: Heidi?

COMMISSIONER ALLEN: Returning to the issue of housing for people with mental health conditions or substance use disorders, just thinking about kind of three systems intersecting, behavioral health, physical health, or thinking the Medicaid program and traditional managed care organizations and housing, I guess one of the things I really want to keep an eye on is potential for duplication of services. And then parallel to that, gaps, so where are

we kind of overlaying two groups doing the exact same thing and yet missing an opportunity for one group to do something that's really key.

And in particular, thinking of those vulnerable populations, I'm thinking about peer support specialists who check in with people every day, who really know folks. I think very few Medicaid programs pay for them directly, and so I'm curious whether or not more money will go to these positions through these kind of new benefits and if there will be more stability for those funded positions, because I think so many times they're funded through these limited grant opportunities that then go away. So there's the loss of the infrastructure, and then there's a new grant, and they hire new people. And then those people get trained, and there's a loss of the grant.

So, I mean, I think one of the big moves forward in this is creating some operational and financial stability so that these things can endure, but kind of what I heard is that maybe some of this might still be happening through grants.

So I just would like to keep an eye on that kind of overlay.

CHAIR BELLA: Thank you, Heidi.

John?

COMMISSIONER McCARTHY: It's great that we got to talk to the two states that are the newest in some of these things.

Going back to evaluation, North Carolina has now been doing it for a little while, and there have been some evaluations out on those. I think that's one of the things that would be helpful is to bring those evaluations that have been done to the Commission so we can talk about those things.

It sounds like CMS looked at some of those and then in their negotiations with these states made some changes, you know, kind of going forward. So I think it's good for us to, you know, back to what Carolyn was saying, return on investment. Like, let's look at what's been going on and then seeing how that's going to use in the future.

CHAIR BELLA: Thank you, John.

Rhonda?

COMMISSIONER MEDOWS: Just a last add and recommendation. When they're talking about evaluation, the

ability to reduce ED through housing is one piece, but the other piece that's being calculated by health systems is length of stay, hospital length of stay, particularly when the person has a comorbidity regarding mental health. And they're already doing the work, so that might actually make it easier for the states to gather information from hospital systems that are large Medicaid providers.

CHAIR BELLA: Thank you, Rhonda.

Dennis?

COMMISSIONER HEAPHY: I'd like to better understand how the coordination of all these services work. If you've got the MCO and then you've got behavioral health and the fee-for-service system and then you have the housing system, how are they all working together as coordinators to support the ability of folks to stay in their housing?

I was actually in a conversation with Dr. Jim O'Connell from Health Care for the Homeless, and retention of folks in housing is such a huge problem, and it is. It's for reasons other than the ability to pay rent, although that may be one -- that is one of the reasons. But it's behavioral health stuff. It's just all these

other -- and then there's no one in there, in that department building or that place, coordinating and supporting those services.

If you look at this, if the MCO is contracting with the support services and the housing, are they coordinating on the ground, or is it just more, "Well, we contracted with this entity to provide the services, and now it's not our problem"? They just have to show us they're doing the work. Like, how is this actually functioning in reality? And it's far more complex than I think.

I think we just -- I think it would be helpful to really think about the types of questions we really need to ask in terms of -- and then look at measurements as well, as states are doing. But there's so many different players that need to come together, and if there's not one involved in it, then it all falls apart.

I'll just give an example. There are two women in my building who are older, long-term homeless, very -- staples in the community. When they came into the building, they used to eat dinner in the lounge together, and people were complaining that they left the mess in the

lounge. No one really used the lounge that much, so they were leaving messes in the lounge. There was no one there to support these two ladies. One of them ended up going to a nursing home prematurely, really unnecessarily, and the other woman, I don't even know what happened to her. But if there had been someone in there advocating for them, with a housing manager, saying, "Why can't these women eat together in the lounge? They're isolated. They're lonely. This is a formal community. Let's make this work." That's the sort of stuff we need to ensure that people can remain housed and don't lose their housing.

CHAIR BELLA: Thank you, Dennis.

Jami?

COMMISSIONER SNYDER: Dennis, I think you're right on the mark with that, in particular, in this scenario, where other parties are coming into the system, including community-based organizations who have limited -- sometimes limited, experience working in the Medicaid space.

And then, as we discussed with the states, there are states, many states, that have these waiver approvals, are looking at a third party to actually support CBOs in

administering the benefit of the housing and nutritional supports end of things. And so that's just another party that needs to be a part of that kind of coordinated approach to care for members. And so I think that's a really important point.

CHAIR BELLA: Well, I think it -- I mean, Hemi said it. The housing world and the Medicaid world speak two different languages, right? It's the same thing that we got when we had the panel on criminal justice. Those worlds speak two different languages. So trying to figure out how we can help non-Medicaid parts of the world that are coordinating to help Medicaid folks work better within the Medicaid system, I think is really important.

COMMISSIONER HEAPHY: And there's also not just one housing. There's federal, state, county, all different types.

CHAIR BELLA: Other comments?

[No response.]

CHAIR BELLA: Tamara, when you were doing any prep with them, did you get a sense of -- is there anything you want to say about the evaluations or anything that we didn't get to? Otherwise, we can just have it as a next

item of discussion at some point.

MS. HUSON: Yeah. So, you know, both New York and Oregon are fairly early on. They chatted a little bit about monitoring throughout the period of the evaluation, but that data would not be available for a number of years.

I think somebody mentioned North Carolina, which is one of the first states to get approval. They are farther along. I believe an interim evaluation was posted recently. I have not had a chance to read through it yet, but I expect it will still be a number of years before we have any good evaluation data for us to look at.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: But the evaluation plan is critical here. It's not just about doing the work and waiting for the time to give us the data. If the plan is not a robust and well-thought-out plan and is doable, then we'll never get the answers we're looking for.

CHAIR BELLA: Very common theme here you're hearing today, Tamara.

Other comments from Commissioners? Rhonda?

COMMISSIONER MEDOWS: Tamara, you did an excellent job. Thank you.

MS. HUSON: Thank you.

CHAIR BELLA: You know how we love the panels and the Medicaid directors, in particular, so thank you. That's just invaluable.

All right. Any additional comments from Commissioners? Otherwise, we'll open it up to public comment before we close out.

[No response.]

CHAIR BELLA: Okay. We'll welcome anyone from the public to make a comment. If you'd like to do so, please use your hand icon. Introduce yourself, the organization you represent, and we ask that you keep your comments to three minutes or less.

Grant, you're welcome to speak.

PUBLIC COMMENT

* MR. BEEBE: Hey, thank you so much. My name is Grant Beebe. I work for the American Health Care Association and National Center for Assisted Living, representing All Things Medicaid inside our reimbursement team.

I want to thank you first for the opportunity to enter some comments and for this incredibly thoughtful

discussion on health equity operationalization, and I apologize for entering a potentially secondary topic but would ask for the opportunity for us to revisit our concerns that have been noted and entered in multiple instances here recently, encompassing our 14,000 members across the nation's long-term and post-acute care community.

We envision our mission as improving lives through solutions for quality care and are currently challenged by the ripple effects of the recent cyberattack on Changed Healthcare. The impact of this outage has been profound, and our facilities face substantial hurdles in submitting claims, receiving timely payments, and reconciling remittances, all critical processes for sustaining the high level of care our residents depend on.

The outage has placed a significant strain on our ability to operate within standard workflows and directly affected those who are entrusted to our care.

In response, we've reached out to the Department of Health and Human Services, advocating for immediate actions to help mitigate these challenges, including the issuance of accelerated payments similar to those available

under Medicare.

And I'm now appealing, I hope, for your support to consider a parallel pathway for Medicaid payments upon which the majority of our residents rely. I'm asking for your help in several key areas to ensure clarity around timely claims filing provisions, to promote collaboration with managed care organizations and MLTSS programs, to facilitate efficient exchanges of billing and remittance information, help us guarantee timely payment for states affected by the outage, and to continue exploring options for advanced and accelerated payments to providers who are facing billing challenges due to this incident.

Our commitment to our residents is unwavering, and we stand ready to collaborate on solutions that ensure their care continues uninterrupted.

We believe firmly that MACPAC can play a crucial role in addressing these challenges and look forward to your guidance and support. If I can provide further details or if anyone wishes to discuss potential solutions, please let me know how I personally can be in service or how we, AHCA/NCAL, can be at service. Together, we believe that we can navigate this challenging situation and

continue to provide essential care that our communities rely on.

I thank you for your consideration and attention to this matter and your ongoing support of long-term and post-acute care providers.

CHAIR BELLA: Grant, thank you very much for your comment and for providing a letter to us as well. We're happy to sit down and have a longer discussion with you if that would be of interest.

We're closely monitoring what CMS is doing and how they're evaluating some opportunities for provider-accelerated payments and also follow closely what the National Association of Medicaid Directors is doing on this front as they try to help states help providers. So thank you very much for your comments.

MS. BEEBE: Thank you, Chair Bella.

CHAIR BELLA: Dan.

MR. MISTAK: Good morning, Commission. Thank you so much for recognizing me. My name is Dan Mistak, and I am Acting President and Director of Health Care Initiatives for Justice-Involved Populations at Community Oriented Correctional Health Services, or COCHS.

I am really excited that you all are wading into and tackling some of the questions around health-related social needs, and I just want to flag something that has been really interesting that I've had the pleasure of working on.

Besides working at COCHS for the last 10 years, I took a two-year sabbatical to work for the Legal Aid Society of Hawaii, where I started a medical-legal partnership at the federally qualified health center on the west side of the Big Island of Hawaii. In that role, I had the chance to see plenty of people who were coming through the federally qualified health center with some significant legal needs that were absolutely impacting their behavioral health, their mental health, and even their physical health.

One really important case that I took in the process was where an individual who was receiving special mental health housing from the state, which had been contracted to a housing provider inside of the county, was just completely ignoring the contractual responsibilities that they had to ensure that somebody had due process before they were evicted. And in my role as an attorney

working at the medical-legal partnership, I was able to identify what his rights were and help him be able to remain in his housing.

So, as you all are looking into different ways in which Medicaid can support some health-related social needs, I would encourage you also to look into the ways in which the medical-legal partnership model and, in particular, the ways in which they try and address the health-harming legal needs that individuals might have, could play into the ways that you're thinking about the opportunities in the future.

Medical-legal partnerships are probably unique among many providers. The attorneys that work there are billing -- or keeping track of their hours down into six-minute increments, understand pretty well what their costs are associated with this. So I think that there's a lot of really great opportunities to build on the medical-legal partnership in order to really have some powerful advocacy tools to keep people inside of their housing and to also help them wind their way through many of the different social systems that can be challenging for people to be able to maintain their health and work on their family and

mental health as well. Thank you.

CHAIR BELLA: Dan, thank you very much. I know you built that in Hawaii. If you have any other states or areas that you would point us to, you're welcome to do so now or offline, so we don't put you on the spot.

MR. MISTAK: Great, yeah. And the National Center for Medical-Legal Partnerships would probably be an excellent partner, beyond just my experience of bouncing around that, but we'll happily reach out offline too.

CHAIR BELLA: Thanks very much for your comment.

Anyone else like to make a public comment?

[No response.]

CHAIR BELLA: All right. Any last comments, questions from Commissioners?

[No response.]

CHAIR BELLA: No? Kate, anything?

[No response.]

CHAIR BELLA: All right. We will close out our March meeting. Our April meeting is the 11th and 12th, and we'll be voting on some things for the June report. Thank you to the MACPAC team. Thank you to the tech team and to Kate.

And we are adjourned. See you all in April.

* [Whereupon, at 11:56 a.m., the meeting was adjourned.]