PUBLIC SESSON

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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

[11:00 a.m.]

CHAIR BELLA: Good morning. Welcome to the April MACPAC session and our final session for this work cycle. We're going to kick it off with Bob leading us through our first discussion.

VICE CHAIR DUNCAN: Thank you, Madam Chairwoman. Good morning. We are honored to have Linn join us again today to walk through the chapter on the Medicaid data and looking for our thoughts on the tone and clarity so we can move forward.

With that, Linn, take it away.

MEDICAID DEMOGRAPHIC DATA COLLECTION

* MX. JENNINGS: Thank you. Good morning, Commissioners. The Commission has committed to prioritizing and embedding health equity in all of its work to inform policy and advance health equity. Last year, in the March 2023 Report to Congress, the Commission made two recommendations on updating the race and ethnicity questions on the model application and developing training materials to encourage responses and improve the usability of data.

As a continuation of this work, this past work cycle we evaluated the availability of primary language, limited English proficiency (LEP), sexual orientation and gender identity(SOGI), and disability data for purposes of measuring and addressing health disparities and access to care and outcomes among the Medicaid population.

To inform this work we conducted a literature review and federal survey assessments, fielded an online survey of all state Medicaid programs, and conducted stakeholder interviews.

Based on the Commission discussion over this work cycle, the draft chapter highlights several considerations for expanding and improving the collection of these data. Additionally, it emphasizes that there are existing data sources that do include these demographic data, and efforts to use and measure and address health disparities should not be delayed. Further, the Commission notes its previous recommendations that CMS field an annual federal Medicaid beneficiary survey to address some of the limitations and demographic data gaps identified by this work.

So today I will present the draft chapter, Medicaid Demographic Data Collection, to be included in the

June Report to Congress.

I will start by providing an overview of why demographic data collection needs improvement, and then I will present on data collection priorities and uses, the current availability of Medicaid administrative and federal population survey data, current demographic data limitations, and considerations for demographic data collection as we look ahead to future efforts to use these data.

Demographic data can provide meaningful insights into the experiences of historically marginalized populations, and these data are important in supporting independent research and state monitoring efforts, informing policy decisions, civil rights enforcement, and improving stakeholder knowledge about the health service needs of the many populations covered by Medicaid.

Research findings about these populations indicate that generally individuals with language service needs, sexual and gender minorities, and individuals with disabilities experience disparities in health care access and use, health outcomes, and quality of care, when compared to their counterparts. However, due to data

limitations, less is known about Medicaid beneficiaries and those with multiple demographic or marginalized identities.

In recent years, health equity has also become a greater priority for federal and state governments, and improving and expanding the collection and use of demographic data is a key area of focus. The Biden administration has launched several efforts focused on improving the measurement of health disparities experienced by underserved communities. For example, in 2022, the Biden administration issued an executive order to advance equality for lesbian, gay, bisexual, transgender, and intersexed individuals, and this order required the development of the Federal Evidence Agenda on LGBTQI+ equity, federal agency SOGI data action plans, and best practices for collecting COGI data on federal statistical surveys.

In 2023, HHS released two notices of proposed rulemaking related to discrimination on the basis of SOGI and disability in health and human services programs.

CMS is also focused on health equity efforts, and their health equity framework prioritizes demographic data collection. As part of this effort, in November 2023, CMS

released a new model application with SOGI questions and provided guidance for including these questions on state Medicaid and CHIP applications.

Some states are also taking steps to update data collection and reporting and to include these types of demographic data, but many of these efforts are in their nascent stages. Additionally, interviewed health services researchers and advocates as well published literature emphasizes the importance of including these demographic data as part of all demographic data collection efforts.

Beginning with Medicaid administrative data, state Medicaid programs typically collect demographic data with other eligibility enrollment data on the application, and many states use the CMS model single streamlined application, which includes questions about sex, optional questions about preferred spoken or written language, race and ethnicity, and then beginning in November of 2023, SOGI questions. However, it does not include questions on LEP or self-reported demographic disability.

States have the flexibility to modify the model application or develop an alternative application with CMS approval, and this includes adding additional demographic

questions, as long as they are optional.

One recent review of state applications found that almost all Medicaid programs collect primary or preferred language on the application, and some states collect other demographic data, but there is great variability in the questions and category options included on the applications. States are also able to report most of these demographic data to T-MSIS.

As of December 2023, states are required to report disability type to T-MSIS, and they can also report primary language and LEP data, but those are not required. And currently, T-MSIS does not have data elements for SOGI, but CMS has indicated that states should be able to report these data as early as calendar year 2025.

Federal population surveys are another tool for understanding the experiences of Medicare beneficiaries when they are accessing services, satisfaction with and quality of care, and health outcomes across many demographic groups that aren't always available in the administrative data. However, there are also limitations with these data due to data comparability and small sample sizes for some of these subpopulations.

And so in a review of 13 federal population health surveys, the State Health Access Data Assistance Center, SHADAC, identified which of these surveys collect each type of demographic data, and the same size for those covered by Medicaid to assess whether these data would be usable for analyses. And as you can see on this figure, the majority of surveys include questions to identify individuals with functional disability, but many surveys do not include questions to identify these other populations.

Now moving to the data limitations, in a review of Medicaid demographic data collection we identified several limitations that make it challenging to measure health disparities experienced by these populations. So the findings from our work identified limitations due to the absence of data collection and incomplete reporting. Most state Medicaid programs do not collect LEP, SOGI, or self-reported disability data, and this can lead to the exclusion of these populations from efforts to assess and address health disparities. Of the states that do collect these data, there is inconsistency in the measures collected and the quality of the reported data to T-MSIS.

We also identified limitations due to lack of

representativeness and the use of different measures and categorical responses. For example, federal survey data often have small sample sizes for these populations. With administrative data there are also challenges. With disability data, for example, they are collected for eligibility purposes and can identify individuals who are eligible on the basis of disability, but do not include beneficiaries who enrolled in other eligibility groups. So this could underestimate the number of Medicaid beneficiaries with disabilities.

There are also limitations due to data accuracy. For example, administrative data are only reported often by head of households and only collected once, so the data may not be representative of someone's self-identity and changes in identity over time.

You probably recognize this figure by now. I have shown it in the other presentations. These are key considerations for demographic data, and they align with many of those raised in the Commission's prior recommendations regarding the collection of race and ethnicity data, and with some additional considerations that were raised in prior presentations in this work cycle.

So I will go through each of these in the next few slides.

For data collection purposes, based on our findings, states reported primarily using language and disability data for programmatic purposes. For research, most states did not report considering collecting LEP or self-report disability data, but some states have reported considering adding SOGI questions to the application, and reported that they could use these data to assess and ensure the program is inclusive of sexual and gender minorities and that their health care services are being met. However, states are still very early in the development and implementation of these questions.

And then for state and beneficiary burdens, states reported challenges with updating state data collection and reporting systems. Regarding the updates to the application, states reported challenges due to lack of data standards, the need for translating new questions, updating applicant assister training to assure assisters can explain the purposes of these questions, and application length.

Regarding the data systems, states reported challenges with updating the systems used to store and

report state Medicaid eligibility and enrollment data to T-MSIS, and concerns about adding new questions to the reporting system prior to knowing how to report them to T-MSIS.

Regarding data quality considerations, self-reported data are considered the best method for collecting information that reflects an individual's identity, and identities can also change over time, and interviewed experts discussed the importance of collecting these data multiple times to allow individuals more opportunities to provide responses that were reflective of their current identities.

Question standardization can improve the comparability and accuracy of these data, but standardization is still needed for some types of data.

Data collection methods should also allow for the data to be generalizable to the Medicaid population. However, survey data are often limited by sample size, and this can prevent researchers from using these data.

And then finally, when demographic data are collected, the collection mode should specify how the data can and cannot be used and that responding is optional.

Federal protections exist to ensure data privacy and protect sensitive data and specify how the data can and cannot be used. State Medicaid agencies are required to restrict Medicaid beneficiary and applicant information for uses that only directly pertain to the administration of the Medicaid state plan.

So looking ahead, the findings from this work identify challenges with collecting consistent and comparable demographic information, and this can impede the availability of data that are representative of the many populations served by Medicaid and the ability to measure and address health disparities and advance health equity.

There is ongoing work by the federal government and state Medicaid programs and researchers to address limitations like expanding and improving demographic data collection. Our findings also indicate that these data are already available from a number of sources, and the current limitations should not prevent the use of these existing data to more fully understand the experiences and health care needs of all Medicaid-covered populations. Research should capitalize on existing Medicaid demographic data to measure health disparities and access to care and health

outcomes experienced by historically marginalized communities.

For the next steps we will be publishing this chapter in the June Report to Congress, and today I welcome your feedback on the draft chapter as well as any comments on tone and clarity. And with that I will turn it back to the Vice Chair.

VICE CHAIR DUNCAN: Thank you, Linn, and again, thank you for the great work that has gone into this. You and your team have done a tremendous job in looking through this.

Now I will open it up to fellow Commissioners on thoughts about the next chapter for June. Yes, Heidi.

COMMISSIONER ALLEN: I'm sorry. I didn't have a chance to do a deep dive into the chapter this week, but I'm wondering if we reference the recommendations that MACPAC made to Congress last year about the need for an annual beneficiary survey, and if that is in there, and if not if we could make that.

MX. JENNINGS: Yes, it is included in the chapter.

COMMISSIONER ALLEN: Awesome. Thank you.

VICE CHAIR DUNCAN: John.

COMMISSIONER McCARTHY: When looking through the chapter and looking at our data sources, what I didn't see is any connection to electronic medical records. Is that accurate?

MX. JENNINGS: Yeah, in some of our interviews we did hear about that, especially with SOGI data but also with disability data and using them to kind of potentially eventually link back to state Medicaid data. But it is very early in the development. So a few states were doing that, but we decided to kind of scope it to the Medicaid application because it links to T-MSIS. But it is definitely an area that is growing, and a lot of states, I think, are looking into opportunities to use EHR data.

COMMISSIONER McCARTHY: I was just thinking of it from the standpoint of, the Medicaid application is already so long, and one of the things I know myself and individuals are never happy with is when you have to answer the same question multiple times, you know, especially things that are on there annually and things like that. So I was just trying to think of other alternative methods where the data exists that we may not have right now, but

to look at into the future. As we are getting a more connected Medicaid system, more states are putting some of those requirements in RFPs, especially for managed care and connectivity to EHRs.

I would like to see us explore that possibility of going to other data sources, so again, we are not asking the same questions, making the application longer than it already is. We need the data. This is really important data to have. But at the same time trying to make sure we are not burdening people on the program. Thanks.

VICE CHAIR DUNCAN: Thank you, John. Dennis.

COMMISSIONER HEAPHY: Thanks, Linn. Thank you very much for what you put into this. I have got a couple of things. One is collecting at the Medicaid enrollment is really important, but it gets muddied when you have ACOs collecting data, providers collecting data, and all different plans collecting data. How does all this come together to ensure we have an accurate picture of the populations that are on Medicaid? I'm not asking you to do that job. I'm just saying that somewhere it would be helpful to say that there are a variety of different efforts going on at the state level to try to give a more

comprehensive picture of the population itself. Because it's not just about this one area of data collection.

And the other thing is the intersectional piece and how important that is in ensuring that we are not just siloing populations, but that the data that is being collected can be crosswalked across populations to understand where the real population needs are, where the social drivers of health really impact health care access and health outcomes.

MX. JENNINGS: Thank you. I appreciate that.

COMMISSIONER HEAPHY: And do you have any thoughts about what's happening in terms of all the variety of ways states are collecting data?

MX. JENNINGS: Yeah. This is something that I think came up more with the race and ethnicity work. There were questions about sort of true source and how do you think about which data are overriding other data. It didn't come up as much in this particular work, and maybe it's because some types of data are so new that there isn't as much of that, that that isn't coming up as as much of an issue. But I'm sure it will be.

And I think, also going to the other point that

John was making about having to answer these questions multiple times, that's something we heard, specifically with disability data, that some of the stakeholders we talked to talked about how having to answer those questions multiple times is actually quite a burden on the individuals themselves and that they want that data to kind of carry over between sources.

And so it didn't seem like there was a good answer at this point, but I think that is something we can continue to kind of monitor and look into with future work.

COMMISSIONER HEAPHY: And part of it, I think, may also be cultural, because there are folks who don't identify as having a disability even though they do have a disability, and may not be to the level where they are eligible for Medicaid, but that because of self-identity they won't say they have a disability. Some may use a wheelchair around their apartment, but because they can get up and walk around their apartment they won't self-identify as having a disability. And so I think that is an important piece of this culturally.

And then with SOGI, a lot of that has to do with trust, and just giving that data to an anonymous person in

Medicaid may not be something that people are going to do.

I don't have an answer, and I agree with John in terms of the number of times that questions are asked. But a lot of it is about trust and who is asking the question and what the purpose is.

VICE CHAIR DUNCAN: Thank you, Dennis. I've got Rhonda, then Tricia, then Patti, and then Adrienne.

COMMISSIONER MEDOWS: One, thank you for doing the report and the heavy lifting. I have a request that when we are talking about doing the data collection that that we mention that obviously be the first step, the first of many steps. This data has to be collected, analyzed, risk stratification, and then actual intervention, when there is a deficiency noted. Right? I just want to make sure that's actually -- because I think people kind of think, well, we do data collection. We checked that box and we're done. And that's just the beginning of the work.

But I think also when we talk about we don't want to ask people multiple times the same questions, I think it's more about switching how we approach it. If they have access to being able to see how they are identified, maybe they don't need to change it. Whether it’s eligibility

systems or whether it's electronic medical record, those need to feed into the same source of truths, regardless of who the collector of the information is.

And I want to also thank you again, Linn, for saying up front self-reported data is the preferred way to go. I have heard the stories about people being identified at the point of service by clinic staff and not the person themselves identifying who they are. Thank you.

VICE CHAIR DUNCAN: Thank you, Rhonda. Tricia.

COMMISSIONER BROOKS: So this is a little bit on the state burden side. When we piecemeal collection of information we have do the same steps multiple times. And I guess at what point do we have sort of a reckoning of, okay, we've got this data. Now we want to go after this one, and now we want to go after this. When do we look at it globally and make a determination that when we make changes, when we make changes to systems or whatever, we need to think long-term and have a plan for that, so that we are not repeating the same steps, which I think are not terribly cost effective and just really push out over time getting to the endpoint where we want to be.

VICE CHAIR DUNCAN: Thank you, Tricia. Patti.

COMMISSIONER KILLINGSWORTH: Linn, I want to thank you for this work. It is quite comprehensive when you think about all the different populations that you've focused on, so we appreciate that.

I just think that we have this sort of multiplicity of issues. One is are we collecting the data. The second is really are we using the data that we have, or how do we use the data once we collect it. So I want to hone in just a little bit on disability data, because I do think it is an area where we have data that we aren't using, at least in all the ways that it could be utilized. So we collect a lot of disability data. We do it primarily for purposes of eligibility determination, whether that's eligibility for Medicaid or eligibility for long-term services and supports. And then we kind of stop.

Maybe we use it to identify needs for accommodations. I hope that we do that. I hope that we do that in order to make sure that we understand the supports that people may need in accessing benefits. But I think where we tend to stop short, even with the good disability data that we have, is in really understanding how that impacts access and utilization and what we need to do about

that. So I'd love to see us, as we sort of progress in this work, to really hone in on that.

I have, fully understanding the value of self-reported data, especially for some groups, I do have some concerns about that as it relates to people with disabilities. I think if you began to sort of think about a policy framework where we make recommendations around how data should be utilized, the data probably needs to be consistent, and there needs to be some standard associated with it, which you are probably not going to get with self-reported disability data.

On the other hand, if states are gathering disability data for purposes of eligibility determination you have a pretty rigorous standard, if you will, that these are, in fact, individuals who likely need certain kinds of support and being able to access Medicaid benefits in the right way. And then I think we have a little bit more opportunity, if you will, to make some recommendations around how that data should be utilized to really monitor access.

Thank you again.

VICE CHAIR DUNCAN: Thank you, Patti. Adrienne.

COMMISSIONER McFADDEN: Linn, I want to echo the other Commissioners' gratitude for this work. I really especially wanted to appreciate you for making sure that you noted that self-identity is the gold standard for identity-based data. And I also was really pleased to see the assister language in there, as well.

The one thing I wanted to point out, which I think Dennis sort of touched on, was the fact that identity data evolves over time. I think there may be some benefit to calling out specifically that there probably is a secondary step to making sure that we have credibility of that data over time. To the points of the other Commissioners, yes, we don't want to over-question, but because this identity does evolve, we can't under-question either. So there needs to be some standards to making sure that that data is accurate and credible. Thanks.

VICE CHAIR DUNCAN: Thank you, Adrienne. Good point. Yes, John.

COMMISSIONER McCARTHY: I've been trying to kind of help move this forward with some thinking of recommendations in the future on this one. I think we've now hit on a few areas, one of them being -- and Adrienne,

just on this, we don't want to over-question but we don't want to under-question -- and I forgot who brought this one. It might have been Rhonda. You know, the idea of showing people the data that they have on them.

So going back to the idea of using an EMR, or whatever data sources we have to gather that data so it's there, so you're not asking them multiple times, reviewing data to say is this accurate, is different than asking the person again and again and again, in my opinion. So I think that might be one of those things, as we think about this, to explore it.

I think the other thing is we are taking on -- and a couple of people said this -- very different questions on this data, self-reported, and there are very different areas. So we may also have to think about them differently too, and how they are collected and how they are used, and different pieces like that. And we have hit on this -- some of this is very sensitive data. Giving it to somebody can be difficult in doing some of these things because you don't know how it's going to be used. And it might be fine now, but five years from now it may not be, or it may be. We have dealt with this with other diseases

and things that we have had, so I think we really need to be thinking about that also, and do we need to think about data protections, stronger data protections on some of these things. Thanks.

VICE CHAIR DUNCAN: Thank you, John. Any other comments on the chapter?

[No response.]

VICE CHAIR DUNCAN: Seeing and hearing none, Linn, thank you again. I think you have got the work cut out on the chapter. But as you heard in the discussion today, I think this is some questions for us to continue to explore, moving forward, and think that is a testament to the work that's laid the foundation here, so thank you.

Do you feel like you've got everything?

MX. JENNINGS: Yeah. Thank you very much. This is really helpful.

VICE CHAIR DUNCAN: Madam Chairwoman, it's all yours.

CHAIR BELLA: Thank you. Thank you, Linn. Thank you, Bob.

Chris is going to join us for our discussion of improving transparency in Medicaid and CHIP financing. As

Commissioners know, we have been working on this during this work cycle. We are bringing back two recommendations for discussion right now.

Chris, take it away.

IMPROVING THE TRANSPARENCY OF MEDICAID AND CHIP FINANCING

* MR. PARK: Thanks, Melanie, and as you mentioned today, I'll be providing a brief overview of the draft chapter and recommendations. These are the same recommendations and same language that we presented last month. We'll do a quick overview of some of the information presented in the chapter, really highlighting the gaps in existing transparency requirements and some of the themes that came out of our stakeholder interviews. And then we'll go through the recommendation language, rationale and implications.

As you know, Medicaid is jointly financed by the states and the federal government, and states are authorized to finance the non-federal share from a variety of sources. These sources include state general funds, which are the primary source of financing and come from state revenues such as income taxes and sales taxes;

health-care related taxes, often referred to as provider taxes are defined as taxes for which at least 85 percent of the tax burden falls on health care providers or services; and then intergovernmental transfers, IGTs, and certified public expenditures, CPEs; are funds from state or local governments, and this can include publicly owned providers such as public hospitals.

When providers do pay a health care-related tax or contribute IGTs or CPEs, it does represent a cost that effectively reduces the net payments that these providers receive from Medicaid. And states are increasingly using these provider sources to fund the non-federal share.

Analyses from the Government Accountability Office have shown that from 2008 to 2018, state general funds declined from 75 percent to 68 percent of the non-federal share, and provider taxes increased from 7 to 17 percent of the non-federal share.

There is not a comprehensive source of information on how states finance the non-federal share. CMS currently collects some information on state financing methods when it reviews state plan amendments or managed care directed payments that change the way the states are

setting these rates. And also when a state may seek waivers of federal requirements and provider taxes. However, this information is not publicly available and can be difficult to compile.

States are statutorily required to report annually on the amount of health care-related taxes that they collect each year. However, this information is considered informational and does not affect the federal match, so it has not been a priority for CMS, and the data are incomplete.

States are not currently required to collect and report provider-level financing amounts.

MACPAC has previously made recommendations to collect provider-level data on financing for hospitals and nursing facilities, and the recommendations we are discussing today would expand on those prior recommendations by including all providers and services, not just hospitals and nursing facilities, including all sources of non-federal share, not just those from providers, and including both state and provider-level financing amounts.

Over the past year we have conducted several

interviews with policy experts, states, and providers. There is broad support for collecting financing data for purposes of improving analyses by using both gross and net payments to evaluate policies. However, some stakeholders did express some concern that the data could be used to reconsider existing financing arrangements.

There was agreement that there is a lack of comprehensive information on state financing methods and amounts, and what information is available can be incomplete and would be challenging to compile in a comprehensive way.

Stakeholders also pointed out some challenges and limitations with data collection. It can be challenging for states to attribute specific financing sources to specific types of Medicaid payments or services, since some states comingle provider contributions with other sources of funding that support the overall Medicaid budget.

It can also be challenging to attribute financing to specific facilities or providers affiliated with a larger health system, such as physicians affiliated with academic medical centers that are financed by state university hospitals. So any reporting should try to

balance the information requested with that administrative burden.

The first recommendation focuses on improving transparency in Medicaid financing. It reads:

In order to improve 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 the non-federal share of Medicaid spending derived from specific providers. The report should include:

-- a description of the methods used to finance the non-federal 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 non-federal 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 non-federal share of Medicaid spending, including administrative fees and other costs that are not

used to finance payments to the provider contributing the non-federal share.

This report should be made publicly available in a format that enables analysis.

The Commission has long held that analyses of Medicaid payment policy require complete data on all Medicaid payments that providers receive as well as data on the cost of financing the non-federal share necessary to calculate net Medicaid payments at the provider level.

We also heard similar comments during our interviews about the importance of considering both gross and net payments when assessing payment policies.

The current data that CMS collects on financing of the non-federal share of Medicaid payments are fragmented and incomplete. CMS only collects information on the methods that states use to finance Medicaid payments when states make changes to those payment policies, in either the state plan or directed payments, and this information is not publicly available. CMS has not prioritized reporting of provider tax amounts, and so these data are often incomplete.

During our interviews we heard that states

generally keep track of the amounts financed through different sources for budgeting purposes, and many states also tracked the amount financed from individual providers, as well, so this information does exist. During our research we also have learned that the Texas State Legislature recently required the state Medicaid agency to report provider-level financing data in a standard way that could be used as a model for other states.

It is important that any new financing data are publicly available to enable analyses by all stakeholders, not just CMS and other federal entities, similar to the way Congress required that supplemental payment information be made public.

As part of the rationale we also include some design considerations to consider when implementing this reporting. As part of the discussion, we want to include information on the parameters of the tax, such as the tax rates on different entities, any administration fees that the state may keep, and other descriptive information that could help inform analyses of state- and provider-level information.

Furthermore, CMS should establish process

controls to review the accuracy of the data submitted so that it can be more accurate and complete than the existing information. And finally, CMS should design the reporting to be useful for future analyses, including provider identifiers that can be used to link the data to other sources, information on both the date the funds were paid to the state, and the applicable period of payments financed by those funds, options to tie the financing to specific payment programs, where possible, and clear identification of administration fees.

For implications of this recommendation, CBO estimated no change in federal direct spending. There could be some additional federal burden, but that could be reduced if CMS aligns reporting with the existing systems and requirements.

For states, there could be an additional administrative burden to report these new data. To the extent that there are any costs, states could offset some of those costs by retaining additional administrative fees from the financing providers.

And then there is no direct effect on plans or providers in terms of costs, but there could be some

potential administrative burden if the state doesn't already collect the financing information. And then there is no direct effect on beneficiaries.

For the second recommendation, this complements the first one by applying the requirements to CHIP. It reads:

In order to provide complete and consistent information on the financing of Medicaid and the State Children's Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act to apply the Medicaid financing transparency requirements of Section 1903(d)(6) of the Act to CHIP.

For the rationale, states are permitted to finance the non-federal share of CHIP spending using the same methods that they are allowed in Medicaid. There is little information available about how states finance separate CHIP programs. Separate CHIP is only subject to Medicaid rules described in Section 2107(e) of the Act, and regulations do apply many of the federal financing policies to CHIP, but the statute does not explicitly require CHIP to comply with the financing transparencies that may be put into place through the first recommendation into Section

1903(d)(6).

So making this statutory change would apply consistent transparency requirements in Medicaid and separate CHIP without adding substantial administrative burden.

The implications of this recommendation are similar to the first one in that there is no direct change in federal spending. There could be additional administrative burden for CMS, states, or providers and health plans, depending on what additional information may need to be collected, and there is no direct effect on beneficiaries.

As a reminder, we will be voting on these recommendations tomorrow as a package. Please let us know if you have any edits to the recommendation language so that those could be made before the voting session tomorrow. And finally, if you have comments on the draft chapter, we will be happy to hear those.

In terms of future work, we will emphasize the importance of data on provider financing as we continue our work on examining and evaluating hospital payments, which you will hear about a little bit later. And then we will

continue to monitor larger trends in federal spending, including the share of Medicaid spending financed by states, providers, and the federal government.

And with that I will turn it back over to the Commission.

CHAIR BELLA: Thank you, Chris. Can we go to the slide that has the recommendation on it?

All right. I'll open it up to Commissioners. We need any feedback on the language of the recommendation, any questions about the rationale, or any comments on the chapter, or, Tricia, any general questions. I'll let you get us started.

COMMISSIONER BROOKS: Thank you. No, this is great, and I think the recommendations are wonderful. But I was just curious about whether states, when they use Medicaid for targeted low-income kids eligible for CHIP funding, is that information always included as part of Medicaid? Because all of the rules apply, right, with the exception of a child has to be uninsured. And I'm just wondering where that split occurs.

MR. PARK: Sure. So all the financing rules for Medicaid would apply to Medicaid Expansion CHIP, as you

mentioned, and this is where CMS may need to consider how it's reported, because the CMS-64 that we referenced, there are different forms. Medicaid is reported on a set of forms, and Medicaid Expansion CHIP is reported on a different set of forms that are similar in format but they are considered distinct because they are used to calculate the federal share. So the different matching formulas would apply to that. So that is the place where CMS could consider how they structure their report to either keep Medicaid and Medicaid Expansion CHIP separate or if that should be combined somehow.

COMMISSIONER BROOKS: When you look at the CHIP Financial Management Reports you see three buckets, right -- the M CHIP, the qualifying states that are getting extra money because they expanded Medicaid before CHIP came along, and then, of course, the separate CHIP programs. So I can see it that way. So the split goes to CHIP in that regard, but it technically belongs in Medicaid.

CHAIR BELLA: Thank you, Tricia. Tim?

COMMISSIONER HILL: So a comment on the recommendation.

[Pause.]

COMMISSIONER HILL: First, just the overall report. On the recommendation, I don't know if I'm going to get this right, but I worry, on the point you just made about the disparate reporting, 64, different forms on the 64, there's T-MSIS. I worry about us now creating yet another set of reporting that is going to somehow be dissonant or not connected with other reporting we have. I don't know if there's anything we can do in drafting or making a recommendation to limit that, and I'll give it some thought, but I do worry -- and we talked about this last time -- about creating a recommendation with another report that then has to be reconciled to a bunch of other stuff. And is there a way, in the recommendation, to make it clear that we want the report to tie to either a certain CMS-64 reporting or a certain set of reporting under T-MSIS, just so that we are kind of limiting the dissonance to the extent that exists?

MR. PARK: Yeah. I'm not sure if that should go in the recommendation language, but we could try to make that a little bit more clear in the policy considerations, about like CMS working to kind of minimize reporting, and kind of reconstituting existing reporting structures.

COMMISSIONER HILL: Right. And then the other more conceptual comment, can you go back to your first slide, the slide where you say that the financing can result in reductions in net payments to providers.

I guess, and I've struggled with this as we've talked about it, yes, and. Like yeah, okay, it may result in net payment reductions to providers, but as the last bullet shows, only because state general revenue or states have made decisions that other means of financing aren't available. So it seems to me that the issue is more nuanced to that than that, right. It may create a floor to providers, but it may be that without this financing arrangement there is no other source of payment for providers. So it's not just, you know -- I guess it's not just that we're cutting payments to providers. It's that this may be the only lifeline or floor that's available. So I think it leaves unsaid the more nuanced, complex arrangements around state financing for these and what it might mean for hospitals or other providers if these sources of revenue weren't available.

MR. PARK: Yeah, certainly, and we will kind of discuss this a little bit in the supplemental payments

session. But because you kind of see one number, like the hospitals are getting paid Medicare or average commercial rates, that does not necessarily mean they have access to all of that revenue to provide services. So certainly there is a nuance there, and that's why we would want this information to kind of understand both the gross payments and the net payments and how that kind of leads to certain outcomes in terms of access or quality.

CHAIR BELLA: Thank you, Tim. Sonja, then Heidi, then Patti, then John.

COMMISSIONER BJORK: Thank you. I just wanted to comment on the implications page on recommendations. So it says no direct effect on health plans but a potential administrative burden. So in some states it's all managed care and the health plans are the ones who provide the state with the needed data. And so I think it's likely administrative burden in many areas. So I just wanted to emphasize it's not nothing. It'll be a big endeavor to make sure that all the right information gets in a timely way to the right folks at the state.

MR. PARK: Yeah, and it's unclear, because this is financing and generally comes directly from the provider

versus the plan being involved in that transfer of the tax revenue to the state, that the plan may not be that involved on that side. But certainly on the payment side the plan would be more involved.

CHAIR BELLA: Thank you, Sonja. Patti?

COMMISSIONER KILLINGSWORTH: Chris, super helpful. This is such complicated subject matter and you do such a great job of breaking it down.

I am really grateful for the policy considerations, what I really think of as sort of guideposts. I think at the end of the day the reason why I support recommendations that we know will add some degree of burden is that those guideposts have really helped us to get the information that we feel like is really needed to look at access in the least administratively burdensome way. Because I think that there will be some, but I think we've tried to come to a recommendation that helps to get there is as little burden as possible across all of the entities -- providers, health plans, and the state.

I would echo just a little bit of Tim's comment, and I think I brought this up in previous sessions where we discussed this topic. While I understand the statement, as

a practical matter what these payments generally do is generate higher payments to providers than would otherwise be possible. So while I understand sort of the net effect, that it looks like it's a reduction, the reason why providers support these is because it is a mechanism for raising the Medicaid payment, and therefore, by the way, a benefit to the provider types that are eligible to participate in these kinds of taxes, whereas other provider types are not.

And so I would be remiss if I didn't just mention that this is another area where I feel like there is an institutional bias in the Medicaid statute that allows primarily -- not explicitly, but primarily -- institutional providers to be able to benefit from these kinds of funding mechanisms that allow them to generate a higher Medicaid payment whereas home and community-based services providers, for example, are not able to participate in these kinds of taxes, and therefore have to really rely on state general revenue to be able to support increased rates. Thank you.

CHAIR BELLA: Thank you, Patti. John, then Jennie, then Carolyn.

COMMISSIONER McCARTHY: One of my questions has to do more with, Chris, not exactly the work that you're doing but just more of how MACPAC makes recommendations on some of these things and how specific or non-specific we have to be. So in Recommendation 1, in my opinion I think we need to have a little more clarity in there. Because I know we say it's an annual report, but we don't say it's an annual report for actual expenditures. So in CMS world the 64 is actual expenditures, but the 37 is future expenditures. And so I would think that states right now would be like, oh yeah, we give you all this information.

And so I'm assuming what we want is actual -- I don't know the right word here -- is it collections, it's not costs, but we need to think about that wording. So that's one question is we need to put that in there.

Second, do we need to put in there also auditable, because I think this is kind of where Tim was getting. And the point of this is like, hey, they're going to give us this report, but should we also recommend that this report should be audited to ensure that it actually matches with the data that's there. Having run these programs it's like I know the state has the data. Maybe

not down to the provider level, but at least at the state level, if you're saying, hey, this is how much IGT we used, this is how much taxes we used, they would have that data and it would be available to share, to be able to have that information.

So those are more questions of are those things that are necessary to put in there, or do we normally leave it a little more generic so as to let others decide what needs to be in there.

And I don't know if that's a Chris question, a Kate question?

CHAIR BELLA: Well, I'm going to start. I'm neither Chris nor Kate. I think in the design consideration section we address auditability, right, in the chapter?

EXECUTIVE DIRECTOR MASSEY: The design considerations, Chris, I thought said that CMS needed a mechanism to be able to validate the data.

MR. PARK: Yeah, and certainly that's part of it, in terms of that second bullet of establishing process controls or the accuracy of the data submitted. To the extent, particularly like the state level amounts, were

incorporated into the CMS-64, would that address your issue about auditability, because the states do attest that those are accurate.

COMMISSIONER McCARTHY: No. Only because they're not -- it's back to what Tim was saying before -- it's not audited and things aren't necessarily tied back to another. So maybe "audited" is not the right term to use. So maybe it's a moot point because we're saying it should be tied together.

And I didn't read it as it is that clear that those things are being tied together, and it sounded like Tim kind of felt the same way too, that we weren't saying these things were going to kind of tick out on these things. So I guess that's where I'm just a little bit -- I'm trying to think of the right words. I'm not a words person. I'm a finance person. I can think on the numbers side of it but I don't know exactly how to say it.

MR. PARK: Sure. So I would say just because we may want to iterate on the language a little bit, and we need to do the vote tomorrow, that that type of language could be included in the rationale or design considerations section, where it doesn't have to be final by tomorrow

morning, and then we keep the recommendation language as is to vote on.

CHAIR BELLA: Can we go back to the recommendation language, please?

COMMISSIONER McCARTHY: Do we need to say that it's an annual report of actual collections and expenditures?

CHAIR BELLA: Let us come back to that question. Tim, did you have a comment on that?

COMMISSIONER HILL: No, just to piggyback here. The way I think about it is -- and I don't know how you write it, and we can come back to it -- like if I was building this de novo, it would have to be related to a claim that the state had made. So if they're making the claim on the 64, then in all the attestations and all the integrity that associates with that claim, that report should be associated with that 64. And I get it. It's all past data, and there's adjustments and all that.

But having it tied to something that they already report, that there is some integrity around, I worry about audit. I mean, that would be an expense for the state, if you talk about burden. But the states already certify, and

there's already a sense of integrity around that, the claiming.

CHAIR BELLA: Tricia, do you want to comment on that piece?

COMMISSIONER BROOKS: Well, I mean, the recommendation says net Medicaid payments, so that says to me actual expenditures, not something different. So I guess I'm a little confused by the conversation.

COMMISSIONER HILL: I'm being hyper-technical. It doesn't say the time period. It doesn't say for when. I guess I'm coming at it from a very scar tissue, CMS perspective, where you're trying to introduce, trying to write regs, or guidance, to just be uber precise. We don't want a report from the states about an 18-month period that has no relationship to the current claiming period, for example. It's just to make it clear that it's attached to, and the timing and when it's reported is somewhat specified, so that we're not getting a report that's not at all related to claim dollars.

MR. PARK: Yeah, and some of that, maybe we can make it a little bit clearer in that second sub-bullet, clarifying the differences between when the funds that were

transferred to the state versus the date of payment, which we're talking about like when payments were made for those particular services or providers. So I think that is partly how that UPL supplemental payment report is now done, in terms of it provides fields to kind of say this was for expenditures in this particular quarter. So maybe we can be a little bit more clear about how it should tie back to specific CMS-64 reporting of spending.

COMMISSIONER BROOKS: But isn't this a little bit about how statutes are crafted versus regulations, right? The statute is usually more vague, and CMS has to build it out.

MR. PARK: And that's partly why we have this design considerations, because first we didn't want the recommendation being like two pages long, but also because some of this is more implementation than the actual statute. And so there is a lot more consideration that needs to be done there as we implement it.

EXECUTIVE DIRECTOR MASSEY: Right. And I would just add, Chris, that when it comes to that transition between this recommendation that is directed to Congress that would make a change to statute versus guidance that

CMS will articulate to make sure that the reporting facts and some of the principles that John and Tim are talking about regarding time frame and what have you are detailed, that because we had, as one of the design considerations, and one of the themes that has come through the work, not being overly administratively burdensome to states, that if we were to opine and anticipate, define, for example, a time frame, we may be creating unintended consequences of upping that administrative burden when CMS, as the regulator and the overseer of the activity, might have a better handle on how to implement this as seamlessly as possible.

CHAIR BELLA: Tim, is just having some empathy for the people at CMS that are going to be on the side of figuring that out.

All right. John and Tim, if you're okay with it we'll leave the wording as is and we'll just see if there are opportunities to tighten it a little bit in the chapter, particularly around the design considerations. Does that work for both of you?

All right. Heidi, I skipped you, so I'm coming back to you, and then Jenny and Carolyn.

COMMISSIONER ALLEN: Thank you. I really appreciate these recommendations. I'm excited to vote on them tomorrow.

I just wanted to check in before we -- and this is probably around design considerations, as well, before we're moving forward -- have we fully threaded the needle in making sure that this information will be linked to all of the databases that are used to determine payment and access, payment and quality, those kind of payment and affordability, particularly nongovernmental researchers who don't have access to internal data systems?

I mean, a report that's publicly available and can be useful for analysis, and we mentioned linking to some, but have we taken advantage of every opportunity to say we think that this needs to be able to be useful for researchers?

MR. PARK: Yeah, and we can certainly look at the specific language that is included in the chapter to see if we can emphasize that a little bit more. We certainly say it should be publicly available, to enable analysis by all stakeholders. You know, here are the design considerations. We really want the data to be linked with

other types of reports, like Medicare cost reports or other things at the provider level where we would use common identifiers like NPI or hospital CCN, some way that you could try to link sources. Because, just from our perspective, as MACPAC, we would want to look at individual claims data and T-MSIS.

COMMISSIONER ALLEN: That's what I'm wondering.

MR. PARK: And so do we have the same identifiers, like NPI, hospital CCN, or the Medicaid ID. That's the ideal state is to have these provider identifiers that could be used to link to different data sources.

COMMISSIONER ALLEN: Yeah, and if you're working in the virtual environment, are you able to utilize those different datasets to do this kind of research, or is that only if you have access to the proprietary data and can do the merging yourself?

MR. PARK: I mean, we certainly have not thought that far ahead. To a certain extent these won't necessarily have to be protected data, because there is no PII there, and really, we're kind of looking at the Texas model of how they basically have a report that's publicly

available on their website that shows this provider paid this amount in this quarter or year, without getting into the whole systems issue about what you can and can't import in and out of the system, I'm not sure about.

COMMISSIONER ALLEN: Well, I'm thinking about health services researchers who really have been wanting this kind of data for a long time, who are now going to be moving to a virtual data center to work with T-MSIS. Will they have the ability to link? Because unless it's already linked, I'm not sure that they would have access to be able to do this kind of analysis, or become a very expensive study because you would have to -- I don't know how you would do it.

MR. PARK: Yeah. I mean, certainly the way the supplemental payment data has been conceived, that CMS is now collecting and should report publicly, that's like a spreadsheet where it will have certain amounts that were paid to individual providers, with a particular provider ID. And I don't think that has to be directly linked to T-MSIS. You could do a summary out of T-MSIS on the claims paid to that provider. So Provider XYZ got X millions of dollars in the year. And then from that kind of summary

extract you could then link to the supplemental payment data.

And so we're envisioning that you could also link the financing of either base payment, supplemental payments, or however it ultimately comes about, with that provider identifier. That wouldn't necessarily have to occur within that virtual system.

COMMISSIONER ALLEN: Okay. I think that just any opportunity that we can take to emphasize that we want this data to be usable to external researchers to be able to use payment information to understand its relationship to access and quality and equity I think would be great. Thank you.

CHAIR BELLA: Thank you. Jenny, then Carolyn, then Jami, and then we're going to be wrapping to public comment.

COMMISSIONER GERSTORFF: Chris, one of the key points that you made in the chapter was on administrative costs to the state, and using Texas's experience of their implementation, that they had tried to implement this but didn't have any funding. And so it really was only successful after they had appropriated additional funding,

and so now we have these reports.

I think it could be important to highlight that more clearly and maybe connect it somehow with where we say there would be no increase in funding necessary for adding this report. I know the CBO scored it as no additional federal funding. But you also noted in the chapter that states can get enhanced federal match for setting up a Medicaid enterprise system, and so that feels like there could be additional federal spending there.

And also it sounds like Texas did not apply for the enhanced federal match. They just used their standard 50 percent.

So also making that more prominent, highlighting that states do have this ability to apply in advance for funding to set up a data warehouse that would collect this information.

MR. PARK: Okay.

CHAIR BELLA: Thank you, Jenny. Carolyn?

COMMISSIONER INGRAM: Yeah, thank you, and thanks, Chris, for your work on this section. It's obviously really complicated.

I wanted to go back to one of the things that

Sonja talked about, just to make sure I'm clear in understanding. I think it was on page 37 in the report you talk about the managed care companies and the effects on them in terms of taxes, and make sure that it's clear. So managed care companies pay taxes, they pay assessments. In those sections you were talking about both taxes and assessments, right?

MR. PARK: Yes. States use different terminology, but generally we would consider assessments under the same umbrella as health care-related taxes.

COMMISSIONER INGRAM: Okay. And so those are all paid out, obviously, and tracked already by the state, maybe not too heavy of a burden to get that information put into the report.

But I think the other section Sonja brought up was all the different directed payments that go out to providers, whether it be like a gross receipt tax that's tacked onto their fees, or it could be an extra payment to a hospital.

In terms of the reporting, I think maybe in that section we talked about there's not much of a lift there, but I have to agree with Sonja, there is going to be quite

a bit of lift to make sure that those things are reported separately. Either it's going to have to happen by the state or the health plan. It goes in through encounter data. So one of the entities is going to have to separate that out and make sure that it gets reported, and I think that's probably where she was going with that thought. So we do need to make sure it's clear in there that there will be an effect for those two sections.

And that's all I have. Thank you.

CHAIR BELLA: Thank you. Jami?

COMMISSIONER SNYDER: Chris, again thank you for this important work. I'm going to go back to something that Tim mentioned earlier around the statement, on Slide 3, where we talk about health care-related taxes and local government contributions to the non-federal share -- I'm sorry, the cost of those taxes and contributions to the non-federal share reducing the net payments to providers.

I think we do need to pay attention to that language a little bit. As we know, these types of payment programs that rely on taxes and IGT contributions don't rely on GF dollars are playing an increasingly important role in funding Medicaid programs and supporting providers.

So I just wonder if we just want to modify that language a bit, and rather than saying reduce the net payments, impact to the net payments, because I think it's a perception issue, especially for those benefitting from these programs. And these programs are playing an increasingly important role in funding Medicaid programs. And maybe that's a little in the weeds or wonky, but I think there may be some merit to just modifying that language.

MR. PARK: Sure.

EXECUTIVE DIRECTOR MASSEY: Jami, could I just ask a follow-up question? I mean, it's directional, right. So the cost of the tax will always reduce the net payment. I guess when we talk about a change impacting it, it feels like it's opening a door to make it seem as if it's a positive net impact, and I don't [audio interruption] on the gross payment, though, right? If we go back to the Texas example, what we were talking about was that the provider contribution helps raise the gross, but that when you take their contribution into account it brings it down on a net basis.

CHAIR BELLA: But I think Jami's point is without

it, I mean they're still better off than they would be without it, and this implies that we're hurting -- they could be better off, if everyone is better off, depending on how the dollars get redistributed.

COMMISSIONER SNYDER: And maybe it's not impact. Maybe it's another word.

MR. PARK: Yeah. I think maybe we can try to be a little bit more specific in that these methods of financing can increase overall payments to providers, or revenue to providers, but the amount they receive after taking into account these costs is lower than the initial amount that was paid to them.

COMMISSIONER SNYDER: We recognize that we need to account for their contributions in better understanding the net payment, or something along those lines.

MR. PARK: Yeah.

CHAIR BELLA: Tricia?

COMMISSIONER BROOKS: But don't we have to be careful? It's not a quid pro quo, and that's what Congress stepped in to prevent at some point, that you don't just charge a tax and then capture federal match and pay it back to the provider. So there's a fine line here.

CHAIR BELLA: Yes, yes, and I think, Chris, I think what we're asking is to make it clear there is a benefit to providers who have these opportunities, and when we're looking at the allocation of those we will take into account when they put something up for what they get back without having it be a quid pro quo.

I think we just want to make it not seem like this is penalizing providers, I think is where Jami was going.

MR. PARK: We're talking generically about providers and not individual provider per se. And so hospitals, in total, you know, will generally receive more than if they didn't finance it, but then individual hospitals may or may not actually get more.

COMMISSIONER BROOKS: That's true. Systems and not individual hospitals.

MR. PARK: Yeah.

CHAIR BELLA: Okay. Given how deep Chris is in this I am confident that he will work some magic with the chapter to make sure that conveys.

Any other comments from Commissioners?

[No response.]

CHAIR BELLA: Chris, any clarifications you need before we open it up to public comment?

MR. PARK: Nope. It sounds like we will just bring back the recommendation language as it is now for the vote tomorrow, so I think we're fine.

CHAIR BELLA: Yes. We'll do that, and then you'll take care of the comments we've discussed in the chapter. Perfect.

CHAIR BELLA: All right. Thank you very much, everyone. We're going to open it up to public comment. We will invite people in the audience to raise your hand if you would like to say something. Introduce yourself, the organization you represent, and we ask that you keep your comments to three minutes or less, please.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: All of our commenters must be waiting for our afternoon session. We don't have any comment right now, so thank you, everyone, for your engagement this morning.

We're going to break until 1:30, and we're going to come back and talk about state Medicaid agency

contracts, fondly known as SMACs. So we will see you all back here at 1:30. Thank you.

* [Whereupon, at 12:10 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:30 p.m.]

CHAIR BELLA: All right. Welcome back, everyone, to our afternoon session. We are going to start off. Drew is going to talk to us about state Medicaid agency contracts. And just as a reminder to folks, there are two recommendations that we are moving toward a vote tomorrow for an inclusion in the June report.

So welcome, Drew. I will turn it to you.

OPTIMIZING STATE MEDICAID AGENCY CONTRACTS (SMACs)

* MR. GERBER: Good afternoon, Commissioners. Today I'll be walking through an overview of a draft chapter for the June Report to Congress on optimizing state Medicaid agency contracts, or SMACs. This chapter includes two recommendations which the Commission will vote on tomorrow.

The chapter begins by covering some background on dually eligible individuals in integrated care, as well as on Medicare Advantage dual eligible special needs plans, or D-SNPs, and the SMACs they must sign in order to operate in a state. Then the chapter reviews work I presented back in

November on how various states include provisions to leverage their SMACs, and the findings I presented in January from our interviews with key stakeholders on optimizing and overseeing these contracts. I'll then touch on several considerations for states which led to the two recommendations included in the draft chapter, before opening the conversation back up for Commissioner discussion.

D-SNPs are a type of special needs plans, or SNP, designed to provide targeted care to dually eligible beneficiaries. In calendar year 2021, from our Duals Data Book, there were 12.8 million dually eligible individuals. Focusing in on the full-benefit duals or those that received full Medicaid benefits, as these are the individuals most likely to benefit from integrated care models. Of those full-benefit duals who received Medicare benefits exclusively from managed care, 60 percent of those individuals were enrolled in a D-SNP, with the other 40 percent of full-benefit duals enrolled in other Medicare managed care plans, which would include Medicare-Medicaid plans under the Financial Alignment Initiative or the Program for All-Inclusive Care for the Elderly, PACE, as

well as traditional Medicare Advantage plans.

The Medicare-Medicaid Coordination Office, MMCO, estimated that in fiscal year 2022 about 1.75 million full-benefit dually eligible individuals, or 21 percent of full-benefit duals, were enrolled in an integrated care plan. This includes other integrated models such as MMPs and PACE, and includes some D-SNPs but not all. As we have discussed previously, levels of Medicaid-Medicare integration in a D-SNP can vary, even among those that CMS considers to be integrated.

D-SNPs differ from traditional MA plans in several ways, but most notably, like all SNPs, D-SNPs are required to establish a model of care that describes the basic framework for how to plan or meet the care coordination needs of its enrollees. And uniquely, D-SNPs are required to contract with state Medicaid agencies to provide or coordinate Medicaid benefits through the SMAC.

As we've said before, while D-SNPs are required to sign a SMAC to operate within a state, states are not required to contract with every D-SNP. In general, federal law sets few minimum requirements that must be included in these SMACs, and states have authority to go beyond what

federal law requires, to require greater integration or to better tailor how D-SNPs serve the dually eligible populations in their state. Minimum requirements were established by the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA, and additional requirements were included in the Bipartisan Budget Act of 2018, and these requirements have continued to be refined in rulemaking.

These requirements are primarily described in 42 CFR 422.107, but they also include requirements related to eligibility, care coordination, member materials, and enrollee advisory committees.

In order to better understand what provisions states included in their SMACs and how commonly they were leveraged, we worked with a contractor to review contract year 2023 SMACs for all states. Through our review we found that provisions that states add to their SMACs above the federal minimum requirements fell within five domains: coverage of Medicaid benefits, care coordination, integrated materials and member experience, data sharing, and reducing health disparities and improving quality.

Our review showed that state adoption of SMAC

provisions are uneven, without any clear identifiable or consistent patterns. While some provisions were more common, even these weren't leveraged by a majority of states with D-SNPs. Our review illustrated the SMAC landscape, but more information was needed to understand why states include the provisions they do and how they oversee the requirements they do choose to include. For example, data-sharing provisions were commonly included in SMACs, as we found in our review, for both states with more integrated D-SNP types as well as those with minimally integrated D-SNPs. However, our review alone cannot reveal how states use or oversee the data that they require D-SNPs to report.

This led us to the next phase of the project, a series of interviews with key stakeholders to the SMAC process. Through these interviews we attempted to learn how states choose to optimize and oversee these contracts.

In our interviews we focused on a number of questions: How do states consider which provisions to include in their SMACs? What types of relationships do states have with the D-SNPs that operate within the state? How do states operationalize their contract requirements,

and to what purpose? How do states oversee and enforce their SMACs?

For these interviews we spoke with state officials in five case study states, federal officials at CMS, and health plan representatives for two plans that operated across our case study states. The states which we selected for their high levels of integration and their experience with D-SNPs and oversight of additional SMAC requirements include California, the District of Columbia, Idaho, Minnesota, and New Jersey.

Several key themes arose from our interviews. When considering whether to contract with a D-SNP, state officials said that they prioritize state goals, namely increasing alignment between Medicare and Medicaid plans under the same parent organization, as well as limiting disruption for beneficiaries.

All states we spoke with required D-SNPs to submit a range of data in the form of reports, yet officials said that many of these reports are only assessed for timeliness, completeness, and accuracy, and are not used in a meaningful way for oversight. Instead officials said that appeals and grievance data and complaints to the

Ombudsman Office typically helped to spotlight issues with the program.

To ensure compliance with their SMAC requirements, states rely on a number of enforcement tools and penalties, both monetary and non-monetary, while few currently include performance incentives in their contracts with D-SNPs. However, we learned that some of these enforcement tools may sit within the Medicaid managed care contract rather than within the SMAC, which CMS said could influence how and when states choose to use these enforcement tools.

We also heard in our interviews about barriers that states face in optimizing and overseeing their SMACs, which I will touch on in a moment.

Taking into account the current SMAC landscape and what we heard from our interviews, the chapter addresses some considerations for states as they look to optimize and oversee these contracts. Beginning with some barriers, we learned that states face barriers in leveraging and overseeing their SMACs with D-SNPs that mirrored the larger challenges that states have in pursuing integrated care models as a whole. A lack of staff

capacity and Medicare knowledge place operational limits on what state staff said they can require in their SMACs, and to earn buy-in from state leadership, staff said it is important to be able to explain the value of requirements and connect the SMAC design to larger state goals, and furthering those goals.

Over the years the Commission has explored integrated care, we have heard states express issues of capacity, primarily resources and expertise. The Commission made recommendations to Congress in 2020 and in 2022 to support building state capacity to pursue integrated care. Legislation has been introduced that would follow the Commission's recommendations, but Congress has not yet enacted the recommendations to date.

Looking at strategies for effective oversight that we gleaned from our interviews, states at any stage along the path to integrating care for dually eligible beneficiaries should understand their contracting authority and ensure they are collecting data necessary to effectively oversee D-SNPs in their state.

Our interviews identified two tools that could represent a starting point for states to optimize and

oversee their contracts, that being care coordination data and MA encounter data. Care coordination data could include health risk assessments, or HRAs, which plans are required to administer when a beneficiary is enrolled and then annually, or, for example, the ratio of care coordinators to beneficiaries. For example, a state that is interested in racial or ethnic disparities among duals could require that D-SNPs stratify HRA data for the state by race and ethnicity.

Plans also submit MA encounter data to CMS as risk adjustment data, and states only receive these data currently if they require the D-SNP to submit to the state, as well. These data can be used in various ways, such as for setting capitation rates for Medicare cost sharing, as is done in the District of Columbia, or to inform the design of care transition policies, as California plans to do.

I'll note here that CMS recently issued a final rule this month, officially published, I think, April 23rd, that would more readily allow states access to MA encounter data to improve the Medicaid program. In its rule, CMS noted that several dozen states have requested such data

from it already, and that is more than what we have seen reflected in SMACs. CMS said it sees MA encounter data as useful for states to promote underutilized services or to identify duals with unaligned coverage, among other things.

Moving towards our recommendations, our first recommendation reads:

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.

As I began to outline in March, we feel our research points to data on care coordination and MA

encounters as priority areas for states to effectively oversee D-SNPs. Care coordination is central to integrating care and a key feature of the D-SNP model, and data on care coordination was highlighted by both state and federal officials as a useful measure of performance.

A number of states currently collect Medicare Advantage encounter data as well, but few use these data for oversight at the moment. However, interviewees noted that these data are necessary to understand the health of the dually eligible population and to inform quality improvement efforts.

Finally, we believe that states at any level of integration can begin requiring these data from D-SNPs in order to optimize and oversee their program as a first step towards larger oversight.

Looking at the implications, the Congressional Budget Office, or CBO, estimates this recommendation will have no direct effect on federal spending, and similarly we anticipate no direct effect on providers from this recommendation.

States, should they choose to require these data reports, may see substantial upfront administrative burden,

especially when it comes to ingesting and processing MA encounter data. Other groups, such as MedPAC, have highlighted the challenges with using MA encounter data. However, we believe there is enough value in states having utilization data, as highlighted by CMS in its final rule this month, as well as the technical assistance available from the Integrated Care Resource Center.

We don't anticipate a direct effect on enrollees, though we acknowledge they may benefit from more integrated care if states can leverage these data to ensure beneficiaries are receiving the care coordination that the state expects or if they are used for quality improvement.

And finally, we expect that there would be an administrative burden on plans to submit these data to the states in the manner required in the SMAC, but plans inherently would agree to shoulder this burden by signing the contract.

And our second recommendation, I would like to footnote that there is a minor language change from the version that Commissioners received in their materials. We edited the recommendation to say "should update" in lieu of "should issue," in order to better reflect the level of

effort we think would be necessary for CMS, as they've previously issued similar guidance to states in 2018.

The recommendation now reads:

The Centers for Medicare and Medicaid Services should update guidance that supports states in their 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.

The Commission's prior recommendations, including the recommendation that CMS require states to develop integrated care strategies, still stand. However, we believe that new CMS guidance could prompt states to consider their integrated care strategy, even in the absence of a requirement, by outlining the tools available to states. Specifically with D-SNPs, federal officials said that a lack of awareness of state contacting authority and its limitations, as well as the value to be gained from a SMAC, hinders states from doing more with their contracts.

CBO estimates this recommendation has no effect on direct federal spending, but did note that discretionary federal spending might increase in order to support CMS staff in issuing guidance. States could benefit from guidance to bring greater clarity on their contracting authority, and could catalyze state Medicaid agencies and their leadership to investigate how integrated care could best serve their populations.

We expect no direct effect on enrollees, but would note that they may gain greater access to integrated care options if guidance prompts uptake of integrated care among states. We expect no direct effect on plans or providers, although some providers may also benefit from more information on integrated care models to better understand how they could participate in these models or to inform their engagement as stakeholders with the state.

Looking to some next steps, the draft chapter will have votes on the two recommendations I presented tomorrow. Staff will then finalize the chapter for the June report, incorporating the conversation that we hear from Commissioners today. And finally, we will continue to track legislation and rulemaking related to integrated

care.

I will pass it back to Melanie.

CHAIR BELLA: Thank you, Drew. Comments or questions from Commissioners? Patti, I see your hand.

COMMISSIONER KILLINGSWORTH: Drew, no surprise to anyone but I care deeply about this work. I just think this is such an important population, and it is certainly one that has so many challenges in terms of access across two very complex federal health insurance programs.

I do just want to sort of tie back to the whole aspect of why D-SNPs exist. They were created as a mechanism to coordinate benefits across the two programs. So when we talk about the value of care coordination data, it seems so obvious that it should be a priority for us. And I do think it's really important that, I think, collecting data sort of is a way of getting measurable proof, if you will, but I really do think that before sort of that data has to come these policy goals. What is it that we are hoping to achieve here with care coordination requirements? What is it that we are really hoping to look at through receiving our encounter data? We need to sort of articulate that and be sure then that we receive that

information and we use it in a way that is actually meaningful.

I think when we think about coordination of benefits, particularly those areas that cross both programs, the one that always comes to my mind is when people are admitted for an inpatient stay in the hospital, and making sure that data is being readily exchanged, which is now sort of a minimum requirement. But I think having some reports on that, understanding the timeliness of that really matters. Understanding whether coordination is actually happening as it relates to home- and community-based services. Medicare doesn't really have, for all intents and purposes, much of a home- and community-based benefit. And so making sure that that coordination is there, and I think reports can really get at that kind of information, and it's really valuable in order to do so.

And then when we think about encounter data, golly, there's so much we can do with encounter data to really understand the value that integrated care models bring, or don't bring, but I believe it is bring, to people by really looking at how does it impact their utilization of health care. Are they more likely to receive

preventative care? Are they less likely to go into an inpatient setting? Those kinds of things really matter, and so having timely access to that encounter data allows a state and/or a health plan to really be able to utilize that data, understand impacts, and then, honestly, to be able to intervene in a timely way to help improve health care outcomes.

I would just reiterate one thing, and I think you laid this out beautifully, that this is a starting point. So all of the things that I'm saying, Drew, I don't think impact the recommendations at all. I'm fine with the recommendations. I think in the chapter if there are opportunities to sort of highlight any of these things more than they already are, that would be terrific.

And one of those is just underscoring again the need for integrated care models, available in every state, with support for states in terms of capacity building to really be able to do that work. This is a way to get everybody sort of started, but it's certainly not where we need to finish.

So we, as a Commission, I believe have an obligation to continue to press forward on making sure that

integrated care options are available to everyone. Thank you so much.

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

COMMISSIONER HEAPHY: Thanks. Give me one second.

[Pause.]

COMMISSIONER HEAPHY: Drew, Kate, don't hate me. I think there are a lot of challenges that the states have in developing the SMACs, and I'm going to focus my comments on one area, and that's that we need to place more emphasis on advancing state goals that align with independent living philosophy in the recovery model, and ensuring that the consumer voice is involved in the development of the SMACs and the overall state MOC. And if folks are wondering what IL philosophy is or what the recovery model is, maybe that's the place to start, is that the next iteration of the work that you do, Drew, is to really look at how independent living philosophy can be operationalized, and how important the recovery model is -- I see you've written about this in the past -- is to advancing care for folks.

In terms of care coordination, it really should

be direct positive impact on enrollees, and anything that we recommend, enrollee experience needs to be front and center. As the data collection improves the experience, it is therefore necessary. For example, off the top of my head, is that care coordinators be trained in operationalization of independent living philosophy and the recovery principles, that institutional rebalancing, in our care coordinators helping people to move out of nursing homes more to keep people in the community.

How are we defining care coordinator encounter data? Is it just they touch base by phone, or is there an outcome there? Do care coordinators merely give people a list of providers and have the person sort out the list of providers for themselves, or do they actually work with the person to find the provider that meets their needs, not necessarily about medical providers but home health agency or some other entity that meets their needs. Are there increases in the number of people engaging with certified peer specialists or recovery clerks as a result of their interaction with care coordinators? Are care coordinators working with people to get them off waiting lists for services? And are the states keeping records of these

things? Are care coordinators working with utilization management to overturn modifications and denials? Do we see a reduction in modifications and denials? Are care coordinators actually engaged with discharge planning? And you just mentioned this before, there are some things that we really need to focus on.

And then, also, how does the care coordinator work with and interface with the care team? And then beyond that is how is care coordination and care integration hampered by the use of algorithms? We are increasingly seeing algorithms being used and plans getting their hands slapped. And I'm not saying all plans are doing this, or maybe there's a negative reason why algorithms are always used. But we're seeing plans getting in trouble for using algorithms, so how are states max ensuring that the care coordinators and the integration is protecting enrollees from the use of algorithms that might negatively impact them?

So I guess at some point it is reframing the conversation around not what is just good for the state model, because you said there are so many different models, and SMACs, and it seems there's nothing that ties them

together. And I just think that independent living philosophy and recovery model are two really key elements of independent living and life for folks with disabilities that could really do that.

So I don't know what your thoughts are on that, Drew, but that's just what I was thinking as I was relooking at the document today.

MR. GERBER: Thank you, Dennis. I think those are all things that we sort of began to consider. Again, we are trying to start at a 101 level of just making sure that states understand that these two elements are really the priority areas that they need to focus on if they want to effectively measure performance of their D-SNP and understand how a D-SNP is performing for their enrollees. I think that there is probably a lack of understanding in many states that have D-SNPs. Again, we spoke with states that were sort of the most experienced, that have the highest integration models of D-SNPs. I would assume that other states may have even less experience or facility in terms of being able to understand what is truly happening within these plans for their enrollees.

So I think that you bring a lot of good points.

Those are conversations we are hoping that between our first recommendation and second recommendation that states will begin having, sort of to define what does care coordination actually mean for us and what we are hoping to get from these plans for our beneficiaries. So thank you.

CHAIR BELLA: Thank you, Dennis. Jami, then Jenny, then Carolyn.

COMMISSIONER SNYDER: Drew, I think you may have just answered the question I was about to ask. Just curious. Can you remind us what sort of data elements you are contemplating under that care coordination bucket?

MR. GERBER: Right. So I think we left it somewhat undefined in terms of we want states to be able to choose the data among these two domains that best fit their own goals. But largely I would say examples of care coordination data that we focused on would be from the health risk assessment, whether that's just receiving the actual findings of those assessments, requesting that that data be stratified according to an indicator that of interest to the state.

I think there are other examples such as states could request a sample of care coordination, individualized

care plans, to understand whether requirements are being carried out in those plans. You know, if they have specifically, let's say, there needs to be the documented inclusion of a certain Medicaid, let's say, LTSS provider in there.

So again, we're leaving this sort of open for states to consider and think about. I think most would really sort of be beginning at that first step, which would be receiving HRA data, understanding sort of what's in there beyond process measures, which right now would be completion within X number of days as required by the state.

COMMISSIONER SNYDER: And I can't remember. Do we actually speak to that in the draft chapter, just some of those examples?

MR. GERBER: We do list a few examples, yes.

COMMISSIONER SNYDER: Okay, great.

CHAIR BELLA: Thank you. Jenny?

COMMISSIONER GERSTORFF: Thanks, Drew. I have a little recommendation on the recommendation language, and then I have some comments to kind of build on what other Commissioners have said. Can you go to the Recommendation

3.1?

So I may be the only one who interpreted it this way, but I kind of got confused where it switches at the end to "if Congress chooses to require that all states develop a strategy," that sentence. I think because of where the subject and object are, I interpreted this as being something directed towards Congress as they consider, you know, with the new proposed legislation, the strategies, or requiring states to submit a strategy. But I think spending more time with it, this is really a continuation of recommending to states that if they are required to create these strategies that they should be considering how data will be used and integrating that into their plan.

So I would maybe propose -- and I am interested in feedback from others -- if you flip there, instead of "if Congress chooses to" say something like "if states were required by Congress to develop a strategy," and then continue as that is.

MR. GERBER: We can, I think, take that back.

COMMISSIONER GERSTORFF: Sure. From there, kind of building on what Patti said about this being a first

step, I think we could have more framing of that in the chapter. It felt like some of that was kind of missing, the idea of having the data and learning how to use it and ensuring validation is really a first step to improving any kind of oversight. And that's why it's so important that we are recommending that they collect data.

And I think recognizing more clearly, too, that states have limited resources, and we heard from states that they are pulled in all different kinds of directions, and they are lacking resources. But this is so important, we think it should be at the top of their list. That is really important.

And then I noticed that, for our recommendations being focused on data, we really don't touch on the idea of data until way late in the chapter. So maybe bring forward some of the points that you make later on into the beginning, where you introduce the introductions, or the recommendations, just to kind of maybe give some of those examples of what care coordination data are and how you would use the Medicare Advantage encounter data, that sort of thing, would be helpful.

And then recalling back to Chris' chapter earlier

today, something that was mentioned in the chapter was the opportunity for states to have enhanced match for administrative activities in their Medicaid enterprise system. So I think to the extent that would be an option here, as well, that states would qualify for enhanced match if they file an advanced request from CMS, I think that could be important to note, to give states the idea that additional funding could be available.

And then I think multiple people have said we really look forward to future opportunities in this body of work. I think you've done a fantastic job pulling together a culmination of lots of things. That's a starting point. And so I look forward to seeing where it goes in the future, and hopefully continue to get insight on how states are using data, what different data sources are available readily already, how states are using it, and maybe where it can be improved over time.

And then my last thing, I just want to put a little plug in your Appendix 3A. I really love it. It's really nice to see very clear strategies outlined there that states are using, and how many states are using them. I think that will be helpful to everyone.

CHAIR BELLA: Thank you, Jenny. Carolyn.

COMMISSIONER INGRAM: Thank you, and thanks for the work on it. As Jenny mentioned, it is an important area I think to everybody on the Commission.

The one thing that I didn't see in the report that I do think is worth calling out is just the barriers, actually, to using a SMAC agreement. So if a state wants to there are some barriers to getting there, and it's primarily because it's the only tool left to integrate care, because of the MMP demonstration really going away.

And one of the barriers that we have seen across states is how the Medicare program and how CMS decide to use stars, and how star ratings are occurring with plans and not specific to the state and the quality that happens in that state but across the whole country. And I think it's something that creates a barrier to a state to be able to really implement and use a SMAC agreement if they want to.

So the quality of a program in New York shouldn't really affect the quality of a program in Washington. So I do think it's important in the chapter to mention that barrier, and I know we can't make recommendations about

what Medicare does. But looking at that consideration more around what else can states do then if they really want to have an integrated approach, but their health plans meet different requirements, and what can be done to really have that stars approach reflective of the quality in that particular state and what's going on in that state.

MR. GERBER: Thank you. Yeah, I think we should be able to consider that, especially in the context of the final rule CMS just put out, which sort of talks about the Medicare role with contracting with D-SNPs, that we may be able to fit something into the chapter about sort of the non-state issues when it comes to signing SMACs.

CHAIR BELLA: Thank you. John.

COMMISSIONER McCARTHY: I'm really struggling with this first recommendation, not that I don't think it's a good recommendation. I think it's a good recommendation. But the fact that we are saying states "should" do this, and put a "should" in there. Because I think some states want to do it, but it's this issue of, well, you tell them you should, what are they going to deprioritize? There might be something else that they're doing that we think is also important that then they don't do. So I'm really

struggling with this one because I agree, from the overall big picture, it's the right thing to do, and in a state, like this is something to do, but it's like how -- it's almost like I was trying to think of a fix to it, not just saying here's the problem but here's a fix, is something to the effect of, you know, NAMD, the National Association of Medicare Directors should create a working group to explore how to help states do these things, or something to that effect.

I'm struggling with that, us telling states, do this. Because it comes across as we're telling states, it's not a shall. I know it's not a shall, but that's what it comes across as. I'm struggling with that part of it, when states are under-resourced.

I know we talk about resources later on in there, and some of those different pieces. But I am assuming that states, you know, if they wanted to do this, they would be doing it, because some have.

CHAIR BELLA: Yeah. I think that we've had a lot of conversations about the need for state capacity, and we certain don't want to appear tone deaf to what we're hearing from the states. At the same time, we've been

making recommendations to Congress. They're not taking those recommendations right now. With this we're deciding, okay, and then let's also send a statement to states about signaling what is important, right. Because they don't have time to read the chapter about whatever the states are doing in their SMACs. And so trying to take an opportunity to say, these are things are really important.

And I agree with you. If there was a magic word other than "should," but it is also -- at some point some forcing function has to happen to get people and states in a position to be able to take action on these things.

So I guess, John, the point here is to recognize that states are sort of the key here. We have not made a recommendation directly to states in the past, and this is an opportunity to do that. And I think we have to keep pushing. We have to keep pushing the states, too. At some point this has to be more of a must-do instead of something that falls off, you know, every time something else comes along.

So I think it makes it really important for us to continue to recommend to Congress, as well, the importance of things we said in the past, supporting states through

whatever form of support that is to build capacity, to having all states have to have a strategy. States have to have a quality strategy, so they should have to have an integrated care strategy and an equity strategy, and those things all should tie together.

So I think that it is an important opportunity for us to signal something to states, and that is the intent. And I think the important thing is making sure the chapter is sensitive to that, and I think that Drew has been working on that, Drew and Kirstin and Kate. And we can also make sure that NAMD and others understand the spirit in which this is made and that we're going to continue to work on the other pieces, that we try to support states in doing this.

And if between now and tomorrow morning you come up with a new magic word, we can probably swap that in.

I have a few comments -- shocking, I know, but this is my last time, so you're going to hear them.

Verlon, and then Rhonda, and then we need to dispense with what Jenny has put on the table, as well.

COMMISSIONER JOHNSON: So ironically, I was thinking I wanted something stronger than "should," but I

always think "must" is really the word that we wanted to steer away from it, and I thought "should" was a better word.

But I do want to say to Drew, thank you for incorporating our previous recommendation around the strategy, because I thought that was very important. I do wonder, though, I think our 2020 recommendation, is that highlighted at all in the chapter at all? Okay, so I just wanted to make sure that was in there, as well. Thank you.

CHAIR BELLA: Thank you, Verlon. Rhonda?

COMMISSIONER MEDOWS: I don't have anything. You already covered it. I'm good.

CHAIR BELLA: Okay. Because this is the last time I get to talk about duals from this seat I'm just going to remind us of kind of, kind of by a little walk, but a very quick walk down memory lane.

We have this guiding principle, sort of our north star, is that all duals should have access to an integrated product, and we identified three ways that we thought we could drive that goal. And despite all of the efforts of states, of CMS, of Congress, of this Commission, we still only have about 20 percent of people who are full duals in

an integrated product, and the spending now is almost $500 billion, a year. And if you do that math, we are not getting economy, efficiency, access. We're not getting anything, arguably, for the amount of resources that we're spending on this most complex population.

And in all other conversations of health care we seem to be seeking to simplify, and nothing we're doing is simplifying. So we're doing a great job of trying to do the best we can to use a SMAC to make Medicaid and Medicare work together, but at the end of the day we still have -- and Dennis can chime in here -- some of the worst examples of the misalignment comes in coverage of home health, coverage of DME, where the two programs have different standards, they do not work well, they do not support independence, they do not support community living, none of that.

And so all I'm saying is this is a really important recommendation because we looked at MMPs, we looked at D-SNPs. D-SNPs have the largest amount of enrollment. They are a vehicle of the future, and understanding how states can use those tools. But we also looked at one point about the elements of what a unified

program would look like. And I know a unified program is frightening to some. But the opportunity we have to think about how we would simplify and meet the goals of a choice for everyone of that kind of product, with economy, efficiency, access, all those things, I just would encourage us to take advantage of the fact that this has bipartisan interest, and Congress hasn't acted on it since 2018.

And so I will actually be in the audience calling in, in future years, if you choose to continue on this, and I will continue to make that comment. But in the meantime, appreciate very much that we are actually recognizing the role of states in this recommendation and also the partnership with CMS and their willingness to continue to try to provide direction on ways to move the ball forward.

So with that, Jenny has suggested that we change the second sentence, I believe to say, "If states are required by Congress to develop a strategy," with the rest of it continuing. It is a non-substantive change. If people are fine with that, Drew and Kate and Kirstin can talk and make sure there are no concerns. But generally, is the Commission fine with it, given that it's non-

substantive?

I'm looking at the video screen for any heads. Yes, heads are nodding. Okay.

So unless you all decide that there is some technical issue with doing that, we'll assume that it will come back that way tomorrow for our vote in the morning.

Drew, do you need anything from us?

MR. GERBER: No. this has been very helpful. Thanks.

CHAIR BELLA: You didn't think you would get this much interest, huh? Maybe we should recommend something other than SMAC. Like we were going to recommend something other than BAG, these acronyms that we have.

And John, are you okay with where this is landing? He will keep us in suspense until the vote tomorrow.

All right. Drew, thank you very much, and thank you all for letting us run a little bit over.

We're going to move into our next session, and Bob is going to take it away.

VICE CHAIR DUNCAN: Thank you. That's timely, as in timely access to home and community-based care. I

thought I'd add a little levity to the thing.

So we've got Tamara and Asmaa joining us to walk through a new phase of work, and nobody looking for considerations from Commissioners as we embark on this new phase.

So I don't know which one of you ladies is taking it first. Asmaa, all right. I will turn it over to you.

TIMELY ACCESS TO HOME- AND COMMUNITY-BASED SERVICES: ENVIRONMENTAL SCAN RESULTS

* MS. ALBAROUDI: All right. Good afternoon, Commissioners. Tamara and I are here today to provide background on timely access to home- and community-based services, or HCBS, and share findings from an environmental scan that identified state policies that affect individuals' timely access to HCBS.

The presentation will begin with some background information. Then we will move into our key findings on state flexibilities, level of care determinations, and person-centered service plans. We will then wrap up with some next steps for the Commission.

First some background on timely access.

Given the Commission's focus on access to HCBS,

we worked to identify eligibility and enrollment-related barriers as well as opportunities for process improvements that could enable more timely receipt of services. States have several options to streamline Medicaid enrollment for people who need HCBS for both Section 1915 and 1115 authorities. For this project we focused on the use of eligibility flexibilities and processes meant to reduce the time it takes for non-MAGI individuals to receive a Medicaid eligibility determination.

The project scope explores eligibility flexibilities such as presumptive eligibility, expedited eligibility, and retroactive coverage, the level of care, or LOC, determination process and the person-centered service plan, or PCSP process. States can leverage different points in these processes to connect beneficiaries to HCBS faster.

Timely access to HCBS is essential to ensure individuals receive care in the setting of their choice. In order to be eligible to receive Medicaid HCBS, individuals must meet both financial and functional eligibility criteria. Financial eligibility includes both income and assets. To quality for LTSS, they must meet

additional functional criteria. To determine whether an individual meets the state's functional eligibility criteria, which generally an individual must be found to require an institutional level of care, states use functional assessment tools, sets of questions that collect information on an applicant's health conditions and functional needs.

Once determined eligible, designated staff work with the individual on a PCSP, which can be informed by the information collected from the assessment tools. A PCSP is a document that describes the services and supports that are important for the individual to meet the needs identified in the functional assessment as well as what is important to the individual with regard to preferences for the delivery of HCBS. Beneficiaries are required to have a PCSP in place before receiving HCBS. HCBS beneficiaries must be reevaluated annually to ensure continued eligibility and that their PCSP is current.

For many groups of Medicaid beneficiaries, such as adults without dependent children, states use modified adjusted gross income, or MAGI, standards for counting income and household size. Individuals whose eligibility

is determined using MAGI standards are typically not subject to an assets test or a functional assessment for the purposes of Medicaid eligibility, and states are required to determine eligibility within 45 days of application.

Many states are able to process MAGI applications much faster than applications for individuals whose income is not determined on the basis of MAGI, also known as the non-MAGI group. For non-MAGI groups, which includes individuals who are determined on the basis of age or disability, or seeking Medicaid LTSS, states have up to 90 days to make an eligibility determination.

There is no national reporting data for non-MAGI application processing times, but the additional documentation requires of non-MAGI applicants as well as the administrative complexity of making these eligibility determinations can result in lengthy processing times. For example, most states take between one and two months, on average, to complete a non-MAGI eligibility determination, but at least five states take longer.

There are different mechanisms to shorten application processing times. They include use of

electronic data sources, which can alleviate administrative burden for applicants as well as state staff, as well as accepting self-attestation of income and assets, which only a handful of states do.

MACPAC contracted with The Lewin Group, or Lewin, to conduct a comprehensive environmental scan from September 2023 through March 2024, of all approved Section 1915(c), (i), (k), and 1115 authorities, for all 50 states and the District of Columbia. They also reviewed American Rescue Plan Act spending plans, Appendix K COVID addendums, Medicaid disaster relief SPAs, CMS-372 reports, and other state resources.

The scan identified state use of presumptive eligibility and expedited eligibility for non-MAGI populations as well as retroactive coverage of HCBS. The scan also captures information on LOC and PCSP processes and any flexibilities that they incorporate to streamline the process and accelerate beneficiary access to services.

By starting with an environmental scan, we can gauge state take-up, variation, and areas where barriers may exist, all of which can inform the next phase of stakeholder interviews.

Of note, the focus of this work is not financial eligibility, and it does not address other barriers to care such as the direct care workforce shortage.

As of March 2024, this scan found that 46 states and D.C. operate a total of 251 Section 1915(c) waivers, 15 states have 1115 waivers that cover some HCBS, 16 states and D.C. offer 1915(i) state plan benefits, and 8 states have a 1915(k) Community First Choice Program.

The scan was sent to state officials to review and confirm the accuracy of the information, and 34 states responded to our feedback request.

Now I'll turn it over to Tamara to walk through the key findings.

* MS. HUSON: Thanks, Asmaa. So I'm going to start with a discussion of some of the flexibilities that states have to streamline eligibility and enrollment processes for individuals in need of HCBS.

First, I want to talk about presumptive eligibility. Presumptive eligibility allows individuals who have not yet been determined eligible for Medicaid to obtain Medicaid-covered services while completing the full Medicaid application process. The presumptive eligibility

period lasts for up to 60 days. States can allow qualified entities, such as hospitals, to make a presumptive eligibility determination for MAGI-based eligibility groups and certain other populations, including non-MAGI populations who might be seeking HCBS.

It is important to note, though, that providers furnishing HCBS during the period in which a beneficiary is deemed presumptively eligible are reimbursed by Medicaid, but the home- and community-based services delivered during this time must be rendered after a plan of care is established.

Our scan found that 9 states used presumptive eligibility for HCBS, and again I want to be clear that while many states use PE for other populations, most often for children and pregnant women, we only documented states that use it specifically for HCBS.

We found that states use various mechanisms to implement presumptive eligibility for HCBS. We found that three states used Medicaid disaster relief SPAs to temporarily expand hospital presumptive eligibility in non-MAGI populations; two states used Section 1115 demonstrations; one state used a Section 1915(I) SPA; one

state used ARPA dollars to pilot the use of presumptive eligibility; one state proposed a pilot in a state bill; and one state, Ohio, describes in its administrative code the use of presumptive eligibility for two different Section 1915(c) waiver populations. And I will note that Ohio's program is funded with state-only dollars.

The next flexibility we looked at was expedited eligibility, also referred to as fast-track eligibility. This is when an individual's Medicaid application is processed in an accelerated manner for the purposes of making a Medicaid eligibility determination. And there is no uniform definition of expedited eligibility. Instead, states can make adjustments within certain parameters, such as setting specific timeline requirements. And one common way that states do this is to accept self-attestation of information needed to determine Medicaid eligibility.

Again, our scan looked at the use of expedited eligibility specifically for HCBS. We found that four states currently use expedited eligibility for HCBS, one state is expanding a pilot, and one state is planning to use it in the future. So four states use or plan to use expedited determinations for both functional and financial

eligibility. For example, California has a requirement that an expedited authorization should be made within 72 hours for individuals discharging from a hospital or a nursing facility who will need community-based adult services.

I will also note that Colorado is the state that is in planning. They are currently working to identify ways to expedite both financial and functional eligibility. And Indiana is the state that is expanding a pilot statewide.

We also found that Rhode Island's policy allows for self-attestation of financial eligibility only, and Hawaii's policy allows for self-attestation of functional eligibility only. We also found that North Carolina allowed for self-attestation of level of care during the PHE, but it was unclear whether the state made this permanent.

Next, we looked at the use of retroactive coverage. States must provide three months of retroactive coverage from the date an application for Medicaid was received to any Medicaid enrollee if that individual received Medicaid-covered services prior to enrolling in

the program, but would have been eligible at the time those services were received. However, HCBS are generally excluded from retroactive eligibility periods due to the requirement that individuals have a care plan in place before receiving services.

So as part of our environmental scan, we asked Lewin to look to see if any states have been able to find a way to provide retroactive coverage for HCBS, despite the care plan requirement, and the results essentially affirmed our understanding that it is not allowed. So Lewin found that only one state, Connecticut, is using retroactive coverage in a very, very limited way, for behavioral health services that are delivered via Section 1915(c) waivers and Section 1915(i) state plan benefits. So in Connecticut, Medicaid enrollees receiving certain behavioral health services can be granted backdated eligibility, and providers can receive payment for services authorized during the backdated period. Providers must submit requests for payment within 90 days of the individual's eligibility status update.

During document review, Lewin also found five states are engaging in additional efforts to streamline

their eligibility processes. For example, Maine is developing a public-facing, web-based referral form that allows consumers to self-assess their needs, which will be automatically entered into appropriate data systems to begin provider-level referrals, follow-up, and prescreens for eligibility.

Another example, in Rhode Island, Rhode Island is expanding No Wrong Door activities to address use of access and how an applicant navigates the state system. So the state is expanding person-centered options counseling and other outreach about HCBS programs to underserved communities, updating business processes, and integrating IT systems.

Next let's turn to level of care determinations. States have timeline requirements, both for conducting the functional assessment and for approving the level of care determination. There are no federal timeline requirements. Our scan found that 32 states have requirements for how long assessors can take to complete the functional assessment, ranging from 2 to 45 days. Another example within this range that we saw included 3 days, 5 days, 7, 14, and 30 days.

Some states also identified a timeframe in which a level of care assessment must be approved. Our findings indicated that 17 states have such requirements for at least one HCBS program in their state, and these approval requirements ranged from 5 to 30 days.

The level of care determination may be made directly by the Medicaid agency or another designated entity. In some states, two different entities may conduct and approve the level of care as shown in the table on this slide. So the table here includes all 50 states and D.C., but I want to note that individual states may be classified under multiple entity types when one or more HCBS program within the state has implemented an approach. So for example, in a state with two programs, in one the Medicaid agency may conduct the level of care assessment, and in the second it may be an operating agency, so therefore the state has been counted in both groups.

Across states we saw that in many with HCBS programs that serve medically complex populations it often the Medicaid agency that is responsible for both the level of care completion and approval in these programs. And we also saw that many HCBS programs serving older adults with

disabilities often use other types of entities such as managed care organizations, case management agencies, or trained medical staff.

Level of care assessments can be conducted in person, by telephone, virtually, or by record review. Of the 47 states and D.C. that reported an assessment method, all states offer in-person options, 19 allow telephonic or virtual options, and 32 use record review. And record review is always combined within another assessment method such as in-person.

States are required to reassess participants no less frequently than annually. So our scan found that all 50 states and D.C. have at least one program that uses the 12-month reassessment interval. Six states use a 6-month reassessment interval in select HCBS programs, and these programs are not consistently aligned with a certain population or a level of care. And 4 states use alternative approaches for scheduling reassessments for one or more HCBS programs. For example, California varies the frequency of reassessments between 180 and 365 days, based on the participant's acuity.

During the PHE, CMS provided guidance to states

on options to pursue temporary flexibilities related to the eligibility and service planning provisions of HCBS programs. Forty states implemented at least one temporary flexibility related to level of care assessments, and the top two most common flexibilities states used were, one, extending due dues for reassessments for up to one year, which we saw in 27 states, and two, allowing professionals to conduct assessments by telephone or virtually, in addition to in-person, which we saw 35 states use. And while public information is still emerging about state decisions to make temporary policies permanent, our scan found that 10 states have made their policy changes permanent.

Okay. Our last focus area is around person-centered service planning processes. This slide and the next provide background on the requirements for developing PCSPs. All states use PCSPs to identify the services and supports that person needs to live successfully in the community. PCSPs, among other requirements, are designed to identify the individual's goals and desired outcomes, and reflects the services and supports, both paid and unpaid, that will assist the individual to achieve their

identified goals. It should also reflect the individual's strengths and preferences as well as risk factors and measures that are in place to minimize them.

One requirement that I want to highlight is that PCSPs should reflect cultural considerations and be accessible to enrollees. And we captured this in our scan, and we saw that states employed a range of strategies to provide language assistance and ensure accessibility. For example, states provide translated versions of applications and other documents as well as interpretation services such as for American Sign Language.

These are more requirements.

Following the level of care assessment process, a PCSP must be established to guide the care needs of the beneficiary. However, the time frame in which states develop a PCSP varies by state. Our scan found that 48 states have timeline requirements, with most states requiring the PCSP be completed within 30 to 45 days. And many states have assessment requirements across their HCBS programs. In a few states, the case manager begins to develop the PCSP during the functional assessment meeting.

PCSPs must be reviewed and updated annually, or

more frequently at state option. Most states use the same frequency review across all their HCBS programs, but some states vary frequency by program or other factor. Our scan found that most HCBS programs required PCSPs to be reviewed and updated every 12 months, with 48 states having at least one program that reviews PCSPs annually. Twelve states update PCSPs every 6 months for one or more programs, and 4 states require updates every 3 months. And then 10 states use other timelines. So for example, one of D.C.'s Section 1915(c) waivers requires review of the PCSP quarterly, when an individual is newly enrolled, and then allows the schedule to shift to annual updates.

PCSPs should be developed at times and locations convenient to the individual, and they should include any other individuals who have been invited by the participant. And with the exception of two states that did not report an assessment method, our scan found that all states use in-person meetings. States can also allow PCSP meetings to be conducted by telephone or virtually when an in-person visit would pose a risk to the participant or the individual preparing the plan, such as during the PHE, and 25 states allow meetings to be conducted by telephone or virtually.

And 3 states use record review.

A number of different types of professionals are responsible for PCSP development, and states frequently allow more than one type to lead the PCSP development. There is no federal requirement that medical professionals must be responsible for PCSP development, but CMS self-regulatory guidance states that their qualifications should be reflective of the nature of the program's population. So our scan found that 46 states use case managers, 23 states use licensed nurses, 2 required licensed physicians, and 35 listed other types of professionals.

In order to expedite receipt of Section 1915(c) services, CMS allows for a provisional plan of care, also called an interim service plan, which identifies the essential Medicaid services that can be provided in the person's first 60 days of waiver eligibility. And provisional plans' care have been allowed since 2000, when it was described in a state Medicaid director letter, known as Olmstead Letter 3, which was issued in response to the 1999 Olmstead Decision. And our scan found that 17 states allow for the use of provisional plans of care across 41 waiver programs.

The use of electronic signatures can make signing documents a more efficient process, and their use has increased in recent years, especially since the PHE. Medicaid HCBS programs can use e-signatures to collect an HCBS participant's signature on the final PCSP following the service plan review meeting, and our scan found that 33 states permit the use of e-signatures for PCSPs in one or more programs.

This slide and the two that directly follow it summarize some of the key findings from our environmental scan, but for the sake of time I'm not going to reread these points, but I'm happy to turn back to them during the discussion if it would be a helpful reference.

Finally, I want to conclude with some details on next steps for this project. First, we plan to publish the full environmental scan on our website this spring. The scan helped us develop a preliminary understanding of the many policies I just described and the state uptake. But we would like to develop a better understanding of state processes and potential barriers, so we plan to interview stakeholders including state officials, CMS, and other experts this summer.

We will return in the fall with the results of our stakeholder interviews, to be presented over three Commission meetings, with one meeting dedicated to each of the three focus areas of this presentation. So one being eligibility and other streamlining flexibilities, two, level of care determination, and then the third being person-centered planning processes.

During Commissioner discussion today it would be helpful for us if you could raise any considerations that are applicable to these three topic areas. We are also happy to answer any clarifying questions on what we just presented.

With that now I will turn it back, and thank you.

VICE CHAIR DUNCAN: Thank you. All right, Commissioners, I see Jami is ready to roll.

COMMISSIONER SNYDER: Thanks so much. I actually just have a question. You noted that a handful of states implemented presumptive eligibility under either a disaster relief SPA or under their ARPA HCBS plan. Do you know if any of those states are planning to or pursuing permanent implementation of presumptive eligibility?

MS. HUSON: That is a great question. So New

Hampshire, again, is using ARPA dollars to pilot it, so I assume that it would depend on the outcome of the pilot. And then I don't remember off the top of my head if the states that use the other authorities made those permanent. I would have to go back to the scan to see if they indicated that during review.

COMMISSIONER SNYDER: That would be great. Thank you.

VICE CHAIR DUNCAN: Thank you, Jami. Patti.

COMMISSIONER KILLINGSWORTH: I'm always astounded at the level of review that goes into these analyses, so thank you both very much. Just a really comprehensive body of work.

I wanted to sort of make this real for just a second, specifically as it relates to eligibility. I have had the honor and the challenge of caring for multiple family members over my lifetime, and if at any point one of those family members had needed long-term services and support in a way that I was no longer able to meet those needs, I could have gone to my local nursing home, and upon applying for Medicaid, or offering to private pay, whichever the case may be, but let's just say for a moment

that I couldn't private pay, that nursing home could have admitted my loved one, filed the Medicaid application, waited the amount of time that it took for that application to be processed, knowing that that coverage would be retroactive to their admission to that facility, so long as they met nursing facility level of care requirements.

So it's not a guarantee of payment but it's almost an assurance of payment so long as it appears that person meets level of care standards.

If, on the other hand, I had wanted home- and community-based services for my loved one, I would have filed an application, waited the average month to two months, maybe more, for that application to be processed, during which time any services that they might need would not be available unless I was able to private pay for them, even after they are approved for Medicaid. That is the reason why so many people end up in nursing homes that don't need to.

And so as we look at these issues, I appreciate the fact that presumptive eligibility is available to states. I do not appreciate the fact that retroactive eligibility, retroactive coverage of nursing facility

benefits is available to people while home- and community-based services are not. And I think it is a fundamental institutional bias, one of many, in the federal regulations that result in people being institutionalized when they don't want to be and don't need to be.

And so the reason why we need presumptive eligibility is because there is not equal access inherent in the law to people who want to receive home- and community-based services. I think fundamentally that is an issue that we need to really press into and highlight in whatever product we produce out of this. I hope it ultimately generates recommendations to Congress to address, or to CMS from a regulatory perspective, to really address this in their regulations.

And then the other thing that I would just note, it's picked up a little bit in the comments about the level of professional who is involved in developing the person-centered support plan. It's also an issue, I think, as it relates to level of care eligibility, that there are still some states who require physician involvement in the level of care determination for home- and community-based services in the person-centered support plan, and that

sometimes that can result in unnecessary delays for people, because physicians are very, very busy, and it can be hard to get that kind of signoff. So I think that may be another issue that we could press into a little bit.

But my big issue of contention is this institutional bias around eligibility, so I'd love to press into that. Thank you.

VICE CHAIR DUNCAN: Thank you, Patti. Any other commissioners? John.

COMMISSIONER McCARTHY: I feel like I have to say something since I'm pointed out in the memo that there's a lawsuit against me that would not allow retroactive eligibility on these things.

I agree with everything that Patti said. I think this is a really difficult one from the standpoint of where do we focus kind of going forward. Because I think this is an area ripe for recommendations going forward, on some of these different areas. But at the same time I think we have to balance the idea of how do we look at services from a standpoint of if people get -- how do I say this? -- the level of care and the plan of care is there for a reason.

And I'm struggling with exactly what Patti is

talking about, but there are also barriers to getting people services when they need it so we can keep them out of a nursing home. But at the same time, if you don't have a plan of care, a person could be receiving -- and I'm going to make up something over the top -- you know, 3-to-1 care 24 hours a day, which we would say, hey, that's not an acceptable level of service. So it's how are we balancing those things.

I think that's the area that I would like to see us kind of look at going forward, is why were those things in place in the first place, and then how do we look at that and balance some of those different issues going forward. And again, at the same time, trying to remove the institutional care bias. Because exactly what Patti said. It's like, okay, we've got this over here, but yeah, we could just go to a nursing home and get in.

And I do have to say, and this stuff varies state by state quite a bit. Because in Ohio, for instance, there is home health aide services in the state plan, up to 8 hours a day, which you can get before getting on a waiver. So there is a whole bunch of nuances in here too of ways that states have dealt with these issues, which you have

not addressed in here. You focused on waivers, but there are state plan ways to address some of the issues, not all of it, but some of the issues around these things, to fill some gaps on it. So I think that's another area of what are other ways states are looking to fill some of these gaps when people need services.

And lastly, I want to point out, because you brought it up too, in Ohio we had the retroactive piece, and we just used state-only dollars for it. And it was because we were running into these issues. We had emergency situations and we wanted to deal with them. So as a state we thought it was a priority, and so we put our money where our mouth was on these things.

VICE CHAIR DUNCAN: Thank you, John. We have Carolyn, then Dennis, then Sonja.

COMMISSIONER INGRAM: Thanks. One of the questions I had, just in your work, and maybe this is something that we need to go back and look at the interviews about, but was one able to ask or find out anything about the cost implications in terms of the different choices that states had made around these options? And I think about the point that Patti made,

where it's actually usually less expensive to have somebody in a home- and community-based waiver service than it is in a nursing home. So did we collect any information about the cost implications, looking at these options?

MS. HUSON: No. That was not something we were able to collect during the environmental scan, but that's something that we will ask about during the interviews in the next phase of the project.

COMMISSIONER INGRAM: Okay. And then the last question I had, and maybe this was also done in the research and I'm sorry I didn't pick it up, was for people who have a permanent condition that's not going to change. Was there any way that states are addressing those in an easier fashion instead of making the person go through so many hoops to qualify?

MS. HUSON: I don't think we saw anything specific to that in what was pulled out during document review of the environmental scan, but I will definitely note that again as something we can ask states during interviews.

COMMISSIONER INGRAM: Okay. Thanks.

VICE CHAIR DUNCAN: Thank you, Carolyn. Dennis.

COMMISSIONER HEAPHY: I really appreciate everything that Patti said. And I'm wondering whether you are anywhere near a place of making a recommendation on presumptive eligibility, or if you need a lot more data.

And the other question I have is -- well, two questions. One is about presumptive eligibility in folks who are leaving a hospital setting. How does that work? Because somebody can be eligible to go to a nursing home. When they're leaving the hospital but they may not be eligible to get community-based services, and is there a way maybe, Patti, you can -- and I'm messing this up -- for someone to be able to get, as part of their discharge planning, an evaluation by a nurse or someone else when they get home so those services can start right away, as part of the discharge planning process?

And then my other question is, are you going to be interviewing folks with disabilities who have engaged in that planning process, to get their perspective on how that process worked or didn't work for them?

EXECUTIVE DIRECTOR MASSEY: Tamara, let me answer that first question about the policy options. Dennis, we are at the very beginning of this project, so we are not at

the point right now where we've had an opportunity to even identify policy options. We completed the environmental scan and we are moving into the interviews, and I actually think that this could span more than one analytic cycle. So it's going to be, I think, a while before we press on each of these three buckets to get to the point of policy options.

CHAIR BELLA: I do think, though, I mean, the way this is teed up, Dennis, just to be clear, next year, I mean, each of these is going to be a dedicated session to that. And the way it's framed and kind of what we're hearing is lending itself down a path of recommendations, if we continue, I think, to get these kinds of data and this kind of information.

So I think you're a few steps ahead of us, but in a very good way. So I just want to assure you that the point of trying to break this out and get concrete and get evidence to back this up in those three areas is to be moving in the direction that you're interested in moving.

COMMISSIONER HEAPHY: And for now is it possible to strengthen information on how easy it is for folks to get into nursing homes at this point in your writing?

Because I think it's important to be able to show that, as Patti was stating, how presumptive eligibility is very easy for getting someone into a nursing home, but it becomes more complex when applying for community-based services. Just do a comparison of the two.

MS. HUSON: Yeah, absolutely. I think the information in our scan has a number of examples that lend itself to what you're asking about, Dennis. For example, one that I can give you is in Illinois we saw that they are using expedited eligibility for individuals who are at imminent risk of a nursing home placement, that they receive services within two business days of their eligibility determination. So I do think we have a number of examples that we could provide of ways that states are thinking about that hospital to nursing facility or hospital to home- and community-based services pipeline, and trying to ensure that people who would like HCBS can receive it. So I think we can highlight that more.

COMMISSIONER HEAPHY: And what about institutional bias itself? Is there a way to provide a nuanced reference to that more globally?

MS. HUSON: I imagine we could take that back and

do that.

COMMISSIONER HEAPHY: Thank you.

VICE CHAIR DUNCAN: Thank you, Dennis. Sonja?

COMMISSIONER BJORK: Thank you. I am very excited about this body of work. The possible areas for exploration are ones that are very practical. A lot of times we're tackling issues and we think, oh, it's so hard to figure out what to do about this, and it takes us a long time to figure it out. But you've already done such great background work, and I think with what Dennis has raised for the interviews, I think we're going to get great information to support really practical answers to why don't people use home- and community-based services? Why is it so hard?

So I just really want to focus on particularly presumptive eligibility. I think that is such an important key. So thank you.

VICE CHAIR DUNCAN: Thank you, Sonja. Asmaa and Tamara, do you feel like you have direction?

MS. HUSON: Yes, absolutely, and we're excited to come back with lots more information next year.

VICE CHAIR DUNCAN: Thank you. I appreciate it.

I think you saw that your environmental scan opened up a lot of opportunities around the three areas that you highlighted. So we look forward to continued discussion as we learn more, so thank you.

VICE CHAIR DUNCAN: And with that we have open session for the public to comment, and I would ask that you identify yourself, the organization you are with, and limit to your comments to three minutes.

And Laura Cohen, you are first.

PUBLIC COMMENT

* MS. COHEN: Hello.

VICE CHAIR DUNCAN: We can hear you.

MS. COHEN: My name is Laura Cohen. My company is Rehabilitation and Technology Consultants. And I also have had the privilege of being a care provider but also caring for a loved one. And this area is very exciting to me, to hear you discuss. Tamara's report was excellent, and I wanted to echo some of the other comments from the Commissioners.

As a physical therapist, on Slide 27 of Tamara's report it specified which professionals are involved in identifying the person-centered planning process and the

location of care. And conspicuously missing from that group are the 27 people. I'm very curious who they are.

There seems to be bias towards physicians, nurses, case managers, and what's missing are the involvement of the rehab professionals that are specialists in mobility, safety, home modification, durable medical equipment, et cetera. And I would like to advocate that we drill down deeper in that data and find out who are those professionals, and I would argue also that it would be helpful to include those rehab professionals.

Back earlier in health care -- because I'm old -- rehab professionals used to be able to do discharge planning and transition planning from inpatient rehab. We could go home with the patients. We could look at them in their home. We could make recommendations for home modifications or adaptations equipment, you know, just practical solutions that would help them accommodate their needs. And rehab professionals seem to be missing from that equation.

And having worked in Georgia with people, trying to get people transitioned from nursing facilities into the home, there was a tension of conflict between the nursing

facilities, that really didn't want to see the person move home, and the person who wanted to get home but couldn't get the services of the professionals that were needed to go evaluate the environment they were moving to, the equipment that they needed. And they weren't allowed to get those because of policy barriers while they were at a location where they could receive training on how to use those technologies.

So I'm very excited to hear you talk about this, and I just wanted to add a perspective. Thank you.

VICE CHAIR DUNCAN: Thank you, Laura, and I appreciate you bringing that perspective.

Anyone else?

[No response.]

VICE CHAIR DUNCAN: All right. Seeing none, we are running a little behind. Let's take a break, Madam Chairwoman until --

CHAIR BELLA: 3:05. Please be back at 3:05 for the final session on hospital supplemental payments. Thank you.

*** [Recess.]**

CHAIR BELLA: All right. Welcome back,

everybody. We're getting ready to get going. Jerry, Chris, this is going to be a very engaging panel to end our day. We are going to talk about the hospital supplemental payment analysis, and I know there is a lot for us to talk about once you get through the presentation, and we're really excited about that. So we'll turn it over to you.

UPDATE ON HOSPITAL SUPPLEMENTAL PAYMENT ANALYSES

* MR. MI: Great. Thank you. Good afternoon, Commissioners. Today I'll be walking through our preliminary analyses on non-DSH supplemental payments.

I'm going to first start by reviewing some background from our prior work about the different types of supplemental payments and their various goals. As a note, much of this information is included in our updated Base and Supplemental Payment Issue Brief that was released early this week.

Next, I'll discuss MACPAC's provider payment framework, which aims to think about the various statutory goals for Medicaid payments. I'll then discuss some preliminary analyses using the newly available provider-level non-DSH supplemental payment data, and I'll continue with some policy questions to help facilitate discussions

on potential policy principles that could guide our ongoing work. I'll finally conclude with next steps in the context of our ongoing work plan on hospital payment.

First, I want to start with some background. As you know, Medicaid supplemental payments are a large share of Medicaid payments to hospitals. For example, in fiscal year 2022, supplemental payments accounted for more than half of fee-for-service payments to hospitals, and in managed care, we also see that a large share of payments is made through directed payments.

Although CMS doesn't officially categorize directed payments as a supplemental payment, we have included them in our analysis because most of the spending under these arrangements is for large, uniform rate increases, which are similar to supplemental payments in fee-for-service. When combined, directed payments and supplemental payments make up about 40 percent of all hospital payments.

One of the challenges of this work is that there are multiple different types of Medicaid supplemental payments to hospitals, and each of them are subject to different rules and are trying to address different goals.

This table lists some of the different types of payments and how they're used, based on the intent of the payment implied from the federal rules.

For example, most supplemental payments pay for Medicaid-enrolled patients, but disproportionate share hospitals, or DSH, and uncompensated care pool payments can pay for uninsured individuals. Delivery system reform incentive payments, or DSRIP, and directed payments have ties to quality improvement.

In addition, these payments have different characteristics in how they are approved, which delivery systems they can be used for, and the limits on payment. Starting at the top of the table are DSH payments, which are statutorily required payments intended to offset unpaid cost of care for Medicaid payments or Medicaid shortfall, and unpaid cost of care for uninsured individuals. When DSH grew very rapidly in the early '90s, Congress established state-specific limits on DSH, known as DSH allotments. In addition, DSH payments to an individual hospital are limited to its amount of uncompensated care costs.

The next type of payment here are upper payment

limit, or UPL, supplemental payments. These are fee-for-service payments intended to offset the difference between fee-for-service base rates and an estimate of what Medicaid would pay. One of the limits with UPL payments is that they can only be made for services provided in fee-for-service, and so as states have moved from fee-for-service from managed care, their ability to make UPL payments has diminished.

Graduate medical education, or GME, payments primarily support teaching hospitals, and unlike UPL payments, they can be made in both fee-for-service and managed care. Some states make GME payments as a supplemental payment, while others account for GME costs when calculating base payments at teaching hospitals.

Because UPL payments can only be made in fee-for-service, some states have sought Section 1115 demonstrations as a way to continue to make supplemental payments in managed care. The two main types of 1115 supplemental payments are uncompensated care pools payments, which are similar to DSH, and DSRIP, which are intended to advance quality and delivery system reform goals.

In recent years, CMS has encouraged states to move away from these 1115 supplemental payments and more towards directed payments, which was added in 2016. Directed payments are primarily intended to help offset Medicaid shortfall through those uniform rate increases, but some of them are also tied to quality improvement goals.

I also just want to quickly point out that there is currently no upper limit on the amount of directed payments that a state can make. CMS has recently proposed a limit on directed payments based on the average commercial rate, which is much higher than what Medicare would pay.

Now that we've talked through the different types of payments, we also want to highlight the wide variation in the use of supplemental payments by state. This figure shows supplemental payments as a share of total Medicaid benefit spending in fiscal year 2022, and you can see a wide variation in the total amount of payments as well as in the mix between DSH, non-DSH supplemental payments, and directed payments.

In fiscal year 2022, hospitals supplemental

payments and directed payments accounted for less than 5 percent of Medicaid spending in 13 states, and more than 25 percent of Medicaid spending in 6 states.

One of the challenges of our review of supplemental payments so far is that we've only had state-level data, and to enable further analysis the Commission has long recommended more collection of provider-level data on all types of Medicaid payments to hospitals.

Our ultimate goal is to use all of this data to understand the extent to which Medicaid hospital payments are consistent with the statutory goals of efficiency, economy, quality, and access. And to do so, we are guided by MACPAC's provider payment framework, which is an attempt to define some of these terms and think about how they relate to each other.

So according to the framework, we think of economy as primarily a measure of what is spent on payments and measured by things such as the payment rate, and we think of access and quality as measures of what is obtained by that payment. Efficiency sort of ties it all together and compares what is spent to what is obtained.

As we seek to apply the framework to different

Medicaid payment policies, we aim to collect information to inform discussion about these principles. We want to understand state payment methods and payment amounts and then compare that to various measures of outcomes related to payment.

So moving on to our analysis of non-DSH supplemental payment data. Recently, the Consolidated Appropriations Act required states to begin reporting some of this provider level data, beginning October 1, 2021. The data aren't yet publicly available, but CMS has made them available for our initial review. This includes information on payment amounts as well as some limited narrative information about payment methods and goals. The new non-DSH supplemental payments include UPL data as well as Section 1115 supplemental payments, but they don't include information on directed payments.

We found that the fiscal year 2022 non-DSH supplemental payment amounts were reliable and could be matched to other data sources such as the Medicaid cost reports. However, additional data on base payment amounts were unreliable, and supplemental payment methods were often incomplete.

In addition, we are still missing data on provider contributions to the non-federal share, such as provider taxes or intergovernmental transfers. A lot of these supplemental payments are financed by providers, and ideally, we would want to have that data on provider contributions in order to calculate net payments to providers.

So using this new data we found that in fiscal year 2022, 62 percent of non-DSH supplemental payments were made to hospitals that already received DSH payments. This suggests that some states may also be using non-DSH supplemental payments to make up for low DSH allotments. Compared to DSH payments, a small proportion of non-DSH payments were made to deemed DSH hospitals and rural hospitals.

Our understanding of targeting is also limited because we did not have the data to know how supplemental payments are related to base payments that those providers have received. Just a reminder, base payment data quality was unreliable.

It is important to note that national averages masked considerable state variation in the use and

targeting in non-DSH supplemental payments.

In fiscal year 2022, 14 states made non-DSH supplemental payments to less than 20 percent of hospitals in their state, and 11 states made non-DSH supplemental payments to more than 80 percent of hospitals in their state.

Listed on this slide are several potential reasons for state variation, in both the use and targeting of non-DSH supplemental payments. State DSH allotments vary widely by state, and since payments to hospitals are fungible, states with low DSH allotments may use non-DSH supplemental payments to provide additional support to providers, such as safety net hospitals.

Different types of supplemental payments are also subject to different federal limits. For example, DSH payments are limited by both the allotment as well as the hospital-specific limit. However, UPL limits are established in the aggregate, and these payments to individual hospitals can exceed the hospitals' costs as long as total payments for each class of providers are below the UPL.

Some types of supplemental payments are limited

to either fee-for-service or managed care. So for example, UPL supplemental payments are only available under fee-for-service, while directed payments are available only under managed care.

States are also permitted to finance the non-federal share of Medicaid spending from multiple sources, including state general funds, health care-related taxes, and intergovernmental transfers, or IGTs, or certified public expenditures, or CPEs, from local governments. We found that states that financed DSH payments with broad-based provider taxes often distribute DSH payments broadly, while states that financed DSH payments with funds from local governments, such as public hospitals, also often target those DSH funds to public hospitals.

Based on our prior work, Medicaid expansion states have lower unpaid costs of care for the uninsured than states that did not expand Medicaid. However, Medicaid expansion can also increase hospitals' Medicaid shortfalls if base rates are not sufficient to cover the cost of care for Medicaid-enrolled patients.

In addition, at least 11 states used provider taxes to finance the state's share of Medicaid expansion,

so in these states, the hospitals that pay the tax often receive supplemental payments to help offset those costs.

Finally, the wide variety of market contexts may affect how supplemental payments are used. For example, some safety net hospitals use DSH funds to support unprofitable services that other hospitals in the area do not provide, such as inpatient psychiatric care or advanced trauma services. Some safety net hospitals use DSH funding to support access to care outside of the hospital setting, through outpatient clinics and investments in social determinants of health.

So to sort of illustrate how federal, state, and local policy factors affect the use and distribution of supplemental payments, we examined supplemental payment methods in five states. The first one is North Dakota, which is a state that leverages supplemental payments based on local hospital market characteristics. North Dakota makes most payments to hospitals via base payments that are financed with state general funds. The state primarily uses DSH payments to support a state psychiatric hospital, and UPL payments to support rural critical access hospitals.

New Mexico has a low DSH allotment and uses non-DSH and directed payments to provide additional support for safety net providers. The state's DSH payments are targeted to teaching hospitals, and the state's non-DSH payments are primarily used to support sole community providers, rural hospitals, and a state teaching hospital.

Over the past several years, the state has transitioned UPL payments into an uncompensated care pool and DSRIP-wide incentive program, through the state's Section 1115 demonstration. And more recently, the state has begun transitioning Section 1115 payments to managed care directed payments.

Florida is another state with a relatively low DSH allotment, and makes large non-DSH and directed payments. Florida has not expanded Medicaid, so hospitals have relatively high levels of unpaid costs of care for uninsured individuals. Most of its non-DSH supplemental payments are made through an uncompensated care pool, authorized through its Section 1115 demonstration, also known as the low-income pool, which helps to pay for these uncompensated care costs and makes most of its payments to deemed DSH hospitals.

Virginia also has a low DSH allotment, and recently expanded its use of non-DSH and directed payments after the state expanded Medicaid under the ACA. Virginia is financing its Medicaid expansion with a hospital tax, and so we see that in fee-for-service the state makes UPL payments up to an estimate of what Medicare would pay for the same service, and in managed care the state makes directed payments up to the average commercial rate, which, once again, is substantially higher than what Medicare would pay.

Finally, New Hampshire is a state with a large DSH allotment and relatively low non-DSH supplemental payments. Virtually all hospitals in the state receive DSH payments, and the state uses UPL payments to provide additional support to rural hospitals. Even though virtually all hospitals in the state receive DSH payments, 40 percent of DSH and non-DSH supplemental payments are targeted to deemed DSH hospitals. The broad distribution of DSH payments across hospitals may reflect the fact that the state finances DSH with a provider tax.

So on to the supplemental payment policy principles.

Our preliminary analysis of the new non-DSH supplemental payment data highlights how states have used different types of supplemental payment authorities interchangeably to advance a variety of different goals. States' use of these authorities varies widely, and appears to be affected by federal, state, and local policies.

As we continue to work in this area, it would be helpful to get Commissioner feedback on how we can begin evaluating our results using MACPAC's provider payment framework. In addition, staff welcome Commissioner feedback on any federal policy levers that we should consider to help ensure that payments are consistent with statutory goals.

In particular, it would be helpful for the Commission to discuss the reasons for state variation in targeting supplemental payments, and if there are any particular principles that should guide our work as we evaluate how payments are targeted. Some possible areas of consideration include to maintain or increase access to services, should states have unlimited flexibility to target supplemental payments to hospitals they identify, or should targeting be tied to specific measures of use or

need.

Given Medicaid's emphasis on economy, should there be limits on supplemental payments, and if so, should there be variation in the limits set for different types of supplemental payments.

How should policymakers evaluate the efficiency of hospital supplemental payments? So in other words, these payments should be driving value for the program. How can we measure, quantify, and assess the outcomes that these payments produce?

The different types of supplemental payment authority allow for state flexibility in designing hospital payment policies. However, the overlap in these authorities and differences in federal rules for these authorities create complexity for states, CMS, and policymakers in determining total hospital payment in a relationship to particular policy goals such as access and quality.

As we continue this work, the Commission could consider the extent to which these authorities should remain distinct or whether there could be further alignment in the federal rules for the types of supplemental

payments.

So staff are still working on reviewing the supplemental payment narratives, and we aim to develop a compendium of supplemental payment methods. We will also soon be convening a technical expert panel to discuss the feasibility of developing a payment index to assess total base and supplemental payments across states and relative to external benchmarks, such as Medicare payment rates.

We also plan to update MACPAC's issue brief analyzing managed care directed payments. The brief will help us inform future discussions about the extent to which states are using directed payments in place of DSH and non-DSH supplemental payments.

Thank you.

CHAIR BELLA: Thank you very much. Let's go to the last slide, or the slide before that. Yeah, let's go there. Who would like to start us off. Oh, Angelo.

COMMISSIONER GIARDINO: Yeah, thank you for a really interesting overview of this area. I remain convinced that nobody that's involved in the system would have designed it this way. So I think organically this has emerged, all these various payment schemes have emerged to

deal with a chronically underfunded program and massive needs for people that are traditionally underserved.

So I guess I just want to make sure. There is no implication that anybody is doing anything wrong. It's just that in an environment where you're essentially trying to scrape the resources together to do a good job you end up doing all this.

So I would love to understand how we could review this and not make these providers who are doing all this work feel threatened and more make it clear that we are trying to put the sunlight on this so that we can decide how to be more rational to serve the populations that they have to serve, just because I really do worry that people that are working very, very hard in these rural safety net hospitals and in the teaching hospitals and in the municipal hospitals that have very large, underserved populations, that they are going to feel that they are now being threatened, and that, I don't think, is our intention at all.

CHAIR BELLA: Yeah, thank you, Angelo. I mean, this is just scratching the surface of this topic, and it's exploratory. So we can make sure that the language is non-

threatening. And I think that's one of the really important reasons to have some principles that we keep coming back to, because the principles do ultimately tie to the relationship of payment and access and being able to have providers and safety net providers stay strong in the program.

So I think your point is consistent with the way the team is approaching this work.

Bob, and then Tim.

VICE CHAIR DUNCAN: Thank you both Angelo and Madam Chairwoman for those comments. I support and appreciate this is not about a punitive. It's about understanding and making sure we are providing access to our beneficiaries that need it. And then in full disclosure, I work for a children's hospital, so before I make my comments I want to make that publicly known, that receives no supplemental payments other than DSH.

But what I would like to call out is, as you look at those, and Angelo mentioned some of those hospitals, the safety nets and others, that see a high number of both high Medicaid population as well as uncompensated care. And when you think about the children's hospitals across the

country and you look at their Medicaid mix, it's usually 2-to-1 compared to adult systems as others.

So as we have this conversation, I think it is imperative to include some of those children's hospitals at the table to understand what those supplemental payments look like and the impact, because Madam Chairwoman's comment, at the end of the day we want to be able to provide access. So when you ask the third question, how do we measure, I think access and the quality of care are two of the areas we need to look at. And I think quality of care is both the outcome, but that for the parents and children who may have to travel farther distances to receive that type of care.

So those kinds of nuances I think need to be called out and pulled out in understanding the impact of supplemental payments. Thank you.

CHAIR BELLA: Thank you, Bob. Tim, and then John.

COMMISSIONER HILL: Just a thought on the principles and a methodological question. You know, when I think about the supplemental payments generally, and kind of what you're doing, which I think is great work, one, I

think it's going to be increasingly impossible to separate this conversation with the financing conversation that we had earlier. And no matter how you articulate the policy principles there's always going to be a relationship because there's just a relationship.

And the way I like to think about the principles for supplemental payments, and I think you've got the right ones, but we build it in. But asking ourselves what is it about the payment systems that the states have built that is causing them to have to have supplemental payment. If it's managed care capitation, if it's a fee-for-service payment system, if it's a value-based payment system that's supposed to be paying providers for accessing and quality and economy, why is it that then you need a supplemental payment?

It almost introduces a level of why is this the exception. What it is about their system that's not working -- well, not not working, but isn't meeting the needs of these facilities.

And then the other question I'd have is why are we limiting this to hospitals? Particularly when you think about the financing conversation from earlier, and you

think about group practices and nursing homes and other entities that are rightly taking advantage of the flexibility under the statute, it is more than just hospitals. And I think it would be important for us, if we are going to develop principles, to think about it more broadly than just inpatient.

MR. PARK: Just a note on, we are focusing on hospitals right now because that's the biggest category of spending. But we would intend to try to apply similar principles to other services.

COMMISSIONER HILL: We are health policy people, after all. We go after the biggest stuff first.

CHAIR BELLA: Thank you, Tim. John?

COMMISSIONER McCARTHY: First question. Jerry or Chris, go back to that Table 4 that you had up there. I just had a question on North Dakota and what I'm missing on this one. It's zero percentages for everything across the table except at the end it's 71 percent of payments is supplemental payments. Is the math that it is just very small and that adds up?

MR. MI: Yeah. So the zero percent is zero percent of total Medicaid benefit spending. So that

basically means that the supplemental payments are a very, very small share of the total Medicaid benefit spending.

COMMISSIONER McCARTHY: Okay. That was number one.

Number two, I do think this is really important work and I want to go back to what Angelo said around this issue of we're not after people. I agree. I think the issue always is, as you're looking at any policy decision, when you look at just one little piece it's easy to focus on that piece. And I've done this in the past as Medicaid director and say, okay, I'm going to go after this piece, or this is an issue. And what you're missing is the bigger pictures on all of these things.

And my examples is when I first was Medicaid director, I was against all these types of payment methodologies, and like, oh, it's not useful. And then I went out and visited hospitals, and I visited rural hospitals in Ohio, obviously not in D.C. because there are no rural hospitals. But in Ohio I visited rural hospitals, and you find out that 80 percent to 90 percent of the people that they serve are on Medicaid or Medicare. And so their commercial population is tiny,

So for me coming up through the system it was always, oh, Medicaid rates are low because the expectation is that they're cross-subsidized. That was actually an expectation at some states. And so when I went out to meet these rural hospitals, I was shocked at how could they possibly survive with the payer mixes that they had. So we started looking into some of these things and Ohio has done some of those, and they've done provider taxes and things like that to help support some of the hospitals.

And the reason I bring this up is because earlier in the conversation today, when we were talking about financing, somebody brought something up around access, and are we really getting access through this. But what we don't know is how many hospitals would close if you didn't do this. Like you don't have that. You just don't have that information, and I don't think we can actually get that information, because we wouldn't know. Like we wouldn't know. We also don't know how many have dropped their OB departments or dropped their emergency departments. Like there's all those things.

So I wanted to bring it back to your slides that you had, the last part on efficiency and economy. I think

these are really hard to come to on some of these, in looking at it in just this one specific piece. So I look forward to the challenge of us working on these things and how to look at it, but it is really, really hard to measure access, and what does access mean.

And again, just my experience, you know, when I was here in D.C., Medicaid director, and I would have people complaining about a lack of access to services in D.C., and I was like, oh, my goodness, it's 10 miles long -- and it used to be 10 miles wide. But, you know, it was like, oh, we don't have enough access. Then you go to certain places, like North Dakota. I've worked with North Dakota. Talk about access issues. It's a long way to places. So how do we think about that as we go forward.

So I want to make sure when we look at these different pieces, we're cognizant of those efforts and how it leads to other areas. Because even in the financing piece you talked about physician supplemental payments, and you talked about, well, it's really a physician supplemental payment, but really we need to look at it as system-wide. Maybe. Maybe not. I think that's one question.

Having said all that, I agree with Tim -- again, a lot of agreements with Tim today. At the same time it's like what is the fundamental issue that we're running into on some of these things.

I'm sorry. One last point. The other thing is whatever policy we come up with going forward we also need to be cognizant of where people are right now. So when you look at that one chart with the DSH payments, one of the things about the DSH program that is a little bit unfair, depending on what state you're from, is that they were states that went forward and did a lot of things legally under DSH to get their DSH payments really high, and then that's when things changed, Congress changed, and then capped DSH at where it's at.

So, you know, states that have done some of these things -- we talked about this at the last meeting -- states that have done some of these that are at a certain level, if we say now, oh, we're just capping it where it's at, then states who hadn't done those are at a disadvantage. And I think you see that with some of the DSH, low-DSH versus high-DSH states and how some of those can be used.

Again, another policy piece that we need to be considering when we're making recommendation going forward. Thanks.

CHAIR BELLA: Thank you, John. Every meeting you say you're agreeing with Tim a lot, so I think it actually happens every meeting. Now you even sit next to each other.

Tim, you said you had a methodological question. Did you ask that?

COMMISSIONER HILL: It was about [unclear].

CHAIR BELLA: Okay. I have a comment and then --

COMMISSIONER HEAPHY: Melanie?

CHAIR BELLA: Oh Dennis, yes.

COMMISSIONER HEAPHY: On the slide Access, Economy, and Efficiency, to me it's easier to think of this as access, efficiency, and then economy, because I can't think about putting limitations on things that I don't understand yet, and that's the efficiency part. So like children's hospitals, it's a positive that children go there quite often because they need care often. So that's part of efficient care. So I can't get to economy until I understand the efficiency of the hospital, and each hospital has a different mission and population that it

serves.

So I just can't get to economy without understanding access and efficiency first. Maybe this is my brain, but I really just can't -- this ordering just bothers me, because I think we're skipping over what's more important, which is really about how we're defining efficiency, based on the populations and the needs of the folks that are being served. Maybe a safety net hospital that is serving a high opioid use population, so we would need to get to efficiency before we think about what economy might mean. And again, this is just my perspective.

CHAIR BELLA: Thank you, Dennis. We can flip the order as we go forward, because I think economy is a function of access and efficiency, so that's a good point.

I'm going to make a couple of comments, and Commissioners we haven't heard from, I'm just wanting to take everyone's pulse. This is a big body of work, an investment that the Commission would be making over the next period of time. So it's important to make sure that everyone is on board with that.

While you consider your thoughts, could we go to

Slide 5, please? So what I find fascinating about this, like I kind of wish there was a way to get 5 and 6 on one page with people that have aging eyesight like me could still read it. But I'd also like to throw on a couple of other columns, hypothetically, about when each of these started, and what the growth was until there was a limit, and just to see what happens. I think that's part of what we're looking at, for example, with directed payments, is the Commission has gone on record wanting to understand more about that because we like to understand transparency. But also there's been pretty material growth in that particular option for states.

And I think when I look at these, and Slide 6, and think about -- it goes back to the point Angelo made -- it's kind of like we had something, we added something else, we capped something so we added something else, and this is a real opportunity for the Commission to step back and take a look at all of it and think about things. Like we had UPL, and UPL didn't apply in managed care. We created a directed payment opportunity in managed care, and we have two different standards. Like why?

So we're at the "why" thing, and again, this is

not meant to suggest anyone is doing anything wrong or try to take money away. But if we are trying to get a sense of what's happening in the system, asking those fundamental questions I think will be really helpful and part of the questions that you all had on the back. Because right now it would be really difficult, I think, for someone to use logic to explain sort of how it's evolved, even though how it's evolved makes total sense, if I'm making any sense.

So I appreciate these two slides a lot, and I think they're pretty telling, if people can kind of get their heads around them, who we're trying to talk to about this.

Heidi, and I want to make sure no one has concerns or no one has anything else they want to add to the mix of this, because again, our comments today will really be taken back to figure out the direction that we want to go next year.

COMMISSIONER ALLEN: I very much support transparency in financing and understanding what the goals of different ways of paying for things are in terms of making sure that populations have access to the things they need. And where I think I get hung up on the principles is

just, my mind spins out on how all of the things are related to these big data gaps.

What I don't want us to do is set principles based on missing information, and then create policies that have negative spillover effects, because we think we're making a common-sense recommendation but maybe we're not because things are happening and money is shifting, and it's like this shell game that's really hard to observe.

So I think that one thing that would be really helpful is even just starting with a table, going back to those principles of economy, efficiency, access, and thinking of kind of transposing what we know about financing, what data we can see and what data we can't see, and how that ties into different areas. Like what kind of principles should we stage in order to focus on the ones for which we have the best data possible, and then what are things that we would do a better job with if Congress or CMS implemented some of our recommendations about new data that's necessary?

I think that would help me. I find it really overwhelming to think of it all at once because I know that we have all these different requests and recommendations,

and then we have new data, and how would that new data help us observe. But just to kind of get a sense of a starting place and maybe one of these we take on first, based on the least amount of missing data, that's how I think I would like to do it.

CHAIR BELLA: Thank you, Heidi. Patti?

COMMISSIONER KILLINGSWORTH: I do think this is a really important body of work. I appreciate the comment that was made earlier about we're starting with hospitals but this is really about more than hospitals. It's about supplemental payments more broadly and sort of a policy framework around those.

So in that vein, Angelo described so beautifully sort of how all of this has evolved, and let us not forget that it has evolved on a policy framework that is fundamentally institutionally biased. And I know I sound like a broken record, but I have to keep making the point that when the Medicaid program began, it began only with an institutional benefit, a very teeny, tiny, limited home health benefit, but primarily an institutional benefit. And so payment policies, as they have evolved, have continued to sort of be built on this framework of that

institutional bias, such that the kinds of supplemental payments that we are looking at are largely only available to institutional providers.

So when we think about access, it is important to understand their impact on access? Absolutely. Is it also important for us to understand the impact on access for other services that don't have access to these kinds of payment mechanisms, and specifically when it comes to supplemental payments for nursing homes and the fact that they're not available to home and community-based services providers. It's so hard to look at one thing in isolation because they are all interrelated.

So again, I know today we're looking at hospital payments. This is bigger than hospital payments, and I think we have to be mindful of that as we continue to move forward in this work, which I do agree is really important.

CHAIR BELLA: Thank you, Patti. Tricia?

COMMISSIONER BROOKS: This is really more about the words that we use because economy and efficiency I don't think appeal to everyone, as they appeal to the economists, to the MBAs in the room. But is it what we are really interested in is cost-effective services that

produce outcomes. And I just wonder about continuing to hit on these particular terms. Are they really reflecting the vision that we have for how we pay for health care services in Medicaid.

CHAIR BELLA: I feel a recommendation to amend the MACPAC statute, because it actually uses those words.

COMMISSIONER BROOKS: We can do that.

CHAIR BELLA: Whose hand did I just see? Jenny.

COMMISSIONER GERSTORFF: If you go back to Slide 13 again, I just wanted to comment a couple of things that would pop into my head as questions when I look at these numbers. The first one is looking at these levels of supplemental payments. What do the fee schedules look like for hospital services in these states? Are they way under Medicare for base rates, are they at Medicare, that sort of thing, would help with some of the context of understanding those. And then also how much of hospital spending is in managed care versus fee-for-service.

CHAIR BELLA: Thank you, Jenny. Other comments?

[No response.]

CHAIR BELLA: All right. I'm going to take silence as interest. Normally I would not do that, but I

see nodding heads.

All right. We are going to open it up for public comment and then we'll go back and see if any Commissioners would like to add anything. In the meantime, Jerry and Chris, do you have what you need? Would you like anything else?

MR. PARK: I think we're good.

CHAIR BELLA: Okay. We're going to open it up to public comment for any of the sessions that we've had this afternoon or earlier today, for anyone who wasn't here then. If you would like to make a comment please use your hand icon, introduce yourself and the organization you represent, and we ask that you keep your comments to three minutes or less, please.

PUBLIC COMMENT

* [No response.]

CHAIR BELLA: Well, I would have lost that bet. I thought for sure we might get some comments. So we don't appear to have any public comments at this time. Folks should know that they're always welcome to send comments to MACPAC, comments@MACPAC.gov. You can send those via email.

Any last comments on this or anything else from

Commissioners or Kate?

[No response.]

CHAIR BELLA: No. All right. Well, we get started tomorrow at 10:00. We will start with votes and them move right into a panel session, which will be about the Medicaid unwinding and lessons we're learning and how we can further garner some research in this area.

So thank you all for your engagement today. We will see you tomorrow morning.

* [Whereupon, at 3:45 p.m., the meeting was recessed, to reconvene at 10:00 a.m. on Friday, April 12, 2024.]

PUBLIC SESSION

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

FRIDAY, April 12, 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
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 our second day. We're going to kick off this morning voting on our recommendations for the June report.

Chris, are you going first? Perfect.

The way this is going to work is we're going to go through the recommendations, we're going to understand if there's any comments, I'm going to read a conflict of interest statement, and Kate will take the votes. We have two sets of recommendations today. Thank you, Chris.

VOTE ON RECOMMENDATIONS FOR THE JUNE REPORT TO CONGRESS

* MR. PARK: Great, so these recommendations address the transparency in financing of Medicaid and CHIP.

Recommendation 1 reads:

In order to improve 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 the non-federal share of Medicaid spending derived from specific

providers. The report should include:

-- a description of the methods used to finance the non-federal 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 non-federal 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 non-federal share of Medicaid spending, including administrative fees and other costs that are not used to finance payments to the provider contributing the non-federal share.

This report should be made publicly available in a format that enables analysis.

Recommendation 2 reads:

In order to provide complete and consistent information on the financing of Medicaid and the State Children's Health Insurance Program (CHIP), Congress should amend Section 2107(e) of the Social Security Act to apply the Medicaid financing transparency requirements of Section

1903(d)(6) of the Act to CHIP.

CHAIR BELLA: Thank you, Chris. Any comments, questions from Commissioners?

[No response.]

CHAIR BELLA: Okay. We are going to vote on this one before we go to through, right?

EXECUTIVE DIRECTOR MASSEY: Yes. So are you going to read a conflict of interest script.

CHAIR BELLA: All right. Get ready for this. This is a voting meeting, and as a result MACPAC's conflicts of interest rules apply. Our policies are posted on the MACPAC website.

As required by our statutory authority, MACPAC's Commissioners represent a wide range of backgrounds and disciplines and thus bring diverse views to their service. Moreover, we all bring reportable interests to the table.

Our conflict of interest policy is meant to ensure that certain kinds of financial and other interests and affiliations, should they rise to the level of a potential conflict, will be disclosed during the voting meeting.

The policy requires Commissioners to report

certain interests, both at the time of their candidacy and annually thereafter. These reportable interests, which can also be found on our website, form the basis of the information that may be evaluated to determine if an interest rises to the level of a potential conflict of interest in connection with a vote on a specific recommendation.

Under the policy, the MACPAC Chair appoints a Conflict of Interest Committee that represents a mix of all of us. In advance of a voting meeting, the committee reviews the reportable interests on file for each Commissioner and any other information that the committee deems relevant.

On March 15th, the MACPAC Conflict of Interest Committee met by conference call and determined that for purposes of our votes today, under the particularly, directly, predictably, and significantly standard that governs our deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest related to the recommendations under consideration.

Our Conflict of Interest Committee is chaired by the esteemed Bob Duncan, our Vice Chair, and the members

include Jenny Gerstorff, Angelo Giardino, Tim Hill, Verlon Johnson, Jami Snyder, and Kathy Weno. Thank you to all of you.

With that on the record we may now proceed with the vote.

EXECUTIVE DIRECTOR MASSEY: Okay, great. So voting on the two recommendations in support of changes to Medicaid financing, data transparency. Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows? Not present.

Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. So that's 16 in favor, 1 not present.

CHAIR BELLA: Thank you all. Thank you, Chris.

Drew, we will go to our next recommendations.

MR. GERBER: So today we have a set of two recommendations aimed at supporting states in optimizing and overseeing their state Medicaid agency contracts with dual eligible special needs plans, and in addition to supporting states in pursuing integrated care as a whole.

The first recommendation is:

State Medicaid agencies should use their contracting authority at 42 CFR 422.107 to require that Medicare Advantage dual eligible special needs plans, or D-SNPs, 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 states were required by Congress {as previously recommended by the Commission) to 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.

The second recommendation is:

The Centers for Medicare and Medicaid Services should update guidance that supports states in their 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.

CHAIR BELLA: Go back to 3.1 just for a second, please. Thank you, Drew.

Commissioners, and for folks listening in, yesterday there was discussion of this recommendation to make sure the intent was clear enough around the second sentence regarding what point we were making when a point involves both states and Congress, and was also a nod back to a prior recommendation that we had made. So there were a couple of language tweaks to reflect that, most notably adding, in parentheses, "as previously recommended by the Commission," just to try to make the intent of the Commission clear.

So I wanted to note that for the Commissioners and note that for the record.

Does anyone have any questions or comments about these recommendations?

[No response.]

CHAIR BELLA: Okay. I think we're ready for a vote, and let it be said that my final vote as a MACPAC Commissioner is on a duals recommendation. I mean, that could not have been planned better if we had tried.

EXECUTIVE DIRECTOR MASSEY: Okay. So calling a vote on the two recommendations affecting dually eligible beneficiaries. Heidi Allen?

COMMISSIONER ALLEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Tricia Brooks?

COMMISSIONER BROOKS: Yes.

EXECUTIVE DIRECTOR MASSEY: Sonja Bjork?

COMMISSIONER BJORK: Yes.

EXECUTIVE DIRECTOR MASSEY: Bob Duncan?

VICE CHAIR DUNCAN: Yes.

EXECUTIVE DIRECTOR MASSEY: Jenny Gerstorff?

COMMISSIONER GERSTORFF: Yes.

EXECUTIVE DIRECTOR MASSEY: Angelo Giardino?

COMMISSIONER GIARDINO: Yes.

EXECUTIVE DIRECTOR MASSEY: Dennis Heaphy?

COMMISSIONER HEAPHY: Yes.

EXECUTIVE DIRECTOR MASSEY: Tim Hill?

COMMISSIONER HILL: Yes.

EXECUTIVE DIRECTOR MASSEY: Carolyn Ingram?

COMMISSIONER INGRAM: Yes.

EXECUTIVE DIRECTOR MASSEY: Verlon Johnson?

COMMISSIONER JOHNSON: Yes.

EXECUTIVE DIRECTOR MASSEY: Patti Killingsworth?

COMMISSIONER KILLINGSWORTH: Yes.

EXECUTIVE DIRECTOR MASSEY: John McCarthy?

COMMISSIONER McCARTHY: As I talked about yesterday, I really have a hard time voting or telling states to do something. But I do believe this is the best policy moving forward on this so I will vote yes today.

EXECUTIVE DIRECTOR MASSEY: Adrienne McFadden?

COMMISSIONER McFADDEN: Yes.

EXECUTIVE DIRECTOR MASSEY: Rhonda Medows? Not present.

Jami Snyder?

COMMISSIONER SNYDER: Yes.

EXECUTIVE DIRECTOR MASSEY: Kathy Weno?

COMMISSIONER WENO: Yes.

EXECUTIVE DIRECTOR MASSEY: Melanie Bella?

CHAIR BELLA: Yes.

EXECUTIVE DIRECTOR MASSEY: Okay. So that's 16 in favor, 1 not present.

CHAIR BELLA: All right. Thank you for all this work, Chris and Drew. Thank you, Kate and Commissioners.

CHAIR BELLA: And we will now move into our final session of the day, which is a very exciting one. Martha is back with a panel. Actually, we are a little ahead of time, but we can see if everybody is ready to go.

We've talked a lot, as a Commission, over the past few years about the pandemic and the unwinding and trying to figure out exactly where is the proper place for the Commission to engage to make sure that as we unwind people are continuing to get the services they need and they are eligible for. Martha has put together a fantastic panel of folks who are going to talk to us about what are we learning and what can the research tell us as we are kind of at this point with the redetermination process.

So Martha, I will turn it to you.

MS. HEBERLEIN: One second. I'm checking with my IT buddies to see if everybody is here.

[Pause.]

LESSONS LEARNED FROM MEDICAID UNWINDING: WHAT CAN THE RESEARCH TELL US?

* MS. HEBERLEIN: Okay. I see some happy faces on the screen so I'll get us started. Thank you, Melanie, and good morning, Commissioners.

After a year into the unwinding of the continuous coverage requirements, and as states are concluding the process in the next few months, the Commission is shifting its focus to what can be learned from the unwinding and areas for future research. So today's meeting will feature our panel of researchers who will share their work and their perspectives on learning opportunities coming out of the unwinding.

I am joined today by Genevieve Kenney, Vice President and Senior Fellow at the Urban Institute Health Policy Center; Daniel Meuse, Deputy Director at State Health & Value Strategies; and Jennifer Tolbert, Deputy Director, KFF Program on Medicaid and the Uninsured.

In the interest of time I will not read their bios, but Commissioners, there is more information about the panelists in your materials.

Similar to prior unwinding panels, this will be a moderated session, and I will be asking the panelists a few questions before I turn it back to Melanie to facilitate the discussion with the Commissioners.

Jenny, to kick us off, could you provide us with some thoughts on what we may be able to learn from the unwinding and what questions might remain unanswered?

* DR. KENNEY: Let me start by thanking you, Martha, and MACPAC for focusing attention on this important issue.

The unwinding of the continuous coverage requirement in Medicaid provides what I see as an unprecedented opportunity for us to learn more about how Medicaid programs can minimize coverage losses when enrollees are going through the redetermination process. Historically, both eligible and ineligible enrollees have lost Medicaid coverage at redetermination, and we know that many eligible enrollees who disenroll subsequently enroll or return back into coverage in Medicaid or CHIP. The resulting gaps in coverage cause people to delay or go without the health care they need and raise administrative cost burdens.

While churn is a long-standing issue in Medicaid, we still have a lot to learn about how to prevent it and the impact that it has. The unwinding period has brought laser focus to the renewal process. The variations in state approaches to unwinding provide us with new information that will help us understand more about both the causes and the consequences of coverage losses for enrollees who are eligible for Medicaid. And there has never been a time when we've had so much information publicly available on Medicaid disenrollment levels and patterns, nationally and across states.

So what can we expect to learn from the unwinding period? I'll just highlight a few things that I think will come out of this period. I think we'll emerge with more insights about why renewal outcomes vary so much across states, and whether they relate to broad differences in state policies, such as the extent of the adoption of administrative and outreach flexibilities that CMS made available, and how many months a state took to complete redeterminations during the unwinding period.

I expect we'll have a much better idea how to improve transitions from Medicaid to separate CHIP programs

and to marketplace coverage. In addition, I think we are going to gain hard evidence with respect to some particular state policy choices from a number of experiments that have been launched around outreach communication and ex parte or automatic renewal strategies. I also expect we'll have a much stronger handle on the consequences of churn.

But I do not expect that we'll be able to fully assess the contribution of individual policy choices or combinations of policy choices, given how many different dimensions along which state policy choices vary, about which you'll be hearing more from Dan shortly.

I also anticipate that we're going to encounter challenges associated with assessing coverage impacts, given the recent growing disconnect between Medicaid administrative enrollment counts and Medicaid counts based on household survey data.

And finally, I'm afraid we're going to have much less information than we want about the impacts of the unwinding and of specific policy choices on different demographic and socioeconomic groups. Thanks.

MS. HEBERLEIN: Thank you, Jenny, and you did set my question up for Dan very well, so I appreciate that.

Dan, can you say more, given the variation in state policy decisions, there are so many factors in the mix, which makes it really difficult to determine the effects of specific policy choices. Could you describe how these policies could be assessed and some of the examples of the work that SHVS has facilitated?

* MR. MEUSE: Yeah. Thank you, Martha, and thank you to the Commission and staff, Commissioners, and to my fellow panelists.

The question around state variation is one that we struggle with mightily when we try to figure out how are the outcomes shaping up from an "is this good, is this bad, what does good and bad mean" but also how can we compare across states. Because the variation between states is so great and the policies that have been chosen with flexibilities offered from CMS for unwinding but also policy choices that were made prior to unwinding.

So I'm going to start on ex parte, automatic renewals, as kind of one of the biggest areas of differences across states, and try to think about are there ways where we could say, or at least opine as to whether or not a flexibility choice made a difference in having a

higher or lower ex parte rate.

Generally, when we talk to states, the states will suggest that the zero income flexibility and the 100 percent income flexibility tend to be the places where there is the most opportunity to say yes, we feel like this made a difference, because states are able to say, "If I didn't have this flexibility, I can say that this person would not have made it through the ex parte process."

And so really the assessment for some of these flexibilities really comes down to a state-by-state analysis. If you didn't have this flexibility, how do you feel like it would have worked, and how would it have worked prior to the unwinding, kind of prior to the continuous coverage requirement.

Staging renewals I think is one of those places where we can do some comparison across states because we know that there are states that decided to conduct the renewal process in different ways. For example, one state might say we're just going to assume the same renewal month for our members, and renew them in 2023, 2024, for that month. Some states said we've been collecting information through a renewal process that did not end up in

termination. We are going to stage the people who we feel are least likely to remain eligible, and kind of that process really looks different and ends up in different results.

I would say there are five or six other ways where we could look at the differences between states. What we hear from states in our technical assistance work started on the outreach side -- How can we text? How can we get in touch with folks? -- and quickly move to the ex parte side. How can we improve our ex parte process, because we don't think communications is having a significant impact in the results.

So I will pause there because I know we have a lot of questions to go through, but that's kind of where I would start.

MS. HEBERLEIN: Thanks, Dan. And Jen, turning to you, given the variation that we just talked about, and knowing that you've done some work looking at particular states, could you talk a little bit about some of the themes that have been emerged in your work, looking at different state approaches to the unwinding?

* MS. TOLBERT: Sure, and first thank you, Martha

and Commission staff and Commissioners. It is a pleasure to be here.

I think I'll probably build on some of what Jenny and Dan just said. We conducted interviews with state officials in Arizona, Indiana, and Pennsylvania as well as stakeholders in those three states and in Florida back in the fall, to kind of get a sense of how things were going. And we certainly learned a lot about different state approaches to the unwinding and what was going well as well as where there were challenges.

I will note this was sort of at a very high level, so to Dan's point we didn't dig in, and we weren't able to isolate any specific issues or policies. But also, I'll talk about some of the broad themes that we heard from states and our key takeaways.

You know, across the board states talked about the efforts to increase and improve outreach to enrollees, and we heard certainly a lot about this. They've introduced new methods of communication, like texting, but also increased the number of communication touchpoints with enrollees, both through broad outreach efforts as well as targeted messaging.

I think importantly both states and stakeholders talked about the need to kind of shift from the broad outreach strategies that sort of just threw everything against the wall to see what might stick, and seemed maybe not to work, and moved to more targeted messaging, directed at specific populations around things like trying to get people to complete the renewal form and avoid procedural disenrollments.

I think another area of success in this was certainly what Dan talked about, was state efforts to increase ex parte renewal rates. Obviously, states did a lot. They adopted a number of (e)(14) waivers, but they also undertook other strategies. And I think we saw in the data, which we did not have previously, that states were able to increase ex parte rates.

And even in some states where there were systems limitations that prevented states from automating ex parte rates -- so we saw this in Pennsylvania -- the state adopted a manual process which state officials credited with helping to reduce procedural disenrollment rates.

I will also note that one area that seemed like sort of across-the-board as a positive outcome from the

unwinding was enhanced state engagement with community-based organizations and others involved with unwinding. Most of the study states that we talked with really stepped up their engagement with these community partners, through regular meetings and other efforts.

And the stakeholders talked about how these meetings and the enhanced outreach from the state enabled them to share on-the-ground experiences, create feedback loops that helped to build the relationship with the state as well as trust in the process. So I think that was uniformly viewed as a positive, but less related to kind of procedures and engagement with enrollees.

And again, as I said, a lot of these it's hard to assess the impact of specific policies, and as both Jenny and Dan noted, I think there's a need for ongoing research in this area.

And then in terms of challenges, I'll just note quickly that some states were hampered by outdated eligibility and renewal systems. But even when systems were working well, and we identified, and in both Arizona and Indiana everyone, state officials as well as community partners, talked about systems working fairly well, the

need to make system updated and related to adopting new waivers or to respond to CMS guidance takes time and poses challenges for states, and did so throughout the process.

And then at the time of our interviews, states acknowledged that staffing shortages and inadequately trained staff were contributing to slower processing of renewals, and in some cases incorrect disenrollments because of failure to kind of follow federal rules. And then in addition some of the manual workarounds that states had to adopt exacerbated some of the staffing shortages.

And then I'll just wrap up with even as states were increasing outreach and communication efforts, there were problems with both renewal notices and termination notices that created confusion for enrollees, and long call center wait times meant enrollees were often unable to get the help that they needed to complete the renewal process or to understand even why they had been disenrolled and maybe what steps they needed to take to have their coverage reinstated.

MS. HEBERLEIN: Thanks, Jen, and that's actually a great segue to my next question. I saw that you guys, hot off the presses, released a survey this morning, and

I'm curious if you can share a little bit more about what you learned from the beneficiary perspective on the unwinding.

MS. TOLBERT: Sure. I'm happy to talk about our survey. The findings hot off the presses this morning. We conducted a survey of Medicaid enrollees that focused on their experiences during the unwinding. And so some of the key findings -- and again, this relates to some of the things we were just discussing, perhaps not surprisingly, but despite increased efforts by states to conduct outreach prior to and after the start of unwinding, about half of respondents in our survey said they had heard little or nothing about Medicaid unwinding.

However, a larger share, about 7 in 10, say they do remember receiving information about their needs to renew their coverage. So that's good, but it does mean about 3 in 10 reported that they did not receive any renewal information. And not surprisingly, people who did not receive renewal information were much less likely to say they took action to try and renew their coverage.

Among respondents who did try to renew their coverage, while most found the process easy, about half

described their process as at least somewhat stressful. Additionally, about 6 in 10 experienced at least one problem, most commonly long phone wait times. Again, this is something we know from other work. But also problems with gathering and submitting documents.

Overall, about three-quarters of enrollees say they had to submit proof of income to renew their coverage, but enrollees in non-expansion states were much more likely than those in expansion states to say they also had to submit proof of residency as part of their renewal process.

The survey also found that about 1 in 5 enrollees say they were disenrolled from Medicaid, and that's consistent with our tracking of unwinding renewal outcomes. And of the enrollees who were disenrolled, 70 percent say that they became uninsured when they lost their Medicaid coverage, though again, for many that was a temporary situation.

But this has implications for access to care, as we know, and more than half say that they skipped or delayed needed care while trying to renew their coverage. And many say losing Medicaid led to worries about both their physical as well as their mental health.

And so then we also asked about the current health coverage of those who reported being disenrolled from Medicaid. Interestingly, nearly half reenrolled in Medicaid, suggesting that they were actually likely still eligible at the time that they were disenrolled. Twenty-eight percent enrolled in other coverage, but that left nearly a quarter who say that they are currently uninsured.

And so I think these findings help to identify specific problems enrollees are experiencing and sort of build on the body of evidence that we know are some of the problems that people are encountering. And they also provide evidence that, as we expected, the unwinding is leading to an increase in the number of people who are uninsured. I think still for a variety of reasons, including that the survey was only of adults on Medicaid and did not include children, and because current health coverage is influx for many. About a third of people who are uninsured said that they were still trying to get back on Medicaid. It's much too early to say what the final impact of unwinding will be on increases in the number of people who are uninsured.

MS. HEBERLEIN: Thanks, Jen.

Dan, turning it back to you, you mentioned a little bit about the technical assistance that SHVS provides to the states and I'm curious, what areas have states raised with you about what they're most interested in understanding about what happened during the unwinding, both in terms of what they want to hold onto but also in terms of additional changes that may need to be made?

MR. MEUSE: Yeah. So I think that there is a particular interest in eligibility policy choices, and that is not a surprise here. We know what happened during the unwinding, especially for those states that are finished or very close to finished, and they say what policy choices could we have made differently, including those were not temporary flexibilities. So I think some of these things include ex parte data criteria, how old can the data be, what are their sources of the data, to change that ex parte process.

I also think that there is, especially for states where the eligibility processing and systems live in a separate state agency, there is a kind of ongoing analysis of what is that functional relationship like and how can we, as a Medicaid agency, influence how the application

looks, feels, how easy is it for consumers to get through. So that kind of ease of use is definitely a place where we're hearing states request information and assistance.

Communications and outreach is also an area where we're hearing a need, and I think that need comes from the fact that there was an investment in communications and outreach by state legislatures during the unwinding, and there is an assumption that that investment will end because unwinding is over. And so states are looking at what are the highest return on investments communications and outreach channels that we could continue to leverage, that we could argue for continued funding. Texting seems to be one that is on the mind of a lot of states, given its relative low cost. So there's a little bit of trying to understand what can and can't we do from a texting perspective.

I also think that the loss of coverage among children was particularly noted by states, and they are trying to figure out why, and then trying to figure out, okay, how does the new continuous enrollment requirement going to fit into what we know happened, and can we make changes to our systems to help that process.

Jen mentioned notices. Notices is definitely on the mind of states. I am a recovering state official, but it was 12 years ago, and even back then, the notice problem is not a new one. And so, because all of these renewals happened all at once, and we can see differences in states, states can start to share different notices in what seemed to work and what seemed to not work from the enrollee side.

The last thing I would say is -- and there's not a solution to this -- states are really struggling with understanding how consumer ESI enrollment affects their Medicaid population, especially when we are looking at continuous eligibility periods. If you have folks that get a new job, get into ESI, but are still in that CE period, how do you encourage folks to continue to respond to Medicaid mailngs, to renewal requests, et cetera.

So I would say those are the area where we're hearing the most demand from states.

MS. HEBERLEIN: Thanks. And Jenny, to close us out, looking forward, what is the role that researchers can play, and are playing, to inform future policy directions based on what we can learn from the unwinding?

DR. KENNEY: Well, fortunately many research

teams are studying unwinding, looking at different geographies, national studies, state-specific studies, looking at different groups within Medicaid, MAGI, non-MAGI populations, using different data sources and methodological approaches, both quantitative and qualitative. And I think that's really critical. We need to build an evidence base that braids in evidence from multiple sources.

And I expect that the individual studies are going to yield critical information on different aspects of the unwinding, but also see a real need to synthesize the findings across studies, to assess robustness of evidence, for different research questions, and to help us construct as complete an understanding as possible of the implications of different policy choices and of interactions between them.

Given the need for CMS to make decisions about which flexibilities to extend beyond 2024, research that can yield meaningful findings in the coming months, there's urgency around this aspect of the unwinding, would be particularly valuable.

One area I'd really like to see more analysis,

and it really tees off something that Dan alluded to, is around ex parte redeterminations. I'd like to see researchers partnering with states to evaluate state eligibility and enrollment data, which are not publicly available.

This is not going to be something that researchers across the country can jump into. But it's going to be essential for helping us understand how redeterminations and procedural denials are affected, for example, by automatic renewals that are based on SNAP eligibility or the zero-income case, and by what information is being used in a particular state for ex parte renewals.

This would provide CMS and the field with a much more concrete foundation for understanding the role that these state-level decisions are playing, and inform thinking on what CMS might need to consider requiring of states, not just making flexibility available, if we really want to minimize the number of children and adults who lose Medicaid coverage, even though they still qualify for it. And I think Jen did a really important public service in drawing attention to the potential and deleterious effects

of even gaps in coverage.

But beyond the immediate period I'm hoping that researchers will also dig in and undertake longer-term analyses that rely on data sources, gold standard federal surveys in many cases, that will only be available with a lag to study how the unwinding affected a host of outcomes that go beyond enrollment and disenrollment and coverage, to look at impacts on receipt of needed care and some health outcomes overall, and for our groups of high policy concern, such as those with chronic health care problems and those in historically marginalized groups, and to help us understand whether and how those impacts varied across states.

Those types of analyses will be really important for shaping Medicaid policies with respect to renewal and enrollment going forward, and the unwinding period, I think, can help us do a much better job with redetermination decision point well beyond this period.

Thank you, Martha and panel.

MS. HEBERLEIN: Thank you all. So with that, Melanie, I will turn it back to you for Commissioner discussion.

CHAIR BELLA: Thank you so much to the three of you. If you watch us, we love panels. We just cannot get enough, and we cannot get enough of understanding what you're seeing and helping us decide, as a Commission, what can we be doing that's going to be most effective and productive to support the work that is already going on in this area. So thank you for that. Martha, thank you.

We'll open it up to Commissioner questions. Tricia, to start us off.

COMMISSIONER BROOKS: Hello, friends, familiar faces in the squares. Thank you so much. I was sitting here really picking my brain to try to identify something you didn't mention, but I have to say that you did a really good job of covering all of the bases.

But I guess I have two questions. The first one is, what, in particular, might have surprised you in terms of how the unwinding has occurred?

I stumped them.

MR. MEUSE: I'm happy to jump in. Here's what I would say surprised me the most. At SHVS we tracked a lot of activity leading up to the unwinding and then in the first couple of months of unwinding. And one of the things

that we saw was this kind of cohort of states. They were making specific investments in smaller community organizations to assist with unwinding, so that you could have folks doing door-to-door, you could really get into the community and make an impact.

We did not see a relationship between those investments and unwinding outcomes. We did not see that funding small community organizations to support the unwinding process made a difference in procedural termination numbers. It did not make a difference in overall renewal numbers. And so one of the things that were trying to think through is what other elements would have led to a disparate outcome in those states that implemented those types of programs. Because when you talk to the states who implemented them, they are like, "It was great. If we didn't have this program our numbers would be worse." But when you compare the states that made those investments, they were not aligned.

MS. TOLBERT: And I can jump in. One of the things that surprised me from our tracking of the unwinding renewal outcomes was the stubbornly high procedural disenrollment rate. You know, it started out high at about

76 percent, but we assumed with all of the state efforts to reach enrollees, the additional communication touchpoints, that enhanced outreach, the delaying of procedural disenrollment so states could do additional outreach and try and contact states.

My assumption, at least, was that that procedural disenrollment rate was going to come down over time. And, I mean, it has dropped to about 70 percent. We did see it drop very briefly to 69 percent, but it really has remained stubbornly high. And I think we just don't have a lot of insights into why that is happening. And I do think that's an area that we need to try and investigate more and understand, are these barriers.

We know that some of the people who aren't completing the renewal process, they know they are no longer eligible, so they're not going to complete the process. And we also know from our survey data that half of people that have been disenrolled are back on to Medicaid, which suggests that they shouldn't have been disenrolled in the first place.

So there are barriers, and we know what some of them are. I think we just need to maybe do some additional

investigating to understand what those pressure points are and what is preventing people from completing the renewal process.

DR. KENNEY: And maybe a surprising comment from me. Despite the somewhat discouraging news from the Kaiser survey today, I've actually been somewhat surprised that things have gone as well as they have. I was worried about a meltdown, a real worst case scenario. I just think it was unprecedented what the states were facing, over 90 million enrollees, all needing to go through the redetermination process, many of which may have never experienced it, and those who had could have experienced it 5, 6, 7, 8 years ago. And states without the muscle memory as to how to do it.

And I've been really surprised in a positive way with how much, as a field -- I'm thinking about CMS, I'm thinking about the states, I'm thinking about the role that folks on this panel and others are playing, in real time make use of the data we have to identify problems and solve them.

I'm not a Pollyanna usually, and I am really worried about the losses, and we don't have the visibility

on the kids that we want. The Kaiser survey is fantastic with respect to adults, but we do expect a very different potential scenario for kids. So I would just sound a note of relief and worry at the same time.

COMMISSIONER BROOKS: And my second question is based on what we've learned so far, what do you think are the top one or two priorities for states, going forward, to try to improve retention?

DR. KENNEY: I'm going to wait to hear Dan and Jen's answer, but I really think it's critical that they maintain lines of communication with enrollees while they're enrolled. I think that trying to figure out to reach enrollees after an absence of 12 months is really bound to cause problems. And I'm really convinced that the ex parte, that we need to look a lot more at differences across states. The variation in ex parte rates is still very large, and to the extent that that means that the states that have much lower ex parte rates also have higher disenrollments rates and coverage losses, I think we really need to have a handle on that, and that needs to be prioritized.

MS. TOLBERT: Well, I'll just say that building

on what Jenny just said, I do think understanding -- and Dan has mentioned this, too -- the focus on the ex parte renewals rates, and really understanding what is driving the differences in these rates, but also what are the factors that are improved? What are the specific policies that can help to improve those ex parte rates?

Because we have done some analysis and found when looking at enrollment declines, not surprisingly how far along in the process states are had no bearing on their overall enrollment decline. But what seemed to have some import was the policy decisions that states made. Unfortunately, we didn't have the data to be able to dig more deeply on that, but I think understanding these ex parte rates, but maybe also beyond that, what are the specific policies that states can adopt to really maintain coverage among those people who are still eligible and avoid these procedural disenrollments and coverage and care disruptions.

MR. MEUSE: And I would say on top of ex parte there is also, for those folks who don't make it through ex parte, what does the system look like, and can we think about a more enrollee-centered, person-centered design for

this whole process, so that there are multiple channels of contact to say, hey, you need to take an action, that there is an easy way to get into a modern, mobile-friendly system to take that action, that does not require a paper-based, find-my-pay-stubs, find-a-way-to-print-out-my-pay-stubs style of renewal process.

And that means talking to folks who didn't make it through the process, who lost their coverage, and then came back in, to understand what about our notice didn't you understand. What about the system was difficult for you to work through, and how can we make those changes. We know we're going to have to make changes to our eligibility system anyway because of the new rule that came out and because 44 states are under compliance plans from CMS for their eligibility system. If we're going to change the system anyway, let's make it better while we're making those changes.

COMMISSIONER BROOKS: Thank you.

CHAIR BELLA: Thank you, Tricia. Heidi, then Jami, then Dennis, then Patti.

COMMISSIONER ALLEN: Thank you all so much for your work in this area. I am truly, truly grateful.

I wrote my dissertation in 2008 on Medicaid churn, so it's disappointing to see that all of these years later that this is still happening to the extent that it is.

A couple of comments that I'd like to make. One, stepping back and thinking about the role of Medicaid during national emergencies, I'm still very proud of the way that our policymakers allowed Medicaid to be a part of the safety net and the support system during such a terrible time. Medicaid really did step forward, and I think that should be applauded. And I hope that people are also capturing that so that the next time we have a national emergency that we are prepared to come forward and say how important it was for people when employment numbers, you know, unemployment went up, and state budgets went down, that Medicaid was able to be there.

So I'm curious if you know of any efforts to really study that and make that story told.

I'm also struck by the KFF survey, that showed that half of respondents hadn't heard of the unwinding, and it reminds me of other policy implementations, like work requirements, where you think there's so much media

coverage, you feel like there's so much going on, everybody is talking about it, and then you talk to enrollees and they're like, "I don't know what you're talking about."

And I just wonder how we would do policy differently if we started with the assumption that people don't know what Medicaid is doing, and how would we behave differently if we assumed that our communication strategies are not as effective as we think they are.

And I'm also very excited to see that there is so much individual research happening. And Jenny, you mentioned that there are some data that researchers don't have access to. And I'm curious if you know of any efforts within CMS, within ASPE, I'm curious if you've had conversations with the staff at MACPAC of how some of those analyses can happen so that we can make sure we take advantage of all the data and all the information.

And I also would like to issue a call to fellow Commissioners that I feel like we have a real opportunity to develop some recommendations on where ongoing flexibilities could be helpful in addressing churn, and what kind of support CMS can give to states in doing some of the things that Dan mentioned about bringing us into a

modern enrollment and eligibility system. And I hope we do take that opportunity. Thank you.

CHAIR BELLA: Thank you, Heidi. Did anyone want to comment on anything that Heidi put out there, on the panel?

DR. KENNEY: I would just share with Heidi that I do think a number of researchers are focused on the question of what the impacts of the continuous coverage requirement itself was. There are tricky aspects to trying to assess that, but I think people really do understand that it was a vital policy tool for keeping families whole and maintaining coverage. And it's really important to understand the additional impacts it might have had on their access to care and affordability of care. So I would say I think a number of people are working on that question.

When I was referring to data that researchers don't have access to, I was thinking about a presentation that Alice Middleton, Deputy Director at Hilltop, did recently, that assessed kind of the SNAP waiver for ex parte renewal. And it was really useful and important, and sort of along the lines of what Dan was saying, that states

can actually look and see how many additional people they're able to confer automatic renewal for with that policy lever, or they can look at, well, if we insist on the data being one month old versus two months old, how many fewer people can we automatically renew?

It's really possible within the system to do that in a sequenced way, and to understand kind of the bang for the buck for the different policies if you implement them in different ways.

Researchers don't have access to that data. It's what's in the administrative and eligibility determination files. And I think linking that to the subsequent disposition of the case is important as well.

But I think there are states that are really able to look at this, and may be willing to, but would probably need support and maybe resources to do it. It's not a costless exercise, given all the other things that they're facing. But I would say that there would be a real payoff to doing those type of analyses.

I don't know if Dan and Jen think similarly.

MR. MEUSE: I would agree. I would also say that we are rapidly losing access to data. The CAA's

requirements for the unwinding data was -- I don't think anybody thinks it was perfect, but it was there and we knew we had relatively standardized data across the states, that disappears as unwinding ends. And we are likely to get back into a place where some states report, some states don't. It's a lag when we have to look back, and perhaps a significant lag when we look back, and sometimes that data is not available.

For example, there was never really data captured on procedural terminations prior to unwinding. So we can't actually go back and say we're doing better or worse, because there just isn't information there. And we don't want to lose access to that understanding of what the consumer and enrollee experience is and what churn actually looks like.

MS. TOLBERT: And if I can just add to that briefly. I think this issue of data and the ongoing availability of data is a vital one. We believe that CMS has the authority to continue to require states to report much of the data that was required by the CAA, and we do hope that CMS will exercise that authority, because as Dan noted, prior to the unwinding we really didn't have access

to this data, and we didn't have insights into how renewals were going and what was happening across states and to see the state variation.

So in order to just continue to be able to monitor how things are going post-unwinding, we are going to need to retain access to some level of data. And I think that's going to be vitally important going forward.

CHAIR BELLA: Thank you all. Jami.

COMMISSIONER SNYDER: Thanks so much for joining us this morning. This question might be a little bit beyond the scope of today's conversation but I'm curious. Are any of you looking at the impact of disenrollments on providers, and in particular community health centers throughout the country?

MS. TOLBERT: Well, we actually have a piece coming out, hopefully sometime next week, that is just a quick update on health centers. Unfortunately, there is a bit of a data lag, at least in terms of the data that we have access to. So we are not yet seeing the effects of unwinding, but that is certainly an area that we intend to investigate. We expect UDS data to be available later in the summer, and we'll certainly be mining that to assess

impacts.

But we are hearing sort of anecdotally and through some data that health centers themselves are reporting, that, yeah, that unwinding is already having an effect, the number of Medicaid patients which grew during the pandemic, and while continuous enrollment was in place, the number of patients with Medicaid is dropping, and obviously the number of uninsured patients arriving.

So that's going to have a significant impact on health center financing, and I think something that we certainly need to pay attention to going forward.

CHAIR BELLA: Thank you. Dennis, then Patti, then Sonja.

COMMISSIONER HEAPHY: Thank you for the presentation. As a dual eligible beneficiary it doesn't surprise me the low response rates by folks. We're overwhelmed by mailings from Medicaid, those of us with Medicaid and Medicare. Many of these mailings are contradictory. For example, we'll receive a denial notice one month and the next month we'll receive an approval notice. And the mailings just continue. What that's saying is often a level of inertia, and the system will

just fix itself. And that eventually it's just going to be solved. And if it's really a problem, that someone is going to contact me so it will get fixed.

We also need to recognize will literacy rates be able to help with cognitive impairments, change of address, and other factors that make the Medicaid population distinct, which seems to be lost in the conversations that a lot of policymakers have?

And all this is recognized by an article that was in JAMA just put out yesterday, about the need for policymakers to implement strategies to minimize Medicaid coverage losses for really the vulnerable and minoritized populations.

So my question, I guess, for you is given the cost of churn, given the loss of continuity of care, and all these expenses for the state, and for beneficiaries, and for insurance companies, what do think the greatest barrier is to having a national policy that puts in place an ex parte rule across the country, and what can we do to address that?

Because it just seems like it should be a given, if someone has zero income that they automatically get a

letter in the mail that says, "you are now eligible for all these benefits, X, Y, and Z," and then boom, it's one-stop shopping sort of statement that people get. And they can opt out of any one of them that they choose. And so rather than an opt-in system, make it an opt-out system.

MR. MEUSE: I'll start and say in some cases the difficulty of conducting an application or a renewal process was put in kind of purposefully as a feature, not a bug, and I think that those are policy choices that have been made over the years, and those efforts can come and go. And I think that the idea of a set of ex parte standards, kind of recognizing there's balance between having states run the system that they're running versus with a set of minimum criteria, versus a flat standard of everybody does it this way, is one of those ongoing push and pulls in the Medicaid system.

I think that there's value in the learnings from the unwinding process to understand the difference between how ex parte policy choices affect enrollees and affect different types of enrollees differently. I think that we are likely to see, to the extent that we can over the course of the next probably many months, where communities

that have experienced, losing power, being marginalized, were affected differently in states with different ex parte policies, whether that be because of their ethnicity, because of their language, because of their disability status. And I think that will lead to advocacy and policy efforts to have changes to the standards on the ex parte side.

COMMISSIONER HEAPHY: Thank you. I don't know if anybody else is going to answer. And just one more quick follow-up question, and that is regarding CBOs. You need more research into the success, and what efforts with CBOs worked and which efforts by CBOs were unsuccessful. Because as we're thinking about health equity and trusted partners, are there ways to lift up when CBOs were effective, and how they're effective.

And not just for the unwinding but for future ongoing relationships between Medicaid agencies and CBOs. So it's not just a crisis situation but it's an ongoing relationship. I don't know if there's any research you're planning on doing in follow-up to this.

MR. MEUSE: So I would expect, and we are currently working on a project to focus on non-citizen

coverage, which really includes for language access is a really important element, and for experience in mixed-status families, the trusted community organizations are the source of truth for those communities when government tends not to be.

And so I think that there would be interest from our side to understand, especially for non-English-speaking and mixed-status families the extent to which investments in community-based organizations that are those trusted messengers made a difference.

You know, California kind of releases ongoing survey information about unwinding, and one of the things that they have said is that non-English speakers tend to have significantly higher levels of procedural disenrollments, expressed challenges in being able to access the renewal process, and ongoing questions about, yes, I am no longer in Medicaid but I would like to be back in Medicaid. And so leveraging community organizations that can be those assisters, that can be those trusted partners in communities.

And kind of leveraging what we learned from the 2020 COVID testing and initial vaccine rollout, that we

need to go beyond the traditional community-based organizations for Medicaid and to non-traditional organizations like faith-based organizations, and very small, kind of micro-community organizations, to say here is what's happening, and have that message be repeated over and over because of this lack of awareness that we see in multiple surveys.

DR. KENNEY: Martha, could I say something about the first question? It's two things. One is until we both hold states accountable for their eligible but uninsured, and the folks they have on their rolls who are not eligible, we're holding states accountable for the latter. States are very anxious about that. That is audited. But the former is not something that is a metric that is tracked. So I think that asymmetry is a barrier to what you proposed.

But I also think the state financing piece is a barrier. You know, it's a jointly federal and state financed program. I haven't been a state official but I have talked to enough state lawmakers to know that the Medicaid budget is a perennial source of stress, and it just feels like a real barrier to me sometimes for making

those kinds of changes at a federal level.

CHAIR BELLA: Thank you. Dennis, anything else?

COMMISSIONER HEAPHY: Yeah, just a quick follow-up. I just think of the cost of people losing Medicaid and then relying on emergency departments, and whether there's any analysis done on what that actual cost is of what happens when people lose insurance, when they lose their Medicaid, and the continuity of care with their providers, or the cost of going back to providers or having to find new providers, the cost of churn. I know there has been some research done on churn, but how do we better understand that churn from the perspective of the actual cost in total to the state budget. Like to understand states are under a lot of pressure, but maybe this is a way of providing evidence to say the cost of not doing this is even greater than doing it, until they're ex parte. Or am I being naïve?

DR. KENNEY: I've just been disappointed so many times when I think that calculus is going to work in favor of things like that. I think a lot of the costs are being borne by the families and the individuals. I think they're going without care. I think they're paying out of pocket.

So the societal costs are far greater. But I don't know that it's really hitting state budgets. That's a guess.

MR. MEUSE: And I would say it definitely doesn't hit state budgets the way that continued enrollment, especially in a managed care environment, where no PMPMs are going out the door, hit state budgets.

CHAIR BELLA: It's not naïve, Dennis. It's logical, which is why it just doesn't go anywhere.

All right. Thank you very much. We'll move to Patti, and then Sonja.

COMMISSIONER KILLINGSWORTH: So Martha, thank you for this incredible panel, and thank each of you, really, for the incredible work that you've done to advocate as it relates to this really super important issue.

I've had the experience of going through Medicaid redetermination, and I've actually had the experience of a procedural termination. And then I've had almost 25 years of experience on the Medicaid state side, including experience being responsible for these processes and for the notices that go out to beneficiaries and for the outreach and really trying to make that work on behalf of people. And so it is an area where we continue to have so

many opportunities, I think, to learn and to grow.

And one of the benefits of COVID -- and Jenny, I'm glad you sort of noted this -- is it forced us to have to do a lot really fast. And I talk a lot about these rapid-cycle pilots that happened during COVID, where we had flexibilities we hadn't had before, and we tried new things that we hadn't tried before, and we learned a lot about things that worked that we didn't realize would work, or policy changes that might make sense, that had never been considered before.

Dan, you talked about all of the states who are working on their eligibility systems, and I 100 percent agree with you that it would be really nice if instead of sort of chipping away if we could really step back and rethinking how we approached eligibility, and even do it sort of in a calculation-specific way.

Because I really want to hone in for just a minute on people with disabilities, older adults and people with disabilities, and by the way, care deeply about all of these populations and wanting to make sure that people who need Medicaid and qualify for it remain on the rolls.

But I do think that people with disabilities,

older adults, face additional challenges, if you will. And they're also uniquely impacted because oftentimes they're using these benefits on a daily basis. The services that they're receiving are just critical to them, literally sometimes to be able to get out of bed in the morning and do the things that we just all take for granted in our lives.

And so an interruption, a gap in service for someone who is receiving home and community-based services, for example, is huge, and really should be very unlikely. For the most part, their income doesn't change. Very rarely are their needs going to become such that they no longer meet the functional eligibility requirements. And yet we sort of look at them mostly the same way as we do everybody else. Actually sometimes I think they have a higher bar to cross because of all of the asset requirements and the transfer requirements and all of those things.

So while they have the most sort of to risk, if you will, in this redetermination process, they don't necessarily have the greatest accommodations always available to them. So if there's a population, I think we

need to step back and relook at it's that population.

I haven't seen -- and please correct me if I've just missed it -- data that's sort of unique to this population, especially to the long-term care population, people who receive home and community-based services. How have they been impacted by this, and in your research have you seen things kind of uniquely tailored to these populations of older adults and people with disabilities that's been very successful in supporting them through this redetermination process?

CHAIR BELLA: Thank you, Patti. Before you all answer I want to be sensitive to your time. I think we asked you to join us until 11:15, so that's a minute from now. So please raise your hand if you need to drop off. Otherwise, if you have time to answer this question and maybe one more, we'll get you out of here within five minutes. But if anyone needs to drop off, we'll get you to be able to answer first.

DR. KENNEY: I do have an answer, which is that there is a team at Penn and the University of Michigan that is doing a study that's focused on unwinding impacts on older adults with Medicaid and Medicare, precisely for the

reasons that you've flagged. They're not broken out in the statistics and there are unique issues with them. I'm glad to share with Martha information on that team and what they're doing.

COMMISSIONER KILLINGSWORTH: Thank you.

DR. KENNEY: And then also I wanted to draw your attention to a Code for America experiment that happened this past year, for non-MAGI adults in Minnesota with ex parte renewal, which was very tantalizing in terms of suggesting benefits, for that population, and as you rightly note, they don't necessarily get access to automatic renewals to the same extent. Again, I'll share that with Martha.

COMMISSIONER KILLINGSWORTH: Thank you. Thank you for that.

CHAIR BELLA: Jen or Dan, anything to add?

MR. MEUSE: Yeah, just very quickly. We know that ex parte for the non-MAGI population was one of the biggest areas of state deficiencies when states were investigating their eligibility systems. And I think between that highlight and some of the changes in the new eligible enrollment rule hopefully we can see changes in

the coming years.

I would also say we do work with territories, as well, and one of the territories experienced a significant challenge where they lost a number of non-MAGI enrollees, but then hit their cap, and so don't have space to re-enroll them, and are trying to figure out how to provide services to a population that clearly needs services and clearly would qualify, but because of the cap and the territory funding structure they do not have space to enroll folks. So one of the challenges to think about as we look at kind of around the country, how the non-MAGI population is service by Medicaid.

MS. TOLBERT: And I'll just quickly add that at that outset of our tracking of our renewal outcomes effort we had hoped to be able to dig in a little more deeply to see how different populations were affected. But I'll just note that on a broad level the data just weren't available. CMS didn't require states to report renewal outcomes by eligibility group. A handful of states made that data variable, but we tried looking at it and there was just so much inconsistency across states we couldn't draw any conclusions.

But this is another area where just the lack of data really hampers our ability to monitor and assess how different populations have been affected by this process.

CHAIR BELLA: Thank you. Sonja?

COMMISSIONER BJORK: Thank you. I was wondering if any of the panelists felt there was value in looking in to state fair hearings by state, if there's anything to be gleaned from that information. And then secondly, our Consumer Advisory Committee at the health plan I work at, these are really engaged consumers, and even they ran into so many troubles when they were going through the renewal process. And some of it was related to very newly hired eligibility workers, so we all talked a lot about the workforce issues. And then counties did a great job bringing on a whole bunch of new people, but many of them were new at their jobs, and so they would get conflicting information, depending on who they talked to. Then they would call the State Ombudsman and get a different pathway.

So I'm not sure if there's any way to look at the value of some training programs or things like that, if there's a way to look at the effectiveness of those and the impact they might have. Thank you.

MS. TOLBERT: I'll just note on this the issue of workforce training. This definitely came up as a major issue in our interviews with states and other stakeholders, just exactly what you just said. You know, there was a recognition by state officials their workforce was perhaps inadequately trained because so many people had been newly hired. And then from the enrollee perspective it was people were being disenrolled, didn't know why, and then when they would call the call center, if they could get through, they couldn't talk to somebody who could answer their question or help them resolve their problem. So they were spending hours and hours, over multiple days, to try and resolve issues.

So I don't have any particular insights on what training programs are most effective. I will note, though, that at least among the states that we spoke with there was a recognition this was an issue and they were adopting and enhancing training as they went along. We haven't gone back to talk to states since our earlier interviews, but the hope is that that maybe some staff are now more experienced, that have gotten more training. But this is a real issue going forward, and I think it warrants attention

by states to ensure, and to avoid problems for enrollees.

CHAIR BELLA: Thank you. Did either of the other two panelists want to comment?

[No response.]

CHAIR BELLA: All right. Well, we've made it through our questions and we're well past our time. Thank you so much for the work you're doing, for sharing that with us. And I know that you are all resources to Martha, and I know she's not a shy person. So we will continue to follow your work and try to benefit and support that work. So thank you very much for joining us today. We really appreciate it.

All right, Martha, we have, what, 20, 25 minutes to talk about what we heard, what we might be interested in, kind of reflections. I'll open it up. Heidi, I know you have something so I'll give you first shot.

COMMISSIONER ALLEN: I would just like us to think about how we can help be an organizer of lessons learned and opportunities to improve the process moving forward and make recommendations as they are helpful for recognizing how much activity has happened in this space, and what an incredible opportunity this is to try to make

it better for the next time, or just for enrollees in general.

So I know Tricia is often the person on the committee who is really pushing this forward, but I would like to throw my weight behind that, as well, that I think this is a really important body of work that we could have some important influence in.

CHAIR BELLA: Tricia, that's a good tee-up for you.

COMMISSIONER BROOKS: So as far as I'm concerned, we're not going to know everything we want to know, and we need to sort of double down on the area that we think could have most impact. One of those, of course, would be how to improve ex parte processes, whether that's policy changes at the federal level, whether it is CMS setting thresholds of standards for ex parte rates, setting additional guidance. Right now the guidance says that states get to decide what data sources are useful and how old the data is. Those are all things I think that are very ripe for policy change.

The second area, of course, that's been mentioned is maintaining the data collection and transparency in the

data. And I agree with Jen Tolbert that CMS does have the authority. I think Dan suggested that perhaps this reporting would go away, but not if CMS doubles down and says we need these data. There are requirements for performance indicator data. Those data have been out there for more than 10 years. We don't see all of it, but it can be enhanced, and CMS talked about that a lot back 10 years ago.

The third area is notices, and no one wants to tackle notices. And notices have been a problem ever since I've heard the word Medicaid. I mean, we're going back 30 years. This is a perennial problem, and I just don't understand where we have to figure out an end to make an impact.

And then the last thing is going forward we really need to double down on outreach and how to reconnect people and what the messaging and best practices are, what's most effective.

So for me those are the four primary areas that are ripe for additional work. We can work around the fringes, but again, we're just not going to know everything we want to know.

CHAIR BELLA: Thank you, Tricia. Carolyn?

COMMISSIONER INGRAM: Thanks. I think I'm going to probably just echo what Heidi and Tricia just covered, but to summarize I think it's really important that we keep this top of our agenda to learn from what worked, in terms of the flexibilities that were in put in place, and what should now continue to be there, in terms of those flexibilities, as we move forward, so we don't lose that experience and just go back to something else just because it was easier. Thanks.

CHAIR BELLA: Thank you, Carolyn. Verlon.

COMMISSIONER JOHNSON: Thanks. That was very helpful and also very nice to actually interact with the folks. There are things that I read a lot that they do right.

I was struck by the comment, and I think Jenny made, about real-time data, making real use of the real-time data that we have to solve the problems that we have at hand. And so I do appreciate Heidi's comments about lessons learned. I think that's really important, and of course, everything that Tricia said is always top of mind.

But I also think it's important for us to not

just think about this in terms of all the unwinding activity, but also as we think about other recommendations that we make, how are the things that we've learned here, how can we impart that in some of the recommendations that we want to move forward in other things.

So when I think about the importance of the communication strategies, that's something that's really important on every issue that we talk about. And also as we think about working with things like CBOs and how can we integrate that in some of the other recommendations that we have.

I thought this was really good overall, and I really appreciate you bringing this panel together. But I just wanted to make sure we put that through everything, weaving that through all the different things we're thinking about I think moving forward would be helpful. Thank you.

CHAIR BELLA: Thank you, Verlon. Dennis?

COMMISSIONER HEAPHY: Thanks. I'll agree with all the comments that have been made so far. I'm wondering, how do we elevate enrollee experience or their stories into what's presented? Because oftentimes the

MACPAC materials are very dry and don't share the direct impact on individuals and what their stories are. Is there a way to actually put something into materials that actually reflect here's how this impacted this person's life, because I think that's something that we miss in all of this. I don't know how you do it, Martha or Kate, how you would do that, but how we actually bring this to life, so that people understand the direct impact on folks' lives. Thanks.

CHAIR BELLA: Thank you, Dennis.

COMMISSIONER HEAPHY: -- minority populations, and non-English-speaking populations in this case.

CHAIR BELLA: Thank you. I see Martha's head nodding, so we'll let her work some magic there.

Tim.

COMMISSIONER HILL: I just want to kind of echo the human-centered beneficiary perspective. Being somewhat new to Medicaid and having grown up in Medicare, and never having to deal with eligibility issues, we like talk our way around it and it becomes -- and it is incredibly complex, and lots of policy and lots of technical assistance. But we just miss, I feel like we miss what it

means to have a beneficiary who has to fill out the forms. That story just doesn't get told in a way that's meaningful to policymakers, I think. And if we can find some way to do that, I think it would be a real service. It may not help, to the point earlier that there are legislators and money involved, but at least it would bring into base relief some of what this impact is and out of us talking to each other about a lot of technical things that are hard to follow sometimes.

CHAIR BELLA: Thank you, Tim. John.

COMMISSIONER McCARTHY: I think there are a couple of things in here, and Dan hit on one of them. I want to go back to what Tim was just talking about a little bit, and from the standpoint of, you know, I've said before the most complicated thing I ever did was the MMP program, and the second-most complicated thing was implementing an eligibility system. I mean, Medicaid eligibility, if you go across to any state, I would argue that you've got a lot of good policy people in there, but very few of the policy people understand eligibility at the level that it is. You may have one or two people, and think that's a little bit of what we saw in some of these things, but they're just

not people that maybe understand some of these things.

And so I think some of the work we should be looking at is simplification in the Social Security Act, of what do we need to do on some of those things.

Second is states have, for a long time, been encouraged to do combined eligibility systems for federal programs. It's a great idea, and we just ran out of time, but I wanted to ask Dan because he had talked about this a little bit, is when Medicaid agencies had their systems and sister agencies, and the reason for this because it's a combined eligibility system, did they look at any states' combined versus non-combined systems to see if they had any better results from those two things. Like is there something that we think we're making things easier and we're actually making it harder, and we don't realize it?

And then that kind of circles back to notices. If there's anything we can do on notices, and I know we've looked at it, but it is a constant struggle when you're a Medicaid director on notices because you have, on the one hand, people saying "simplify, simplify, simplify" and when you simplify it then you get pushed of, "Well, you left all these legal notices out, and people don't know their legal

rights," and so you have to put that back in. Those two things do not go together. They simply do not go together.

And I know a lot of people have worked on this, but I think that is one of the issues. And having personally helped people through redeterminations coming out of this, I looked at states' notices to people, and they were incomprehensible. And like Dennis had said earlier, there was a person I was helping in a Midwestern state, which would be looked at as they were trying to be helpful, but in providing so many options it was just unclear, even for me, as a Medicaid director, to figure out what would be the best way to go through on this one.

So the other thing I would encourage us to take a look at is how states work with individuals on the program and testing their forms and notices and usefulness of it.

And then lastly -- I'm sorry, I said lastly, but one more -- Dan hit on this one. Trisha and I have been talking about this one is states moving to apps, on your phone, an application for your phone. So many individuals on Medicaid, we used to hear before people don't have access to the internet. It may or may not have been true. But what we have seen many times is people do have access

to the internet through their phone. Many states have focused on websites, which don't come across well on your phone, moving that to an app instead of an HTML page that is converted to phone.

Would we see any improvements from that? Dan kind of talked about that a little bit of like if you had an app and it's all of a sudden dinging, telling you, hey, something's coming up, or you need something, and you can just use it to take a picture of whatever it is you need, or things like that, and upload those things, you know, how useful would that be going forward?

CHAIR BELLA: Thank you, John. Patti?

COMMISSIONER KILLINGSWORTH: So many good suggestions. I want to offer one thing for consideration as a specific recommendation. We've talked a lot about notices and the challenges of notices. And fully recognizing that Medicaid is a joint partnership between the federal government and states, and that every state Medicaid program is different, it still seems to me that there could be some standardization of notices.

It's a little beyond me as to why there aren't sort of model notices that states could and should use for

these purposes. We do it in the Medicare program for certain kinds of things related to D-SNPs, for example. So rather than having 50 states working within their local advocacy communities to try to craft notices that are understandable and meet all of the federal requirements, why can't we just create some notices that do, and maybe allow some minimal customization of those notices. But really try to begin to standardize the way that these communications occur in ways that are as easily understandable as possible.

Maybe that work is ongoing and I'm just not aware of it.

MS. HEBERLEIN: Melanie, can I jump in? CMS, over the years, has issued at least two rounds of model notices -- I might be misremembering -- since the ACA passed. I think, to John's point earlier, there is --

[Audio interruption.]

MS. HEBERLEIN: -- required for beneficiary protections and their ability to appeal, plus, on the flip side, how to say yes, you are approved, those are in conflict. And I think that CMS has tried to do that. Whether or not, you know, we talked a little bit internally

about we don't know how many states have adopted those model notices, if at all, so that's something we've thought a little bit about looking into more. But we've heard in prior work, in the denials and appeals work that was presented earlier this year, as well as some of the beneficiary communications work that Tamara did, in prior years, that notices are a mess, and as Tricia said, they've been a mess since 1965, and it's because of this conflict that John was talking about.

So there are model notices. I don't know why they're not more widely used. That's a question that we've been talking about internally and trying to understand better. So I think there is some room there, but the model notices exist. They haven't solved the problem, and why I think is an outstanding question.

COMMISSIONER KILLINGSWORTH: Maybe that's a question we could dig into from a research perspective, I mean just to understand, again, why are they being utilized, where are they being utilized, why aren't they being utilized, and consider again whether that could or should be a recommendation around some expectations that states are really using those, if in fact they're good,

right, and that beneficiaries say that they are understandable.

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

COMMISSIONER McFADDEN: So I think for this session I thought it was really great, but it's sort of the icing on this two-day meeting for me, which is it feels like we're in this perpetual state of quilting in trying to solve for things through patchwork. And I would really love to see how we can get more to crafting a comforter instead of continually working on this quilt.

So part of me wants to challenge my fellow Commissioners -- are there ways that we can maybe propose policy opportunities for using CMMI to have an edge or a peripheral sort of innovation opportunity to change some of these things without disrupting the core so that we can actually finally create a comforter versus continually doing this quilting patchwork.

CHAIR BELLA: Thank you, Adrienne. Jami?

COMMISSIONER SNYDER: I just want to very briefly go back to the question that I asked of the panel around impact to providers. I really would like to see us explore

that topic a little further. In fact, impact to payers and providers, but most notably safety net providers like community health centers.

COMMISSIONER BROOKS: I don't know if Martha's seen it yet, but JW just released something on community health center impact.

[Pause.]

CHAIR BELLA: Okay. That was a pregnant pause. Nobody said anything anyway.

What I'm hearing is extreme interest in notices, which is fabulous, continued interest in ex parte, the data piece sounds real about the ability and need to continue collecting the data, excitement about outreach, and I know we've already been trying to think about which flexibilities could continue, and then Jami talking about provider impact, and Tim and John on the eligibility systems. It's exciting to think about how the Commission might look at how those things could be done better, either from more standardization of that and better use of all those dollars that are going toward the eligibility systems or through apps or other things.

And then challenge from Adrienne to make a

comforter and not a quilt. CMMI may not have the latitude to do that in Medicaid, but it certainly is important for the Commission to step back and say like how do we look at this in totality instead of just trying to layer one more sort of tweak here or there.

So I think you have plenty of feedback, as always. Any last comments from you, Martha?

MS. HEBERLEIN: No. I'm just always pleased for the interest, but also when my list mostly aligns with your list. There are only a few things I didn't have, so I appreciate that. Thank you.

CHAIR BELLA: That's wonderful. All right. Thank you again for getting a fabulous panel put together.

Oh, it looks like Patti and Dennis, do you have comments?

COMMISSIONER KILLINGSWORTH: Just a couple of things about your list, Melanie. One is not just continuing to get data but getting better data, getting data that gets us more insight especially into the subpopulations and the impact on them. I think we talked about this, kind of way back in the beginning, and I want to reup that. I think it's really important that we

understand kids versus adults with disabilities, adults without disabilities, that we could really look at that specific data.

And the other thing that wasn't explicitly on your list but I think is really important is the role of managed care organizations in this whole process. It is a such a large percentage of beneficiaries are now in some sort of a managed care program, I think that managed care organizations can have a hugely positive impact on people's ability to maintain coverage, and I'd like for us to dig into that a bit.

CHAIR BELLA: Thanks, Patti. Dennis?

COMMISSIONER HEAPHY: I appreciate that notices are really important, but one of the biggest complaints raised by MCOs and ACOs is the inaccuracies of the mailing information that Medicaid often sends out. So that's a major concern. So how do we get at that issue? And that's why I was talking about CBOs as being really important, is that CBOs can reach people in ways that a notification can't.

So I think notifications are very important, but the bigger issue is how do we get people who know the

communities engaged in the process at the start. Mailing it to the wrong address doesn't mean anything.

CHAIR BELLA: Yep. Thank you, Dennis. That's a great point to end on.

CHAIR BELLA: We will now open it to public comment. If anyone in the audience would like to provide 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.

It looks like we have Damon.

PUBLIC COMMENT

* MR. TERZAGHI: Hi. My name is Damon Terzaghi, and I am with the National Association for Home Care and Hospice.

I just wanted to add a little bit to the discussion of the subpopulations, and I really want to thank Patti for bringing this to the forefront because it's an issue that I've been paying a lot of attention to and am very concerned about for a while now.

Like Kaiser talked about earlier, I have also been trying to glean information on disenrollments from the state data reports, and it's very piecemeal when it is

available. It's hard to parse out. But from the states that I've been able to pull the information it's roughly about 10 percent of all disenrollments appear to be the non-MAGI populations, which would extrapolate to almost 2 million older adults and people with disabilities across the country, if that holds.

So I really encourage you at MACPAC to look into that through whatever means you have, whether it's your research capabilities or even your bully pulpit, to get other groups to look into this more closely. I appreciated the conversation about the University of Michigan, but limiting it to dual eligibles really does miss a wide swath of individuals that may be impacted by this.

The other thing I would just raise is for the community perspective, speaking with our members, the home care agencies around the country, many of them have tried very hard to be active partners in the renewal and verification process. And it varies based upon state, but many of them really struggled to get timely information, the appropriate resources to help their individuals renew. So looking into that and potentially making some recommendations down the line as to ways to better support

states engage with their provider community to support renewals, I think would be great, as well.

Thank you.

CHAIR BELLA: Thank you, Damon, for those comments.

Anyone else want to make a public comment?

[No response.]

CHAIR BELLA: All right. Martha, thank you again.

Well, we had a great panel. We passed some recommendations. The June report will be coming out in June. And this is a wrap for our year.

I just personally want to say it's been an honor to serve on this Commission with all of you and in service of the Medicaid and CHIP programs, so thank you. Thank you to this amazing staff, and thank you to Kate.

And with that we are adjourned, and the Commission will be back in the fall. Thank you, everyone.

* [Whereupon, at 11:44 a.m., the meeting was adjourned.]